PREGNANCY, SUBSTANCE USE & THE CHILD WELFARE SYSTEM

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REPRODUCTIVE JUSTICE

“the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”

• SisterSong, Women of Color Reproductive Justice Collective
“More and more laws are treating a fetus as a person, and a woman as less of one, as states charge pregnant women with crimes…”

“The New York Times, The Washington Post, Time, Newsweek and others further demonized black women ‘addicts’ by wrongly reporting that they were giving birth to a generation of neurologically damaged children who were less than fully human. . .”

CHARGES

• Murder
• Feticide
• Assault of “unborn child”
• Criminal child abuse
• Civil child abuse & neglect
Does “a woman's use of opioids while pregnant, which results in a child born suffering from neonatal abstinence syndrome (NAS), constitute child abuse”?
Amicus briefs were filed in support of Mother by:

(1) American Civil Liberties Union of Pennsylvania (“ACLU”) and Feminist Majority Foundation (“FMF”);

(2) Frederick M. Henretig, M.D., Hallam Hurt, M.D., Juvenile Law Center, KidsVoice, Philadelphia Department of Human Services, and Support Center for Child Advocates;


CURRENT DRUG USE IS COMMON

Figure 5. Current, Binge, and Heavy Alcohol Use among People Aged 12 or Older: 2017

Figure 11. Numbers of Past Month Illicit Drug Users among People Aged 12 or Older: 2017

Note: The estimated numbers of current users of different illicit drugs are not mutually exclusive because people could have used or misused more than one type of illicit drug in the past month.
EVERYONE WHO USES IS NOT ADDICTED

Figure 2: Estimated proportion of alcohol, tobacco, and other drug users who have developed clinical syndromes of drug dependence as defined according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised. The data were obtained from the National Comorbidity Survey, 1990–1992.

SOURCE: Adapted from Anthony et al. 1994.

Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants: Basic Findings From the National Comorbidity Survey

James C. Anthony, Lynn A. Warner, and Ronald C. Kessler

Percentage of Substance Users Who Become Addicted

- Nicotine: 32
- Heroin: 23
- Cocaine: 17
- Alcohol: 15
- Stimulants: 11
- Cannabis: 9
- Sedatives: 9
- Psychedelics: 5
- Inhalants: 4
Those who can’t quit or cut back - likely have a substance use disorder

Continued use in pregnancy is pathognomonic for addiction
Comprehensive treatment and pharmacotherapy are rare and unavailable for most pregnant women with OUD.
“There is no such thing as a baby ... If you set out to describe a baby, you will find you are describing a baby and someone. A baby cannot exist alone, but is essentially part of a relationship” (D.W. Winnicott 1966)
IF IT IS NOT DYAD IT IS A DISASTER
She Was Addicted and Had Her Son. She Wants Him to Stay.

Lindsey Jarratt is now sober and on solid ground, but her son, Brayden, remains in foster care.

By Jeneen Interlandi
Ms. Interlandi is a member of the editorial board.

Jan. 13, 2019

Lindsey Jarratt’s son, Brayden, was a year old when the Child Protective Services of Dinwiddie, Va., took him to live with strangers. There are things about the months surrounding that moment that Ms. Jarratt can’t remember — heroin has a way of erasing time. But this much is still etched in her mind: how he screamed and sobbed, the way his baby fists clutched at the nape of her shirt, the feel of his tiny body pressed so desperately against hers that the two had to be pried apart.

Jude Parker Smith
Chicago, IL | Jan. 14

Some people should not be allowed to have children.

Sure, the parents love the child but do they love him more than the other.

Pw
San Francisco | Jan. 14

Using H while pregnant is the deal breaker. Sorry lady.

James
DC | Jan. 14

I have no sympathy for her. You don’t care about the child. Period.

There
Here | Jan. 14

There are consequences of being a junkie. You just don’t return to life expecting all you had before.

The state needs to let the children from junkie parents as heroin is a tough addiction and one that she’ll probably fail to beat based on statistics.
THE 4th TRIMESTER - POSTPARTUM

• Critical Period
  • Newborn care, breastfeeding, maternal/infant bonding
  • Mood changes, sleep disturbances, physiologic changes
  • Cultural norms, “the ideal mother” in conflict with what it is actually like to have a newborn

• Neglected Period
  • Care shifts away from frequent contact with PNC provider - to pediatrician
  • Care less “medical” (for mom) and shifts to other agencies (WIC)
  • Insurance and welfare realignment
  • SUD treatment provider(s) - care is constant
RECOVERY IS THE GOAL OF TREATMENT

- Recovery is more than abstinence
- Building a life of integrity,
- Connection to others,
- Purpose and
- Serenity
- Recovery is fully compatible with the use of medications
PUNISHING PREGNANCY IN PENNSYLVANIA

• State v. Dischman (2017)
  • Aggravated Assault of an Unborn Child: A person commits aggravated assault of an unborn child if he attempts to cause serious bodily injury to the unborn child or causes such injury intentionally, knowingly or recklessly under circumstances manifesting extreme indifference to the life of the unborn child. 18 Pa.C.S. § 2606(a).
  • Nonliability: Nothing in this chapter shall impose criminal liability upon the pregnant woman in regard to crimes against her unborn child. 18 Pa.C.S. § 2608(a)(3).

• State v. Osei (2019)
  • Endangering Welfare of Children: A parent, guardian or other person supervising the welfare of a child under 18 years of age, or a person that employs or supervises such a person, commits an offense if he knowingly endangers the welfare of the child by violating a duty of care, protection or support. 18 Pa.C.S. § 4304.
CIVIL CHILD ABUSE

• Child Abuse: Intentionally, knowingly or recklessly causing bodily injury to a child through any recent act or failure to act or creating a reasonable likelihood of bodily injury to a child through any recent act or failure to act. 23 Pa.C.S. § 6303(b.1)(1), (5).

• Perpetrator: A person who has committed child abuse as defined in this section. The term shall include only the following:
  (i) A parent of the child.
  (v) An individual 14 years of age or older who resides in the same home as the child.
23 Pa.C.S. § 6306(a)(1).

• Pennsylvania Supreme Court held a mother could not be found to be a “perpetrator” of child abuse under the Child Protective Services Law (CPSL) based on her use of opioids while pregnant, even if that use resulted in her child being diagnosed with neonatal abstinence syndrome (NAS).

• The definition of “child” under the CPSL does not include a fetus or unborn child. In re L.J.B. (2017)
“We should not delude ourselves into thinking that our decision does not open the door to interpretations of the statute that intrude upon a woman's private decision making as to what is best for herself and her child. . . Should a woman engage in physical activity or restrict her activities? Should she eat a turkey sandwich, soft cheese, or sushi? Should she drink an occasional glass of wine? What about a daily cup of coffee? Should she continue to take prescribed medication even though there is a potential risk to the child? Should she travel to countries where the Zika virus is present? Should she obtain cancer treatment even though it could put her child at risk? Should she travel across the country to say goodbye to a dying family member late in her pregnancy? Is she a child abuser if her partner kicks or punches her in her abdomen during her pregnancy and she does not leave the relationship because she fears for her own life?”

• Concurring Opinion by Strassburger, J., In the interest of L.B., 177 A.3d 308, 315 (Sup. Ct. PA 2017).
Women have a constitutional right to decide to terminate their pregnancies and a constitutional right to decide to carry their pregnancies to term and give birth to a child.
PUBLIC HEALTH CONSENSUS

• “Seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing. Addiction is a chronic relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes.” American College of Obstetricians and Gynecologists Committee on Ethics, Committee Opinion 473, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist (2011, reaffirmed 2014).

• “It is inappropriate to reflexively move from the possibility to an alleged certainty of defective parenting or danger to the child simply because of evidence of substance use... Sanctions against parents under child protective services interventions should be made only when there is objective evidence of danger, not simply evidence of substance use... State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as ‘child abuse or maltreatment,’ and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care services for these women.” American Society of Addiction Medicine, Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids (2017).

• “Treating this personal and public health issue (perinatal substance use) as a criminal issue-or a deficiency in parenting that warrants child welfare intervention-results in pregnant and parenting people avoiding prenatal and obstetric care and putting the health of themselves and their infants at increased risk...The threats of discrimination, incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate prenatal care. Perinatal providers promote better practices when they adopt language, attitudes, and behaviors that reduce stigma and promote honest and open communication about perinatal substance use.” National Perinatal Association, Position Statement, Perinatal Substance Use (2017).
THANK YOU
Pregnancy, Substance Use and The Child Welfare System

April 12, 2019
10:15-11:45

Program Agenda

Introduction of the Panelists (Amber Khan, JD) (10:15-25)

Introduction to the Discussion (Amber Khan, JD) (10-25-40)
Introduction of the concept of reproductive justice and its connection to the civil child welfare system, as well as the concept of personhood and the use of the “war on drugs” to police pregnant women. Will also provide an introduction of the PA Supreme Court case, In re LJB, and the question the court addressed for the audience to consider: does a pregnant woman’s use of opioids, if her newborn baby is later diagnosed with neonatal abstinence syndrome, constitute civil child abuse?

Panel Discussion & Moderated Questions (25 minutes each / 50 minutes total)

Dr. Terplan will explain the nature of substance use disorders and treatment of pregnant women, with particular attention on treatment options and the importance of the post-partum period, including information specific to opioid use and neonatal abstinence syndrome. He will further explain his involvement in the case of L.J.B., and the importance of experts.

David Cohen, JD will discuss his work with the Women’s Law Project and the decision to represent the respondent mother in her appeal to the Pennsylvania Supreme Court, as well as the case, In re LJB, itself and the arguments made by the appellant. He will also explain the strategic reasons to put forth the chosen arguments, particularly explaining the constitutional arguments.

Audience Questions (15 minutes)

CLE Materials:
- LJB decision (PA 2017);
- amicus briefs (ACLU) (DPA) (NAPW/CLS) filed in support of appellant in LJB;
- Dischman decision (PA Sup. Ct);
- Amicus brief filed in support of Ms. Dischman;
199 A.3d 868
Supreme Court of Pennsylvania.

In the INTEREST OF: L.J.B., a Minor
Appeal of: A.A.R., Natural Mother

No. 10 MAP 2018
Argued September 25, 2018
Decided December 28, 2018

Synopsis
Background: County children and youth services agency filed dependency petition on behalf of minor child, alleging child was without proper parental care or control under the Juvenile Act, and that child was a victim of child abuse under the Child Protective Services Law (CPSL) due to mother's use of illegal drugs while pregnant. After entering order finding child dependent pursuant to Juvenile Act, the Court of Common Pleas, Clinton County, Juvenile Division, No. CP–18–DP–0000009–2017, Craig P. Miller, J., issued opinion and order finding that agency could not establish child abuse under CPSL based on actions committed when child was a fetus. Agency appealed. The Superior Court, No. 884 MDA 2017, Moulton, J., 177 A.3d 308, vacated and remanded. Mother appealed.

Reversed and remanded.

Saylor, J., filed concurring opinion in which Dougherty, J., joined.

Dougherty, J., filed concurring opinion.

Mundy, J., filed dissenting opinion in which Todd, J., joined.

*869 Appeal from the Order of the Superior Court at No. 884 MDA 2017 dated December 27, 2017 Vacating the Order of Clinton County Court of Common Pleas, Juvenile Division, dated May 24, 2017 at No. CP-18-DP-0000009-2017 and remanding for further proceedings, Miller, Craig P., President Judge

Attorneys and Law Firms
Frank P. Cervone, Esq., Support Center for Child Advocates, Katharyn Ivera Christian McGee, Esq., Duane Morris LLP, for Dr. Henretig, Dr. Hurt, Juvenile Law Center, KidsVoice, Support Center for Child Advocates, Amicus Curiae.


Marcel S. Pratt, Esq., for Philadelphia Department of Human Services, Amicus Curiae.

Sara Jeannette Rose, Esq., AMERICAN CIVIL LIBERTIES UNION, for American Civil Liberties Union of Pennsylvania, Amicus Curiae.


Amanda Beth Browning-Richardson, Esq., for Clinton County Children and Youth Services, Appellee.


Charles Rock Rosamilia III, Esq., Rosamilia, Brungard & Rosamilia, for Guardian Ad Litem, Appellee.

SAYLOR, C.J., BAER, TODD, DONOHUE, DOUGHERTY, WECHT, MUNDY, JJ.

OPINION ANNOUNCING THE JUDGMENT OF THE COURT

JUSTICE DONOHUE

The Pennsylvania General Assembly enacted the Child Protective Services Law, 23 Pa.C.S. §§ 6301-6386

(“CPSL”), based on its finding that child victims of abuse urgently need effective services to prevent further injury and impairment. *Id.*, § 6302(a). Its purpose is to encourage more complete reporting of suspected child abuse; to the extent permitted by this chapter, to involve law enforcement agencies in responding to child abuse; and to establish in each county protective services for the purpose of investigating the reports swiftly and competently, providing protection for children from further abuse and providing rehabilitative services for children and parents involved so as to ensure the child's well-being and to preserve, stabilize and protect the integrity of family life wherever appropriate or to provide another alternative permanent family when the unity of the family cannot be maintained. It is also the purpose of this chapter to ensure that each county children and youth agency establish a program of protective services with procedures to assess risk of harm to a child *870 and with the capabilities to respond adequately to meet the needs of the family and child who may be at risk and to prioritize the response and services to children most at risk.

*Id.*, § 6302(b). A finding that a person has committed child abuse *1 results in the inclusion of the actor in a statewide database, *id.*, §§ 6331, 6338(a), the purpose of which is to protect children from further abuse. *P.R. v. Dep't of Pub. Welfare*, 569 Pa. 123, 801 A.2d 478, 483 (2002). Inclusion on the statewide database impacts a person's ability to obtain certain kinds of employment, housing, and participate in certain volunteer activities. See*23 Pa.C.S.* §§ 6344, 6344.1, 6344.2.

We address here an issue of first impression under the CPSL: whether a woman's use of opioids while pregnant, which results in a child born suffering from neonatal abstinence syndrome (“NAS”), constitutes “child abuse” as defined. *2 We conclude, based on the relevant statutory language, that a mother cannot be found to be a perpetrator of child abuse against her newly born child for drug use while pregnant. We therefore reverse the decision of the Superior Court and remand the matter for reinstatement of the trial court's order.

As all of the pertinent terms are defined by statute, we set forth the relevant statutory definitions in order to provide context for our discussion of this case. The CPSL defines “child abuse,” in relevant part, as “intentionally, knowingly or recklessly ... (1) [c]ausing bodily injury to a child through any recent act or failure to act,” or “(5) [c]reating a reasonable likelihood of bodily injury to a child through any recent act or failure to act.” *23 Pa.C.S.* § 6303(b.1)(1), (5). A “recent act” is “[a]ny act committed within two years of the date of the report to the department or county agency.” *Id.*, § 6303(a).

Not every person who harms or injures a child is a perpetrator of “child abuse” under the CPSL. Instead, a “perpetrator” is defined as “[a] person who has committed child abuse as defined in this section,” *id.*, and is limited to the following individuals:

(i) A parent of the child.

(ii) A spouse or former spouse of the child's parent.

*871 (iii) A paramour or former paramour of the child's parent.

(iv) A person 14 years of age or older and responsible for the child's welfare or having direct contact with children as an employee of child-care services, a school or through a program, activity or service.

(v) An individual 14 years of age or older who resides in the same home as the child.

(vi) An individual 18 years of age or older who does not reside in the same home as the child but is related within the third degree of consanguinity or affinity by birth or adoption to the child.

(vii) An individual 18 years of age or older who engages a child in severe forms of trafficking in persons or sex trafficking, as those terms are defined under section 103

Id., § 6306(a)(1). The CPSL defines a “child” as “[a]n individual under 18 years of age.” Id., § 6303(a).

With these definitions in mind, we turn to the uncontested facts of this case. In 2016, A.A.R. (“Mother”), was released from incarceration, after which she relapsed into drug addiction, using opioids (pain pills) and marijuana. Mother subsequently learned that she was pregnant with L.J.B. (“Child”). She estimated that she was approximately four months pregnant at that time. Thereafter, she sought treatment for her addiction, first through a methadone maintenance program and then with subutex. Mother again relapsed and in mid-January 2017 she tested positive for opiates, benzodiazepines and marijuana, none of which were prescribed for her.

Mother gave birth to Child on January 27, 2017 at Williamsport Hospital. At the time of Child's birth, Mother tested positive for marijuana and subutex. By the third day of life, Child began exhibiting symptoms of NAS, including tremors, excessive suck, increased muscle tone and loose stools, which doctors treated with morphine. Mother reportedly left Child in the hospital and did not consistently check on her or stay with her (despite the availability of a room for her to do so). Hospital personnel communicated all of this information to the Clinton County Children and Youth Social Services Agency (“CYS”).

On February 7, 2017, CYS sought and was granted emergency protective custody of Child. The juvenile court held a shelter hearing on February 10, 2017 and ordered Child to remain in CYS' care. CYS then filed another dependency petition containing the same allegations of dependency and child abuse, but adding information concerning visits between the parents and Child and Mother's admitted continued drug use.

On March 15, 2017, by agreement of the parties, the juvenile court adjudicated Child dependent pursuant to section 6302(1) of the Juvenile Act. It deferred to a separate proceeding the question of whether Mother's drug use while pregnant constituted child abuse, and ordered the parties to file memoranda of law for the court's review.

CYS filed its brief in support of a finding of child abuse on March 23, 2017, therein averring that Mother's conduct satisfied subsections (1) and (5) of the definition of “child abuse” in that her “recent act” caused or created a reasonable likelihood of causing bodily injury to Child. See 23 Pa.C.S. § 6303(b.1) (1), (5); supra, p. 870. Mother filed a memorandum of law the following day, asserting that the CPSL does not protect a fetus or unborn child, and thus Mother's actions could not be deemed child abuse as a matter of law.

The juvenile court held argument on May 9, 2017. After taking the matter under advisement, it issued an opinion and order, agreeing with Mother (and CYS) that the definition of “child” in the CPSL does not include a fetus or unborn child, and that her conduct caused or was reasonably likely to cause injury to Child who, now born, constituted a “child.” Juvenile Court Order, 5/24/2017, ¶ 1.

CYS appealed to the Superior Court, which reversed. In a unanimous opinion, the court found, “Under the plain language of the statute, Mother's illegal drug use while pregnant may constitute child abuse if the drug use caused bodily injury to Child.” In re L.B., 177 A.3d 308, 311 (Pa. Super. 2017). Although agreeing with Mother (and CYS) that the definition of “child” in the CPSL does not include a fetus or unborn child, it found that “Mother's drug use is a ‘recent act or failure to act’ under 6303(b.1)(1) and (5),” and that her conduct caused or was reasonably likely to cause injury to Child who, now born, constituted a “child.” Id. It therefore held “that a mother's use of illegal

Id., § 6306(a)(1). The CPSL defines a “child” as “[a]n individual under 18 years of age.” Id., § 6303(a).

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The juvenile court held argument on May 9, 2017. After taking the matter under advisement, it issued an opinion and order, agreeing with Mother that “the law does not provide for [a] finding of abuse due to actions taken by an individual upon a fetus.” Juvenile Court Opinion, 5/24/2017, at 4. It thus held that CYS “cannot establish child abuse in this matter on the actions committed by Mother while [C]hild was a fetus.” Juvenile Court Order, 5/24/2017, ¶ 1.

CYS appealed to the Superior Court, which reversed. In a unanimous opinion, the court found, “Under the plain language of the statute, Mother's illegal drug use while pregnant may constitute child abuse if the drug use caused bodily injury to Child.” In re L.B., 177 A.3d 308, 311 (Pa. Super. 2017). Although agreeing with Mother (and CYS) that the definition of “child” in the CPSL does not include a fetus or unborn child, it found that “Mother's drug use is a ‘recent act or failure to act’ under 6303(b.1)(1) and (5),” and that her conduct caused or was reasonably likely to cause injury to Child who, now born, constituted a “child.” Id. It therefore held “that a mother's use of illegal
drugs while pregnant may constitute child abuse under the CPSL if CYS establishes that, by using the illegal drugs, the mother intentionally, knowingly, or recklessly caused, or created a reasonable likelihood of, bodily injury to a child after birth.” *Id.* at 309 (emphasis in original).

Senior Judge Eugene B. Strassburger authored a concurring opinion, which the majority author joined. Judge Strassburger joined the majority opinion, agreeing that “the language of the statute” required that result. He wrote separately to express his concern of “whether treating as child abusers women who are addicted to drugs results in safer outcomes for children,” as this could cause a pregnant woman to avoid a hospital, fail to seek prenatal care, or decide not to pursue treatment for her addiction.

*L.B.*, 177 A.3d at 313-14 (Strassburger, J., concurring). He also acknowledged that the majority’s holding could easily be extended to other areas of a pregnant woman’s decision making (e.g., drinking coffee, traveling, eating sushi, or undergoing cancer treatment). Judge Strassburger expressed doubt that the General Assembly intended for actions taken by a woman prior to her child’s birth to constitute “child abuse,” but ultimately agreed with the majority that this is the *873* interpretation that the language of the statute required. *Id.* at 315.

Mother timely appealed to this Court, and we granted review of the following issues:

(1) Does [the CPSL] allow a mother to be found a perpetrator of “child abuse” in the event she is a drug addict while her child is a fetus[?]

(2) Is the intent of 23 Pa.C.S. § 6386 limited to providing “protective services” to addicted newborns and their families and not so expansive to permit alcoholic or addicted mothers be found to have committed child abuse while carrying a child in her womb[?]


This case presents questions of statutory interpretation for which our standard of review is de novo. *Commonwealth v. Fant*, 637 Pa. 135, 146 A.3d 1254, 1260 (2016). A court’s role when interpreting a statute is to determine the intent of the General Assembly so as to give it its intended effect. 1 Pa.C.S. § 1921(a). “In discerning that intent, the court first resorts to the language of the statute itself. If the language of the statute clearly and unambiguously sets forth the legislative intent, it is the duty of the court to apply that intent to the case at hand and not look beyond the statutory language to ascertain its meaning.” *In re L.B.M.*, 639 Pa. 428, 161 A.3d 172, 179 (2017); *see also* 1 Pa.C.S. § 1921(b) (“When the words of a statute are clear and free from all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit.”).

Mother and her amici*5* forward various arguments to this Court in support of reversing the Superior Court’s decision. As we must, we begin by addressing the arguments aimed at the plain language of the statute. Mother contends that pursuant to the clear and unambiguous language of the CPSL, she did not commit “child abuse” while she was pregnant because there was no “child,” and she therefore was not a “perpetrator,” at the time she committed the act in question. See Mother’s Brief at 12-21; 23 Pa.C.S. § 6303(a), (b.1). *See also* ACLU and FMF Amici Brief at 6-8. She observes that section 6386 of the CPSL requires medical personnel to report to CYS when a child is born, inter alia, experiencing withdrawal symptoms because of prenatal drug exposure. *6* *874* She argues, however, that the CPSL neither requires nor permits a finding of “child abuse” on this basis, again pointing to the pertinent definitions of section 6303, as well as failed amendments to the statute that would have made her conduct “child abuse” (but did not). *See* Mother’s Brief at 21-28; 23 Pa.C.S. § 6386. According to Mother, a finding of child abuse based on harm caused by a mother’s ingestion of narcotics during pregnancy also contradicts the stated purpose of the CPSL because it would do nothing to protect children from “further abuse,” as this form of “abuse” is not repeatable against the child. *See* Mother’s Brief at 29-30; 23 Pa.C.S. § 6302 (stating, in pertinent part, that one of the purposes of the CPSL is “providing protection for children from further abuse”).

In response, CYS does not address Mother’s assertion that she cannot be a “perpetrator” as defined by the CPSL. Instead, it points to section 6386 and its contemplation that the county agency may institute “child protective services” following its safety assessment after receiving a report from a healthcare provider that a child was born affected by prenatal drug exposure. Because “child protective services” are only instituted in cases of child abuse, CYS reasons that the General Assembly intended for drug use while pregnant to constitute an act that could be deemed child abuse once the child is born affected by his
or her prenatal exposure to drugs. See CYS' Brief at 5-9; 23 Pa.C.S. § 6303(a) (defining “child protective services” as “services and activities provided by the department and each county agency for child abuse cases”). CYS further contends that a finding of child abuse in this circumstance aligns with the legislative intent provided in section 6302 of the CPSL because Mother “may well be pregnant again in the future.” It asserts, without explanation, that a finding that Mother abused Child by using illegal drugs while pregnant would somehow “protect these children as well.” CYS' Brief at 12-13.

As stated hereinabove, a “perpetrator” is “[a] person who has committed child abuse” under the CPSL. 23 Pa.C.S. § 6303(a). Thus, at the time the individual committed the act that caused or was reasonably likely to have caused bodily injury to a child, he or she must have been a “perpetrator,” as defined. The delineation of each individual who is permissibly identified as “perpetrator” under the CPSL is based on his or her relationship to a “child” – in Mother's case, as “[a] parent of a child.” Seeid., § 6303(a)(1). Reading the clear and unambiguous language of the relevant definitions together, a person cannot have committed child abuse unless he or she was a perpetrator, and a person cannot be a perpetrator unless there is a “child” at the time of the act. See 23 Pa.C.S. § 6303(a), (b.1).

In the case at bar, however, the act alleged (ingesting opioids) occurred when Mother was pregnant. As the parties agree, and the Superior Court found, the CPSL's definition of a “child” does not include a fetus or an unborn child. By its plain language, a “child” is a person who is under eighteen years of age. See 23 Pa.C.S. § 6303(a). Had the General Assembly intended to include a fetus or unborn child under the protections of the CPSL, it would have done so, just as it has in other statutory schemes. See, e.g., 18 Pa.C.S. §§ 2601-2609 (Crimes Against the Unborn Child Act); 18 Pa.C.S. §§ 3201-3220 (Abortion Control Act). “We are bound by the unambiguous language of the statute and cannot read language into it that simply does not appear.” Commonwealth v. Vasquez, 562 Pa. 120, 753 A.2d 807, 809 (2000). As such, Mother cannot be found to have committed child abuse against Child based on her illegal drug use while pregnant because she was not a “perpetrator” at the time of the act.

The Superior Court never considered the definition of “perpetrator” when arriving at its conclusion that Mother's actions while pregnant could constitute “child abuse.” Instead, it focused, almost exclusively, on the fact that Mother's drug use occurred within two years of Child's birth, which, in its view, constituted a “recent act” under the CPSL. See In re L.B., 177 A.3d at 311. By reaching back to consider conduct while Mother was pregnant, the Superior Court failed to account for the fact that at any time prior to the birth of Child, Mother could not be a perpetrator of child abuse because a perpetrator must be “the parent of a child.” 23 Pa.C.S. § 6306(a)(1)(i). The Superior Court thus created a statutory relationship between a pregnant woman and a fetus that the CPSL does not recognize. Language was available to the General Assembly to create a category of child abuse to address this scenario, but it did not, and we must consider this omission as part of the legislative intent. See Kmonk-Sullivan v. State Farm Mut. Auto. Ins. Co., 567 Pa. 514, 788 A.2d 955, 962 (2001) (“As a matter of statutory interpretation, although one is admonished to listen attentively to what a statute says; one must also listen attentively to what it does not say.”). The plain language of the CPSL requires the existence of a child at the time of the allegedly abusive act in order for the actor to be a “perpetrator” and for the act to constitute “child abuse.” The fact that the actor, at a later date, becomes a person who meets one of the statutorily-defined categories of “perpetrator” does not bring her earlier actions – even if committed within two years of the child's bodily injury – under the CPSL. 8

876 We also find CYS' reliance on section 6386 of the CPSL to be misplaced. As noted hereinabove, the version of section 6386 in effect at the time of Child's birth did not use the phrase “child abuse,” nor did it mention, cross-reference, or purport to modify section 6303. See supra, note 6. Instead, it created a protocol to be fulfilled by healthcare professionals when a baby was born experiencing withdrawal symptoms because of prenatal drug exposure and corresponding responsibilities in the county agency. See 23 Pa.C.S. § 6386 (amended Oct. 2, 2018).

After performing a safety and/or risk assessment, the statute gave the county agency an option if it found that the family required agency involvement: in cases involving child abuse, to institute child protective services, or otherwise to institute general protective services. Seeid., §
6386(b). Contrary to CYS' argument, section 6386 cannot be read to require that the birth of a child experiencing symptoms of NAS means that the mother who gave birth is a perpetrator of child abuse. The definition of perpetrator in section 6303 precludes the institution of child protective services based solely on a newborn's drug exposure in utero because, as discussed above, the General Assembly did not intend for this to constitute child abuse. See Olson v. Kucenic, 389 Pa. 506, 133 A.2d 596, 598 (1957) (“In interpreting a statute it must be construed as an integral part of the whole structure affected and not as a separate matter having an independent meaning of its own.”); Commonwealth v. Smith, ——— Pa. ———, 186 A.3d 397, 402 (2018) (when discerning legislative intent, “we do not read words in isolation, but with reference to the context in which they appear”).

We observe that safety and risk *877 assessments require the county agency to investigate both the subject child and any other children who live in the child's household. See 23 Pa.C.S. § 6368(c) (1) (providing that investigation of reports by the county agency requires “[a] determination of the safety of or risk of harm to the child and any other child if each child continues to remain in the existing home environment”). Reading the provisions of the CPSL together and giving effect to every provision contained in these statutes, as our Rules of Statutory Construction require, “child protective services” could be instituted after notification that a child was born experiencing symptoms of withdrawal if the county agency discovered, through its risk and/or safety assessment, indicia of child abuse as it relates to other children in the home. See 1 Pa.C.S. § 1921(a) (“Every statute shall be construed, if possible, to give effect to all its provisions.”).

Further, CYS' argument that a finding of abuse under the circumstances of this case somehow protects future children from abuse lacks any support in law or in fact. As stated above, the CPSL was enacted because of the General Assembly's finding that “[a]bused children are in urgent need of an effective child protective service to prevent them from suffering further injury and impairment.” Id., § 6302(a) (emphasis added). Its purpose is to protect the abused child and other children from suffering further abuse at the perpetrator's hands. Id., § 6302(b). Labeling a woman as a perpetrator of child abuse does not prevent her from becoming pregnant or provide any protection for a later conceived child while in utero. It also does not ensure that the same woman will not use illegal drugs if she does again become pregnant.

Moreover, once labeled as a perpetrator of child abuse, the likelihood that a new mother will be able to assimilate into the workforce and participate in activities of the child's life would be diminished. This would contravene the laudatory goal of preserving family unity and a supportive environment for the child.

Mother's act of ingesting opioids while pregnant did not constitute child abuse. We therefore reverse the decision of the Superior Court and remand the matter for reinstatement of the trial court's order.

Justices Baer and Wecht join the opinion.

Chief Justice Saylor files a concurring opinion in which Justice Dougherty joins.

Justice Dougherty files a concurring opinion.

Justice Mundy files a dissenting opinion in which Justice Todd joins.

CONCURRING OPINION

CHIEF JUSTICE SAYLOR

In terms of plain meaning, I believe the Superior Court's interpretation is reasonable in light of the two-year statutory lookback period. Nevertheless, I also find sufficient ambiguity to apply the principles of *878 statutory construction, and on that basis I concur in the result.

Justice Dougherty joins this concurring opinion.

CONCURRING OPINION

JUSTICE DOUGHERTY

I concur in the result and join Chief Justice Saylor's concurring opinion. I write separately to emphasize the ambiguous nature of the applicable statutory text which, as exemplified by the divergent conclusions expounded by my colleagues on this Court and the lower tribunals, may result in reasonable minds reaching disparate interpretations.
As the plurality aptly explains, the Superior Court determined prenatal drug use may constitute a “recent act” causing or creating the reasonable likelihood of an injury to a child under the CPSL; thus the “recentness” relates back to the act from the time of the reported injury, regardless of whether a child existed at the time of the act. Under such reasoning, an individual need not be a perpetrator at the time of the behavior causing or risking an injury to a child in order to later be found a perpetrator of child abuse following the injury. In reversing, the plurality determines an individual must be a perpetrator, i.e., a person having some statutorily defined interaction with a child, at the same time as the commission of behavior causing or risking the injury; thus, prenatal drug use cannot be construed as child abuse.

As the statutory text provides, child abuse requires “intentionally, knowingly or recklessly ... (1) [c]ausing bodily injury to a child through any recent act or failure to act[,]” or “(5) [c]reating a reasonable likelihood of bodily injury to a child through any recent act or failure to act.” 23 Pa.C.S. § 6303(b.1)(1), (5) (emphasis added). This statutory definition of child abuse does not contain the word “perpetrator,” nor does it reference who may commit child abuse. Indeed, the temporal proximity between a CPSL-defined “perpetrator” and a CPSL-defined “recent act or omission” described by the plurality, though logical, is not defined or referenced anywhere within the statutory text. Further, the intended use of the word “through” within its context here is also unclear: whether “through any recent act” is intended to temporally link the commission of the act to the injury as occurring within one block of time, or, instead, “through” merely means “by way of,” casts further ambiguity upon the language conferring a temporal period the plurality determines is clear from the plain language of the statute. For these reasons, I disagree that the plain language of the statute is clear and unambiguous.

In construing ambiguous statutory language, “we presume to be erroneous any interpretation that leads to an absurd or unreasonable result[.]” Freedom Med. Supply, Inc. v. State Farm Fire & Cas. Co., 635 Pa. 86, 131 A.3d 977, 984 (2016); 1 Pa.C.S. § 1922(1). Individuals must be able to rely on the law to afford them notice of when, temporally and qualitatively, certain relationships and interactions with children might trigger the consequences of perpetrating child abuse as delineated by the CPSL. Requiring the anticipation of the potentially injurious effects of one's behavior upon a child who does not exist seems, in my view, manifestly unreasonable, and as Judge Strassberger's concurrence below illustrates, the myriad of foreseeable circumstances fitting well within the plain language of the definition of child abuse extends to situations which are patently absurd. See In re L.B., 177 A.3d 308, 313-14 (Pa. Super. 2017) (Strassburger, J., concurring). Thus, in my view, to the extent the CPSL's definition of child abuse encompasses an act or omission which predates the existence of a child (even if, at some later point, there is a child who suffers or is at risk of injury as a result of the act or omission) it is erroneous.

Nevertheless, I agree with the plurality's assessment of the legislative history and analysis of legislative intent, as well as the statutory construction requiring temporal proximity between the existence of a perpetrator, as the term is defined by the CPSL, and the behavior causing or risking injury to an existing child.

DISSENTING OPINION

JUSTICE MUNDY

“The term ‘child abuse’ shall mean intentionally, knowingly or recklessly ... [c]ausing bodily injury to a child through any recent act or failure to act.” 23 Pa.C.S. § 6303(b.1)(1). A recent act is defined as “[a]ny act or failure to act committed within two years of the date of the report to the department or county agency.” Id., § 6303(a). Because Mother caused bodily injury to L.J.B. through a recent act, Mother perpetrated child abuse. Id. (defining perpetrator as “[a] person who has committed child abuse as defined in this section”).

The plurality concludes that “at the time the individual committed the act that caused or was reasonably likely to have caused bodily injury to a child, he or she must have been a ‘perpetrator’ as defined.” OAJC at 10-11. Asserting that “[b]y reaching back to consider conduct while Mother was pregnant, the Superior Court failed to account for the fact that at any time prior to the birth of Child, Mother could not be a perpetrator of child abuse because a perpetrator must be ‘the parent of a child.’ ” I conclude that the individual is a perpetrator at the time the injury is manifested, not solely at the time of the act or failure to act that caused the injury. As the plain language
of the statute states, child abuse is defined as “causing bodily injury.” 23 Pa.C.S. § 6303(b.1)(1).

In a majority of cases the act and the resultant injury occur in close temporal proximity, such as when a child is injured through physical force. The instant facts, however, present a scenario where the act and the injury do not occur simultaneously. The facts in this matter more closely resemble neglect cases where the injury manifests at some point in time after the neglect as in cases of malnourishment from lack of food, or suffering from a severe diaper rash from failure to routinely change diapers. Child abuse by neglect is defined as “causing serious physical neglect to a child.” Id., § 6303(b.1)(7).

When a malnourished child, or the baby suffering severe diaper rash are reported, the first determination made is whether the child has been abused. The inquiry then proceeds to ascertaining who perpetrated the abuse. The failure to provide food or change a diaper on one isolated occasion is not going to necessarily rise to an act of abuse, but the repeated failure to properly care for the child that causes serious physical neglect, is child abuse by definition. Similarly, when a person has caused a physical injury, they have committed child abuse, and they are the perpetrator.1

*880 Determining whether a child is a victim of child abuse first requires a determination that there is abuse, followed by a determination of who perpetrated the abuse. SeeIn re L.Z., 631 Pa. 343, 111 A.3d 1164, 1165 (2015) (examining “whether the child at issue in this case suffered abuse and whether that abuse was perpetrated by his mother”). L.J.B. suffered bodily injury after birth when she began exhibiting withdrawal symptoms. The bodily injury L.J.B. suffered was a direct result of a recent act of Mother, the use of illegal narcotics. Therefore, Mother was the perpetrator of the abuse on L.J.B., after birth, notwithstanding the fact that she ingested the drugs prior to birth. Accordingly, Mother was “a parent of the child” and “caused bodily injury through a recent act.” See23 Pa.C.S. § 6303(a), (b.1)(1).

In my view, under the plain language of the statute, the Superior Court correctly determined Mother committed child abuse. Therefore, because I would affirm the Superior Court, I dissent.

Justice Todd joins this dissenting opinion.

All Citations

199 A.3d 868

Footnotes

1 Such reports are either “founded” or “indicated.” See23 Pa.C.S. §§ 6303, 6338.
2 Opioid addiction has reached a crisis level in the United States, and Pennsylvania has not been immune from its effects. Recent statistics place Pennsylvania among the states with the highest rates of drug overdose deaths, with opioid-related overdose deaths occurring at a rate of 18.5 per 100,000 persons. Center for Disease Control and Prevention, Drug Overdose Death Data (Dec. 19, 2017), https://www.cdc.gov/drugoverdose/data/statedeaths.html (providing 2016 statistics indicating that “the states with the highest rates of death due to drug overdose were West Virginia (52.0 per 100,000), Ohio (39.1 per 100,000), New Hampshire (39.0 per 100,000), the District of Columbia (38.8 per 100,000), and Pennsylvania (37.9 per 100,000)” – a forty-four percent increase from 2015 to 2016); National Institute on Drug Abuse, Pennsylvania Opioid Summary (Feb. 2018), https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/pennsylvania-opioid-summary (stating that Pennsylvania’s rate of opioid drug deaths are above the national average of 13.3 deaths per 100,000 persons). Indeed, on January 10, 2018, in the hopes of combating opioid addiction, Governor Tom Wolf took the unprecedented step of proclaiming the heroin and opioid epidemic to be a statewide disaster emergency. See Press Release, Governor Wolf Declares Heroin and Opioid Epidemic a Statewide Disaster Emergency (Jan. 10, 2018), https://www.governor.pa.gov/governor-wolf-declares-heroin-and-opioid-epidemic-a-statewide-disaster-emergency/. The issue we address today emanates from this epidemic.
4 Subutex, also known as buprenorphine, is a prescription pill used to treat opioid dependence. Seehttps://www.accessdata.fda.gov/drugsatfda_docs/label/2011/020732s006s007bl.pdf (last visited 12/19/2018).

At the time the parties submitted their briefs in this matter, section 6386 was titled “Mandatory reporting of children under one year of age,” and provided as follows:

(a) When report to be made.--A health care provider shall immediately make a report or cause a report to be made to the appropriate county agency if the provider is involved in the delivery or care of a child under one year of age who is born and identified as being affected by any of the following:

(1) Illegal substance abuse by the child’s mother.

(2) Withdrawal symptoms resulting from prenatal drug exposure unless the child’s mother, during the pregnancy, was:

(i) under the care of a prescribing medical professional; and

(ii) in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional.

(3) A Fetal Alcohol Spectrum Disorder.

(b) Safety or risk assessment.--The county agency shall perform a safety assessment or risk assessment, or both, for the child and determine whether child protective services or general protective services are warranted.

(c) County agency duties.--Upon receipt of a report under this section, the county agency for the county where the child resides shall:

(1) Immediately ensure the safety of the child and see the child immediately if emergency protective custody is required or has been or shall be taken or if it cannot be determined from the report whether emergency protective custody is needed.

(2) Physically see the child within 48 hours of receipt of the report.

(3) Contact the parents of the child within 24 hours of receipt of the report.

(4) Provide or arrange reasonable services to ensure the child is provided with proper parental care, control and supervision.


In fact, we note that in 2011, Senator Patricia H. Vance proposed an amendment to section 6303’s definition of “child abuse” to account for this very behavior by adding, “It shall be considered child abuse if a child tests positive at birth for a controlled substance as defined in section 2 of the act of April 14, 1972 (P.L. 233, No. 64), known as The Controlled Substance, Drug, Device and Cosmetic Act, unless the child tests positive for a controlled substance as a result of the mother’s lawful intake of the substance as prescribed.” S.B. 735, Printer’s No. 761, Reg. Sess. (Pa. 2011). The bill was referred to the Senate Aging and Youth Committee on March 7, 2011, but it was never considered or voted upon by the full Senate.

The status of a “perpetrator” must be acquired at the time of the abusive act to give effect to the legislative intention in other contexts under the CPSL. For example: a twelve-year-old boy intentionally breaks the arm and leg of his ten-year-old brother who lives in the same household. The twelve-year-old boy does not become a “perpetrator” once he turns fourteen even though “[a]n individual 14 years of age or older who resides in the same home as the child” is a “perpetrator” and, in our example, his act occurred within two years. See 23 Pa.C.S. § 6303(a)(1)(v), (b.1)(1). In choosing the age of fourteen to define a perpetrator in this subsection, the General Assembly made a policy decision as to the appropriate age to trigger a finding that the actor committed child abuse. The same type of policy decision was made by the General Assembly in requiring a parent-child relationship and not a pregnant woman-unborn child relationship in section 6303(a)(1)(i).

The Dissent is of the view that a person need only be a perpetrator at the time the injury to the child manifests, not at the time of the act that causes the injury. See Dissenting Op. at 879. Respectfully, this ignores the aforementioned policy decision of the General Assembly as to who is a perpetrator. Modifying the above example, take instead a twelve-year-old boy who intentionally strikes his younger brother in the head with a baseball bat. No injury is initially apparent, but two years later the younger brother develops a massive brain hemorrhage that was caused by his brother’s act. Under the Dissent’s interpretation, the now fourteen-year-old is labeled a perpetrator for the act committed when he was twelve. This, respectfully, is an absurd result given the General Assembly’s clear definition of the term. The General Assembly

made it abundantly clear that fourteen is the age that triggers the designation of “perpetrator” under section 6303(a)(1)(v) CPSL. It likewise made clear that a parent of a child, not a woman pregnant with an unborn child, triggers the designation of “perpetrator” under the CPSL.

The General Assembly’s recent amendment to section 6386 resolves any ambiguity that may have arisen from the language used in the prior version of section 6386 entirely. In July 2018, the General Assembly completely overhauled section 6386, and the amended version took effect on October 2, 2018. The amendment changes the title of the statute to “Notification to department and development of plan of safe care for children under one year of age.” It further adds subsection (a.1), which states, “The notification by a health care provider to the department and any transmittal to the county agency by the department shall not constitute a child abuse report,” and removes reference to the county agency instituting “child protective services” based on notification from hospital personnel that a baby was born affected by prenatal drug exposure. See 23 Pa.C.S. § 6386(a.1). A large portion of the statute is now dedicated to the “[d]evelopment of interagency protocols and plan of safe care” to ensure that the child’s needs, as well as those of the child’s parents and immediate caregivers, are appropriately met. See id., § 6386(b.1). This provision even contemplates that “[o]ngoing involvement of the county agency after taking into consideration the individual needs of the child and the child’s parents and immediate caregivers may not be required.” Id., § 6386(b.1)(2).

Admittedly, these are not completely analogous scenarios because the perpetrator would meet the definition of perpetrator throughout the duration of the neglect. The important component is that in this scenario child abuse is “causing serious physical neglect.” The child abuse determination is triggered at the time the serious physical neglect manifests. Likewise, child abuse manifests when a serious physical injury is caused. At the time a serious physical injury occurred, Mother met the statutory definition of perpetrator, and child met the statutory definition of child. 23 Pa.C.S. § 6303(a).
IN THE SUPREME COURT OF PENNSYLVANIA

No. 10 MAP 2018

In the Interest of: L.J.B., a minor

Appellant: A.A.R., Natural Mother

BRIEF OF AMICI CURIAE
AMERICAN CIVIL LIBERTIES UNION OF PENNSYLVANIA
AND FEMINIST MAJORITY FOUNDATION


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STATEMENT OF INTEREST OF AMICI CURIAE

ACLU of Pennsylvania

The American Civil Liberties Union (ACLU) is a nationwide, nonprofit, nonpartisan organization with more than 1.75 million members dedicated to the principles of liberty and equality embodied in the Constitution and our nation’s civil rights laws. Since its founding in 1920, the ACLU has been dedicated to preserving and defending the principles of individual liberty and equality embodied in the United States Constitution and civil-rights laws. The ACLU of Pennsylvania is one of its state affiliates, with more than 59,000 members throughout Pennsylvania. The ACLU and ACLU of Pennsylvania have appeared many times as amicus curiae in federal and state courts at all levels, including both civil and criminal proceedings, in cases involving the rights of women, including pregnant women, to equal treatment under the law. The proper resolution of this case is thus a matter of substantial importance to the ACLU and its members.

Feminist Majority Foundation

Founded in 1987, the Feminist Majority Foundation (FMF) is a national organization dedicated to women’s equality, reproductive health, and the empowerment of women and girls in all sectors of society. FMF engages in research and public policy development, public education programs,
grassroots organizing projects, and leadership training and development programs. Through its work, FMF seeks to end sex discrimination and advance the legal, social, economic, and political equality of women, people of color, and LGBTQ individuals.

**STATEMENT OF JURISDICTION**

*Amici* incorporate the Statement of Jurisdiction in Appellant’s Brief.

**ORDER OR OTHER DETERMINATION IN QUESTION**

*Amici* incorporate the statement of the Order or Other Determination in Question in Appellant’s Brief.

**STATEMENT OF THE SCOPE AND STANDARD OF REVIEW**

*Amici* incorporate the Statement of the Scope and Standard of Review in Appellant’s Brief.
STATEMENT OF THE QUESTIONS PRESENTED

1. Under 23 Pa. C.S. § 6303 et seq., can a woman be a “perpetrator” of “child abuse” for her actions while pregnant that might affect the health of her newborn?

2. Under 23 Pa. C.S. § 6386, is the consequence of a mandatory report for children experiencing neonatal withdrawal symptoms limited to providing protective services to newborns and their families or is this section an indication that the General Assembly believes that the mother should be found to have committed child abuse?

STATEMENT OF THE CASE

Amici rely on the facts and procedural history in the Statement of the Case in Appellant’s Brief.

1 These are the Questions Presented as stated in Appellant’s Brief. The language differs slightly from the Court’s grant of allocatur but presents the same issues.
SUMMARY OF ARGUMENT

This is a case of statutory interpretation. Despite explicitly acknowledging the Pandora’s box of privacy-invading interpretations its decision would open, the Superior Court interpreted the definition of “child abuse” in the Child Protective Services Law (“CPSL”) to include any act or failure to act that “creates a reasonable likelihood of bodily injury to a child once he or she is born, so long as she consciously disregards a substantial and unjustifiable risk that such an injury may result.” As Judge Strassburger noted in his concurrence, which was joined by Judge Moulton, “[t]his is quite broad indeed.”

But this Court can and should interpret the CPSL far more narrowly. In holding that any act or omission while pregnant, or even the existence of an underlying health condition that might affect the health of a child once born, could form the basis of a charge of child abuse, the Superior Court decision violates a number of fundamental principles of statutory interpretation. First, under the CPSL, findings of child abuse may only lie against “perpetrators” of abuse, a limited category of people defined by their relationship to a child. This Court granted allocatur on precisely this issue: Whether a woman can be a “perpetrator” of child abuse for her actions while pregnant that might affect the health of her newborn. Accordingly, the definition of
“perpetrator”—which is set forth in the CPSL, but was not addressed at all by the Superior Court—is central to the decision in this case.

Contrary to the Superior Court decision below, when the provisions of the CPSL are read together, the plain language of the statute provides that an individual cannot be a perpetrator of child abuse for acts undertaken before any of the statutorily recognized relationships to the child exist.

But even if the plain language of the CPSL were ambiguous, this Court should hold that it does not apply to acts or omissions that occur before the birth of the child. First, for the reasons set forth in Appellant’s Brief, the General Assembly never intended to include acts or omissions during pregnancy within the definition of child abuse.

And second, the cardinal principle of constitutional avoidance requires this Court to reverse the decision below. To hold otherwise, would violate fundamental notions of due process, as well as the right to procreative and medical privacy, the right to parent, and the right to equal protection under the Fourteenth Amendment and the Pennsylvania Equal Rights Amendment.

For these reasons, this Court should reverse the Superior Court’s decision and hold that acts or omissions taken while pregnant, or even underlying health conditions of a pregnant woman, that could cause harm to
a child once born cannot form the basis of a finding of child abuse under the law.

ARGUMENT

I. THE PLAIN LANGUAGE OF THE CPSL DEMONSTRATES THAT WOMEN CANNOT BE “PERPETRATORS” OF CHILD ABUSE FOR PRENATAL ACTS OR OMISSIONS OR UNDERLYING HEALTH CONDITIONS.

The threshold question in this case, which the Superior Court failed to address, is whether a pregnant woman may be considered a “perpetrator” of child abuse on the basis of acts or omissions while pregnant, or underlying health conditions, that could have an impact on a child once born. The plain language of the CPSL demonstrates that she cannot.2

A finding of child abuse against any parent in a dependency adjudication requires the court to find that the parent was a “perpetrator” of child abuse.3 As set forth more fully in Appellant’s brief, the statutory

2 See, e.g., Phillips v. Cricket Lighters, 883 A.2d 439, 444 n.3 (Pa. 2005) (in construing a statute, courts “are to follow the plain meaning of the provision’s language when the words are free from ambiguity”).

3 In re L.B., 177 A.2d 308, 311 (Pa. Super. Ct. 2017) (“As part of [a] dependency adjudication, a court may find a parent to be the perpetrator of child abuse,’ as defined by the CPSL”); J.G. v. Dep’t of Pub. Welfare, 795 A.2d 1089, 1093 (Pa. Commw. Ct. 2002) (“Where, however, a founded report is based upon a judicial adjudication in a non-criminal proceeding, such as a dependency action, in which the court enters a finding that the child was abused, but does not issue a corresponding finding that the named perpetrator was responsible for the abuse, a named perpetrator is entitled to an administrative appeal before the secretary to determine whether the underlying adjudication of child abuse supports a founded report of abuse.”).
definition of perpetrator plainly requires a statutorily defined relationship to a child at the time the act or failure to act giving rise to the injury occurred.\(^4\) Without such a statutorily defined relationship, an individual cannot be a perpetrator. As the Superior Court properly recognized, a fetus is not a child for purposes of the CPSL.\(^5\) Thus, under the plain language of the CPSL, a woman cannot be a perpetrator for acts or omissions during pregnancy that could harm a child once born because she has no statutorily defined

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\(^{4}\) 23 Pa. Cons. Stat. § 6303 defines “perpetrator” as “a person who has committed child abuse as defined in this section. The following shall apply:

(1) The term includes only the following:
   (i) A parent of the child.
   (ii) A spouse or former spouse of the child’s parent.
   (iii) A paramour or former paramour of the child’s parent.
   (iv) A person 14 years of age or older and responsible for the child’s welfare or having direct contact with children as an employee of child-care services, a school or through a program, activity or service.
   (v) An individual who is 14 years of age or older who resides in the same home as the child.
   (vi) An individual 18 years of age or older who does not reside in the same home as the child but is related within the third degree of consanguinity or affinity by birth or adoption to the child.
   (vii) An individual 18 years of age or older who engages a child in severe forms of trafficking in persons or sex trafficking, as those terms are defined under section 103 of the Trafficking Victims Protection Act of 2000 (114 Stat. 1466, 22 U.S.C. § 7102).

(2) Only the following may be considered a perpetrator for failing to act, as provided in this section:
   (i) A parent of the child.
   (ii) A spouse or former spouse of the child’s parent.
   (iii) A paramour or former paramour of the child’s parent.
   (iv) A person 18 years of age or older and responsible for the child’s welfare.
   (v) A person 18 years of age or older who resides in the same home as the child.”

\(^{5}\) *In re L.B.*, 177A.2d at 311 (“a ‘fetus’ or ‘unborn child’ does not meet the definition of ‘child’ under the CPSL”).
relationship to a *child* at the time the act or omission occurs. Indeed, under the plain language of the CPSL, a pregnant woman is no more a perpetrator of child abuse than a neighbor who fails to intervene to stop a child from being abused—even if that neighbor was later to become the child’s legal guardian. Neither had a statutorily defined relationship to a child at the time that the act or failure to act occurred. Accordingly, this Court should rule based on the statute’s plain language that women are not perpetrators of child abuse for acts or omissions, or underlying health conditions, that could affect the health of a child once born.

But even if the Court determines that the statute is unclear on this point and consequently engages in the analysis under 1 Pa. Cons. Stat. § 1921(c) to determine the intention of the General Assembly, as it must, it will arrive at the same ruling.6 This analysis includes a consideration of the consequences of interpreting the definition of perpetrator to apply to prenatal conduct.7 For

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6 *Amici* agree with Appellant’s conclusion that the General Assembly did not intend to define “child abuse” or “perpetrator” to include acts or omissions during pregnancy. Because Appellant’s Brief ably analyzes the intent of the General Assembly, *amici* will not repeat those arguments here.

the reasons set forth below, such an interpretation would violate both the federal and Pennsylvania Constitutions, and must therefore be avoided.\(^8\) 

II. APPLYING THE CPSL TO ANY PRENATAL ACTS OR OMISSIONS OR UNDERLYING HEALTH CONDITIONS THAT COULD AFFECT A CHILD ONCE BORN VIOLATES DUE PROCESS BECAUSE IT IS IMPERMISSIBLY VAGUE AND FAILS TO GIVE FAIR NOTICE OF PROHIBITED CONDUCT.

“It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined.”\(^9\) A statute will be void for vagueness (1) if it fails to “give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly,”\(^10\) or (2) if it encourages arbitrary and discriminatory enforcement by failing to provide explicit standards for those who apply them.\(^11\) The Superior Court’s construction of the CPSL to apply to any act or

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\(^8\) *Hartford Acci. & Indem. Co. v. Ins. Comm’r of Commonwealth*, 482 A.2d 542, 549 (Pa. 1984) (“It is a cardinal principle that ambiguous statutes should be read in a manner consonant with the Constitution.”); *Atlantic-Inland, Inc. v. Board of Supervisors of West Goshen Township*, 410 A.2d 380, 382 (Pa. Commw Ct. 1980) (courts have an “obligation to adopt a reasonable construction which will save the constitutionality of a statute”).


\(^10\) *Grayned*, 408 U.S. at 108.

\(^11\) See id.; see also *FCC v. Fox TV Stations, Inc.*, 567 U.S. 239, 254 (2012) (“even when speech is not at issue, the void for vagueness doctrine addresses at least two connected but discrete due process concerns: first, that regulated parties should know what is required of them so they may act accordingly; second, precision and guidance are necessary so that those enforcing the law do not act in an arbitrary or discriminatory way”); *Kolender v.*
omission that could harm an embryo or fetus and thereby cause bodily injury to a child once born would fail to satisfy either constitutional requirement.

The nature of the penalty imposed by the CPSL—being listed as a perpetrator of child abuse on the statewide registry and barred from certain types of employment—does not deprive those affected by the statute of due process, as the validity of a vague statute under the Due Process Clause does not hinge on whether the statute is criminal in nature. The Supreme Courts of the United States and Pennsylvania have applied the void-for-vagueness doctrine to regulations that carry only civil penalties or can result in the loss of employment.\footnote{See \textit{Sessions v. Dimaya}, 138 S. Ct. 1204, 1213 (2018) (applying “most exacting vagueness standard” to removal cases even though immigration violations are civil in nature); \textit{id.} at 1229 (Gorsuch, J., concurring) (“This Court has made clear … that due process protections against vague laws are ‘not to be avoided by the simple label a State chooses to fasten upon its conduct or its statute.’”); \textit{Fox TV Stations, Inc.}, 567 U.S. at 258 (explaining that “even when speech is not at issue,” void for vagueness doctrine applies and holding FCC regulations that carried possibility of civil penalties violated due process); \textit{Fabio}, 414 A.2d at 84-85 (analyzing whether police department regulation was void for vagueness).} Here, a finding of child abuse may not only affect an individual’s parental rights, but will result in the individual’s placement on the statewide child abuse registry as either an indicated or founded perpetrator of child abuse.\footnote{See 23 Pa. Cons. Stat. §§ 6303 (relating to definitions); 6338 (relating to indicated reports); 6341(c.1) (relating to founded reports).} An individual who must obtain a child abuse clearance for

her employment would likely lose her job or not be hired in the first instance if her name appears on the registry. Being labeled a child abuser also causes reputational injury.\textsuperscript{14} Both of those penalties are sufficiently severe that stringent due-process protections would apply.\textsuperscript{15}

\textbf{A. The CPSL, as Interpreted by the Superior Court, Fails to Provide Notice that Acts, or Failures to Act, in the Two Years Prior to a Child’s Birth Can Constitue Child Abuse.}

First, as set forth in Appellant’s Brief, the language of the CPSL gives no indication that the term “perpetrator” includes the parent or guardian of an unborn child.\textsuperscript{16}

Moreover, as the concurrence correctly recognized, the Superior Court’s construction of the CPSL necessarily expands the statute to cover any knowing, intentional or even reckless act or omission by a pregnant woman—even continuing a pregnancy despite an underlying health condition, such as

\begin{footnotes}
\item[14] Fox TV Stations, Inc., 567 U.S. at 255-56 (explaining that reputational harm provided grounds for broadcaster to challenge vague regulation it was threatened with civil penalty for violating).
\item[15] Dimaya, 138 S. Ct. at 1229 (Gorsuch, J., concurring) (explaining that heightened standard of review for due process claims should not be reserved solely for criminal cases because today’s civil laws regularly impose penalties far more severe than those found in criminal statutes, including “remedies that strip persons of their professional licenses and livelihoods”).
\end{footnotes}
substance dependency or addiction—that could pose a risk of harm to a child once born. The decision thus subjects women to the risk that they will be reported to the statewide child abuse registry for virtually anything they do (or do not do) during pregnancy—even the decision to continue the pregnancy itself. Justice Strassburger’s concurring opinion acknowledges this uncertainty:

There are many decisions a pregnant woman makes that could be reasonably likely to result in bodily injury to her child after birth, which may vary depending on the advice of the particular practitioner she sees and cultural norms in the country where she resides. Should a woman engage in physical activity or restrict her activities? Should she eat a turkey sandwich, soft cheese, or sushi? Should she drink an occasional glass of wine? What about a daily cup of coffee? Should she continue to take prescribed medication even though there is a potential risk to the child? Should she travel to countries where the Zika virus is present? Should she obtain cancer treatment even though it could put her child at risk? Should she travel across the country to say goodbye to a dying family member late in her pregnancy? Is she a child abuser if her partner kicks or punches her in her abdomen during her pregnancy and she does not leave the relationship because she fears for her own life?17

The examples of conduct that could constitute child abuse under the Superior Court’s interpretation are practically endless and amici will not go into all of them here. Suffice it to say, the Superior Court’s decision “open[s] the door to interpretations of the statute that intrude upon a woman’s private decision-

17 In re L.B., 177 A.2d at 314 (Strassburger, J., concurring).
making as to what is best for herself and her child.” 18 That susceptibility to such broad interpretation would inevitably render the statute void for vagueness.19

Numerous courts in other states have similarly held that prosecutions of women for prenatal conduct that causes harm to the subsequently born child violate principles of due process.20 And at least one Pennsylvania court has held that the prosecution of a woman for recklessly endangering another

18 Id. at 314 (Strassburger, J., concurring).

19 See Com. v. Kemp, 18 Pa. D & C. 4th 53, 63 (Westmoreland C.C.P. 1992) (applying statutes at issue to prenatal conduct “might lead to a ‘slippery slope’ whereby the law could be construed as covering the full range of a pregnant woman’s behavior—a plainly unconstitutional result that would, among other things, render the statutes void for vagueness”); see also State v. Louk, 786 S.E.2d 219, 225 (W.Va. 2016) (“Were we to extend the statute to prenatal conduct that affects a fetus in a manner apparent after birth—conduct that would be defined solely in terms of its impact on the victim—the boundaries of proscribed conduct that would subject a pregnant woman to prosecution under [the statute] would become impermissibly broad and ill-defined.”); Reinstein v. Superior Court, 894 P.2d 733, 737 (Ariz. Ct. App. 1995) (“Allowing the state to define the crime of child abuse according to the health or condition of the newborn child would subject many mothers to criminal liability for engaging in all sorts of legal or illegal activities during pregnancy. We cannot, consistent with the dictates of due process, read the statute that broadly.”).

20 See, e.g., Louk, 786 S.E.2d at 225 (conviction for “child neglect resulting in death” based on prenatal drug use “would offend due process notions of fundamental fairness and render the statute impermissibly vague” because statutory reference to “child” did not include any mention of “unborn child” or “fetus”); id. 226-27 (collecting cases and noting that “overwhelming majority of the jurisdictions confronted with the prosecution of a mother for prenatal conduct causing harm to the subsequently born child, refuse to permit such prosecutions”); Reinstein, 894 P.2d at 736 (because criminal child abuse statute referred to “child” rather than “fetus,” application to pregnant woman’s conduct would offend due process); Sheriff v. Encoe, 885 P.2d 596, 598 (Nev. 1994) (principles of due process prevented court from interpreting child endangerment statute to reach transfer of drugs from mother to newborn through umbilical cord in moments immediately after birth).
person and delivery of a controlled substance based on her use of cocaine while pregnant violated her right to due process guaranteed by the federal and Pennsylvania Constitutions.\textsuperscript{21}

But the reach of the CPSL under the Superior Court’s interpretation, if it stands, will extend far beyond these already unconstitutional results. Because there is nothing in the statute itself that would cabin it to conduct by women during pregnancy, the Superior Court’s construction could apply to an individual’s acts or omissions before pregnancy. Obvious examples of acts or omissions that could cause individuals to reported as perpetrators of child abuse under the statute abound. They include the woman who intends to become pregnant but knowingly and intentionally fails to take folic acid to prevent neural tube defects\textsuperscript{22}; the woman who takes medication for an underlying health condition that could cause severe birth defects, but fails to use birth control to prevent pregnancy\textsuperscript{23}, or even the man who travels to a country where the Zika virus is present but fails to use birth control to prevent

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pregnancy. As construed by the Superior Court, if a pregnancy results and the woman decides to continue her pregnancy to term, rather than have an abortion, these individuals could each be considered perpetrators of child abuse under the CPSL once a child is born.

Indeed, because the definition of perpetrator includes people who reside in the same home as the child, the reach of the statute is even broader and the lack of notice more profound. For instance, the children of women who are exposed to second-hand smoke during pregnancy may experience, among other problems, low birth weight, which is a major factor in infant mortality. Given these well-known risks, anyone who lives with a pregnant woman and smokes cigarettes inside the home would be engaging in conduct that “intentionally, knowingly, or recklessly” creates a reasonable likelihood of bodily injury to a child once born.

Accordingly, if the Superior Court’s expansive interpretation of the CPSL is permitted to stand, pregnant women, their partners—and even their roommates—could be reported as child abusers for “a whole host of

intentional and conceivably reckless activity that could not possibly have been
within the contemplation of the Legislature.” 27 That would cause the
boundaries of proscribed conduct under the CPSL to become impermissibly
broad and ill-defined, leading to absurd or unreasonable results, as several
courts have pointed out.28

B. The Superior Court’s Construction of the CPSL Will Result in
Arbitrary Enforcement and Delegate the Legislature’s Power to
the Judiciary.

In addition to fair notice, due process requires “precision and guidance
… so that those enforcing the law do not act in an arbitrary or discriminatory
way.”29 The Superior Court’s interpretation of the CPSL is highly likely to

interpreted to apply to a pregnant woman’s conduct on the child she is carrying, reckless
endangerment statute could be construed to include “everything from … the continued use
of legal drugs that are contraindicated during pregnancy, to consuming alcoholic beverages
to excess, to smoking, to not maintaining a proper and sufficient diet, to avoiding proper
and available prenatal medical care, to failing to wear a seat belt while driving, to violating
other traffic laws in ways that create a substantial risk of producing or exacerbating
personal injury to her child, to exercising too much or too little, indeed to engaging in
virtually any injury-prone activity that, should an injury occur, might reasonably be
expected to endanger the life or safety of the child. Such ordinary things as skiing or
horseback riding could produce criminal liability.”).

28 See Louk, 786 S.E.2d at 225-26; Reinesto, 894 P.2d at 736 (explaining that “[m]any types
of conduct can harm a fetus, causing physical or mental abnormalities in a newborn,”
including smoking during pregnancy; drinking alcoholic beverages during pregnancy;
failing to obtain prenatal care or proper nutrition; and possibly drinking caffeine); Kemp,
18 Pa. D& C.4th at 62-63 (noting that many “over-the-counter cold remedies and sleep aids
contain warnings that pregnant women should not use them without medical supervision”
and that it is “common knowledge that cigarette smoking and the use of alcohol during
pregnancy may cause harm to the fetus”).

29 Fox TV Stations, Inc., 567 U.S. at 254.
result in arbitrary or discriminatory enforcement. As Judge Strassburger noted in his concurrence, “reasonable people may differ as to the proper standard of conduct” by a pregnant woman. But the Superior Court’s interpretation of the statute would nevertheless allow CYS agencies to report women as child abusers for prenatal conduct that, in the caseworker’s view, recklessly created a likelihood of bodily injury to the newborn child. That is an invitation to arbitrary and discriminatory enforcement by caseworkers that will disproportionately impact poor parents and parents of color.

It will then be up to judges to determine what prenatal conduct, in their view, recklessly creates a likelihood of bodily injury to a child once born. By leaving these important policy decisions up to judges, the Superior Court’s interpretation of the CPSL usurps the power of the legislature to determine the conduct to which the law applies and shields the important issue of

30 In re L.B., 177 A.2d at 314 (Strassburger, J., concurring).

31 See Commonwealth v. Pugh, 969 N.E.2d 672, 693 (Mass. 2012) (explaining that imposing a duty to summon medical treatment during labor “raises issues of due process, for such a duty would be impossible to cabin and would be highly susceptible to selective application. … Given the socially freighted nature of questions surrounding a pregnant woman’s relationship to her fetus, it is not difficult to foresee a patchwork of unpredictable and conflicting prosecutorial and judicial actions” that would result); Brief of Amici Curiae, National Advocates for Pregnant Women and Community Legal Services et al. (“NAPW/CLS Brief”) at 16-21.
whether a woman should be penalized for prenatal conduct from the political process. Justice Gorsuch recently explained the dangers of that approach:

Under the Constitution, the adoption of new laws restricting liberty is supposed to be a hard business, the product of open and public debate among a large and diverse number of elected representatives. Allowing the legislature to hand off the job of lawmaking risks substituting this design for one where legislation is made easy, with a mere handful of unelected judges and prosecutors free to ‘condem[n] all that [they] personally disapprove and for no better reason than [they] disapprove it.’ Nor do judges and prosecutors act in the open and accountable forum of a legislature, but in the comparatively obscure confines of cases and controversies.32

Laws that “impermissibly delegate basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis” are by definition vague.33

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For the reasons set forth above, the Superior Court’s construction of the CPSL in this case would render the statute overly vague, depriving individuals of fair notice and encouraging discriminatory and arbitrary enforcement. For these reasons, the Court should reverse the Superior Court’s decision below.

32 Dimaya, 138 S. Ct. at 1228. (Gorsuch, J., concurring).
33 Id.
III. APPLYING THE CPSL TO WOMEN FOR ACTS OR OMISSIONS DURING PREGNANCY VIOLATES THEIR RIGHT TO PRIVACY.

Courts have an “obligation to adopt a reasonable construction which will save the constitutionality of a statute.”34 Interpreting the CPSL to apply to a woman’s acts or omissions before or during pregnancy would violate this principle of statutory construction, as it would render the CPSL unconstitutional.

Labeling as “perpetrators of child abuse” women who choose to continue their pregnancy while suffering a substance use disorder or other medical condition or while working in a job that could cause harm to a child once born penalizes women for exercising their fundamental right to procreative privacy. Women in these circumstances are forced to choose between terminating their pregnancies or being reported to the statewide child abuse registry. In order to justify this extraordinary burden on women’s decisions to carry their pregnancies to term, the Commonwealth must demonstrate that it has a compelling state interest in labeling women as perpetrators of child abuse for intentionally, knowingly, or recklessly engaging in conduct while pregnant that could result in harm to a child once born.

34 Atlantic-Inland, Inc., 410 A.2d at 82.
born. Because the Commonwealth cannot meet that burden, interpreting “perpetrator” to apply to prenatal acts or omissions that create a risk of bodily injury to a child once born would render the statute unconstitutional.

It is well-settled that the Fourteenth Amendment to the United States Constitution protects the fundamental right to procreate.\(^{35}\) The constitutional guarantee of procreative privacy specifically protects women from measures that burden or penalize the decision to carry a pregnancy to term.\(^{36}\) These protections have equal, if not greater, force in Pennsylvania, as “our Constitution provides more rigorous and explicit protection for a person’s right of privacy” than the federal Constitution.\(^{37}\) The right of privacy “protects the privacy of intimate relationships like those existing in the family, marriage, motherhood, procreation, and child rearing.”\(^{38}\) Even when the government acts expressly in the name of protecting the embryo or fetus and the child that may subsequently be born—and even when the government’s

\(^{35}\) *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942); see also *Carey v. Population Servs. Int’l*, 431 U.S. 678, 685 (1977) (“The decision whether or not to beget or bear a child is at the very heart” of the right to privacy); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (recognizing right “to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child”).

\(^{36}\) See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 859 (1992) (noting that *Roe v. Wade* decision “has sensibly been relied upon to counter” attempts to interfere with a woman’s decision to become pregnant or to carry her pregnancy to term).


\(^{38}\) *Id.* at 424.
asserted concern is prenatal exposure to illegal drugs—the U.S. Supreme Court has clearly recognized that pregnant women are entitled to the full protections of the Constitution.39

For example, in Cleveland Board of Education v. LaFleur,40 the U.S. Supreme Court held unconstitutional a rule that required pregnant schoolteachers to take unpaid maternity leave.41 The Court held that by “penaliz[ing] the pregnant teacher for deciding to bear a child, overly restrictive maternity leave regulations can constitute a heavy burden on the exercise of those protected freedoms,” particularly the “freedom of personal choice in matters of marriage and family life.”42 The question was not whether the policy’s “goals [were] legitimate, but rather, whether the particular means to achieve those objectives unduly infringe upon the [woman’s] constitutional liberty.”43 Thus, “where a decision as fundamental as that whether to bear or beget a child is involved, regulations imposing a

39 See Ferguson v. City of Charleston, 532 U.S. 67, 81-86 (2001) (holding that joint public hospital/law enforcement policy to drug-test pregnant women was subject to Fourth Amendment warrant and consent requirements, notwithstanding government’s asserted interest in protecting embryo or fetus).
41 Id.
42 Id. at 639-40.
43 Id. at 648.
burden on it may be justified only by compelling state interests, and must be narrowly drawn to express only those interests.”

Like the maternity-leave policy in *LaFleur*, applying the child abuse law to a woman’s acts or omissions while pregnant imposes a burden on the right to procreate. The risk of being permanently listed as a perpetrator of child abuse on the statewide registry and potentially denied the opportunity to enter a number of professions is sufficiently punitive to deter women struggling with drug dependency, domestic violence, or any number of medical conditions to continue their pregnancies.

Because such an interpretation would implicate fundamental privacy rights, the Commonwealth bears the heavy burden of proving that applying the CPSL in this manner furthers a compelling interest. Here, however, the Commonwealth cannot establish that placing women on the child abuse registry for conduct while pregnant actually advances any legitimate, let alone compelling, governmental interest. The purpose of the child abuse registry is

44 *Carey*, 431 U.S. at 686.
45 See NAPW/CLS Brief at 5-7.
46 *See Carey*, 431 U.S. at 685-86; *Stenger v. Lehigh Valley Hosp. Ctr.*, 609 A.2d 796, 802 (Pa. 1992) (“Under the law of this Commonwealth only a compelling state interest will override one’s privacy rights.”); *id.* (“Whether or not a given state interest justifies such an intrusion depends, in part, ‘on whether the state's intrusion will effect its purpose; for if the intrusion does not effect the state’s purpose, it is a gratuitous intrusion, not a purposeful one.’”) (quoting *Denoncourt v. Commonwealth*, 470 A.2d 945, 949 (Pa. 1983).
to flag individuals who have a history of child abuse to prevent future abuse from occurring. A finding of child abuse is not necessary to protect the safety of a newborn child, as the Juvenile Act and CPSL offer a legal framework for the safety and protection of infants that does not hinge on a finding of child abuse. A finding of child abuse will, however, result in the parent’s name being placed on the statewide child abuse registry for the rest of the parent’s life.

Because the state interest in placing women on the child abuse registry for acts or omissions while pregnant is virtually nonexistent, penalizing women for continuing their pregnancies would violate their Fourteenth Amendment rights. This Court should thus reject an interpretation of “perpetrator” that would result in the violation of women’s Fourteenth Amendment rights and reverse the Superior Court’s decision below.

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47 See NAPW/CLS Brief at 4-5.
IV. APPLYING THE CPSL TO WOMEN FOR ACTS OR OMISSIONS DURING PREGNANCY VIOLATES THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT.

Despite the Superior Court’s statement that “[t]he sole question before us is whether a mother’s illegal drug use while pregnant may constitute child abuse under the CPSL,”49 its decision in the affirmative necessarily opens the statute up to a much broader interpretation. But even if the statute could be limited to “a mother’s illegal drug use while pregnant,” it would nevertheless be unconstitutional. Any interpretation of the statute that would apply only to women who choose to continue their pregnancies would result in unconstitutional sex discrimination under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution and the Equal Rights Amendment to the Pennsylvania Constitution.

State action that subjects pregnant women to increased criminalization and control “in order to preserve the strength and vigor of the race,”50 is no longer permissible under the Constitution. In *Nevada Department of Human Resources v. Hibbs*,51 the United States Supreme Court recounted with disapproval the long and damaging history of state actors treating women

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49 *In re L.B.*, 177 A.2d at 312-313.
more restrictively based on the view that the “‘proper discharge of [a woman’s] maternal functions—having in view not merely her own health, but the well-being of the race—justify[ies]’” government intervention.\textsuperscript{52} It is now well-settled, however, that state action that places additional restrictions on women to which men are not subject in “reliance on invalid gender stereotypes,” “warrants heightened scrutiny” by the courts.\textsuperscript{53} Such suspect restrictions include those based on stereotypes about “women’s roles … when they are mothers or mothers-to-be.”\textsuperscript{54}

Under the CPSL, child abuse can be committed by a perpetrator’s act or failure to act that recklessly creates a risk of bodily injury to a child. Limiting the definition of perpetrator to include only prenatal conduct by women—but not the prospective biological father who uses drugs alongside the pregnant woman, provides her with illegal drugs, or fails to intervene to stop her from using drugs—also discriminates against women on the basis of

\textsuperscript{52} Id. at 729 (quoting \textit{Muller}, 208 U.S. at 422).

\textsuperscript{53} Id. at 730.

\textsuperscript{54} Id. at 736 (internal citations omitted) (emphasis added); \textit{see also} \textit{Casey}, 505 U.S. at 896 (that women’s reproductive capacities preclude “full and independent legal status under the Constitution … [is] no longer consistent with our understanding of the family, the individual, or the Constitution”) (citation omitted).
sex because men could never be perpetrators of child abuse for their conduct during a woman’s pregnancy.

Gender-based classifications are presumptively unconstitutional under the Pennsylvania Equal Rights Amendment. The Pennsylvania Supreme Court has stated that “[t]he sex of citizens of this Commonwealth is no longer a permissible factor in the determination of their legal rights and legal responsibilities. The law will not impose different benefits or different burdens upon the members of a society based on the fact that they may be man or woman.” In a variety of contexts, the Pennsylvania Supreme Court has applied the ERA to prohibit using a person’s sex to determine the rights and benefits to which he or she is entitled.

To be sure, the ERA does not prohibit classifications of individuals based on their sex for the purpose of conferring benefits or imposing burdens when the sex-based classification is “reasonably and genuinely based on

physical characteristics unique to one sex.” 58 But the fact that only women can become pregnant does not save the Superior Court’s sex-based classification, as both men and women can engage in acts, or failures to act, during the prenatal period that intentionally, knowingly, or recklessly create a risk of bodily harm to a child once born. Penalizing women, but not men, for prenatal conduct is thus an unconstitutional sex-based classification in violation of the ERA.

An interpretation of “perpetrator” that would include pregnant women but not the biological father would also violate the federal Constitution’s Equal Protection Clause by imposing a greater burden on women during the prenatal period than men. 59 No governmental objective is served by applying the CPSL to the conduct of women but not men during the prenatal period. The purposes of the registry are not served when women are reported to the registry for conduct that would not constitute child abuse but for their pregnant condition. On the other hand, the risk that they may be reported by their caregivers and subject to findings of child abuse is likely to deter pregnant women from seeking drug treatment or prenatal care, 60 thereby causing the

60 See NAPW/CLS Brief at 23-26.
very harm that the CPSL is intended to prevent. It is for this reason that public health and medical groups are nearly unanimous in their opposition to penalizing pregnant women for conduct that could harm an embryo or fetus.\(^{61}\)

To avoid a construction of the statute that would violate principles of equal protection, this Court should reject a definition of “perpetrator” that would apply only to women for conduct during pregnancy and reverse the Superior Court’s decision.

V. APPLYING THE CPSL TO WOMEN FOR ACTS OR OMISSIONS DURING PREGNANCY VIOLATES THEIR SUBSTANTIVE DUE PROCESS RIGHT TO MAKE MEDICAL DECISIONS.

Both the federal and Pennsylvania Constitutions protect the right to refuse medical treatment.\(^{62}\) In Pennsylvania, this right is subject to strict scrutiny.\(^{63}\) Pennsylvania courts have recognized that “[t]he right to control and refuse medical treatment is also founded on the common law of this Commonwealth, which has long provided that other than in an emergency,

\(^{61}\) See id. at 24.

\(^{62}\) *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990) (“competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment”).

\(^{63}\) *Commonwealth v. Nixon*, 761 A.2d 1151, 1156 (Pa. 2000) (“In this Commonwealth, only a compelling state interest will override one's privacy rights.”).
medical treatment may not be given without the informed consent of the patient.”

The application of the CPSL to prenatal conduct would violate women’s rights under the federal and Pennsylvania Constitutions to refuse medical care by penalizing women for declining care that doctors recommend for the health of their embryo or fetus. Women could be reported as perpetrators of child abuse for making decisions about their own medical care, including choosing to take a medication that is contraindicated during pregnancy or refusing to take a medication that is prescribed; choosing to give birth unassisted and/or at home rather than in a hospital; and refusing to consent to a surgical procedure, such as a C-section, or undergoing surgery or other medical treatments that may pose a risk to the embryo or fetus.

Penalizing a pregnant woman for choosing—or refusing—medical care that could create a risk of bodily harm to a child once born violates her fundamental right under the Pennsylvania Constitution to make medical decisions. It also contravenes the common law rule that “one human being

64 In re Fiori, 652 A.2d 1350, 1354 (Pa. 1995).
65 See Pugh, 969 N.E.2d at 694-95 (reversing conviction of woman for involuntary manslaughter for the death of her viable fetus during unassisted childbirth); Kathy Pollit, Pregnant and Dangerous, The Nation, April 26, 2004 (describing case of Melissa Rowland, who was charged with murder for death of viable fetus following her refusal to undergo C-section).
66 Nixon, 761 A.2d at 1156.
is under no legal compulsion to give aid or to take action to save another human being or to rescue.” As one Pennsylvania court has explained, this rule, which on its surface appears “revolting in the moral sense” is essential to a free society:

Our society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another. … In preserving such a society as we have, it is bound to happen that great moral conflicts will arise and will appear harsh in a given instance. … For our law to compel defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.

The court in that case declined to order a man to donate bone marrow to save the life of his 15-year-old cousin. But its reasoning is no less applicable to pregnant women.

Coercing a pregnant woman to undergo or refrain from undergoing medical treatments for the health of her fetus by threatening to report her to the statewide child abuse registry will result in the state substituting its judgment for that of pregnant women, in violation of fundamental

68 Id.
69 Id.
constitutional principles of privacy and due process. This Court should reverse the decision of the Superior Court to avoid the serious and predictable interference in women’s medical decision-making that would result from such an interpretation of the CPSL.

VI. APPLYING THE CPSL TO ANY ACT OR OMISSION BEFORE OR DURING PREGNANCY VIOLATES THE FUNDAMENTAL RIGHT TO PARENT.

The right of a parent to care for his children “is perhaps the oldest of the fundamental liberty interests recognized by [the U.S. Supreme Court].”70 The Due Process Clause of the Fourteenth Amendment protects the relationship between parent and child71 and encompasses both “the interest of a parent in the companionship, care, custody, and management of his or her children” 72 and children’s “corresponding familial right to be raised and nurtured by their parents.” Consequently, the U.S. Supreme Court has


71 Quilloin v. Walcott, 434 U.S. 246, 255 (1978) (“We have little doubt that the Due Process Clause would be offended ‘[if] a State were to attempt to force the breakup of a natural family, over the objections of the parents and their children, without some showing of unfitness and for the sole reason that to do so was thought to be in the children’s best interest.’”) (quoting Smith v. Organization of Foster Families, 431 U.S. 816, 862-63 (1977)).

repeatedly struck down governmental practices and policies that infringe upon a parent’s right to the care, control, and custody of her children. 73

To be sure, the right to family integrity is not absolute: It is limited by the compelling governmental interest in the protection of children. 74 But any interference by the government in familial relationships must adhere to the requirements of procedural and substantive due process in order to satisfy the Fourteenth Amendment. 75

Allowing CYS agencies or courts to make a child abuse finding based on a parent’s pre-birth conduct would undermine fundamental parental rights, as such findings are likely to lead to unnecessary intrusions into the parent-child relationship. State law currently provides for mandatory reporting when a health care provider cares for a newborn affected by “withdrawal symptoms resulting from prenatal drug exposure” and a subsequent safety assessment or risk assessment by the county CYS agency. 76 Interpreting the statute to apply to pre-birth conduct would allow CYS to investigate any new parent who, in the two years before their child’s birth, engaged in an activity that created a

73 *Berman v. Young*, 291 F.3d 976, 983 (7th Cir. 2002); *see Duchesne v. Sugarman*, 566 F.2d 817, 825 (2d Cir. 1977) (“right to the preservation of family integrity encompasses the reciprocal rights of both parent and children”).

74 *Croft*, 103 F.3d at 1125.

75 *Id.*

risk of bodily injury to the newborn—even if there is no reason to believe that the parent poses an imminent risk of abuse to the child after birth.

As noted above, the targets of CYS investigations could include parents who chose a home birth over a hospital birth, parents who smoked cigarettes during pregnancy, mothers who lived or worked with people who smoked cigarettes, mothers who used lawful medications that are contraindicated during pregnancy, and on and on. This would not only cause CYS resources to be diverted to families who do not need their services but would constitute a serious intrusion on the rights of parents who pose no risk of harm to their children. This Court should thus reverse the decision of the Superior Court to avoid the unconstitutional interference into the parent-child relationship that would result from applying the CPSL to pre-birth conduct.

**CONCLUSION**

For the foregoing reasons, this Court should reverse the decision of the Superior Court and hold that individuals cannot be found to be perpetrators of child abuse under the CPSL for acts or omissions before or during pregnancy that could affect the health of a child once born.
Respectfully submitted,

Date: May 3, 2018

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CERTIFICATION OF COMPLIANCE

Pursuant to Rules 531(b)(3) and 2135(d) of the Pennsylvania Rules of Appellate Procedure, I, Sara Rose, hereby certify that the foregoing Brief of Amici Curiae complies with the applicable word count limit. This certificate is based on the word count of the word processing system used to prepare the brief.

Date: May 3, 2018

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I, Sara Rose, hereby certify that I caused the foregoing Brief of Amici Curiae to be served upon the following counsel of record via the Court’s electronic filing system or United States mail.

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IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

No. 10 MAP 2018

In the Interest of: L.J.B., a Minor

On Appeal from the Order Entered December 27, 2017
in the Superior Court at No. 884 MDA 2017

BRIEF FOR AMICI CURIAE,
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STATEMENT OF INTEREST OF AMICI CURIAE

Amici are two nonprofit organizations, the Drug Policy Alliance, which leads the nation in promoting drug policies that are grounded in science, compassion, health, and human rights, a nonprofit organization, Families for Sensible Drug Policies, which represents families impacted by substance use and advances comprehensive public health approaches, best healthcare practices, reality-based education and family-friendly drug policy reform, and 8 nationally recognized experts in health, psychology, medicine, and law. These amici have recognized and longstanding expertise in the areas of maternal, fetal, and neonatal health, and in the effects of controlled substances on families and society. Each of the amici curiae is committed to reducing potential drug-related harms at every reasonable opportunity and does not endorse the non-medical use of drugs—including alcohol or tobacco—during pregnancy. It is entirely consistent with amici’s public health, legal, policy, and ethical mandates to bring to this Court’s attention that expanding the definition of “child abuse,” under the Child Protective Services Law, to include actions taken by a pregnant woman that may affect her newborn’s health is detrimental to maternal, fetal, and child health. The questions

1 No counsel for a party authored this brief in whole or in part, and no counsel for a party (nor a party itself) made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amici or their counsel made a monetary contribution to its preparation or submission.
at issue—(1) whether the definition of child abuse includes actions by a pregnant
woman that might affect the health of her newborn and (2) whether a mother of a
child experiencing neonatal withdrawal symptoms should be found to have
committed child abuse—must be reconciled with evidence-based and peer-
reviewed medical and scientific research.

Individual statements of interest of amici curiae are contained in
Appendix A to this brief.

SUMMARY OF ARGUMENT

The Superior Court’s holding – that women may found to be a “perpetrator”
of “child abuse” and registered under the Child Protective Services Law (“CPSL”) for her actions while pregnant that might affect the health of her newborn – is contrary to broadly accepted medical, public health, and scientific evidence. Respectfully, this Court should reverse the Superior Court’s expansive reading of CPSL because it would substantially impair, not advance, safe outcomes for children.

CPSL defines child abuse as causing or creating a reasonable likelihood of “bodily injury to a child through any recent act or failure to act.” 23 Pa. C.S.A. § 6303(b.1)(1), (5). Persons identified as perpetrators of child abuse are listed in a centralized statewide registry, which can be released to “law enforcement, social work agencies, employers in child care services and other related venues.” G.V. v.
The Superior Court held that a woman’s drug use during pregnancy could be the basis of a child abuse finding if the woman “’intentionally, knowingly, or recklessly’ caused, or created a reasonable likelihood of causing, bodily injury to a child after birth.” In re L.B., 177 A.3d 308, 309 (Pa. Super. 2017) (emphasis added). Amici curiae respectfully disagree with the Superior Court ruling. Instead, amici agree with Appellant A.A.R. that the Trial Court ruled correctly that, under CPSL, a child abuse finding cannot be established based on actions committed by a woman while she is pregnant that allegedly cause harm to her child.

Amici recognize a strong societal interest in protecting the health of women, children, and families. However, available medical, public health, and scientific evidence demonstrate that these interests are undermined, not advanced, by expanding the CPSL definition of child abuse to include drug use by pregnant women and then registering those women as perpetrators of child abuse. Although not intended, such threatened punishment would result in less safe outcomes for children. As the medical and mental health communities have long recognized, even when substance use becomes problematic and constitutes a disorder, it is a medical condition best addressed through non-punitive medical and public health approaches that protect and respect patient privacy and decision making.
Highest courts across the country are in accord with the conclusion that
*amici* ask this Court to reach in this case. Albeit in the context of the criminal
prosecution of a women, courts nearly uniformly have held that actions taken by a
pregnant woman that may affect the health of her fetus do not constitute harm to the child.

On appeal, Appellee Clinton County Children and Youth Services (“CYS”) relies on two medically and scientifically unsupported assumptions that *amici* seek to correct. *First*, CYS relies on the popular, but scientifically disproven, perception that in utero exposure to controlled substances uniquely harms the fetus. In fact, the harms associated with prenatal exposure to controlled substances are indistinguishable from other factors, such as social determinants (the conditions in which people are born, grow, and live) and environmental factors (poverty, lack of access to medical care, malnutrition, or chronic stress), which may affect newborn health. Further, scientific and medical research demonstrate that the popular culture view that babies born dependent on opioids experience unique, serious, and long lasting harms is false. In fact, physicians routinely and effectively treat babies born with opioid withdrawal symptoms, just as they treat babies born with myriad other manageable medical conditions.

*Amici* will additionally show that neonatal abstinence syndrome (“NAS”) does not constitute a unique injury to a child. Instead, it is a treatable and
temporary condition. It is not life threatening or permanent, and studies show that newborns with NAS do not develop any differently than other children. Moreover, the current medical standard for treating opioid use disorder in pregnant women is medication-assisted treatment ("MAT"), where pregnant women are prescribed opioid medications, such as methadone or buprenorphine. NAS is an expected and manageable outcome of MAT. Despite the risk of NAS, MAT is more effective than other treatment options at reducing rates of relapse and its associated risks, which leads to better maternal, fetal, and newborn health outcomes.

Second, CYS misunderstands the nature of substance use disorders and treatment outcomes. As amici will explain, substance use disorder is a chronic, recurring condition. There is consensus across substance use disorder specialists that treatment is generally required for substance use disorder stabilization and recovery, and that this treatment should be compassionate and evidence-based.

Punitive approaches such as that adopted by the Superior Court, including labeling a mother a “child abuser,” fundamentally misunderstand the clinical course of substance use disorder which is characterized by repeated substance use despite destructive consequences, physical dependence, and difficulty abstaining notwithstanding the user’s resolution to do so. Relapse is a feature of substance use disorder, and the risk of relapse continues throughout the course of active treatment.
As stated above, MAT is the medical standard for treating opioid use disorder in pregnant women. As with MAT, physicians routinely prescribe pregnant women medications to treat any number of medical conditions, despite potential risks to the fetus. When treating opioid dependency or another chronic illness, physicians prescribe medications because doing so is in the overall best interest of maternal and fetal health.

CYS’s decision to classify drug use during pregnancy as child abuse under the CPSL and register A.A.R. as a perpetrator ignored substantial evidence regarding the effective treatment of opioid use disorder and flouted scientific knowledge regarding A.A.R.’s ongoing risk of relapse. Punishing substance use disorder, a medical condition, in pregnancy undermines public health in Pennsylvania. Instead, it reinforces stigma against pregnant women who use substances and, to the detriment of their own health and the health of their fetuses, decreases the likelihood that they will seek prenatal care and substance use disorder treatment.

ARGUMENT

I. EXPOSURE TO CONTROLLED SUBSTANCES DURING PREGNANCY DOES NOT CAUSE CERTAIN OR UNIQUE HARMS

CYS argues that A.A.R.’s prenatal use of controlled substances constituted child abuse under the CPSL, because her child L.J.B. was allegedly born with opioid withdrawal symptoms. Medical and scientific research do not support
CYS’s assumption that prenatal exposure to controlled substances causes specific or unique harm to the newborn child. A common misperception in popular culture, and shared by CYS, is that prenatal exposure to controlled substances always causes negative health impacts in newborns, and that these health impacts are distinct from harms associated with social and environmental factors or other, routine actions taken by pregnant women. This perception is false. In fact, babies born with opioid withdrawal symptoms are easily treated by physicians just as physicians treat many other manageable medical conditions at birth.

CYS’ argument premised on this false understanding of medicine and science should not provide a basis for finding A.A.R. to be a perpetrator of child abuse for actions taken during her pregnancy that may have affected her fetus. Multiple, peer reviewed scientific studies have failed to prove that in utero

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exposure to controlled substances—such as cocaine, methamphetamine, heroin, or marijuana—causes specific or certain harms to the fetus. And, they have failed to prove that these substances cause harm distinguishable from other behaviors,

3 One comprehensive study concluded that “there is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity difference in severity, scope, or kind from the sequelae of many other risk factors.” D.A. Frank et al., Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure, 285 J. AM. MED. ASS’N 1613 (2001). Subsequent studies confirmed these findings. See, e.g., H.S. Bada et al., Impact of Prenatal Cocaine Exposure on Child Behavior Problems Through School Age, 119 PEDIATRICS e328 (2007); D.S. Messinger et al., The Maternal Lifestyle Study: Cognitive, Motor, and Behavioral Outcomes of Cocaine-Exposed and Opiate-Exposed Infants Through Three Years of Age, 113 PEDIATRICS 1677 (2004) (confirming that “infant prenatal exposure to cocaine and to opiates was not associated with mental, motor, or behavioral deficits”).


6 Marijuana use by pregnant women has not been shown to cause specific harm to the fetus or child. Science has failed to establish that in utero exposure to marijuana causes unique harms distinguishable from those caused by other uncontrollable factors. See, e.g., A.H. Schempf, Illicit Drug Use and Neonatal Outcomes: A Critical Review, 62 OBSTET. GYNECOL. SURV. 749 (2007). See also Am. Coll. Obstetricians & Gynecologists, Committee Opinion 637: Marijuana Use During Pregnancy and Lactation, 126 OBSTET. GYNECOL. 234 (2015).
exposures, conditions, or life circumstances that pose potential risks to a fetus or a child. Use of controlled substances by pregnant women is indistinguishable from other factors—social determinants and environmental conditions such as poverty, lack of access to medical care, malnutrition, or chronic stress—that may cause fetal and maternal harm. In fact leading public health researchers recognize that social determinants of health beyond any individual woman’s control have the greatest impact on pregnancy outcomes.

Several courts that have evaluated this scientific research have rejected the assumption that prenatal exposure to controlled substances necessarily causes unique harms to the fetus. For example, the Supreme Court of South Carolina unanimously overturned the conviction of a woman who that state claimed caused a stillbirth as a result of her cocaine use, noting specifically that the research the prosecutor relied on was “outdated” and that trial counsel failed to call experts who would have testified about “recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor.” *McKnight v. State*, 661 S.E.2d 354,

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8 Id.
Similarly, the Wisconsin Court of Appeals dismissed criminal charges against a woman who consumed alcohol during pregnancy, acknowledging that “substance abuse in pregnant women is better addressed through treatment rather than the threat of punishment.” *State v. Deborah J.Z.*, 228 Wis. 2d 468, 478 ( Ct. App. 1999). Indeed, most courts agree. As noted by the Court of Appeals of Maryland:

> These kinds of cases—prosecutions for reckless endangerment, child abuse, or distribution of controlled substances based on a pregnant woman’s ingestion of a controlled dangerous substance, or, in some cases, excessive amounts of alcohol—have arisen in other States, and the overwhelming majority of courts that have considered the issue have concluded that those crimes do not encompass that kind of activity.

*Kilmon v. State*, 394 Md. 168, 182 (Md. 2006). This is not to say that prenatal exposure to controlled substances is benign. While current studies are

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9 The Court made these comments in the context of finding that Ms. McKnight’s trial counsel rendered ineffective assistance and are the Court’s most current statements on this subject. Previously, the court had affirmed defendant McKnight’s homicide conviction for actions she took while pregnant. *State v. McKnight*, 352 S.C. 635 S.C. (S.C. 2003).

unable to causally link to specific harms caused by exposure to controlled substances during pregnancy, neither do they conclude that such exposure is completely harmless. The key here is that any potential harm that does exist is better managed by creating a public policy that encourages pregnant women who use controlled substances to seek prenatal care and substance use disorder treatment. Declaring these women child abusers shames them and deters them from being honest with medical professionals about their medical condition and seeking help and support. While amici agree that more research is warranted, existing research on the use of controlled substances during pregnancy, both as a matter of science

and law, does not support extending the CPSL definition of child abuse to include the use of controlled substances during pregnancy or registering A.A.R. as a perpetuator of child abuse.

II. NEONATAL ABSTINENCE SYNDROME DOES NOT POSE A UNIQUE INJURY TO NEWBORNs

A. Neonatal Abstinence Syndrome Is A Set Of Transient And Treatable Symptoms, Which Are Not Life Threatening And Do Not Lead To Permanent Harm Or Developmental Delays

CYS erroneously assumes that a child born with opioid withdrawal symptoms at birth has suffered injury under the CPSL definition of child abuse. Some newborns who are prenatally exposed to opioids, such as heroin, morphine, oxycodone, or medication-assisted treatment (“MAT”) medications—including buprenorphine, which was prescribed and used by A.A.R. during her pregnancy—may experience temporary and treatable withdrawal symptoms at birth. These symptoms, which may include trembling, fever, loose stools, and difficulty sleeping, are collectively referred to as neonatal abstinence syndrome.

12 Medication-assisted treatment, including opioid treatment programs, uses behavioral therapy and medications to treat substance use disorders. Medication-Assisted Treatment (MAT), Substance Abuse & Mental Health Services Administration (SAMHSA) (Feb. 7, 2018), https://www.samhsa.gov/medication-assisted-treatment. In the context of opioid use disorder, methadone and buprenorphine are opioids used to treat dependence on opioids such as heroin, morphine, codeine, oxycodone, and hydrocodone. Methadone or buprenorphine can be safely taken for months, years, or even a lifetime. Medication and Counseling Treatment, Substance Abuse & Mental Health Services Administration (SAMHSA) (Sept. 28, 2015).

13 See Section III.A.
NAS is a treatable and temporary condition. It is not life threatening or permanent, and studies show that newborns with NAS do not develop any differently than other children.15

While newborns who were exposed to opioids in utero—including prescribed pain medication, MAT medications, and illicit opioids—may experience NAS, prenatal exposure to opioids does not always result in NAS.16 Medical science has not yet determined why some babies with prenatal opioid exposure develop NAS and others do not.

A combination of emotional soothing and opioid tapering is usually sufficient to care for babies with NAS.17 Research shows that skin-to-skin contact, breastfeeding, and caring for mother and baby in the same room (“rooming in”) are effective methods for managing NAS. Additional resources include:

14 Substance Abuse & Mental Health Servs. Admin, supra note 5.
can significantly reduce a newborn’s hospital stay and need for medication.\textsuperscript{18} There is strong evidence to show that separating mother and baby leads to longer periods of time that the baby must remain in the hospital and take medication.\textsuperscript{19} A recent study shows that hospital length of stay for babies with NAS decreased from 22 days to 6 days without any new complications in babies for whom skin-to-skin contact and breastfeeding were prioritized over medications.\textsuperscript{20} Additionally, when babies were able to spend more time with their mothers, the need for opioid medication to treat NAS decreased from 98 percent of babies to only 14 percent.\textsuperscript{21} When mothers are allowed to room in with their babies, the hospital stays are shortened and the need for medication is dramatically reduced.\textsuperscript{22}

Opioid use during pregnancy does not constitute injury to a child because it does necessarily result in a child being born with NAS. Even when a child is born with NAS, its symptoms do not amount to an injury because they are temporary

\\textsuperscript{18} Ronald R. Abrahams et al., supra note 17; Tolulope Saiki et al., supra note 17; Gabrielle K. Welle-Strand et al., supra note 17; American Society of Addiction Medicine, supra note 17; Matthew R. Grossman et al., supra note 17.

\textsuperscript{19} Karol Kaltenbach & Hendrée Jones, supra note 17; Matthew R. Grossman et al., supra note 17.

\textsuperscript{20} Matthew R. Grossman et al., supra note 17.

\textsuperscript{21} Id.

and easily treatable, and the best, quickest, and most effective treatment requires maternal contact. Thus, A.A.R. should be encouraged to be close to her child and bond with her rather than being shamed and labeled a perpetrator of child abuse.

B. Medication-Assisted Treatment Is The Best Current Medical Practice For Treating Pregnant Women With Opioid Use Disorder, And Neonatal Abstinence Syndrome Is An Expected And Manageable Outcome Of This Treatment

The current medical standard of care for treating pregnant women with opioid dependence is MAT with methadone or buprenorphine, A.A.R. was prescribed the latter by her doctor when she was pregnant.\(^ {23}\) R. 23a, 24a. Taken in constant daily doses, methadone and buprenorphine work by blocking the euphoric and sedating effects of opioids, preventing withdrawal symptoms, and reducing the craving for opioids.\(^ {24}\)

Medical evidence supports MAT using methadone or buprenorphine for opioid dependent pregnant women, rather than medical withdrawal and


\(^{24}\) Medication and Counseling Treatment, supra note 12.
abstinence.25 Pregnant women placed on medication withdrawal and abstinence face high rates of relapse and its associated risks, including overdose, death, and HIV and hepatitis C infection, all of which can detrimentally affect maternal, fetal, and newborn health.26 In contrast, pregnant women with opioid use disorders who are treated with MAT, as A.A.R. was in the present case, experience better pregnancy outcomes and their newborns experience shorter hospital stays. Thus, A.A.R. should not be punished for her participation in MAT by being labeled a perpetuator of child abuse.

Labeling women child abusers, for trying to follow their physicians’ advice and take a medication prescribed to them during pregnancy to best protect their health and the health of their fetus, is contrary to overwhelming medical and scientific evidence.

25 American Society of Addiction Medicine, Public health Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids, (Jan. 17, 2017); American Society of Addiction Medicine, The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, (June 1, 2015).

26 Id.
III. PUNISHING PREGNANT WOMEN FOR FAILING TO COMPLETE SUBSTANCE USE DISORDER TREATMENT IS CONTRARY TO MATERNAL, FETAL, AND NEWBORN HEALTH

C. Opioid Use Disorder Is A Chronic, Biopsychosocial Condition

Because CYS fundamentally misunderstands the nature of opioid use disorder, amici offer the following short primer on opioids and opioid use disorder.

1. Opioids Are Potent Modulators Of Many Physiological And Psychological Processes

Opioids are among the world’s oldest known drugs, with the therapeutic use of the opium poppy predating historical records. Opioids are not foreign to the brain. In fact, the brain creates and uses its own natural opioids, such as endorphins, which are functionally identical to morphine or heroin. These endogenous opioids bind to cell surface receptors in the brain, spine, and nervous tissues and help to modulate pain.

In addition to those produced naturally in the body, opioids can be categorized into several broad classes. Natural opiates, such as morphine and codeine, derive from the alkaloids contained in the resin of the opium poppy. Esters of morphine, such as diacetylmorphine, better known as heroin, are opiates that have been slightly chemically altered. Semi-synthetic opioids are partially created from natural opiates and include pharmaceuticals such as hydrocodone,

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27 The term opiate is often used as a synonym for opioid, but opiate is properly limited to these natural alkaloids found in the opium poppy.
oxycodone, and buprenorphine. Finally, some opioids, such as methadone and fentanyl, are fully synthetic.

Like endogenous opioids, exogenous opiates and opioids exert their effects by binding to specific receptors both within and outside of the central nervous system.\(^{28}\) An analgesic effect is common to all opioids, though it is produced in different degrees and by different mechanisms, depending on the particular opioid and receptor.\(^{29}\)

Opioids that “turn on” receptors when they bind to them—that is, permit or enhance the effects of opioids—are called agonists. Opioids that “turn off” receptors—that is, block or reverse the effects of opioids—are called antagonists. And opioids that turn on receptors but do so less efficiently than agonists, are called partial agonists.\(^{30}\)

The MAT medication that A.A.R. was prescribed and used during pregnancy, is buprenorphine.\(^{31}\) R. 23a. Prior to receiving her buprenorphine prescription, A.A.R. had also taken the MAT medication methadone. \textit{Id.}

Methadone is an opioid agonist and buprenorphine is a partial opioid agonist. Both


\(^{29}\) \textit{Id.}


\(^{31}\) A.A.R. was prescribed Subutex, a brand name for buprenorphine. R. 23a.
block acute opioid effects, suppresses the signs and symptoms of opioid withdrawal, and have limited euphoric effects.32

2. Chronic Opioid Use Can Result In Physical Dependence

Chronic opioid use can lead to opioid use disorder, a form of substance use disorders described in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5).33 The DSM-5 defines a substance use disorder as “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.”34 “Addiction” is no longer used as a diagnostic term by the DSM-5 due to its “uncertain definition and its potentially negative connotation,” but is considered synonymous with a “severe” substance use disorder.35

As previously described, opioids produce their biological and psychological effects by binding to specific receptor sites throughout the body. The human brain

32 See generally D.A. Tompkins & A.C. Strain, Buprenorphine in the Treatment of Opioid Dependence, in P. Ruiz & E. Strain, eds., Substance Abuse, A Comprehensive Textbook 437 (5th ed. 2011); Leen Naji et al., A Prospective Study to Investigate Predictors of Relapse among Patients with Opioid Use Disorder Treated with Methadone, 10 Substance Abuse: Research & Treatment 9 (2016).

33 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 481 (5th ed. 2013) (hereinafter DSM-5). The DSM-5 separates substance abuse disorders by type of drug, such as opioid use disorder, cocaine use disorder, and alcohol use disorder.

34 Id. at 483.

35 Id. at 485.
adapts to all of our experiences, and, when an individual uses opioids, the brain responds by trying to overcome the drug’s effects and return to normal.\textsuperscript{36} Over time, the flood of stimulation caused by chronic opioid use can result in the development of tolerance—that is, more and more of the substance is required to achieve the same level of effect.\textsuperscript{37} In addition, individuals with opioid use disorder experience a physical need for opioids, which results in cravings and withdrawal symptoms.\textsuperscript{38} These physiologic changes constitute physical symptoms that respond to evidence-based treatment, such as MAT using methadone, buprenorphine, or Suboxone.\textsuperscript{39} Meaning that by going to her doctor and getting a prescription for buprenorphine, A.A.R. was choosing to treat her opioid use disorder by taking MAT medicines. R. 23a.

\begin{footnotes}
\item[38] \textit{Id.}
\end{footnotes}
D. Opioid Use Disorder Involves Cycles Of Recurrence (Relapse) And Remission

Studies have increasingly found that relapses are a normal part of recovery from substance use disorder and should be considered “a dynamic, ongoing process rather than a discrete or terminal event.” Only a minority of patients who successfully complete opioid detoxification can stably abstain from opioid use, and more than sixty percent of individuals who have undergone treatment will experience a relapse within the first year. Indeed, most patients experience several recurrences before achieving complete abstinence. The fact that relapse is an almost inevitable feature of opioid use disorder leads to the straightforward conclusion that relapse is “not a weakness of character or will.” It further demonstrates that just because a woman relapses during treatment does not mean that she is choosing not to discontinue her substance use during pregnancy.


While different treatments have different rates of success in reducing the risk of relapse, recurrences can be expected even during active treatment, as happened with A.A.R. in the present case.\textsuperscript{45} MAT medication, such as the buprenorphine that A.A.R. was prescribed, reduces withdrawal symptoms and tempers opioid cravings, which can help patients abstain from opioid use.\textsuperscript{46}

Although MAT addresses some of the physiological obstacles to opioid abstinence, treating opioid use disorder is much more complex than simply quelling cravings. The cognitive and behavioral aspects of substance use disorder present additional barriers to abstention that must also be addressed.\textsuperscript{47}

Punishing A.A.R. by finding her to be a perpetrator of child abuse for continuing to use drugs while seeking substance use disorder treatment fundamentally misunderstands the clinical course of opioid use disorder and how treatment works.


\textsuperscript{46} See e.g., R.P. Mattick et al., supra note 39; S.D. Comer et al., Injectable, Sustained-Release Naltrexone for the Treatment of Opioid Dependence, 63 Arch. Gen. Psychiatry 210 (2006); P.J. Fudala, supra note 39.

\textsuperscript{47} T.J. Gould, supra note 36.
E. Imposing Punishment For A Recurrence Of Opioid Use Undermines Maternal, Fetal, And Newborn Health

1. Punishments For Opioid Recurrence Neither Deter Nor Rehabilitate Individuals With Substance Use Disorder

Under deterrence theory, appropriate punitive sanctions are those that most effectively lessen the likelihood that similar crimes will be committed by the particular offender or other potential offenders. As a matter of both law and medicine, however, individuals who suffer from a substance use disorder “may be unable to abstain even for a limited period.” National Treasury Employees Union v. Von Raab, 489 U.S. 656, 676 (1989). Furthermore, individuals grappling with substance use disorder may “compulsively have urges to abuse and they are remarkably unencumbered by the memory of negative consequences of drug-taking.” In other words, opioid use disorder does not lend itself to deterrence principles. By its very nature, opioid use disorder is characterized by repeated use despite negative consequences and can therefore confound even highly punitive attempts to deter drug-seeking and taking. Thus, for persons with substance use disorders, continuing to use controlled substances is often not a choice.

Additionally, punitive sanctions—such as registration as a child abuser—or the threat thereof, subject individuals like A.A.R. to additional stressors that

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increase the risk of relapse and deter women from seeking prenatal care.\textsuperscript{49} For these reasons, the medical and public health communities regard punitive sanctions for opioid relapse as antithetical to rehabilitation. Accordingly, a pregnant woman who uses drugs should not have to fear being labeled as a child abuser.

2. Punishments For Opioid Recurrence Undermine Public Health By Reinforcing Stigma Associated With Substance Use Disorder

Opinion polls indicate that a majority of the U.S. public believes that people with substance use disorders deserve low priority in health care.\textsuperscript{50} In addition, substance use provokes a greater desire to be socially distant from an individual than do smoking or obesity.\textsuperscript{51} Such stigmatizing attitudes towards people with substance use disorder are held not only by the general public, but also, critically, by the health care professionals responsible for providing them with care.\textsuperscript{52}

\footnotesize{\textsuperscript{49} See Danielle E. Ramo & Sandra A. Brown, Classes of Substance Abuse Relapse Situations: A Comparison of Adolescents and Adults, 22 Psych. Addictive Behavior 372, 377 (2008) (showing that adults are more likely to relapse while in a negative emotional state). See also M.S. Gordon et al., A Randomized Clinical Trial of Methadone Maintenance for Prisoners: Findings at 6 Months Post-Release, 103 Addiction 1333 (2008).

\textsuperscript{50} J.A. Olsen et al., The moral relevance of personal characteristics in setting health care priorities, 57 Soc. Sci. Med. 1163 (2003).


Several factors drive these attitudes and norms, including the perception that people who use substances are to blame for their disorder, stereotypes of unpredictability and dangerousness, and mass media coverage. From this perspective, the criminalization of relapse promotes the perception of “drug users as people who are not wanted in society,” who are criminals and inherently dangerous, and fuels the view—even among health care professionals—that those who relapse have chosen to do so, are bad, and therefore undeserving of treatment.

To avoid stigmatization, both from the public and from health care providers, people who use substances may hide their use, which prevents them from seeking treatment, social services, health care, including prenatal care, and social support. In fact, people who experience stigma regarding their substance providers were less likely to believe that individuals deserved treatment when they were described as “substance abusers” rather than as a “person with a substance use disorder”).


54 Id.


use often identify that as a substantial barrier to treatment and recovery. And, among those who do seek treatment and services, the negative attitudes of health care providers may have an adverse impact on the quality of care that they receive.

Stigma particularly deters pregnant women who use controlled substances from seeking out vital prenatal care and from honestly communicating with their physicians about their drug use. If the CPSL definition of child abuse is extended to include drug use during pregnancy, it will increase the stigmatization of pregnant women who use drugs, deter pregnant women from seeking prenatal care and substance use disorder treatment, prevent them from participating in MAT, the most effective opioid use disorder treatment that exists, and undermine maternal, fetal health, and newborn health.

CONCLUSION

For the foregoing reasons, amici curiae respectfully urge this Court to hold that 1) under 23 Pa. C.S.A. § 6303 et seq., a woman cannot be a “perpetrator” of


“child abuse” for her actions while pregnant that might affect the health of her newborn and 2) under 23 Pa. C.S.A. § 6386, A.A.R. should not be found to have committed child abuse.

Dated: May 3, 2018

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By: /s/ John S. Summers

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CERTIFICATION OF COMPLIANCE WITH WORD COUNT LIMIT

Pursuant to Pa. R.A.P. 531(b)(3), I, John S. Summers, hereby certify that the foregoing Brief for Amici Curiae, The Drug Policy Alliance, Families for Sensible Drug Policy, Avik Chatterjee, MD, MPH, Keith Humphreys, PhD, Hendrée Jones, PhD, Stephen R. Kandall, MD, FAAP, Mishka Terplan, MD, MPH, FACOG, DFASAM, Bruce Trigg, MD, Michael S. Wald, and Tricia E. Wright, MD, MS in Support of Appellant contains 6,739 words, excluding those portions exempted by Pa. R.A.P. 2135(b), and thus complies with the 7,000 word limit set forth in Pa. R.A.P. 531(b)(3).

/s/ John S. Summers
John S. Summers

Dated: May 3, 2018
CERTIFICATION OF COMPLIANCE WITH Pa. R.A.P. 127

I, John S. Summers, hereby certify that the foregoing Brief for Amici Curiae, The Drug Policy Alliance, Families for Sensible Drug Policy, Avik Chatterjee, MD, MPH, Keith Humphreys, PhD, Hendrée Jones, PhD, Stephen R. Kandall, MD, FAAP, Mishka Terplan, MD, MPH, FACOG, DFASAM, Bruce Trigg, MD, Michael S. Wald, and Tricia E. Wright, MD, MS in Support of Appellant complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

/s/ John S. Summers

John S. Summers

Dated: May 3, 2018
CERTIFICATE OF SERVICE

I hereby certify that I am on this day serving a true and correct copy of the Brief for *Amici Curiae*, The Drug Policy Alliance, Families for Sensible Drug Policy, Avik Chatterjee, MD, MPH, Keith Humphreys, PhD, Hendrée Jones, PhD, Stephen R. Kandall, MD, FAAP, Mishka Terplan, MD, MPH, FACOG, DFASAM, Bruce Trigg, MD, Michael S. Wald, and Tricia E. Wright, MD, MS in Support of Appellant upon the persons via first class mail, which service satisfies the requirements of Pa. R.A.P. 121:

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Dated: May 3, 2018

John S. Summers
APPENDIX A

STATEMENTS OF INTEREST OF AMICI CURIAE

*Amicus curiae The Drug Policy Alliance* ("DPA") is a 501(c)(3) nonprofit organization that leads the nation in promoting drug policies that are grounded in science, compassion, health, and human rights. Established in 1994, DPA is a nonprofit, non-partisan organization with more than 20,000 members nationwide. DPA is dedicated to advancing policies that reduce the harms of drug use and drug prohibition, and seeking solutions that promote public health and public safety. DPA is actively involved in the legislative process across the country and strives to roll back the excesses of the drug war, block new, harmful initiatives, and promote sensible drug policy reforms. The organization also regularly files legal briefs as amicus curiae, including in other cases pertaining to pregnant women who use drugs. See, e.g., *Loertscher v. Anderson*, 259 F.Supp.3d 902 (2017).

*Amicus curiae Families for Sensible Drug Policy (FSDP)*, a 501(c)(3) nonprofit organization cofounded by Barry Lessin and Carol Katz Beyer, is a global coalition of families, professionals, and organizations representing the voice of the family impacted by substance use and the harms of existing drug policies. We empower families by advancing and implementing a new paradigm of comprehensive care and progressive solutions for family support based on science, compassion, public health and human rights. The reasons to expand Pennsylvania’s child abuse law to prosecute mothers based on substance use during pregnancy are not supported by science. Research shows that exposure to drugs does not pose a unique or significant risk of medical harm to a newborn especially when compared to the trauma involved of removing the newborn from the mother.

**Individual Experts**

*Institutional affiliations designated with * are provided for identification purposes only.*

*Amicus curiae Avik Chatterjee, MD, MPH* is an internal medicine and pediatrics trained primary care physician at Boston Health Care for the Homeless Program, Instructor at Harvard Medical School, and Associate Epidemiologist in the Division of Global Health Equity at Brigham and Women's Hospital. He is certified in Addiction Medicine by the American Board of Preventive Medicine, and does a significant amount of clinical work treating opioid use disorder and alcohol use disorder in shelter-based outreach clinics. He and his colleagues created a first-of-its-kind family shelter-based opioid addiction treatment program.
for parents with opioid use disorder. He has presented on opioid use disorder and family homelessness at the national conferences of the Society for General Internal Medicine, the Association for Medical Education and Research in Substance Abuse, and the National Health Care for the Homeless Council. He has published articles on innovative models of care for opioid use disorder in vulnerable populations, specifically in parents facing homelessness, in the American Journal of Public Health and Drug and Alcohol Dependence. He continues to work on innovative treatment models for opioid addiction in vulnerable populations in urban areas.

*Amicus curiae Keith Humphreys, PhD* is the Esther Ting Memorial Professor at Stanford University, where he holds faculty appointments in the Department of Psychiatry and the School of Law. He is a clinical psychologist who has treated addicted patients and also has over 30 years of experience as an addiction researcher. He has published over 250 journal articles and book chapters related to substance use disorders and his work has been cited over 10,000 times by addiction researchers around the world. He served as Senior Policy Advisor in the White House Office of National Drug Control Policy in the Obama Administration and also served as a Member of the White House Advisory Commission on Drug-Free Communities in the Bush Administration. He has testified about public policy regarding addiction on numerous occasions in state legislatures, in the U.S. Congress, and in the U.K. Parliament.

*Amicus curiae Hendrée Jones, PhD* is a Professor in the Department of Obstetrics and Gynecology, School of Medicine, University of North Carolina, Chapel Hill and Executive Director of Horizons, a comprehensive drug treatment program for pregnant and parenting women and their drug-exposed children. She is also an Adjunct Professor in the Department of Psychiatry and Behavioral Sciences and in the Department of Obstetrics and Gynecology, School of Medicine, Johns Hopkins University. Dr. Jones is an internationally recognized expert in the development and examination of both behavioral and pharmacologic treatments of pregnant women and their children in risky life situations. Dr. Jones has received continuous funding from the United States National Institutes of Health since 1994 and has published over 190 peer-reviewed publications, two books on treating substance use disorders (one for pregnant and parenting women and the other for a more general population of patients), several book and textbook chapters, and multiple editorial letters and non-peer reviewed articles for clinicians. She is a consultant for The Substance Abuse and Mental Health Services Administration, the United Nations and the World Health Organization. Dr. Jones leads or is involved in projects in Afghanistan, India, the Southern Cone, the Republic of
Georgia, South Africa, and the United States which are focused on improving the lives of children, women and families.

*Amicus curiae* Stephen R. Kandall, MD, FAAP* served as Chief of Neonatology at Beth Israel Medical Center from 1976 to 1998 and retired in 1998 as Professor of Pediatrics at the Albert Einstein College of Medicine. Most of Dr. Kandall's 90 contributions to the medical literature deal with perinatal drug use, and he has contributed chapters to many standard textbooks, including *Substance Abuse: A Comprehensive Textbook* and *Principles of Addiction Medicine*, as well as his own definitive book on the history of women and addiction in the United States, *Substance and Shadow*. Dr. Kandall has lectured throughout the United States, as well as Belgium, Italy, Austria and Australia. He has served as president of his local medical societies, as an advisor to many commissions and panels on drug abuse (including the March of Dimes, Narcotic and Drug Research, Inc., and the Scott Newman Foundation in Los Angeles), and currently advises legislative subcommittees on perinatal health in North Carolina.

*Amicus curiae* Mishka Terplan MD MPH FACOG DFASAM* is board certified in both obstetrics and gynecology and in addiction medicine. His clinical, research and advocacy interests lie along the intersection of reproductive and behavioral health. He is currently Professor in both Obstetrics & Gynecology and Psychiatry and the Associate Director of Addiction Medicine at Virginia Commonwealth University. He is the Medical Director of MOTIVATE – an outpatient Office Based Opioid Treatment clinic, Addiction Medicine Consultant for DMAS (Department of Medicaid Services, VA) and consultant for National Center on Substance Abuse and Child Welfare. Dr. Terplan has active grant funding and has published over 70 peer-reviewed articles with recent emphasis on health disparities, stigma, and women’s access to treatment. He has spoken before the United States Congress and has participated in expert panels at CDC, SAMHSA, ONDCP and NIH primarily on issues related to gender and addiction.

*Amicus curiae* Bruce Trigg, MD* is the Interim Medical Director of the Harm Reduction Coalition. Dr. Trigg was, until 2011, the medical director of the Sexually Transmitted Disease program for Regions 1 and 3 of the New Mexico Department of Health. He also served as medical director of a public health program that offers reproductive and infectious disease programs at the Bernalillo County Metropolitan Detention Center in Albuquerque, NM. For 20 years, Dr. Trigg provided clinical care to patients as part of the Milagro Program, for pregnant women who use drugs, at the University of New Mexico Health Sciences Center. He is currently a Clinical Assistant Professor in the Department of
Pediatrics at the University of New Mexico and on the faculty of the Adolescent Reproductive and Sexual Health Education Project (ARSHEP) of Physicians for Reproductive Health, a project cosponsored by the American College of Obstetrics and Gynecology and the Society for Adolescent Health and Medicine. He has consulted on addiction treatment in several Southeast Asian countries. Dr. Trigg graduated from the City College of NY and the George Washington University School of Medicine in Washington, D.C. He did his residency in pediatrics at the Albert Einstein College of Medicine in New York City and at the University of New Mexico School of Medicine. Dr. Trigg served three years with the US Public Health Service in the Indian Health Service in Native communities in New Mexico and Arizona.

*Amicus curiae Michael S. Wald* is the Jackson Eli Reynolds Professor of Law, Emeritus, at Stanford University. He has been actively involved in designing and implementing polices regarding child maltreatment for fifty years through teaching, research, and practice. He was the reporter for the American Bar Association’s Standards on Child Abuse and Neglect. He has written numerous articles and books regarding the proper scope of child maltreatment jurisdiction. Professor Wald also has held a number of government positions connected to social services for children and families, including Director of the San Francisco Human Services Agency, Deputy General Counsel of the US Department of Health and Human Services, and was a member of the US Advisory Board on Child Abuse and Neglect.

*Amicus curiae Tricia E. Wright, MD, MS* is an associate professor of Obstetrics, Gynecology at the University of Hawaii John A. Burns School of Medicine and the founder, former medical director, and now Women's Health Liaison of the PATH Clinic, an outreach clinic of Waikiki Health Center, which provides prenatal, postpartum and family planning to women with a history of substance use disorders. She is board certified in both OB/Gyn and Addiction Medicine and a Fellow of the American College of Obstetricians and Gynecologists and the American Society of Addiction Medicine. She specializes in taking care of pregnant women with substance use disorders and psychiatric illness. She won funding approval in 2006 from the Hawaii legislature to start the first perinatal clinic for women with substance use issues in Hawaii. She edited the recently published book “Opioid Use Disorders in Pregnancy: Management Guidelines for Improving Outcomes.”
IN THE SUPREME COURT OF PENNSYLVANIA

NO. 10 MAP 2018

In the Interest of L.J.B., A Minor.
Appeal of: A.A.R., Mother.

BRIEF OF NATIONAL ADVOCATES FOR PREGNANT WOMEN, COMMUNITY LEGAL SERVICES OF PHILADELPHIA, AND EXPERTS IN MATERNAL AND CHILD HEALTH, CHILD WELFARE, AND LAW AS AMICUS CURIAE IN SUPPORT OF APPELLANT


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STATEMENT OF INTEREST OF AMICI CURIAE

National Advocates for Pregnant Women and Community Legal Services of Philadelphia file this brief on behalf of amici curiae, who collectively represent experts in the fields of maternal, fetal, and child health, child welfare, public health, and law, committed to the health and rights of pregnant and parenting women and their children (collectively “amici”). ¹ Amici fully incorporate the legal and constitutional arguments made by the mother in this case, and write separately in an effort to assist the Court by bringing to bear relevant information which militates against the judicial expansion of Pennsylvania’s child abuse law to address pregnancy. Amici are concerned that allowing this expansion of the law will undermine public health and the interests of children and families. Applying the child abuse law to actions, decisions, and conditions of pregnant women undermines their human rights and threatens maternal and fetal health by deterring pregnant women from seeking medical care.

No one other than the amici curiae or its counsel paid for the preparation of this amicus curiae brief or authored this brief, in whole or in part.

STATEMENT OF JURISDICTION

Amici incorporate the Statement of Jurisdiction in Appellant’s Brief.

¹ Further information about each amici is included as Appendix A.
ORDER OR OTHER DETERMINATION IN QUESTION

*Amici* incorporate the statement of the Order or Other Determination in Question in Appellant’s Brief.

STATEMENT OF THE SCOPE AND STANDARD OF REVIEW

*Amici* incorporate the Statement of the Scope and Standard of Review in Appellant’s Brief.

STATEMENT OF THE QUESTIONS INVOLVED

*Amici* incorporate the Statement of the Questions involved and Suggested Answers in Appellant’s Brief.

STATEMENT OF THE CASE

*Amici* incorporate the Statement of the Case in Appellant’s Brief.

SUMMARY OF ARGUMENT

The Superior Court’s expansion of “child abuse” in the Child Protective Services Law (“CPSL”) to include pregnancy needlessly and irrationally expands the reach of the statute, undermining its purpose and violating the Constitutional and human rights of pregnant and parenting people in Pennsylvania. Pennsylvania law, the U.S. Constitution, and international human rights principles all have as their foundation the protection of individuals and the family. 23 Pa.C.S. § 6302;

The Superior Court’s expansion of the CPSL’s abuse provisions to include pregnancy or pregnancy outcomes as intentional acts to injure a child is unfounded and undermines these fundamental protections. The lower court’s counter-productive interpretation of Pennsylvania law also inflicts punishment through placement on a child abuse registry. Expanding the CPSL as the Superior Court has done here will also deter women from seeking health care and increase the likelihood of intrusive and stress-inducing surveillance. This Court cannot permit such an interpretation of the law to stand.

² The Universal Declaration of Human Rights, which the U.S. helped develop, established internationally acknowledged principles of human rights. It states at art. 16, “The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.” And at art. 12, “No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence [and] has the right to the protection of the law against such interference or attacks,” See also, Amnesty International, Criminalizing Pregnancy 46 (2017), https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf (“States have an obligation to respect, protect and fulfill the full range of human rights for all people, including pregnant women. These obligations apply to both states’ law and policy-making, criminal and civil law enforcement and provision of services, including health and social services.”)
ARGUMENT

I. Pennsylvania Law Presently Provides a Comprehensive Structure to Protect Children and Taking the Unprecedented Step of Including Pregnancy as a Basis for Placement on the ChildLine Registry Will Have Grave Consequences for Women, Children, and Families.

A. The Juvenile Act and CPSL offer a robust framework for the protection and safety of infants.

This Court may be concerned about the impact of substance use on a person’s ability to safely parent a young child. However, that is not the issue before this Court. The Commonwealth already maintains a robust statutory scheme to protect the welfare of infants, which would not be enhanced by an expansion of the definition of abuse to include pregnancy. An infant who is identified as “affected” by “illegal substance abuse by the child’s mother,” which includes infants that present with Neonatal Abstinence Syndrome (“NAS”)\(^\text{3}\), must already be reported by her health care provider to the county Children and Youth Agency (“CYS”). 23 Pa.C.S. § 6386(a). CYS must then assess the family and determine whether child protective services or general protective services are warranted. 23 Pa.C.S. § 6386(b). CYS also must “provide or arrange reasonable services to ensure the child is provided with proper parental care, control and supervision.” 23 Pa.C.S. § 6386(c). Pennsylvania’s law closely follows the requirements of the Child Abuse Prevention and Treatment Act and its amendments, key federal law in

\(^{3}\) See II(B). infra for definition and explanation of NAS.

If an infant is found to be in danger and needs to be removed from her mother’s care, the Juvenile Act authorizes the court to issue an order of protective custody. 42 Pa.C.S. § 6324. The court may further adjudicate such a child dependent and maintains broad authority to issue any dispositional order best suited to the welfare of the child. 42 Pa.C.S. § 6341; 42 Pa.C.S. § 6351. CYS may even seek to permanently sever the parent-child relationship through the termination of parental rights. 23 Pa.C.S. § 2511. Importantly, a finding of child abuse is not a prerequisite for any of these interventions, however, it does result in the parent’s name being placed on ChildLine, a statewide registry of child abuse, that may remain for the rest of the parent’s life. ChildLine and Abuse Registry, Penn. Dept. of Human Services, (last visited Apr. 26, 2018), http://www.dhs.pa.gov/provider/childwelfareservices/childlineandabuseregistry/.

B. Expanding the CPSL to permit a finding of child abuse based on pregnancy will cause severe and counterproductive economic consequences to women, children, and communities.

The Superior Court’s expansion of the law to permit a finding of child abuse based on an infant being prenatally exposed to a substance will do little to further the welfare of the child, but will instead serve as punishment that erects intractable barriers to recovery and stability for a family. This is because the employment
consequences of being placed on the ChildLine registry are broad and largely irreversible, leading to a lifetime of stigma and severely curtailed employment opportunities in fields that have traditionally served as pathways out of poverty for women.

Job applicants must submit a child abuse clearance when they apply for a wide variety of positions, most often held by low-income women. This includes work as a daycare provider; teacher; school lunch aide; bus driver; crossing guard; school janitor; counselor; caregiver; librarian; pastor; clerk at a children’s store; athletic coach; many health care providers; camp counselor; lifeguard; or as an employee at any “program, activity or service” placing her in direct contact with children. 23 Pa.C.S. § 6344. She would also be prohibited from working for a home health care agency, or providing in home personal care or respite care. 28 Pa. Code § 611.53(b). And yet, unlike forms of abuse that may warrant exclusion from certain jobs (for example pedophiles being prevented from working in schools), being pregnant and having used a substance is not, predictive of, or correlated with a lifetime inability to perform these jobs or to care for children. Indeed, there is no

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4 Although a founded child abuse report within the past 5 years is an absolute bar to employment in these positions, in practice any indicated or founded child abuse report potentially remains on the ChildLine Registry indefinitely and may serve as a de facto bar to employment.

5 Janet Dolgin, *The Law’s Response to Parental Alcohol and “Crack” Abuse*, 56 Brook. L. Rev. 1213,1224 (1991) (“In general, there has been little research on the effects of illegal substance abuse on the children of users . . . there is [also] disagreement among researchers about the extent to which drug use correlates with neglect . . . [one study found] neither drug use nor addiction, per se, produces [child] neglect.”) See also Susan C. Boyd, *Mothers and Illicit Drugs:*
bar to any employer making employment contingent upon a child abuse clearance, and in practice a growing number of employers, including nursing homes and elder care facilities, choose to do so, further limiting the economic opportunities for low-income mothers.

i. The proposed expansion of the CPSL will exacerbate child poverty.


Children in Poverty, Kids Count Data Center, (last visited Apr. 19, 2018), https://datacenter.kidscount.org/data/tables/43-children-in-poverty-100-percent-poverty?loc=1&loct=2#detailed/2/40/false/870,573,869,36,868/any/321,322. The caregiving jobs proscribed by the CPSL are precisely the jobs that serve as pathways out of poverty and toward economic stability for mothers:

Low-income women cluster in caregiving and customer service work. Nationally, 20.51% of the female workforce is employed in retail, while 46.64% of the female workforce is employed in service and caregiving fields… [which] are high growth fields in which there are jobs available. For example, home health care is the largest industry in Pennsylvania—a state with one of the highest elderly populations in the country. As the baby boomers continue to age, the demand for health care workers will only increase, making it an essential field for low-income workers.

Transcending the Myth 60 (1999) (listing studies demonstrating that women who use illicit drugs can be adequate parents), attached as Appendix B.1; Margaret H. Kearny et al., Mothering on Crack Cocaine A Grounded Theory Analysis, 38 Soc. Sci. & Medic. 351, 355 (1994); Brenda D. Smith & Mark F. Testa, The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants, 26 Child Abuse and Neglect 97 (2002), attached as Appendix B.2.

The burden of lack of access to meaningful employment falls not only on mothers, but on their children, because “when women are shut out of the workforce, children are far more likely to live in poverty.” Krohn *supra* at 251. The lifelong effects of child poverty cannot be overstated. Childhood poverty can significantly hinder a child’s educational prospects, and is a widely-recognized risk factor for a host of chronic health issues. David Wood, *Effect of Child and Family Poverty on Child Health in the United States*, 112 J. Am. Acad. of Pediatrics 707, 707-711 (2003). Notably, children who grow up in poverty are more likely to remain impoverished as adults, and are less likely to attain stable employment themselves, creating an intergenerational cycle of poverty. Caroline Ratcliffe & Signe-Mary McKernan, *Child Poverty and Its Lasting Consequence* 1-15 (The Urban Institute 2012),
ii. A child abuse finding may have lifetime consequences for mothers and their families.

The economic and other consequences of a child abuse finding may be lifelong and virtually irreversible. When a child abuse report is indicated, meaning that CYS has made a determination that substantial evidence of abuse exists, 23 Pa.C.S. § 6303, the report generally remains on the registry “indefinitely.” 23 Pa.C.S. § 6338(c). An alleged perpetrator may request a hearing to review the accuracy of the finding, if she does so within 90 days. 23 Pa.C.S. § 6341(a). The CPSL also permits the Secretary of the Pennsylvania Department of Human Services to review a finding of child abuse, and the Secretary may expunge an indicated report for “good cause,” which may include evidence that the perpetrator in an indicated report of abuse “no longer represents a risk of child abuse.” Id. Such relief lies solely in the discretion of the Secretary, and may not be granted until years or even decades after the initial finding. In practice, the consequences of most indicated reports may last a lifetime. The CPSL also allows for expungement in other very limited circumstances. See 23 Pa. C.S. §6338(b), (c), 23 Pa. C.S. §6338.1.
Even the narrow relief available for indicated reports is completely unavailable to those with founded reports. A founded report exists any time there has been a judicial adjudication of child abuse, including, as in the instant case, in the context of a dependency proceeding. 23 Pa.C.S. § 6303. A mother with a founded report may not seek relief from the Secretary at all unless she can establish that the judicial adjudication has been reversed or vacated. 23 Pa.C.S. § 6341(c.1). There exists no opportunity for a mother with a founded report to establish, in any forum or tribunal, that she has rehabilitated or “no longer represents a risk of child abuse.” 23 Pa.C.S. § 6341(a).

This means under the Superior Court’s interpretation, a mother who at age 20 gives birth to a substance exposed infant and is subject to a founded report may remain on the child abuse registry for life. She will experience deep stigma and face crippling employment consequences at age 30, 40, 50, and beyond, regardless of whether she had a substance use disorder at all, or abstains from all drug use, maintains stability, or contributes to the care of her family and community. If so, she will be foreclosed from many jobs that could offer stability and meaningful paths out of poverty. Decades later, she could be prohibited from volunteering in her grandchild’s school. If she is needed as a kinship provider or adoption resource for a family member, she will likely be denied. Worse, her child and any children she has had previously or will have in the future, will be vulnerable to the effects
of these consequences. The consequences created by the Superior Court’s expansion of the CPSL’s reach are destabilizing to children and families; they are not protective and should not stand.

II. Judicial Expansion of Pennsylvania’s Child Abuse Law to Include Pregnancy and Childbirth is an Unsound and Unsupported Policy.

A myriad of factors can influence pregnancy and pregnancy outcomes. As one court noted, every aspect of a pregnant woman’s experience “shapes the prenatal environment which forms the world for the developing fetus” Stallman v. Youngquist, 531 N.E.2d 355, 360 (Ill. 1988). The numerous factors and interactions that can contribute to particular birth outcomes make attempts to expand child abuse law to include pregnancy illogical as well as punitive.

A. Birth outcomes are not “injuries” supporting a finding of child abuse.

“A range of biological, social, environmental, and physical factors have been linked to maternal, infant, and child health outcomes.” Office of Disease Prevention & Health Promotion, Maternal, Infant, and Child Health – Life Stages & Determinants, U.S. Dep't of Health & Human Serv., (last updated Apr. 26, 2018), https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Maternal-Infant-and-Child-Health/determinants. As the U.S. Department of Health and Human Services has found, “[t]hese include race and ethnicity, age, and socioeconomic factors, such as income level, educational attainment, medical insurance coverage, access to medical care, pre pregnancy health, and general
health status.” Id. These are not things the CPSL should be expanded to address in its effort to prevent abuse and protect abused children from further injury. Certainly, the CPSL is not meant to include knowingly or recklessly being poor; older; or stressed, even though each of these are likely to affect child health outcomes.6 Yet the Superior Court’s expansion of the CPSL, which by rationale is not limited to NAS, carries a very real risk that mothers could be punished for a wide variety of birth outcomes not within their control.

   Medical science has great difficulty separating factors and determining a single cause of a pregnancy outcome, even when the outcome is a perinatal loss.7 “[S]ocial characteristics of a community . . . hold important implications for pregnancy outcomes . . . the physical and social environments within which individuals function need to be safe, clean, affordable, socially supportive and adequately resourced in order to maximize every woman’s potential to deliver a full-term and healthy infant.” Am. Public Health Ass’n, Policy No. 20062, Reducing Racial/Ethnic and Socioeconomic Disparities in Preterm and Low Birthweight Births (Nov. 8, 2006); see also Simone C. Gray, et al., Assessing the

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7 More than 20% of pregnancies end in miscarriage or stillbirth. Ruth C. Fretts, Etiology and Prevention of Stillbirth, 193 Am. J. Obstetrics & Gynecology 1923, 1924 (2005), attached as Appendix B.3; Raj Rai et al., Recurrent Miscarriage, 368 Lancet. 601, 602 (2006). See also Donald J. Dudley et al., A New System for Determining the Causes of Stillbirth, 116 Obstetrics & Gynecology 254, 258 (2010)(noting that identifying a single cause of a stillbirth is extremely difficult, as fetal demise can be very complex, and often results from the cumulative effect of several risk factors.)
impact of race, social factors and air pollution on birth outcomes: a population-based study, Environmental Health, Jan. 29, 2014 at 1 (finding that exposure to pollution, individual and neighborhood socioeconomic status, race, and education all impacted birth outcomes). Moreover, research fails to support the assumptions the Superior Court’s conclusion rests on, among these, that prenatal exposure to illegal substances is uniquely dangerous, and that a newborn’s health depends solely or even primarily on the pregnant woman. See Social Determinants of Health, World Health Organization (2017), http://www.who.int/social_determinants/sdh_definition/en/ (“social determinants of health are the conditions in which people are born, grow, live, work and age.”); Kim Krisberg, Shift Toward Social Determinants Transforming Public Health Works: Targeting Causes of Health Disparities, The Nation’s Health, July 2016 (“at least 50% of health outcomes are due to the social determinants . . .”).

B. Child welfare interventions must be evidence-based and in the best interest of the child.

It is in a newborn’s best interest not to have the parent-child bond disrupted. The expansion of the law would subject families to arbitrary interference with that bond in violation of the Commonwealth’s obligation to protect the family unit.8

Prenatal exposure alone to any particular substance also does not constitute an

8 23 Pa.C.S. § 6302; International Covenant on Civil and Political Rights, art. 17, Dec 16, 1966, S. Treaty Doc. No. 95-20 I.L.M. 368 (1967), 999 U.N.T.S. 171. “No one shall be subjected to arbitrary or unlawful interference with his . . . family” (signed and ratified by the United States creating obligations on the federal and state governments to comply with its provisions.).
intentionally inflicted bodily injury necessitating a punitive governmental response against the parent.⁹

Most risks identified as possible outcomes of prenatal exposure to drugs are temporary and treatable, including withdrawal symptoms experienced by some newborns exposed to opioids, called Neonatal Abstinence Syndrome (“NAS”) Substance Abuse & Mental Health Services Administration (SAMHSA), U.S. Department of Health & Human Services, Pub. No. [SMA] 14-4124, *Methadone Treatment for Pregnant Women* (2014).¹⁰ While NAS is understandably concerning, there is no evidence to indicate that with effective modern treatment, NAS itself is life threatening or results in permanent harm. For infants with symptoms of NAS—whether from exposure to prescribed opioids or not, there are safe, effective, and evidence-based protocols to treat such symptoms. American College of Obstetricians and Gynecologists (“ACOG”), Comm. on Obstetric Practice, American Society of Addiction Medicine, Comm. Op. No. 711 (Aug. 2017).

Furthermore, skin-to-skin contact, breastfeeding, and caring for mother/baby in the same room (“rooming in”) is the medically recommended response and can significantly reduce the hospital stay of a newborn diagnosed with NAS and cut the

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need for medication in half.\textsuperscript{11} This underscores what we know about this period in human development where close attachment provides physiologic stability and the building blocks for continued development.\textsuperscript{12} Understanding attachment is now widely regarded as a best-practice in child welfare. N.C. Div. of Soc. Serv., \textit{Attachment and Welfare Practices}, Children's Service's Practice Notes, July 2014, \url{http://www.practicenotes.org/v19n3/CSPN_v19n3.pdf}. In this delicate period CYS involvement should be cautious, and when necessary focused on child welfare interventions, other than an abuse determination, recognizing the unique characteristics of the postpartum period and the importance of attachment for both mother and baby.

Medical conditions of newborns should be treated by the healthcare system, not through a child abuse proceeding and placement on the ChildLine Registry. There is no evidence suggesting that mothers who have used a controlled substance are more likely to prey on or pose a risk of abuse to children – a central purpose of the Registry. \textit{See supra} note 5. On the other hand, there is evidence that supporting a close, uninterrupted connection between a newborn and caregiver immediately after birth, including breastfeeding, protects against child abuse, and will respect

\begin{footnotesize}
\textsuperscript{11} Matthew Grossman, \textit{An Initiative to Improve the Quality of Care of Infants With Neonatal Abstinence Syndrome} Pediatrics May 2017 at e20163360, attached as Appendix B.4; Kathryn MacMillan et al., \textit{Association of Rooming-in with Outcomes with Neonatal Abstinence Syndrome: A systematic review and meta-analysis}, 172 JAMA Pediatrics 345 (2018), attached as Appendix B.5.

\textsuperscript{12} \textit{See Jorge Cesar Martinez, International Perspectives}, NeoReviews, Feb.2007, \url{http://neoreviews.aappublications.org/content/8/2/e55}.
\end{footnotesize}
the basic human rights of the child’s parent. Lane Strathearn et al., *Does Breastfeeding Protect Against Abuse and Neglect? A 15 Year Cohort Study*, 123 Pediatrics 483 (2009). The system imposed by the Superior Court is contrary to evidence-based care and will undermine Pennsylvania’s child protective goals.

C. The judicial expansion of the CPSL to pregnancy will allow for any act or condition, legal or illegal, of pregnant women to be investigated as a potential form of child abuse.

The Superior Court’s decision in this matter suggests the expansion of Pennsylvania’s child abuse law would be limited to cases in which a woman has “recklessly” consumed illicit substances while pregnant. Nothing in the very broadly worded decision, however, limits the use of the statute in such a manner. The Superior Court’s decision opens the door to a dramatic and legislatively unauthorized expansion of the Commonwealth’s power to investigate and intrude upon the rights of pregnant women. As discussed above, many factors impact pregnancy and pregnancy outcomes, as sister jurisdictions have already concluded. See, e.g., *Stallman v. Youngquist*, 531 N.E.2d 355, 360 (Ill. 1988) (refusing to recognize a tort of prenatal negligence); *In re Valerie D.*, 613 A.2d 748, 765 (Conn. 1992) (refusing to apply termination of parental rights statute to mother’s cocaine use while pregnant, explaining that using the law this way would have “sweeping consequences” for other conduct during pregnancy).
As Judge Strassburger noted in his concurring opinion below, using this law to prosecute pregnant women “opens the door to interpretations of the statute that intrude upon a woman's private decision-making as to what is best for herself and her child.” He went on to list the many decisions that may or may not impact a pregnancy, including whether to:

- engage in physical activity.
- eat a turkey sandwich, soft cheese, or sushi?
- drink an occasional glass of wine?
- What about a daily cup of coffee?
- continue medication even though there is a potential risk to the child?
- travel to countries where the Zika virus is present?

*In the Interest of L.B., a Minor, 177 A.3d 308, 314-315 (Pa. Super. Ct. 2017).* He inquired whether a pregnant woman “is a child abuser if her partner kicks or punches her in her abdomen during her pregnancy and she does not leave the relationship because she fears for her own life?” *Id.* Under the lower court’s interpretation, a “woman must act at least recklessly for her decision to constitute child abuse, [but] reasonable people may differ as to the proper standard of conduct” *id.*, especially when it comes to pregnancy.

Applying the abuse law to pregnancy “is quite broad indeed” and can lead to invasive, stressful investigations into every woman’s pregnancy and every aspect of her life, improperly infringing on personal privacy, freedom of decision-making, and undermining public health. *Id.* Judge Strassburger’s concerns regarding jurisdiction over pregnant women’s choices are well founded. *See, e.g., New Jersey Div. of Youth and Family Serv. v. L.V., 889 A.2d 1153 (Sup. Ct. N.J. Chanc. Div.*
2005) (child neglect petition based on mother’s alleged refusal during pregnancy to take medications to reduce the risk of transmitting HIV); New Jersey Division of Youth and Family Serv. v. V.M. & B.G., 974 A.2d 448 (Sup. Ct. NJ 2009) (addressed child neglect petition based in part on mother’s refusal to consent to c-section). Wisconsin, for example, has gone so far as to permit involuntary detention and forced treatment of pregnant women accused of any amount of past or current substance use for the stated purpose of protecting the fetus. Loertscher v. Anderson, 259 F. Supp. 3d 902 (W. D. Wis. 2017) (striking down “unborn child abuse” law as void for vagueness in violation of due process; law remains in effect pending appeal); see also Report of the U.N. Working Group on Arbitrary Detention on its visit to the United States of America, U.N. Doc A/HRC/36/37/Add.2, at 15-16 (2017), http://undocs.org/A/HRC/36/37/ADD.2 (Wisconsin law is a “deprivation of liberty” that “is gendered and discriminatory in its reach and application, as pregnancy, combined with the presumption of drug use is the determining factor for involuntary treatment.”) These cases all demonstrate an attempt to treat pregnancy as a basis for a finding of child abuse, neglect, or maltreatment. This is not and cannot be the law in Pennsylvania, and this Court should reject this harmful expansion of the law.

The judicial expansion here is particularly troubling because it increases the potential for the discriminatory use of the child abuse law against poor parents and
parents of color. Research reveals a disturbing prevalence of race and class disproportionality with respect to when and how alleged child abuse claims are reported to and handled by child welfare authorities. As the National Council of Juvenile and Family Court Judges has noted, “Research has demonstrated that minority children and families experience disparate decision-making in the investigation, substantiation, removal, placement in foster care, and final permanency determinations.” Nat’l Council of Juvenile & Family Court Judges, *Enhanced Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases* 66 (2016),


Specifically, when looking at substance exposed newborns, one study explained that infants born to Black mothers were more likely than those born to white mothers to have been screened for illicit drugs, leading researchers to

\(^{13}\) See also Khiara Bridges, *The Poverty of Privacy Rights* 114-125 (2017) (A national study showed “Two thirds of all cases of maltreatment identified by the study involved families with income below $15,000” Further, “[R]esearch . . . revealed that doctors are more likely to diagnose physical injuries among poor families as “abuse” and to diagnose them as “accidents” among affluent families.”)
conclude that “providers seemed to have used race as a factor in deciding whether to screen an infant for maternal illicit drug use.” Emma Ketteringham et al., *Healthy Mothers, Healthy Babies,* 20 CUNY L. Rev. 77, fn. 53 (2016), referencing Marc A. Ellsworth et al., *Infant Race Affects Application of Clinical Guidelines When Screening for Drugs of Abuse in Newborns,* 125 Pediatrics 1379 (2010).\(^{14}\)

This is despite the fact that drug use by Black and white women occurs at approximately the same rate. U.S. Dept. of Health & Human Services, *Results from the 2013 National Survey on Drug Use and Health Summary of National Findings* (2014),


Thus, the harmful effects of the judicial expansion of this law are overwhelmingly likely to disproportionately burden low-income women and women of color.

**III. Expanding the Child Abuse Law is Harmful to the Health and Human Rights of Families in Pennsylvania.**

Over the course of nearly three decades, nearly every leading medical and public health organization has concluded that responding to issues of pregnancy and substance use through a punitive legal system is wrong. It is “damaging to

public health and human rights.” Amnesty International supra at 50. As a United Nations Working Group has found, “the use in some countries of . . . punitive rather than educative measures to prevent injury to the fetus as a result of drug or alcohol consumption by addicted pregnant women is another manifestation of gender discrimination.” Rep. of the Working Group on the issue of discrimination against women in law and practice, UN Doc. A/HRC/32/44 10 (2016),
http://www.ohchr.org/Documents/Issues/Women/WG/A_HRC_32_44_WithFootnotes.doc. The UN Special Rapporteur on extreme poverty and human rights also critiqued the U.S.’s "confused and counter-productive drug policies" finding them to be "highly punitive regimes directed against pregnant women, rather than trying to provide sympathetic treatment and to maximize the well-being of the fetus.” Philip Alston (United Nations Special Rapporteur on extreme poverty and human rights), Statement on Visit to the USA (2017),

In Pennsylvania, substance use among pregnant women is generally treated as a matter of public health – not a basis for punishment. In 2012, Pennsylvania established a separate Department of Drug and Alcohol Programs. “This change reflects a strong commitment by the Commonwealth to provide education, intervention and treatment programs to reduce the drug and alcohol abuse and
dependency for all Pennsylvanians.” About DDAP, Pa. Dep’t of Drugs and Alcohol Programs (last visited Apr. 26, 2018), http://www.ddap.pa.gov/Pages/About.aspx.

In fact, the Commonwealth issued Guidelines specifically to address opioid use disorders among pregnant women, and recommends the use of methadone and buprenorphine, medication assisted treatments. Commonwealth of Pennsylvania, Prescribing Guidelines for Pennsylvania: Use of Addiction Treatment Medications in the Treatment of Pregnant Patients with Opioid Use Disorder (2016), http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/Prescribing%20Guidelines%20Pregnant%20Patients.pdf. This Court must respect the Commonwealth’s commitment to public health and reject the Superior Court’s attempt to address pregnancy and substance use as a form of child abuse rather than a public health issue.

As explained above, the Juvenile Act and the CPSL already offer a legal framework for the protection of infants that an additional finding of child abuse does not further. In addition to the overwhelming consensus among medical groups that such approaches actually undermine maternal, fetal, and child health\textsuperscript{15} – the Pennsylvania legislature has specifically refused to enact such an expansion of the definition of child abuse. S. 275, 2011 (Pa. 2011) (introduced amendment of child abuse definition to include a child who at birth tested positive for certain

\textsuperscript{15} See infra III.
A. Expansion of the child abuse law to pregnancy will deter women from seeking health care.

Researchers and courts long ago determined that punishing women for being pregnant and using certain drugs is harmful, because fear of prosecution can trigger an avoidance of healthcare. Sarah C.M. Roberts and Amani Nuru-Jeter, Women’s perspectives on screening for alcohol and drug use in prenatal care, 20 Women’s Health Issues 193 (2010). Involvement of the child welfare system is often perceived by pregnant women as punishment. In the context of criminal prosecutions, the U.S. Supreme Court has observed, there is “near consensus in the medical community” that addressing problems of drug use and pregnancy through the criminal justice system will "harm, rather than advance, the cause of prenatal health." Ferguson v. City of Charleston, 532 U.S. 67, 84 n.23 (2001) (noting the amicus submissions of numerous leading medical and public health organizations concluding that searching pregnant women for evidence of drug use and facilitating their arrest will harm prenatal health by discouraging women from seeking prenatal care.) In child protective proceedings, civil courts have recognized that a newborn’s prenatal exposure to a particular substance alone is
not indicative of “harm” so as to be the sole basis for a legal finding against the parent.¹⁶

Eminent medical organizations, including the American Medical Association, have uniformly condemned punitive approaches to substance use during pregnancy. Am. Med. Ass’n, Policy Statement H420.962, Perinatal Addiction-Issues in Care and Prevention (2017) (“Transplacental drug transfer should not be subject to criminal sanctions or civil liability . . . In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible. . .”). The American Academy of Pediatrics and American College of Obstetricians and Gynecologists, among others, have also condemned this approach as dangerous to both women and children. Am. Acad. Of Pediatrics Comm. on Substance Use and Prevention, A Public Health Response to Opioid Use in Pregnancy, 139 Pediatrics 3 (2017) (“The existing literature supports the position that punitive approaches to substance use in pregnancy are ineffective and may have detrimental effects on

¹⁶ See, e.g., Cal. Penal Code § 11165.13 (“For purposes of this article, a positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect”); In re Dante M., 87 N.Y.2d 73, 79 (N.Y. 1995) (“a positive toxicology for a controlled substance generally does not in and of itself prove that a child has been physically, mentally or emotionally impaired, or is in imminent danger of being impaired.”); N. J. Div. of Child Prot. & Permanency v. Y.N., 220 N.J. 165 (N.J. 2014) (court held the fact that newborn experienced neonatal abstinence syndrome as a result of mother's participation in a medically prescribed treatment program while pregnant was insufficient to establish child neglect or abuse.)
both maternal and child health.”); Am. Coll. of Obstetricians & Gynecologists Comm. on Ethics, Committee Opinion No. 473, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (2011, reaffirmed 2014) (“Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing.”)

Research confirms that threats of punishment undermine rather than advance state interests in encouraging healthy pregnancies and improved birth outcomes. Studies have found that fetal health can only “be legitimately pursued and achieved through maternal protection, in the form that nonpunitive therapeutic interventions afford. Results from this study confirm that mothers themselves also have the child’s welfare as their priority concern.” Martha Jessup et al., *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. Drug Issues 285, 299 (2003); see also Nancy Poole & Barbara Isaac, *Apprehensions – Barriers to Treatment for Substance-Using Mothers* 12 (British Columbia Centre of Excellence for Women's Health 2001) (62% of the study’s participants identified fear of losing their children as a barrier to treatment); Sarah Roberts & Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, 15 Maternal and Child Health J. 333, 338 (2011) (study showed that “most women feared that attending prenatal care while

As explained above, both substance use and substance use disorders are treated as a matter of public health in Pennsylvania, for everyone including pregnant women. This Court should not allow an interpretation of the law that would raise Constitutional concerns regarding equal protection, that undermines the Commonwealth’s commitment to the health of its residents, and that could serve as a deterrent for pregnant women to receive healthcare.

**B. Women who seek healthcare will be deterred from sharing information with physicians if such disclosures can be the basis of a child abuse finding.**

The appropriate role for a physician is as “counselor and medical advisor.” Am. Med. Ass’n, Board of Trustees, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2666 (1990).17 A relationship of trust is critical for effective medical care because the promise of confidentiality encourages patients to disclose sensitive subjects to a physician. *The AMA Code of Medical Ethics’ Opinions on Confidentiality of Patient Information*, 14 American Medical Ass’n J. of Ethics 715 (2012) (“The patient should feel free to make a full

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17 Attached as Appendix B.7.
Disclosure of information to the physician in order that the physician may most effectively provide needed services.”) Transforming pregnancy outcomes into the basis for child abuse findings, conscripts health care providers by compelling them to collect evidence from, report on, and testify against their own patients. As the U.S. Supreme Court has recognized, a “confidential relationship” is a necessary precondition for “successful [professional] treatment.” Jaffee v. Redmond, 518 U.S. 1, 10 (1997). “Patients who fear sensitive information may be disclosed to others will be inhibited from honest reporting to their physicians.” Am. Coll. Of Obstetrics & Gynecology Comm. on Ethics, Opinion No. 663, Alcohol Abuse and Other Substance Abuse Disorders: Ethical Issues in Obstetric and Gynecological Practice (2015).

As explained above, healthcare providers in Pennsylvania are required to report “to the appropriate county agency” instances of children who are “affected” by the mother’s “substance abuse.” 23 Pa. C.S.A. § 6386. However, that report is for the purpose “mandating the agency to conduct an assessment . . . to . . . ensure the child's safety, and provide services to the family as needed.”18 In the Interest of L.B., a Minor, 177 A.3d 308, at 313. The Superior Court’s ruling is improperly transforming that report into an accusation that a pregnant woman intentionally injured a child, equating pregnancy and the use of an illegal substance with an

18 Changes made in response to CAPTA’s 2006 amendments.
inflicted injury. This ruling only serves the punitive purpose of placing a new mother on the Commonwealth’s registry of child abuse, potentially for the rest of her life.

Because the threat of such a punitive outcome can discourage pregnant women from honest communication with their doctors or from treatment altogether, reinterpreting laws to use in the context of pregnancy will tragically undermine the Commonwealth’s commitment to its residents’ health.

C. Expansion of the child abuse law infringes upon the reproductive autonomy and bodily integrity of women in Pennsylvania.

A legal regime that threatens civil prosecution and a lifetime on a registry of child abusers in the event of a positive toxicology result for controlled substances, creates an extraordinary risk to women who carry their pregnancies to term. Some women who cannot overcome a substance dependency on pregnancy’s timetable may feel it necessary to eliminate the risk of legal consequences by deliberately terminating an otherwise wanted pregnancy. See *Cleveland Board of Education v. LaFleur*, 414 U.S. 632, 640 (1974) (“there is a right ‘to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.’”) J. Flavin, *A Glass Half Full? Harm Reduction Among Pregnant Women Who Use Cocaine*, 32 J. Drug Issues 973, 985 tbl.2 (2002) (one study reported two-thirds of the women surveyed who reported using cocaine while pregnant also considered having an abortion); Interim report of
the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. General Assembly, 66th Sess., 3 August 2011, UN Doc. A/66/254 (such policies can “violate the right to health by infringing human dignity by restricting the freedoms to which individuals are entitled under the right to health, particularly in respect to decision-making and bodily integrity”).

Inducing women to terminate otherwise wanted pregnancies is manifestly inimical to the purposes the CPSL is intended to serve, and another harmful effect of the Superior Court’s expansion of the child abuse law.

CONCLUSION

For the foregoing reasons, amici curiae respectfully request this Court to reverse the Superior Court’s decision in this matter and reject the judicial expansion of Pennsylvania’s child abuse law to address pregnancy.

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19 In the context of criminal cases, courts have noted how fear of prosecution may impact a woman’s decision to have an abortion. See State v. Greywind, No. CR-92-447 (N.D. Cass County Ct. Apr. 10, 1992) (criminal defendant in North Dakota sought an abortion to avoid prosecution for reckless endangerment of a fetus); Motion to Dismiss With Prejudice, State v. Greywind, No. CR-92-447 (N.D. Cass County Ct. Apr. 10, 1992)(after the defendant terminated her pregnancy, the prosecutor sought dismissal of the case stating that the “legal issues presented are no longer ripe for litigation.”), attached as Appendix B.8; see also Whitner v. South Carolina, 492 S.E. 2d 777, 787 (SC 1997) (J. Moore dissenting); Heather Sprintz, The Criminalization of Perinatal AIDS Transmission, 3 Health Matrix: J. L. Med. 495, 525 (1993) (criminal prosecution of pregnant women’s drug use “implicitly advocates abortion rather than childbirth, to avoid the risk of prosecution.”)
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CERTIFICATE OF COMPLIANCE

The foregoing brief complies with the word count limitation of all relevant Pennsylvania Rules of Appellate Procedure, including Rule 2135. This brief contains 6970 words. In preparing this certificate, the word count feature of Microsoft Word was relied upon.

Dated: May 3, 2018

/s/Kathleen Creamer
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CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that on this 3rd day of May, 2018, a true and correct copy of the foregoing Brief for Appellants was served in compliance with Pa.R.A.P.121.

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Appendix A: Descriptions of Individual Amici

*Amicus curiae* The Allegheny County Bar Foundation Juvenile Court Project (“JCP”) has been representing indigent parents in dependency proceedings, termination of parental rights cases and ChildLine Appeals in Allegheny County for over thirty years and has represented thousands of clients. The JCP’s mission is to ensure that impoverished and underprivileged parents within Allegheny County receive fundamental fairness within the Juvenile, Orphans’, Administrative Law and Appellate Courts concerning their dependency, termination of parental rights and ChildLine Appeal cases. Fundamental fairness includes not only due process and equal treatment under the law but also statutory interpretation analysis that executes only the legislative purpose of the act.

*Amicus curiae* The Allentown Women's Center (“AWC”) has been providing sexual and reproductive healthcare in Pennsylvania's Lehigh Valley since 1978. AWC provides abortion care to 23 weeks of pregnancy, medical and surgical gynecology, professional counseling and therapy services, and has a robust practice providing hormone therapy and transition support to hundreds of individuals who identify as transgender and gender non-binary. AWC is a training site in abortion care and trans-health for nursing and medical students, OB/GYN and family practice residents, and other graduate students.

*Amicus curiae* American Academy of Addiction Psychiatry (“AAAP”) is an international professional membership organization made up of practicing psychiatrists, university faculty, medical students and other related health professionals. Founded in 1985, it currently represents approximately 2,000 members in the United States and around the world. AAAP is devoted to promoting access to evidence-based practices, supporting the development and dissemination of new information in the field of addictions, and encouraging research on the etiology, prevention, identification, and treatment of addictions. AAAP opposes the prosecution of pregnant women based on the belief that the disclosure of personal drug use to law enforcement for use in criminal prosecutions will undermine prenatal care, discourage many women from seeking substance use treatment, and damage the medical provider-patient relationship that is founded on principles of confidentiality.

*Amicus curiae* American College of Obstetricians and Gynecologists (“ACOG”) is a national non-profit educational and professional organization that works to promote the advancement of women’s health through continuing medical education, practice, research, and advocacy. ACOG is the leading organization of
women’s health care providers, with more than 58,000 members, including more than 2,000 obstetrician-gynecologists in Pennsylvania.

ACOG is dedicated to continuously improving all aspects of healthcare for women, establishing and maintaining the highest possible standards for education and clinical practice, promoting high ethical standards, publishing evidence-based practice guidelines, encouraging contributions to medical and scientific literature, and increasing awareness among its members and the public about the changing issues facing women’s healthcare.

ACOG supports evidence-based strategies to address the needs of women with addictions, including the development of safe, affordable, available, efficacious, and comprehensive alcohol and drug treatment services for all women, especially pregnant women, and their families. ACOG opposes the use of the legal system to address and penalize perinatal alcohol and substance use. Although legal action against women who use drugs and alcohol while pregnant may have the intent to produce healthy birth outcomes, negative results, including discouraging and deterring women from obtaining obstetric and gynecologic care, are frequently cited. Seeking obstetric–gynecologic care during pregnancy should not expose a woman to legal consequences. For this reason, among others, ACOG urges that the Pennsylvania law be struck down.

Amicus curiae The American Medical Association (“AMA”) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all US physicians, residents and medical students are represented in the AMA's policy making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty area and in every state, including Pennsylvania. The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

Amicus curiae The American Medical Student Association (“AMSA”) is the oldest and largest independent association of physicians-in-training in the United States. Founded in 1950, AMSA is a student-governed, non-profit organization committed to representing the concerns of physicians-in-training. For more than 60
years, AMSA has represented the voice of physicians-in-training in their efforts to best serve the public. There are four aspirations on which AMSA members focus their activism: advocating for quality, affordable health care for all, global health equality, enriching medicine through diversity, and professional integrity, development and student well-being. To that end, AMSA believes that drug abuse and addiction are not primarily criminal problems, but are health problems with socioeconomic and legal implications, and as such, should be dealt with by health professionals. There are many alternatives to problematic substance use; complete abstinence from substance use is one, but not the only, solution. AMSA supports harm-reduction-based interventions, including medication assisted treatment (MAT) for opioid use disorder during pregnancy, as proven and effective methods of promoting health and reducing harm among substance users who may not be ready to stop using entirely. However, incarceration has not been shown to reduce rates of addiction. AMSA strongly supports a shift of emphasis of drug policy away from overly harsh, punitive policies that inevitably tend to disproportionately affect people of color and poor people, particularly during pregnancy. AMSA therefore discourages a criminal justice response and opposes any actions by the Justice Department and law enforcement that fail to deal with drug abuse and addiction as health problems.

Amicus curiae American Medical Women's Association ("AMWA") is a national, non-profit organization of over 10,000 women physicians and physicians-in-training representing every medical specialty. Founded in 1915, AMWA is dedicated to promoting women in medicine and advocating for improved women's health policy. AMWA strongly supports treatment and rehabilitation of women who use alcohol or drugs during pregnancy, and opposes the arrest, jailing and/or prosecution of pregnant women as a method of preventing or punishing chemical dependency during pregnancy. AMWA encourages all pregnant women to seek prenatal care and believes that breaching the medical confidentiality of these women or otherwise hindering their ability to establish a relationship of trust with their treatment providers will deter women, especially those that may be at high risk for adverse pregnancy outcomes, from receiving prenatal care.

Amicus curiae American Society of Addiction Medicine ("ASAM") is a nationwide organization of more than 5,000 of the nation's foremost physicians and allied health professionals specializing in prevention and treatment of addiction. ASAM believes that the proper, most effective solution to the problem of substance use disorder during pregnancy lies in medical prevention, i.e. education, early intervention, treatment, and research on chemically-dependent pregnant women. ASAM further believes that state and local governments should avoid any
measures defining alcohol or other drug use during pregnancy as a crime and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health services.

Amicus curiae The Association of Reproductive Health Professionals (“ARHP”) is a national nonprofit, interdisciplinary health care association for clinicians and advocates in the reproductive and sexual health care field. Founded in 1963 and comprised of physicians, nurse practitioners, physician assistants, pharmacists, certified nurse midwives, researchers, educators, and other allied professionals, ARHP is an important source of sexual and reproductive health education and information for health care professionals, patients, legislators, industry representatives, and the public at large. With regard to In the Interest of: L.B., a Minor Appeal of: CCCYS, in the Superior Court of Pennsylvania, ARHP is concerned that if this ruling were allowed to become law, it would pose serious general public health risks, including stigmatizing mothers and deterring them from pursuing needed substance abuse treatment and care. For these reasons, ARHP supports this amicus brief.

Amicus curiae the Black Women’s Health Imperative (“BWHI”) has been the only national organization dedicated solely to improving the health and wellness of our nation’s 21 million Black women and girls - physically, emotionally and financially for more than 30 years. BWHI advances and promotes Black women’s health in three ways: evidence-based programs and initiatives; policy and advocacy; and research translation. As part of their advocacy for the health of Black women and their families, BWHI seeks to ensure Black women’s reproductive autonomy is protected. The criminalization and prosecution of pregnant people disproportionately affect low income women and Black women. BWHI works to improve the health of Black women and girls through a reproductive justice lens, which includes pushing back on policies and laws that function to interfere with their reproductive health.

Amicus curiae Center for Gender and Justice ("CGJ") seeks to develop gender-responsive policies and practices for women and girls who are under criminal justice supervision. The Center is committed to research and to the implementation of policies and programs that will encourage positive outcomes for this underserved population.

Amicus curiae The Center for Reproductive Rights (the “Center”) is a global nonprofit organization incorporated and headquartered in New York that uses the power of law to advance reproductive rights as fundamental human rights around the world.
the world. The Center has undertaken a variety of initiatives, both in the U.S. and around the globe, to ensure that women do not lose their core rights to autonomy, dignity, or equality when they become pregnant. As part of its work to ensure legal guarantees to the full range of reproductive rights, the Center works to promote and ensure non-discriminatory access to safe and respectful maternal health care. The Center has advocated against the shackling of women in prison during childbirth in the U.S., and challenged the detention of postpartum women for failure to pay medical bills in Kenya. To carry out its work, the Center promotes the domestic and international application of international human rights instruments and consideration of related precedent in comparative law.

*Amicus curiae* Community Legal Services of Philadelphia (“CLS”) is a non-profit organization that provides free legal assistance to low-income individuals on a broad range of civil matters, including public benefits, landlord/tenant, utilities, mortgage foreclosure, employment and other areas of great need in Philadelphia. While the Employment Unit handles a significant amount of more traditional employment law matters, the largest need for CLS’ clients is addressing barriers to employment, such as criminal records and child abuse reports. Over the past five years, CLS’ office has handled hundreds of abuse expungement cases. The Family Advocacy Unit (FAU) is a unit within CLS which provides high quality representation to hundreds of parents each year in Philadelphia dependency and termination of parental rights proceedings. As part of its mission, the FAU works to ensure that low-income vulnerable families involved with the child welfare system receive the due process to which they are entitled and have meaningful access to justice in these extremely important proceedings. In addition to individual client representation, the FAU engages in policy advocacy and continuing legal education at both a statewide and local level to improve outcomes for children and families.

*Amicus curiae* Delaware County Women’s Center (“DCWC”) is a state licensed private doctor’s office that has a professional medical team specializing in medication abortion services up to 10 weeks of pregnancy. DCWC provides compassionate abortion care and reproductive health services, inspired by DCWC’s belief in the autonomy of the individual, and DCWC’s commitment to strengthening communities and building a better future. DCWC believes that threatening policies against substance-using women will discourage them from seeking medical care or treatment during their pregnancy for fear of facing legal penalization. No one should have to sacrifice their health in order to avoid punitive action.
Amicus curiae Facing Addiction with NCADD (The National Council on Alcoholism and Drug Dependence, Inc. has merged with Facing Addiction). The organization, with its Network of Affiliates, is dedicated to turning the tide on America’s addiction epidemic through education, information and advocacy. The Network of Affiliates provides prevention, education, information, referral, advocacy, and hope in the fight against the chronic diseases of alcoholism and other drug addictions. For nearly 75 years, they have provided confidential assessment and referral services for persons addicted to alcohol and other drugs and their families. In 1990, the NCADD Board of Directors adopted a policy statement on 'Women, Alcohol, Other Drugs, and Pregnancy' recommending that 'states should avoid measures which would define alcohol and other drug use during pregnancy as prenatal child abuse and should avoid prosecutions, jailing, or other punitive measures which would serve to discourage women from seeking health care services.

Amicus curiae Harm Reduction Coalition ("HRC") is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use. HRC was founded in 1993 and incorporated in 1994 by a working group consisting of syringe exchange providers, advocates, and drug users. Today, HRC is a diverse network of community-based organizations, service providers, researchers, policy-makers, academics, and activists challenging the persistent stigma placed on people who use drugs, and advocating for sensible policy reform. HRC advances policies and programs that help people address the adverse effects of the "War on Drugs" and drug use including overdose, HIV, Hepatitis C, addiction, and incarceration. HRC recognizes that the structures of social inequality impact the lives and options of affected communities. Since its inception in 1994, HRC has advanced harm reduction philosophy, practice, and public policy by prioritizing areas where structural inequalities and social injustice magnify drug related harm.

Amicus curiae Harm Reduction International is a leading non-governmental organization working to promote and expand support for harm reduction. Harm Reduction International works to reduce the negative health, social and human rights impacts of drug use and drug policy by promoting evidence-based public health policies and practices, and human rights based approaches to drug policy. Harm Reduction International is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

Amicus curiae the Health Federation of Philadelphia has a mission to expand access to comprehensive, coordinated and culturally responsive health and social
services for underserved populations in the Greater Philadelphia region. Health Federation of Philadelphia advocates for policies that reduce stigma and increase engagement in care for vulnerable adults, children and families and opposes policies that erect barriers to treatment and support.

*Amicus curiae Institute for Health and Recovery* ("IHR") is a statewide service, research, policy and program development agency. IHR's mission to develop a comprehensive continuum of care for individuals, youth and families affected by alcohol, tobacco and other drug use, mental health problems and violence/trauma. IHR focuses on the development of collaborative models of service delivery and the integration of gender-specific, trauma-informed and relational/cultural models of prevention, intervention and treatment. IHR serves individual women and men, and families, with a continuing emphasis on serving pregnant and parenting women and their children, and on fostering family-centered, strength-based and multiculturally competent approaches. IHR members know firsthand the fears pregnant substance-abusing women have regarding prosecution, causing them to be reluctant to seek prenatal care and substance abuse treatment.

*Amicus curiae Legal Action Center* ("LAC") is a national, non-profit law and policy organization, with offices in New York and Washington, D.C., that fights discrimination against and promotes the privacy rights of individuals with criminal records, substance use disorders, and/or HIV/AIDS. LAC’s work includes extensive policy advocacy to expand prevention and treatment opportunities for people with or at risk for substance use disorders and to oppose legislation and other measures that employ a punitive, rather than public health approach, to addiction. LAC has also represented individuals and substance use disorder treatment programs who face discrimination based on inaccurate stereotypes about the disease of addiction. The question posed in this case is of vital concern to LAC's constituency across the country.

*Amicus curiae Legal Voice* is a non-profit public interest organization that works in the Pacific Northwest to advance the legal rights of women through public impact litigation, legislation, and legal rights education. Since its founding in 1978 (as the Northwest Women's Law Center), Legal Voice has been dedicated to protecting and expanding women's legal rights. Toward that end, Legal Voice has advocated for legislation protecting pregnant persons' rights, including their rights to be free from shackling if they are incarcerated and pregnant or in labor. In addition, Legal Voice has participated as counsel and as amicus curiae in the Pacific Northwest and across the country in numerous cases involving the rights of pregnant and birthing women. Legal Voice opposes, and has successfully
challenged, prosecutions of women for their pregnancy outcomes and works to end punitive measures that undermine the humanity and legal rights of all pregnant women.

*Amicus curiae Maternity Care Coalition* (“MCC”), since 1980, has assisted more than 100,000 families throughout Southeastern Pennsylvania, focusing particularly on neighborhoods with high rates of poverty, infant mortality, health disparities, and changing immigration patterns. MCC knows a family’s needs change as they go through the pregnancy and their child’s first years and MCC offers a range of services and programs for every step along the way including helping families dealing with substance use disorder and child abuse. MCC works with families on the frontline starting with MCC’s home visiting programs that help parents with programs which strengthens families, promotes positive parenting practices and encourages early learning. Evidenced based parenting skills are taught that help reduce child abuse and neglect. In addition MCC has programs working with high risk women suffering from behavioral health issues including substance use disorder. MCC works with babies diagnosed with neonatal abstinence syndrome providing home visiting support, which is part of the plan of safe care for the baby. MCC engages in advocacy supporting regional and state efforts addressing the opioid epidemic.

*Amicus curiae National Advocates for Pregnant Women* (“NAPW”) is a non-profit organization that advocates for the rights, health, and dignity of all women, focusing particularly on pregnant and parenting women, and those who are most likely to be targeted for state control and punishment. Through litigation, representation of leading medical and public health organizations and experts as amicus, and through organizing and public education, NAPW works to ensure that women do not lose their constitutional, civil, and human rights as a result of pregnancy. The organization also conducts research and has published a peer-reviewed study on prosecutions of and forced medical interventions on pregnant women. NAPW believes that health and welfare problems experienced by women during pregnancy should be addressed as health issues, not as crimes, and promotes policies that actually protect maternal, fetal, and child health.

*Amicus curiae National Alliance of Medication Assisted Recovery* ("NAMA Recovery") is an organization composed of Medication Assisted treatment (i.e. methadone and buprenorphine) patients and healthcare professionals who support quality opiate agonist treatment. NAMA Recovery has thousands of members worldwide with a network of chapters in the United States and international affiliated organizations. The primary objective of NAMA Recovery is to advocate
for the patient in treatment by destigmatizing and empowering MAT patients. The goals of NAMA Recovery include eliminating discrimination against MAT patients, including pregnant and parenting women; creating a more positive image of MAT; helping to preserve patients' dignity and rights and making treatment available on demand to every person who needs it. First and foremost, NAMA Recovery confronts the negative stereotypes that impact the self esteem and worth of many medication-assisted treatment patients with a powerful affirmation of pride and unity.

Amicus curiae National Association of Neonatal Nurses (“NANN”) is a community of registered nursing professionals at all stages of their careers who care for newborn infants born with a variety of health challenges, including prematurity, birth defects, infection, cardiac malformations, and surgical problems. For more than 30 years, NANN has supported its members and advanced the profession by providing opportunities for members to influence care for neonates and their families, collaborate with leaders and peers in their field, and gain knowledge to improve their daily practice.

Amicus curiae The National Association of Perinatal Social Workers (“NAPSW”) was incorporated in 1980 for the purpose of promoting, expanding, and enhancing the role of social work in perinatal health care. The NAPSW helps individuals, families, and communities respond to psychosocial issues that emerge during the period from pre-pregnancy through an infant's first year of life.

Amicus curiae National Coalition for Child Protection Reform (“NCCPR”) is an organization of professionals from the fields of law, psychology, social work, and journalism who are dedicated to improving child welfare systems through public education and advocacy. NCCPR is a tax-exempt non-profit organization founded at a 1991 conference at Harvard Law School. NCCPR is incorporated in Massachusetts and headquartered in Alexandria, Virginia. Further information about the organization is available on its website, www.nccpr.org

Amicus curiae The National Women’s Health Network (“NWHN”) was founded in Washington, DC, in 1975 to improve the health of all women by developing and promoting a critical analysis of women’s health issues. NWHN works to defend women’s sexual and reproductive health and autonomy against threats that seek to undermine women's ability to make the best decisions regarding their own health.

Amicus curiae New Voices for Reproductive Justice (“NVRJ”) is a Human Rights and Reproductive Justice advocacy organization with a mission to build a
social change movement dedicated to the full health and well-being of Black women, femmes, and girls in Pennsylvania and Ohio. Since 2004, the organization has served over 75,000 women of color and LGBTQIA+ people of color, through community organizing, grassroots activism, civic engagement, youth mentorship, leadership development, culture change, public policy advocacy and political education. New Voices defines Reproductive Justice as the human right of all people to have full agency over their bodies, gender identity and expression, sexuality, work, reproduction and the ability to form families. New Voices stands in staunch opposition to laws that criminalize birth outcomes and pregnant women who have used substances during pregnancy. Such laws create fear of criminalization that could deter mothers who may be struggling with addiction from seeking care, and are likely to unequally harm women of color and poor women. Women of color face disproportionately high rates of pregnancy-related maternal deaths and infant mortality for a number of reasons, including the pervasive effects of institutional racism, stress, and barriers to comprehensive reproductive healthcare. New Voices firmly believes that, rather than criminalizing mothers, lawmakers should pass laws that increase access to a full range of pregnancy related and substance treatment care.

*Amicus curiae* the **Pennsylvania Chapter, American Academy of Pediatrics** ("The PA Chapter") is a state level organization of approximately 2200 pediatricians who are dedicated to promoting the health and well being of children. The PA Chapter accomplishes its mission through advocacy, education, quality improvement and practice support. In carrying out this mission, The PA Chapter collaborates with any entities that touch the lives of children, including families, communities, media, public officials, insurers and other advocacy groups. The PA Chapter is in favor of any initiative that supports families of working women.

*Amicus curiae* **Pennsylvania Coalition Against Domestic Violence** ("PCADV") is a private nonprofit organization working at the state and national levels to eliminate domestic violence, secure justice for victims, enhance safety for families and communities, and create lasting systems and social change. PCADV was established in 1976 as the nation’s first domestic violence coalition, and is now comprised of 60 funded community-based domestic violence programs across Pennsylvania, providing a range of life-saving services, including shelters, hotlines, counseling programs, safe home networks, medical advocacy projects, transitional housing and civil legal services for victims of abuse and their children. Current PCADV initiatives provide training and support to further advocacy on behalf of victims of domestic violence and their children.
Amicus curiae the Pennsylvania Medical Society (“the Medical Society”) is a Pennsylvania non-profit corporation that represents physicians of all specialties and is the Commonwealth’s largest physician organization. The Medical Society regularly participates as amicus curiae in cases raising important health care issues, including issues that have the potential to adversely affect the quality of medical care. Through these efforts, PAMED advocates for the interpretation of laws that are in the best interest of Pennsylvania’s citizens. Accordingly, the Medical Society’s overriding concern in this case is an interpretation of the Child Protective Services law that promotes that health and safety of the mother and child.

Amicus curiae Pennsylvania Society of Addiction Medicine (“PSAM”), is the Pennsylvania branch of ASAM, representing physicians specializing in the care and treatment of addicted individuals. PSAM’s mission is to educate fellow clinicians and the public at large, to advocate for patients to have access to treatment without discrimination, and to combat stigma against addicted persons. PSAM’s parent organization ASAM (American Society of Addiction Medicine) has authored a public policy statement on “Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids.”

Amicus curiae the Philadelphia Department of Public Health has a mission to protect and promote the health of all Philadelphians and to provide a safety net for the most vulnerable.

Amicus curiae Physicians for Reproductive Health (“PRH”) is a doctor-led nonprofit that seeks to assure meaningful access to comprehensive reproductive health services, including contraception and abortion, as part of mainstream medical care. Founded in 1992, the organization currently has over 6,000 members across the country, including over 3,000 physicians who practice in a range of fields: obstetrics and gynecology, pediatrics, family medicine, emergency medicine, cardiology, public health, neurology, radiology, osteopathic medicine, and more. These members, many of whom provide abortion care, include faculty and department heads at academic medical centers and top hospitals.

Amicus curiae Philadelphia Women’s Center (“PWC”) has been continually meeting the needs of women and families by providing professional, confidential and compassionate abortion care since 1972. Philadelphia Women’s Center (PWC) provides compassionate abortion care and reproductive health services, inspired by PWC’s belief in the autonomy of the individual, and PWC’s commitment to strengthening communities and building a better future. PWC believes that
threatening policies against substance-using women will discourage them from seeking medical care or treatment during their pregnancy for fear of facing legal penalization. No one should have to sacrifice their health in order to avoid punitive action.

*Amicus curiae Project RESPECT* (Recovery, Empowerment, Social Services, Education, Community and Treatment) Addiction Recovery in Pregnancy at Boston Medical Center is a comprehensive, multidisciplinary team treating pregnant women with Substance Abuse Disorders in the Greater Boston Area. Dr. Kelley Saia, an Assistant Professor of Obstetrics and Gynecology at Boston University Medical School, is the director of the program. Project RESPECT has been helping and treating pregnant women for several decades; Dr. Saia has been the director since 2006. Project RESPECT cares for and treats more than 125 mother/baby pairs per year, managing their medical, obstetric and psychiatric health. Project RESPECT provides opioid maintenance therapy, including methadone and buprenorphine. As one of the largest addiction treatment and obstetrics clinics in the country, Project RESPECT strongly objects to the appellee’s position in this case. Opioid maintenance therapy during pregnancy is the American College of Obstetrics and Gynecology's recommended treatment for women with opioid addiction during pregnancy. Comprehensive care for women with substance abuse disorders, specifically opioid addiction, which includes methadone or buprenorphine, has been shown to reduce preterm delivery, NICU admissions, and low birth weight, not to mention the harm reduction of morbidity for the mother.

*Amicus curiae SisterReach*, founded October 2011, is a Memphis, TN based grassroots 501c3 non-profit supporting the reproductive autonomy of women and teens of color, poor and rural women, LGBT+ and gender non-conforming people and their families through the framework of Reproductive Justice. SisterReach’s mission is to empower its base to lead healthy lives, raise healthy families and live in healthy communities. SisterReach provides comprehensive reproductive and sexual health education to marginalized women, teens and gender non-conforming people, and advocate on the local, state and national levels for public policies which support the reproductive health and rights of all women and youth.

*Amicus curiae SisterSong: Women of Color Reproductive Justice Collective* ("SisterSong") is a national organization of Indigenous women and women of color and allied organizations and individuals working for Reproductive Justice. Its core principles are threefold: it believes that every woman has the human right to choose if and when she will have a baby and the conditions under which she will
give birth; the human right to decide if she will not have a baby and her options for preventing or ending a pregnancy; and the human right to parent the children she already has with the necessary social supports to do so. Through advocacy, mentoring, and support, SisterSong raises the voices of women of color impacted by human rights violations on the national, state, and local levels.

**Individual Experts**

*Institutional affiliations designated with * are provided for identification purposes only.*

**Amicus curiae Kara R. Finck, JD**, is a Practice Professor of Law at University of Pennsylvania Law School and the Director of the Interdisciplinary Child Advocacy Clinic. In her clinic, she focuses on the civil legal needs of children and families through a holistic, interdisciplinary model of representation. Professor Finck previously served as the Managing Director of the Family Defense Practice at The Bronx Defenders where she oversaw the first institutional representation program for parents accused of abuse or neglect in Bronx Family Court. There she created a groundbreaking model for holistic representation of parents involved in the child welfare system. As a lecturer, she has presented both nationally and internationally on issues including child welfare, parents’ rights, child advocacy and interdisciplinary collaboration. She co-authored “Social Work Practice and the Law” (Springer Publishing, 2011) and has written on child welfare theory and practice in various law journals.

**Amicus curiae Sarah Katz, JD* is an Associate Clinical Professor of Law at the Temple University Beasley School of Law. In that capacity she directs the Family Law Litigation Clinic of the Temple Legal Aid Office, which provides free legal services to low-income residents of Philadelphia in a variety of family law matters. An expert in family law and child protection, a practicing attorney for 15 years, and a clinical law professor, Ms. Katz is deeply concerned about the dampening effect the law at issue in this matter (and similar laws) will have on low income women, and particularly low income women of color.

**Amicus curiae Dorothy E. Roberts, JD**, is the fourteenth Penn Integrates Knowledge Professor, George A. Weiss University Professor, and the inaugural Raymond Pace and Sadie Tanner Mossell Alexander Professor of Civil Rights at University of Pennsylvania, where she holds appointments in the Law School and Departments of Africana Studies and Sociology. An internationally recognized scholar, public intellectual, and social justice advocate, she has written and lectured extensively on the interplay of gender, race, and class in legal issues and
has been a leader in transforming public thinking and policy on reproductive health, child welfare, and bioethics. Professor Roberts is the author of the award-winning books *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (Random House/Pantheon, 1997) and *Shattered Bonds: The Color of Child Welfare* (Basic Books/Civitas, 2002), as well as co-editor of six books on constitutional law and gender. She has also published more than eighty articles and essays in books and scholarly journals, including Harvard Law Review, Yale Law Journal, and Stanford Law Review. Her latest book, *Fatal Intervention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century*, was published by the New Press in July 2011. Among her many public interest positions, Roberts is the chair of the Board of Directors of the Black Women's Health Imperative.
Mothers and Illicit Drugs: Transcending the Myths

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aration as a result of incarceration or child apprehension, they are further stigmatized by society through social ostracism and harsh sentencing (Carlen, 1976, 1983; Daly, 1987; Eaton, 1983, 1985; Mason, 1992).

Women who use illicit drugs are considered to be unfit mothers, out of control, and a danger to their children (Paltrow, 1992; Rosenbaum et al., 1990; Taylor, 1993). However, a comparable set of characteristics concerning fathers who use illicit drugs is lacking in drug literature. Although most research on illicit drug use centers on the male user, his parenting qualities and responsibility to his family are rarely addressed. Rather, the male user has often been described as the ‘man about town’ (Preble & Casey, 1969), and little was known about his family relations until Hanson, Beschner, Walters, and Bovelle (1985) studied male heroin users in the United States. Outside of the area of monetary support, little attention has been given to the family responsibilities of male illicit drug users. This reflects Western ideological assumptions about men, as opposed to ideological assumptions concerning women.

In contrast, research on women who use illicit drugs overwhelmingly explores, and often centres on, the women’s lack of parenting abilities, and failure to be responsible for children and the household (see Chasnoff, 1989; Dembo et al., 1990; Densen-Gerber & Rohrs, 1973; Howard, Beckwith, Rodning, & Kropenske, 1989; Jaudes, Ekwo, & Voorhis, 1995; Julien, 1992; Kantor, 1978; Murphy et al., 1991; Peak & Papa, 1993; Robins & Mills, 1993; Steinberg, 1994; Weston, Ivins, Zuckerman, Jones, & Lopez, 1989).

However, as noted earlier, on reviewing the literature on mothers who use illicit drugs, it becomes apparent that qualitative research with in-depth interviews (see Colten, 1980, 1982; Dreher, Nugent, & Hudgins, 1994; Jackson & Berry, 1994; Kearney, Murphy, & Rosenbaum, 1994; Leeders, 1992; Rosenbaum, 1981; Rosenbaum et al., 1990; Sterk-Elifson, 1996; Taylor, 1993) demonstrate that these mothers can be adequate parents and view mothering as their central role.

For many women, pregnancy is an event that significantly changes their status in society (Kitzinger, 1992; Oakley, 1992; Rothman, 1986). Women who are identified as illicit drug users during pregnancy are closely monitored by medical and social services professionals, who assess, and eventually determine, maternal health and parental fitness.

In the course of the research, it became apparent that the women interviewed perceived themselves as different from male drug users who are parents, because of their role as mothers. The full responsibility of caring for their children shaped their drug use, both positively and nega-
The risk of subsequent maltreatment allegations in families with substance-exposed infants

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Abstract

Objective: This study seeks to: (1) assess the relationship between identified prenatal substance use and the risk of subsequent maltreatment allegations among families involved with child protective services; and (2) compare the types of safety threats encountered by children whose parents had substance-exposed infant (SEI) allegations to the types of safety threats faced by children whose parents had other types of allegations.

Method: Survey data from a probability sample of parents were linked to state administrative data over a 33-month time frame. Cox regression models were conducted to assess the relative risk of subsequent allegations associated with parents whose child welfare case opened following an SEI allegation (the SEI group) compared to parents whose case opened following other types of allegations.

Results: The likelihood of subsequent allegations is greater among parents in the SEI group. However, the increased risk stems almost entirely from subsequent SEI-related allegations. Parents in the SEI group are not more likely to incur other types of allegations such as physical abuse or lack of supervision.

Conclusions: An increased risk of subsequent maltreatment has been used to justify opening child protective cases on the basis of an SEI allegation alone. By looking closely at the types of subsequent

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allegations as well as the incidence of subsequent allegations, this research helps to clarify the maltreatment risks associated with SEI cases. © 2002 Elsevier Science Ltd. All rights reserved.

Keywords: Substance-exposed infants; Parental drug use; Subsequent reports

Introduction

One of the legacies of the cocaine epidemic of the late 1980s and early 1990s is the large number of families who became involved with child protective services as a result of drug enforcement and surveillance policies. Child protective services have been concerned about parental substance use for decades, but with the cocaine epidemic came a new concern: prenatal drug exposure. In response to alarms sounded by medical researchers suggesting that a generation of “cocaine-damaged” infants faced an uncertain future of developmental and behavioral problems, some states moved to mandate the reporting of infant substance exposure to child protective authorities. In addition, fearful of the risks prenatal drug use posed to subsequent child safety and well-being, caseworkers and judges escalated the removal of children from drug-using parents on allegations of “inadequate supervision,” “environmental neglect,” or “risk of harm.”

After a decade, opinions on how best to fashion a child protective response to the problem of prenatal substance use have diverged (see Barth, 2001; Ondersma, Simpson, Brestan, & Ward, 2000). On the one hand, in light of follow-up research that shows the developmental consequences of prenatal drug exposure to be less dire than originally feared (Lester, Freier, & LaGasse, 1995; LaGrasse, Seifer, & Lester, 1999; Mayes, Granger, Bornstein, & Zuckerman, 1992; Slutsker, 1992), hospitals are reconsidering the advisability of testing newborns for substance exposure. Some court jurisdictions are treating prenatal substance exposure as a public health matter and invoking child protective authority only if there is a finding of direct harm to a child. On the other hand, public intolerance for maternal substance use continues. In South Carolina, women who use substances during pregnancy can be prosecuted in criminal court; Wisconsin passed a “Cocaine Mom Bill” enabling the state to mandate substance abuse treatment for pregnant women; and Illinois has a law stipulating that a second substance-exposed infant (SEI) finding shall constitute sufficient evidence to initiate termination of parental rights.

As child welfare administrators and practitioners struggle to form appropriate policy and practice responses to families with substance-exposed infants, researchers have attempted to answer a fundamental question: To what extent does prenatal substance use place children at risk of subsequent abuse or neglect? Generally, evidence points to an association between parental substance use and intervention by child protective services (Children’s Bureau, US Department of Health and Human Services, 1997; Curtis & McCollough, 1993; Magura & Laudet, 1996). And researchers have identified an association between parental substance use and subsequent maltreatment as measured by child protective services reports (Jaukes, Ekwo, & Van Voorhis, 1995; Wolock & Magura, 1996) and incidents of maltreatment found in medical records (Wasserman & Leventhal, 1993). Still, such studies fall short of demonstrating that substance use, per se, increases threats to child safety. Case-control studies that
compare samples of identified substance users in the child welfare system to matched samples from the general population cannot control adequately for the myriad of social, environmental, and other factors that confound the association between parental substance use, threats to child safety, and involvement with child protective services. Differences attributed to substance use might be because of other factors that affect detection or identification of substance use or affect the likelihood of child welfare involvement (see Franck, 1996).

For several reasons there is a distinction between substance-exposed infants identified by the child welfare system and all infants exposed to substances. First, research has identified race and class bias in hospital policy and practice regarding tests for infant substance exposure (Chasnoff, Landress, & Barrett, 1990). Some hospitals have a policy to test every newborn; others test only "high-risk" cases. Second, despite evidence of the deleterious effects of fetal exposure to alcohol, infants are tested for exposure to illicit substances, not for exposure to alcohol. Finally, tests identify substance use in the past several days only; an infant might be exposed to substances at various points during a pregnancy and still test negative at birth.

The distinction between prenatal substance exposure and identified prenatal substance exposure has two implications for studies seeking to assess the subsequent maltreatment risks associated with prenatal substance exposure. First, to avoid the spurious attribution of safety risks to substance exposure when such risks stem from factors associated with child welfare involvement, studies should make comparisons among families already involved with the child welfare system. For example, safety risks among families with substance-exposed infant allegations should be compared to safety risks among families with other types of maltreatment allegations. Second, if researchers cannot isolate the effects of prenatal substance exposure from the effects of identified prenatal substance exposure, studies should clearly specify that their findings apply to identified prenatal substance exposure.

Some researchers have conducted bivariate analyses to assess risks associated with identified prenatal substance use among families involved with child protective services. One study found that infants with verified substance exposure had more caregiving needs than infants with suspected substance exposure (McNichol, 1999). Another study found that families with SEI allegations have higher subsequent maltreatment rates than families with other types of allegations (Goerge & Harden, 1993). Such findings suggest that, even among families involved with child protective services, children in families with identified prenatal substance use face greater subsequent maltreatment risks than children with other types of allegations. Such findings provide justification for opening child protective cases on the basis of prenatal substance use alone. The important implications of such findings warrant investigation using multivariate survival analysis methods.

The purposes of this study are to: (1) assess the relationship between identified prenatal substance use and the risk of subsequent maltreatment allegations among families involved with child protective services; and (2) compare the types of safety threats encountered by children whose parents had SEI allegations to the types of safety threats faced by children whose parents had other types of allegations. A clearer understanding of these relationships can help child welfare agencies develop family-centered protective interventions that better
balance the severity of risks posed by prenatal substance use against the harms of parent-infant separation and out-of-home placement.

The study addresses the following questions:

1. Are child welfare cases that open because of an SEI allegation at greater risk of subsequent abuse or neglect allegations than cases that open for other reasons?
2. Is giving birth to a substance-exposed infant after a child welfare case opens a predictor of subsequent abuse or neglect allegations?
3. What types of subsequent abuse and neglect allegations are parents with prior SEI allegations likely to incur?

Illinois provides a rich source of data for addressing these research questions. In Illinois, unlike many states, evidence of fetal substance exposure constitutes *prima facie* evidence of child neglect, and infant substance exposure is identified as a particular type of child protective services allegation: a substance-exposed infant, or SEI, allegation. The parents of all infants testing positive for illicit drugs are charged with neglect and have a child welfare case opened. Thus, all infants identified as being exposed to illicit drugs can be followed longitudinally with state administrative data.

**Methods**

**Data source**

This study is part of a larger study conducted by the Illinois Department of Children and Family Services (DCFS) using state administrative data and survey data. The survey data were collected from a probability sample of parents who had an open DCFS case in June 1995. To assure adequate representation of families with SEI allegations, the sample was stratified so that half of the sample members had an indicated SEI allegation that preceded their case opening. The sample was also stratified by whether or not a parent had an intact case (no children in state custody) or a placement case (at least one child in state custody). Also, selection chances were weighted by the inverse of the case duration. This step increased the selection chances of shorter-term cases and generated a sample which is more representative of all families who become involved with child welfare services rather than a sample which only represents families with open cases at a point in time (see Wulczyn, 1996), but this step does not rule out the possibility that our sample over-represents long-term cases. Social work students conducted in-home-interviews with the sample members during the spring and summer of 1996. The survey data were linked with state administrative records on child maltreatment reports from June 1995 through March 1998. We refer to this 33-month time period as the study’s “observation window.”

The survey response rate, shown in Table 1, was 55%. While this response rate is only minimally adequate, we have the advantage of having state administrative data from the entire sample. Thus, we can compare respondents to nonrespondents in areas included in the administrative data to better understand how the respondents might differ from the nonrespondents. The respondents are like the nonrespondents in virtually all demographic and
Table 1
Survey response rate

<table>
<thead>
<tr>
<th></th>
<th>SEI</th>
<th>Non-SEI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement</td>
<td>83 of 161 (52%)</td>
<td>92 of 158 (58%)</td>
<td>175 of 319 (55%)</td>
</tr>
<tr>
<td>Intact</td>
<td>59 of 96 (61%)</td>
<td>43 of 93 (46%)</td>
<td>102 of 189 (54%)</td>
</tr>
<tr>
<td>Total</td>
<td>142 of 257 (55%)</td>
<td>135 of 251 (54%)</td>
<td>277 of 508 (55%)</td>
</tr>
</tbody>
</table>

child welfare characteristics compared (age, number of children, race, length of case opening, SEI group status, having a subsequent allegation by March 1998, having a closed case by March 1998, and, among placement cases, having a return home goal). One possible difference exists among sample members with a child in placement. A slightly higher percentage of placement respondents than placement nonrespondents had a return home goal (50% vs. 42%). This difference is not statistically significant ($p = .16$), and it is unlikely to have major implications for this study, but it will be considered in our interpretation of the study findings.

**Definition of variables**

**Dependent variables.** There are two dependent variables in this study. Both are hazard rates (defined below) for substantiated subsequent maltreatment allegations. The first is the hazard rate for any substantiated subsequent maltreatment allegation during the 33-month observation window; the second is the hazard rate for a substantiated non-SEI-related subsequent maltreatment allegation during the observation window. The study focuses only on substantiated allegations. (Substantiated allegations are less than perfect indicators of maltreatment. The distinction should be considered when interpreting the study findings.) The presence of subsequent allegations is indicated in the administrative data; substantiation status and type of allegation are determined by child protective services (CPS) investigators.

In Illinois, an SEI allegation is a particular type of allegation, like physical abuse, lack of supervision, and so forth. However, very rarely does a parent receive only an SEI allegation. Rather, when an investigator assigns an SEI allegation, he or she often assigns a “risk of harm” allegation at the same time. For many investigators, by definition, a substance-exposed infant is at risk of harm. Thus, the two allegations go hand in hand. The second dependent variable, therefore, indicates subsequent allegations that are neither SEI allegations nor risk of harm allegations accompanying an SEI allegation.

**Independent variables.** The SEI group designation refers to respondents whose child welfare case opened within 30 days of receiving an SEI allegation. In such cases, we say the case opened because of an SEI allegation. This status is distinct from receiving a new SEI allegation during the observation window. Eighty-nine percent of new SEI allegations were against members of the SEI group, and 11% were against respondents whose child welfare cases opened following allegations other than SEI (the non-SEI group). Conversely, 22% of the members of the SEI group received a new SEI allegation, and 3% of the non-SEI group received a new SEI allegation during the observation window. The “birth” designation comes
from the survey data. Respondents were asked the birth dates of all their children. Respondents having a child with a birth date between June 1995 and March 1998 are included in the new birth category. New births were further categorized by whether they were an SEI or clean birth. If a respondent received an SEI allegation (determined from the administrative data) within 30 days of a new birth, the birth is classified as an SEI birth; other births are classified as clean births. Respondents classified as “intact” had no children placed out of the home at the time of the sample selection.

The models also contain several control variables that constitute key risk or protective factors for families involved with child protective services: having a family income below the poverty line, living in a public housing high-rise, attending work or school, and living with another adult. Variable definitions are included in Appendix A.

Cox regression

Multivariate models were analyzed using Cox regression—a type of hazards analysis. With hazards analysis, the dependent variable is an unobserved variable, commonly called a hazard rate or hazard function. The hazard rate is the probability at each point in time (such as each day) of an event occurring given that it has not yet occurred (Allison, 1984). This technique offers some advantages over logistic regression, for example, in which the dependent variable is simply an indicator of whether or not an event occurred. First, the models account for the existence of right-censored cases, or cases in which a subsequent allegation has not yet occurred but may occur later. Second, this technique enables us to account for the time-varying impact of independent variables. The effect of a new birth on a subsequent allegation, for example, may vary depending on how closely in time the birth and the allegation are related. Our models account for a new birth on the day it occurs. Finally, the Cox regression models enable us to account for the changing status of being “at risk” of a subsequent allegation. Many parents experience periods of time during the observation window when their risk of receiving a subsequent allegation is markedly reduced, if not eliminated, because their children have been placed in state custody. With hazards analysis, we can specify precisely, at every point in time, whether a parent has custody of at least one child. As individuals gain and lose custody of children or give birth, they move in and out of the set of individuals who are at risk of receiving a subsequent allegation. A parent is included in the “risk set” when she has custody of at least one child.

Findings

Descriptive data

Demographic information. Demographic information about the survey respondents is shown in Table 2. Summary statistics are shown for all respondents and disaggregated by SEI group status. The respondents’ ages ranged from 17 years to 52 years; the average age was 32 years. The number of children ranged from 1 to 13; the average number and the median were both 4. About half of the respondents had completed high school; about one third were currently
Table 2
Descriptive statistics by SEI group and total

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>SEI group (n = 142)</th>
<th>Non-SEI group (n = 135)</th>
<th>Total (n = 277)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Mean</td>
<td>p</td>
</tr>
<tr>
<td>Age</td>
<td>31</td>
<td>33</td>
<td>.01</td>
</tr>
<tr>
<td>Number of children</td>
<td>4.4</td>
<td>3.9</td>
<td>.06</td>
</tr>
<tr>
<td>Personal income last month</td>
<td>572</td>
<td>686</td>
<td>.07</td>
</tr>
<tr>
<td>Household income last month</td>
<td>1004</td>
<td>1149</td>
<td>.21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Percent</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live with another adult</td>
<td>58%</td>
<td>54%</td>
<td>.54</td>
</tr>
<tr>
<td>Completed high school</td>
<td>45%</td>
<td>54%</td>
<td>.13</td>
</tr>
<tr>
<td>Currently work or attend school</td>
<td>20%</td>
<td>36%</td>
<td>.003</td>
</tr>
<tr>
<td>Receive work income</td>
<td>17%</td>
<td>27%</td>
<td>.03</td>
</tr>
<tr>
<td>HH income below poverty</td>
<td>80%</td>
<td>66%</td>
<td>.007</td>
</tr>
<tr>
<td>Live in public housing</td>
<td>15%</td>
<td>5%</td>
<td>.005</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>88%</td>
<td>79%</td>
<td>.05</td>
</tr>
<tr>
<td>White</td>
<td>8%</td>
<td>10%</td>
<td>.58</td>
</tr>
<tr>
<td>Mexican/Puerto Rican</td>
<td>4%</td>
<td>10%</td>
<td>.07</td>
</tr>
<tr>
<td>SEI group (Initial SEI alleg.)</td>
<td>(all)</td>
<td>(none)</td>
<td></td>
</tr>
<tr>
<td>Intact group</td>
<td>42%</td>
<td>32%</td>
<td>.09</td>
</tr>
<tr>
<td>New birth</td>
<td>42%</td>
<td>27%</td>
<td>.01</td>
</tr>
<tr>
<td>SEI birth</td>
<td>22%</td>
<td>3%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Clean birth</td>
<td>29%</td>
<td>27%</td>
<td>.47</td>
</tr>
<tr>
<td>Any subsequent allegation</td>
<td>35%</td>
<td>13%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>SEI subseq. alleg</td>
<td>22%</td>
<td>3%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Non-SEI subseq. alleg</td>
<td>15%</td>
<td>10%</td>
<td>.27</td>
</tr>
</tbody>
</table>

either working or attending school; 24% received some personal income from work. Seventy percent of the respondents had household incomes below the federal poverty line. The racial composition of the respondent group reflects the racial composition of parents involved with child protective services in Cook County: 83% of the respondents were African American, 9% White, and 8% of Hispanic (mostly Mexican or Puerto Rican) decent.

Independent variables. Table 2 also contains descriptive statistics for the covariates included in the analysis. Fifty-one percent of the respondents were in the SEI group. Thirty-seven percent of the respondents had an intact family case. Thirty-five percent of the respondents had a new birth during the 33-month observation window; 13% had a new birth which received an SEI allegation; 28% had a “clean birth” or a new birth that was not identified as substance exposed. (The sum of the SEI and clean births does not equal the overall new birth figure because some respondents had two births: one substance exposed and one not.)

Subsequent allegations. There were 220 subsequent allegations during the observation window occurring in 84 separate events and involving 67 (24%) of the 277 survey respondents. During the observation window, an individual parent could have more than one event leading
Table 3
Distribution of subsequent allegations by type

<table>
<thead>
<tr>
<th>Subsequent allegation type</th>
<th>All subsequent allegations</th>
<th></th>
<th></th>
<th>Most serious subsequent allegation against each mother</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>SEI group</td>
<td>Non-SEI group</td>
<td>Total</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>1%</td>
<td>0</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Substance use</td>
<td>19%</td>
<td>23%</td>
<td>8%</td>
<td>52%</td>
</tr>
<tr>
<td>Lack of supervision</td>
<td>22%</td>
<td>19%</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>Environmental neglect</td>
<td>18%</td>
<td>11%</td>
<td>34%</td>
<td>4%</td>
</tr>
<tr>
<td>Medical neglect</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Risk of harm</td>
<td>36%</td>
<td>43%</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(n = 220)</td>
<td>(n = 159)</td>
<td>(n = 61)</td>
<td>(n = 67)</td>
<td>(n = 49)</td>
</tr>
</tbody>
</table>

To an allegation and, especially with multiple children, more than one allegation stemming from each event. For example, one event resulting in both an “inadequate supervision” and a “risk of harm” allegation against four children would result in eight allegations against a parent. An allegation event typically results in multiple allegations. However, most parents having an allegation event during the observation window had just one event. Our analysis focuses on the first allegation event.

Subsequent allegations by SEI group status

A bivariate comparison of subsequent allegation status by SEI group status (shown in Table 2) indicates that 35% of parents in the SEI group had a subsequent allegation compared to 13% of parents in the non-SEI group. This statistically significant difference (p < .001) is consistent with the findings reported in other research (Goerge & Harden, 1993): parents in the SEI group were more likely than parents in the non-SEI group to incur a subsequent maltreatment allegation.

Types of subsequent allegations

To better understand the greater risk of incurring a subsequent allegation associated with the SEI group, we first looked at types of subsequent allegations. Table 3 shows the distribution of subsequent allegations by type of allegation. Few of the subsequent allegations were allegations of physical abuse: less than 6% of the subsequent allegations in the non-SEI group and none in the SEI group. The most common type of subsequent allegation in the non-SEI group was environmental neglect, the most common type of subsequent allegation involving members of the SEI group was risk of harm. There were no subsequent allegations of sexual abuse or death.

To facilitate a comparison of the types of allegations incurred by each parent, the allegation types were ranked according to severity. (We used our subjective notions of severity as the ranking criteria. Clearly, the severity of maltreatment incidents cannot be definitively determined by the type of allegation. The ranking shown in Table 3 provides
only an indication of severity.) Table 3 indicates the allegation types ranked from most severe to least severe. For almost two-thirds of the parents in the SEI group with subsequent allegations, the most severe subsequent allegation was another SEI allegation; for 18%, lack of supervision was the most serious subsequent allegation; and for 14%, the most serious subsequent allegation was risk of harm. For most parents in the non-SEI group, the most severe type of subsequent allegation was lack of supervision.

Thus, rather than physical harm or lack of supervision, SEI allegations constitute the most serious type of subsequent allegation against most members of the SEI group. This finding raises two questions: (1) Because SEI allegations, by definition, accompany births, to what extent are subsequent allegations associated with subsequent births? (2) Are members of the SEI group simply at greater risk of subsequent SEI allegations or are they at greater risk of other types of allegations as well?

Subsequent allegations by birth, child, and SEI group status

Table 4 again shows the subsequent allegation rate by SEI group status. The top half of the table shows the percentage of parents having any type of subsequent allegation during the observation window; the bottom half shows the percentage having a subsequent allegation which was not SEI-related (neither an SEI allegation nor a risk of harm allegation accompanying an SEI allegation). Because investigators tend to assign risk of harm allegations when they assign SEI allegations, the risk of harm allegations accompanying SEI allegations may
Table 5
Cox regression models: any subsequent allegation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th>Relative Risk [Exp (B)]</th>
<th>Model 2</th>
<th></th>
<th>Relative Risk [Exp (B)]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coeff.</td>
<td>SE</td>
<td></td>
<td>Coeff.</td>
<td>SE</td>
<td></td>
</tr>
<tr>
<td>SEI group status</td>
<td>.87***</td>
<td>.28</td>
<td>2.39</td>
<td>.45</td>
<td>.30</td>
<td>1.57</td>
</tr>
<tr>
<td>Inact family</td>
<td>-.33</td>
<td>.26</td>
<td>.72</td>
<td>-.09</td>
<td>.28</td>
<td>.91</td>
</tr>
<tr>
<td>Birth</td>
<td>2.79***</td>
<td>.28</td>
<td>16.25</td>
<td>2.74***</td>
<td>.28</td>
<td>15.54</td>
</tr>
<tr>
<td>Live with adult</td>
<td></td>
<td></td>
<td></td>
<td>-2.09**</td>
<td>.29</td>
<td>4.00</td>
</tr>
<tr>
<td>Poverty</td>
<td>-.17</td>
<td>.39</td>
<td>.85</td>
<td>.75*</td>
<td>.31</td>
<td>2.12</td>
</tr>
<tr>
<td>Public high rise</td>
<td></td>
<td></td>
<td></td>
<td>-.99**</td>
<td>.50</td>
<td>.37</td>
</tr>
<tr>
<td>Work or school</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vs. White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>.05</td>
<td>.55</td>
<td>1.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hisp</td>
<td>-.21</td>
<td>.81</td>
<td>.81</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** p < .001
** p < .01
*p < .05

Model 1 Log Likelihood = -270.63
Global Chi-Square = 180.40, p < .001

Model 2 Log Likelihood = -259.96
Global Chi-Square = 205.74, p < .001

Contribute to the increased likelihood of subsequent allegations among the SEI group. (Recall that risks of harm allegations are the most common type of subsequent allegation against members of the SEI group, and an SEI allegation is the most serious subsequent allegation for almost two thirds of this group.) Table 4 also compares parents with other children at home (besides a newborn) to parents with no other children at home. We included this comparison to assess the safety of children living with parents, either as part of wholly intact families or as part of families in which the custody of siblings is split between a parent and the state.

Table 4 shows that among parents who had no new births during the observation window, there was little difference between the SEI and non-SEI groups in the subsequent allegation rate. This was true whether or not other children besides a newborn were living with the parents and when comparing all allegations or only non-SEI allegations. Thus, in the absence of a subsequent birth, the SEI allegation does not increase the likelihood of incurring a subsequent maltreatment allegation. Among parents who had a new birth, however, when comparing allegations of any type, the subsequent allegation rate among parents in the SEI group was more than twice as high as the subsequent allegation rate among parents in the non-SEI group. This was true whether or not other children were living with the parents. Thus, if another child is born, the SEI allegation is associated with an increased likelihood of incurring a subsequent maltreatment allegation. However, when only non-SEI-related allegations are considered, the allegation rate difference, based on SEI group status, vanishes almost entirely. The table figures suggest that the higher subsequent allegation rate among parents in the SEI group stems primarily from the birth of subsequently indicated substance-exposed infants.

Multivariate findings—Cox Regression Models

The multivariate hazards results, shown in Tables 5 and 6, affirm the relationships shown
Table 6
Cox regression models: Non-SEI-related subsequent allegation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th></th>
<th>Model 2</th>
<th></th>
<th></th>
<th>Model 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coeff.</td>
<td>SE</td>
<td>Relative Risk</td>
<td>Coeff.</td>
<td>SE</td>
<td>Relative Risk</td>
<td>Coeff.</td>
<td>SE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[Exp (B)]</td>
<td></td>
<td></td>
<td>[Exp (B)]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEI group status</td>
<td>.10</td>
<td>.33</td>
<td>1.11</td>
<td>.27</td>
<td>.33</td>
<td>1.31</td>
<td>-.02</td>
<td>.36</td>
</tr>
<tr>
<td>Intact family</td>
<td>-.17</td>
<td>.32</td>
<td>.85</td>
<td>-.20</td>
<td>.32</td>
<td>.82</td>
<td>.06</td>
<td>.39</td>
</tr>
<tr>
<td>Birth</td>
<td>1.41***</td>
<td>.33</td>
<td>4.08</td>
<td>.61</td>
<td>.46</td>
<td>1.83</td>
<td>.36</td>
<td>.48</td>
</tr>
<tr>
<td>Clean birth</td>
<td></td>
<td></td>
<td></td>
<td>1.91***</td>
<td>.32</td>
<td>6.75</td>
<td>1.91***</td>
<td>.34</td>
</tr>
<tr>
<td>Live with adult</td>
<td></td>
<td></td>
<td></td>
<td>-.59</td>
<td>.38</td>
<td>.55</td>
<td>-.26</td>
<td>.44</td>
</tr>
<tr>
<td>Poverty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.60</td>
<td>.52</td>
</tr>
<tr>
<td>Public high rise</td>
<td></td>
<td></td>
<td></td>
<td>1.08**</td>
<td>.38</td>
<td>2.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work or school vs. White</td>
<td></td>
<td></td>
<td></td>
<td>-.60</td>
<td>.52</td>
<td>.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td></td>
<td>-.32</td>
<td>.64</td>
<td>.72</td>
<td>.05</td>
<td>.85</td>
</tr>
<tr>
<td>Hisp</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** p < .001  Model 1 Log Likelihood = -203.89  Model 2 Log Likelihood = -196.67  Model 3 Log Likelihood = -190.64
** p < .01   Global Chi Square 22.50, p < .001  Global Chi Square 45.91, p < .001  Global Chi Square 60.14, p < .001
* p < .05

in Table 4. Tables 5 and 6 include the coefficient and standard error for each independent variable as well as the exponentiated coefficient, which is also called the risk ratio (Allison, 1984), or relative risk. Table 5 shows the relative risk of having a subsequent allegation of any type. Model 1 indicates that, controlling for new births and intact family status, members of the SEI group are almost two times (95%) more likely than members of the non-SEI group to incur a subsequent allegation. In addition, parents who had a new birth in the observation window are more than 12 times more likely than those without a new birth to incur a subsequent allegation.

To what extent is the SEI group's higher subsequent allegation rate a consequence of prenatal drug use, per se, as opposed to other risk factors associated with the SEI group? Table 5, Model 2 indicates that once additional risk factors are taken into account, the increased risk associated with the SEI group diminishes considerably. The model indicates that members of the SEI group are still about 43% more likely than members of the non-SEI group to incur a subsequent allegation, but the difference is not statistically significant.

Moreover, the model indicates that living with another adult and, perhaps, attending work or school decrease the likelihood of incurring a subsequent allegation. Having a new birth still substantially increases the likelihood of incurring a subsequent allegation. This model shows how the SEI group's higher subsequent allegation rate may be, in part, explained by risk factors associated with the SEI group.

Table 6 restricts the analysis to the relative risk of incurring a non-SEI-related subsequent allegation. Model 1 shows that members of the SEI group are only slightly (23%) more likely than members of the non-SEI group to have a non-SEI-related subsequent allegation. This small difference is not statistically significant. Thus, again, parents in the SEI group are more likely than parents whose cases opened following other types of allegations to incur a
subsequent allegation when allegation type is not taken into account. But the group difference is largely explained by the SEI group’s greater likelihood of having subsequent births and incurring SEI-related allegations. The SEI group is not more likely than the non-SEI group to incur non-SEI-related subsequent allegations.

In addition to the subsequent allegation risk associated with the SEI group, we also assessed the subsequent allegation risk associated with new SEI allegations (those occurring during the observation window). As shown in Table 6, Model 2, parents who gave birth to a new substance-exposed infant during the observation window were more than two times (155%) more likely than parents who had no new births to also receive a non-SEI-related subsequent allegation. However, parents who gave birth and did not receive an SEI allegation (a clean birth) were over four times more likely than parents with no births to receive a non-SEI-related subsequent allegation.

Why should clean births be associated with subsequent allegations? Clearly all births create the opportunity for subsequent allegations. If a parent’s other children are in state custody, a new birth places the parent back in the “risk set” for incurring a subsequent allegation. As shown in Table 4, subsequent allegation rates tend to be higher among parents with a new birth than among parents with no new birth. However, among parents with other children at home, a new birth seems to increase the subsequent allegation rate only for members of the SEI group. New births among custodial parents in the non-SEI group were not clearly associated with subsequent allegations. Might the higher coefficient for new “clean” births be reflecting other risk factors that put children, especially those from the SEI group, at risk?

Table 6, Model 3, tests whether the effect of having a clean birth fades after controlling for other risk factors, especially factors that distinguish the SEI from the non-SEI group. The model indicates that living with another adult decreases the likelihood of incurring a non-SEI-related subsequent allegation, while staying in a public housing high rise increases the likelihood of incurring a non-SEI-related subsequent allegation. However, the model indicates that once other risk factors are considered, clean births are still highly associated with non-SEI-related subsequent allegations. Perhaps once a parent is involved with child protective services, any new babies born to her are considered to be at “risk of harm,” perhaps for good reason or perhaps because of stigma and risk aversion. When a child welfare agency indicates a subsequent birth for substance exposure, it establishes a basis for continued protective services involvement. But if a new baby born to a previously SEI-indicated parent tests clean, the child welfare agency may seek other reasons to maintain heightened surveillance of the family. Either actual harm or risk aversion could explain the higher allegation rate associated with clean births.

Other indications of risk associated with an SEI allegation

The administrative data analysis suggests that the greater likelihood of subsequent allegations among members of the SEI group stems from the much greater tendency for members of this group to have subsequent SEI allegations. We looked to the survey data for other indications of increased risk associated with the SEI group. The survey included a composite scale designed to assess risks to child safety. The scale assessed parent charac-
Table 7

*T*-tests of the difference between the SEI and Non-SEI groups in parent risk factors

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Group</th>
<th>Mean Score</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authoritarianism</td>
<td>SEI</td>
<td>2.46</td>
<td>.54</td>
<td>-.096</td>
<td>.92</td>
</tr>
<tr>
<td></td>
<td>Non-SEI</td>
<td>2.47</td>
<td>.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealistic expectations</td>
<td>SEI</td>
<td>2.99</td>
<td>.59</td>
<td>.019</td>
<td>.98</td>
</tr>
<tr>
<td></td>
<td>Non-SEI</td>
<td>2.99</td>
<td>.58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping difficulties</td>
<td>SEI</td>
<td>2.43</td>
<td>.75</td>
<td>-.092</td>
<td>.93</td>
</tr>
<tr>
<td></td>
<td>Non-SEI</td>
<td>2.44</td>
<td>.84</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Characteristics in three dimensions believed to be associated with child abuse or neglect potential: authoritarianism, unrealistic expectations, and coping difficulties. As shown in Table 7, a comparison of the SEI group to the non-SEI group in the three dimensions measured by this scale reveals no significant differences between the two groups. These bivariate tests are consistent with the administrative data analysis in suggesting that the risk of subsequent harm is no greater among families with an SEI allegation than it is for families with other types of allegations.

Summary and discussion

Child welfare authorities have two primary reasons to open a child welfare case when an infant tests positive for substance exposure: (1) because the infant has been harmed by the substance exposure, and (2) because the substance exposure constitutes a predictor of future maltreatment. Thoughts about the first reason have become more complex in recent years. Although early research suggested that intrauterine cocaine exposure led to severe and chronic health and developmental problems such as irreparable brain damage and sudden infant death syndrome, follow-up research has tempered these early predictions (see Berger & Waldfogel, 2000; LaGasse, Seifer, & Lester, 1999; Mayes et al., 1992; Slutsker, 1992). In early research, conditions associated with drug use such as poverty, poor nutrition, and inadequate prenatal care were not accounted for sufficiently, nor had the effects of legal substances such as alcohol, tobacco, and environmental toxins been isolated adequately from the effects of illicit drugs. More recent research suggests, first, that the effects of cocaine exposure, per se, are limited and, second, that the near-term effects of fetal cocaine exposure can be mitigated by the caregiving environment (Lester, Freir, & LaGasse, 1995).

Focusing on the second reason to open a child welfare case when an infant tests positive for substance exposure, this study addressed the question: Among families involved with child protective services, to what extent does identified prenatal substance exposure increase the risk of future maltreatment allegations? Because Illinois authorities open a child welfare case with every confirmed instance of infant substance exposure, we had the opportunity to track the subsequent maltreatment allegations associated with every confirmed substance-exposed infant among our respondents. Our analysis is consistent with other research (Goerge & Harden, 1993) in finding that parents whose child welfare cases opened because
of an SEI allegation are more likely than parents whose cases opened for other reasons to incur subsequent maltreatment allegations. However, the analysis suggests that the greater likelihood of subsequent allegations among members of the SEI group is largely attributable to subsequent births and accompanying SEI-related allegations. Thus, among open child welfare cases, an SEI allegation may predict subsequent prenatal drug use, but it does not predict other types of maltreatment allegations.

These results do not suggest that there are no risks associated with identified prenatal substance exposure. For one thing, as evidenced by subsequent SEI allegations, the findings indicate that identified prenatal substance exposure is associated with ongoing substance use. For a portion of these families, substance abuse continues despite CPS involvement. In addition, and importantly, the “comparison group” for the families with SEI allegations is comprised of families with other types of maltreatment allegations. We find that, aside from subsequent SEI allegations, the subsequent allegation risks for these two groups are similar, as are their ratings in a measure of parenting beliefs and attitudes.

Still, in clarifying the subsequent maltreatment risks associated with prior SEI allegations, these findings might offer guidance to policymakers and practitioners. These results suggest that concerns about SEI allegations might be balanced with concerns about other risks facing substance-exposed and nonexposed children. The results suggest that child welfare authorities might pursue the same family-centered interventions with families having SEI allegations that are pursued with families having other types of allegations. For example, instead of conditioning reunification upon a parent’s completing drug treatment and remaining drug-free—an endeavor which could easily surpass Adoption and Safe Families Act time-frames—authorities might consider reunification with monitoring after sobriety is attained and a parent successfully engages in out-patient treatment. Delaying reunification not only weakens parent-child bonds, but may also exacerbate, in unintended ways, substance use and other problems related to future births. In addition, because much of the subsequent allegation risk appears related to later births, service plans ought to offer parents with SEI allegations genuine opportunities to obtain family planning services.

Potential limitations

Some issues should be considered when interpreting the study findings. First, the SEI group status is based on identified substance use. It is not a precise indication of prenatal drug use, and it is not generally assigned for prenatal alcohol use. Perhaps sharper distinctions between the SEI and non-SEI groups would emerge if a more precise indicator of prenatal substance use were used. Then again, perhaps being identified as a prenatal substance user versus not being identified indicates a more meaningful distinction for assessing subsequent maltreatment risk than a precise distinction between substance users and nonusers. In any event, the primary purpose of this study was to better understand the risks associated with the SEI allegation. Second, the findings may reflect omitted variable bias. Certainly, the models do not include many factors that may be associated both with having an SEI allegation and the likelihood of subsequent maltreatment. For example, the higher birth rate among the SEI group is largely unexplained. Third, the discovery that respondents were more likely to have a return home goal than nonrespondents suggests that our respondent group may have made
more progress toward reunification than Cook County child welfare clients as a whole and, consequently, may be less likely to incur subsequent allegations. This possibility would have important implications if the study sought to assess the absolute maltreatment risk associated with SEI allegations rather than the relative risk associated with SEI versus other types of allegations. Given the study objectives, we would be most concerned about response bias in which SEI group respondents differed from SEI group nonrespondents. No such differences were detected. Moreover, the fact that this study used a probability sample and has the capacity to assess response bias provides it with an advantage over much of the existing research in this area.

Finally, one might hypothesize that having a child welfare case, in itself, increases the likelihood of receiving a subsequent maltreatment allegation because of added surveillance. On the other hand, one might hypothesize that having a child welfare case, in itself, decreases the likelihood of receiving a subsequent maltreatment allegation because of extra support services, controls, and monitoring. But the study was designed to assess the relative risk of subsequent maltreatment among parents having an open child welfare case, not the absolute maltreatment risk associated with SEI allegations. If we assume that the effect of having a child welfare case is likely to be similar for all cases, regardless of what types of allegations led to the case opening, then the present study is well designed to test the relative risk of subsequent maltreatment associated with SEI allegations compared to the risks associated with other types of allegations. If, however, the effect of having a child welfare case differs for parents with SEI allegations compared to parents with other types of allegations, the difference could have important implications for the study results. For example, if having an SEI allegation exposed parents to additional surveillance or additional risk aversion on the part of decision-makers, such differences could, in turn, affect the likelihood of receiving a subsequent allegation. Such possibilities should be explored in future research.

Conclusions

Three primary lessons emerge from this study. First, efforts to understand the child safety risks associated with SEI allegations should specify whether the “maltreatment” identified in subsequent allegations is SEI-related or not. If infant substance exposure is defined as maltreatment then justified as such because recipients of SEI allegations show an increased likelihood of subsequent incidents of maltreatment, we risk perpetuating a tautology if subsequent incidents tend to be incidents of infant substance exposure. Efforts to assess the risks associated with open child welfare cases should look beyond the status of having subsequent allegations to the types of subsequent allegations and the circumstances surrounding them. Second, we need to look more closely at other risk factors associated with SEI allegations and parental substance use. We often focus on SEI status or substance use, per se, when associated factors may be a more appropriate point of intervention. For example, in this study, living with another adult emerges as a potential protective factor against subsequent allegations. Finally, we need to look at the phenomenon of subsequent births among women involved with child protective services. This study suggests that, among parents with child welfare cases, a substantial portion of subsequent allegations are
related to subsequent births. We are left to wonder whether the association between subsequent allegations and new births indicates harm to newborn children or represents the risk aversion of CPS investigators when parents already involved with child protective services have a new child. All three-study lessons point to the need for better measures of the child safety threats associated with parental substance use. The study findings not only have implications for understanding the relationship between parental substance use and child maltreatment, but they highlight the need to more precisely describe subsequent allegations if they are to be used as indicators of child maltreatment.

Acknowledgments

The authors thank Mark Courtney, Anne E. Fortune, Bonnie E. Carlson, and Jill Doner Kagle for helpful comments.

Appendix A. Variable Definitions

- Living with another adult: A respondent is coded as living with another adult if she included persons over age 18 among the list of current members of her household.

- Poverty status: A respondent is coded as having a household income below poverty if the reported last month’s income is below the federal poverty threshold for her household size.

- Public high rise: A respondent receives this classification if she stayed in a public housing high rise at the time of the survey. This variable is an indicator of place, rather than financing. Survey respondents staying in publicly-funded housing that was not in a high-rise complex would be coded no on this variable.

- High school education: A respondent is coded as having a high school education if she reported completing 12 grades of school or receiving a GED.

- Race/Ethnicity: The respondent classification of her own race and/or ethnicity.

- Parenting risk factors: A composite index including items from the Child Abuse Prevention Inventory (CAPII)(Milner, Gold, & Ayoub 1984), the Adult-Adolescent Parenting Inventory (AAPI)(Bavolek, 1989), and the Michigan Screening Profile of Parenting (MSPP)(Schneider, 1982). A higher score indicates a greater degree of risk.

References


Résumé

**Objectif:** Cette étude a pour but de (1) évaluer la relation entre l’usage avant la naissance de drogues identifiées et le risque d’allégations ultérieures de mauvais traitements dans des familles suivies par des services de protection de l’enfance; et (2) de comparer les types de risques concernant la sécurité
Resumen

Objetivo: El estudio tiene como objetivos (1) evaluar la relación entre el consumo de drogas durante el embarazo y el riesgo de acusaciones posteriores de maltrato entre familias implicadas en los servicios de protección infantil y (2) comparar los tipos de amenazas a la seguridad ocurridas en niños/as cuyos padres/madres fueron acusados de consumo de drogas durante el embarazo con las amenazas a la seguridad ocurridas en niños/as cuyos padres/madres fueron objeto de otros tipos de acusaciones.

Método: Los datos de una encuesta obtenidos de una muestra probabilística de padres/madres se unieron con los datos administrativos estatales a lo largo de un periodo de 33 meses. Se llevaron a cabo modelos de regresión de Cox para evaluar si existe un mayor riesgo relativo de acusaciones posteriores en padres/madres cuyo expediente de protección fue abierto tras una acusación de consumo de drogas durante el embarazo, que en padres/madres cuyo expediente se abrió tras otro tipo de acusaciones.

Resultados: La probabilidad de que se produzcan acusaciones posteriores de maltrato fue mayor en el grupo de padres/madres que habían consumido drogas durante el embarazo. Sin embargo, la mayor parte de estas acusaciones estaban relacionadas con la exposición del niño/a a las drogas. Los padres/madres de este grupo no eran más propensos que el resto a ser acusados de otros tipos de maltrato tales como maltrato físico o falta de supervisión.

Conclusiones: El hecho de que el consumo de drogas durante el embarazo esté asociado a un riesgo elevado de un maltrato posterior, ha sido utilizado como justificación para la apertura de un expediente de protección. Observando detalladamente tanto los tipos de acusaciones posteriores como la incidencia de dichas acusaciones, esta investigación ayuda a clarificar el riesgo de maltrato en casos de abuso de drogas durante el embarazo.
Objective: This is a systematic review of the literature on the causes of stillbirth and clinical opinion regarding strategies for its prevention.

Study design: We reviewed the causes of stillbirth by performing a Medline search limited to articles in English published in core clinical journals from January 1, 1995, to January 1, 2005. Articles before this date were included if they added historical information relevant to the topic. A total of 1445 articles were obtained, 113 were the basis of this review and chosen based on the criterion that stillbirth or fetal death was central to the article.

Results: Fifteen risk factors for stillbirths were identified and the prevalence of these conditions and associated risks are presented. The most prevalent risk factors for stillbirth are prepregnancy obesity, socioeconomic factors, and advanced maternal age. Biologic markers associated with increased stillbirth risk are also reviewed, and strategies for its prevention identified.

Conclusion: Identification of risk factors for stillbirth assists the clinician in performing a risk assessment for each patient. Unexplained stillbirths and stillbirths related to growth restriction are the 2 categories of death that contribute the most to late fetal losses. Late pregnancy is associated with an increasing risk of stillbirth, and clinicians should have a low threshold to evaluate fetal growth. The value of antepartum testing is related to the underlying risk of stillbirth, and although the strategy of antepartum testing in patients with increased risk will decrease the risk of late fetal loss, it is of necessity associated with higher intervention rates.

Methods

A Medline search was used with the MeSh terms “etiology,” “causality,” “pregnancy outcome,” “fetal death,” “stillbirth,” as was limited to human subjects, English articles with abstracts in core clinical journals from January 1, 1995, to January 1, 2005, identified 1445 papers. Articles were chosen if they had sufficient statistical power to address the risk factor of interest and were performed in developed countries. A total of 113 were identified with this search and an additional 9 were cited for their historical information.

Scope of the problem

Although stillbirth is infrequent, it occurs 10 times more often than sudden infant death. In the United States, stillbirth accounts for a large proportion of all perinatal losses, although its causes remain incompletely understood. In developing nations, preterm births and stillbirths are grossly underreported, thus making international comparisons difficult. Even in developed nations, there is considerable variability in the threshold...
for reporting stillbirth. These include differences in either the length of gestation or the birth weight.\textsuperscript{2-4} The World Health Organization (WHO) classification of stillbirth is defined as fetal loss in pregnancies beyond 20 weeks of gestation, or, if the gestational age is not known, a birth weight of 500 g or more, which corresponds to 22 weeks of gestation in a normally developing fetus.\textsuperscript{5}

In the United States during 2002, there were approximately 26,000 stillbirths, a rate of 6.4/1,000 total births. There also were about 28,000 infant deaths (equaling a rate of 7.0/1,000 live births), and 19,000 neonatal deaths (4.7/1,000 live births).\textsuperscript{6} Black women have more than twice the rate of stillbirth of white women and, although some of this increased risk can be attributed both to access to, and quality of, medical care, other factors probably play a role as well.\textsuperscript{6-8} Within the United States, there is no national program of review for these losses. Death certificates are filled out by the delivering clinician typically before autopsy and other data relevant to the stillbirth evaluation are available. Also, there is no international consensus on the classification of perinatal loss.

Since the 1950s, there has been a decline in rate of stillbirth, but it has not declined to the same extent as the neonatal death rate (Figure 1). Indeed, recent data from the United Kingdom show that there has been a slight increase in the stillbirth rate, related perhaps to the growing number of pregnancies in older women, as well as to increased numbers of multiple pregnancies, due in large part to an increase in assisted reproduction techniques.\textsuperscript{9}

In large databases, fetal death is stratified by gestational age into early losses (ie, 20-28 weeks) and late fetal death (29 weeks or more; Figure 2).\textsuperscript{5} Presumably, this approach was used initially to divide those pregnancies that might be salvageable (ie, late losses), from very early term losses, the majority of which would not be salvageable. Recent advances in neonatal care make this distinction somewhat arbitrary, but the causes of fetal death do vary according to gestational age.\textsuperscript{10} The prevention of early fetal losses, in which a large proportion is related to infection, has been the most difficult to impact to date.\textsuperscript{10} Ideally, of course, stillbirths deserve the same systematic evaluation as sudden infant deaths. If an obvious cause of death is not found, then by exclusion the stillbirth is usually considered “unexplained.” Only when fetal deaths are reported according to the specific causes of fetal demise can appropriate strategies be designed to reduce these losses.

Causes of stillbirth

One of the largest and most comprehensive analyses of the causes of fetal death has been compiled and reported with the use of a Canadian database maintained at McGill University.\textsuperscript{10} This analysis evaluated 709 stillbirths among 88,651 births with a 97% autopsy rate. This study was able to track changes in the specific causes of stillbirth over 3 decades (Figure 3). Since the 1960s, when the database was created, the greatest reductions in stillbirth occurred when strategies were developed to intervene in specific causes of fetal demise. Since the introduction of Rh immune prophylaxis, for example, there has been a 95% reduction in stillbirths because of Rh isoimmunization. Stillbirths during labor (intrapartum asphyxia) also decreased by 95% after the introduction of intrapartum monitoring (Figure 3). Currently, these causes of stillbirth account for less than 1 fetal death per 10,000 births. Higher rates of intrapartum asphyxia in fetuses weighing more than 2.5 kg suggests deficiencies in obstetric quality of care.\textsuperscript{11,12} Interestingly, in the McGill experience throughout the 30-year study period, there was a low rate of stillbirths among women who had preeclampsia or diabetes (ie, less than 2/10,000), due in large part to aggressive management of these conditions.

Among other causes of stillbirth, the small-for-gestational-age (SGA) (ie, <2.4th percentile) fetus had an incidence of stillbirth of 46.8 per 1000, whereas the appropriate-for-gestational-age fetus had a rate of 4.0 per 1000 (odds ratio [OR] = 11.8; 95% CI 8.1-17.1).\textsuperscript{10} The identification and appropriate management of the growth-restricted fetus remains a significant opportunity for stillbirth prevention. Indeed, although 25% of
stillbirths that occurred in women carrying a SGA fetus had known risk factors such as maternal hypertension, most pregnancies that ended in stillbirth in nonanomalous growth-restricted fetuses had not been identified as having a problem with fetal growth.

Between 24 and 27 weeks of gestation, the most common causes of stillbirth were related to infection (19%), abruption (14%), or significant lethal anomalies (14%), and 21% were “unexplained.” As noted previously, stillbirths related to infection occur most frequently in fetuses weighing less than 1000 g. The stillbirth rates due to infection, like that of preterm birth, have been quite resistant to change despite the availability and wide use of antibiotics.10 The risk of a fetal death due to abruption has actually decreased modestly over several decades, although it also remains a significant cause of perinatal morbidity and mortality.

Unexplained stillbirth

After 28 weeks of gestation, the most common category of a stillbirth is that of “unexplained,” followed by deaths related to fetal malnutrition, and abruption (Table I.) The proportion of fetal deaths that have no known cause after complete pathologic evaluation increases as gestational age advances.10 A fetal death that is unexplained by fetal, placental, maternal, or obstetric factors is the most frequent type of fetal demise, representing between 25% and 60% of all fetal deaths.13-17 It is also one of obstetrics’ most distressing outcomes, because preventative effective strategies have not yet been identified, in large part because unexplained fetal demise is, by definition, a diagnosis of exclusion and depends on the rigorousness of the stillbirth assessment.15

In the first comprehensive analysis of a single large database, Yudkin et al13 evaluated the timing of fetal demise in 40,635 deliveries in Oxford, England, from 1978 to 1985, in all gestations of 28 weeks or greater. In their examination of 63 unexplained fetal deaths (ie, 43% of all fetal deaths) in this cohort, they found that the risk of unexplained fetal demise more than doubled in pregnancies of greater than 40 weeks of gestation. In the largest study of unexplained stillbirth to date, Huang
et al. described a number of apparent risk factors for unexplained stillbirth in a cohort of women from 1978 to 1996. These risk factors included advanced maternal age (ie, 40 years or older, OR = 3.7, 95% CI 1.3-10.6), low educational attainment (OR = 2.5, 95% CI 1.1-5.5), alterations in fetal growth (ie, between the 2.4-10.0 percentile OR = 2.8, 95% CI 1.5-5.2), infants larger than the 87th percentile (OR = 2.4, 95% CI 1.3-4.4), primiparity (OR = 1.9, 95% CI 1.1-3.1), parity 3 or greater (OR = 2.4, 95% CI 1.0-5.7), and the presence of cord loops (OR = 1.7, 95% CI 1.0-2.97).

Froen et al. using a large data set from Norway, reported findings similar to those of Huang et al, although with slightly higher risk estimates for advanced maternal age (ie, 35 years or older, OR = 5.1, 95% CI 1.3-19.7), low educational attainment (OR = 3.7, 95% CI 1.3-19.7), alterations in fetal growth (ie, between the 2.4-10.0 percentile OR = 2.8, 95% CI 1.5-5.2), infants larger than the 87th percentile (OR = 2.4, 95% CI 1.3-4.4), primiparity (OR = 1.9, 95% CI 1.1-3.1), parity 3 or greater (OR = 2.4, 95% CI 1.0-5.7), and the presence of cord loops (OR = 1.7, 95% CI 1.0-2.97).

Even when evaluating only women who had received adequate prenatal care, Vintzileos et al. found that, in the United States, black women still had twice the risk of stillbirth when compared with white women. The excess of stillbirth was attributed to higher rates of diabetes, hypertension, placental abruption, and premature rupture of membranes. Given that black women are a relatively high-risk group for stillbirth, increasing access to prenatal care, and the identification and management of those medical and socioeconomic risk factors that contribute to stillbirth obviously will be important.

**Advanced maternal age**

Advanced maternal age remains an independent risk factor for stillbirth, even after accounting for medical conditions that are more likely to occur in older women, such as multiple gestation, hypertension, diabetes, previous abortion, and abruptio placenta, all of which are associated with higher rates of stillbirth. Older women are also more likely to have preterm births, and growth-restricted infants. Historically, women 35 years or older also have had an increased risk of stillbirth related anomalies. Nevertheless, with the introduction of prenatal diagnostic testing and the availability of elective abortion, where these services are available, there has been a significant reduction in this cause of perinatal demise. Indeed, longitudinal databases that track anomalies show a transfer of fetal deaths from after 20 weeks to elective terminations before 20 weeks. After the introduction of routine prenatal diagnosis in the McGill population, for example, women 35 years or older had fewer stillbirths related to lethal anomalies, declining to that observed in younger counterparts. In recent years in this population, the only type of stillbirth

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**Table I** Most frequent types of stillbirth according to gestational age

<table>
<thead>
<tr>
<th>Gestational Age</th>
<th>Infection (%)</th>
<th>Unexplained (%)</th>
<th>Unexplained (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-27 weeks</td>
<td>Unexplained</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>28-36 weeks</td>
<td>Fetal malnutrition</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>37+ weeks</td>
<td>Abruptio placenta</td>
<td>18%</td>
<td></td>
</tr>
</tbody>
</table>

Fetal malnutrition was defined as an otherwise unexplained fetus weighing less than the 2.4%, anomalies were only considered a cause of death if they were potentially lethal. The unexplained stillbirth was diagnosed when other causes of death were eliminated with the use of a comprehensive evaluation that included autopsy in 97% of cases. Adapted from Fretts et al. and Fretts and Usher.

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**Figure 4** Reprinted with permission. Fretts RC, Usher RH. Fetal death in women in the older reproductive age group. Contemporary Reviews in Obstetrics and Gynecology 1997;9:173-9.

that of white families, and black women are less likely to receive adequate prenatal care, less likely to have completed a high school education, and more likely to have received publicly funded prenatal care. Black mothers who have had a stillbirth were also less likely than white mothers to have sought obstetric care in the first 3 months of pregnancy.
that was statistically more common in older women was the “unexplained” category of fetal demise, and these were likely to occur late in pregnancy.20

**Obesity**

The prevalence of maternal obesity is increasing steadily and is associated with an increased risk of fetal macrosomia and perinatal mortality.32-36 The reasons for this association are speculated to be due to behavioral, socioeconomic, as well as obstetric factors. Obese women are more likely to smoke and to have pregnancies complicated by gestational diabetes and preeclampsia.37 However, even when controlling for these factors, an elevated BMI remains a significant risk factor for stillbirth,33,36 and the association appears to increase as the gestation advances. A number of mechanisms for the increased risk seen in obese women have been postulated. Thinner women may be better able to perceive decreased fetal movements. Maternal obesity is also associated with hyperlipidemia,38 which may contribute to increased endothelial dysfunction, platelet aggregation, as well as to clinically significant atherosclerosis. Sleep studies of pregnant women have shown that obese women spend more time snoring (32% vs 1%; P < .001), have more apnea-hypoxia events (1.7 vs 0.2/h; P < .05), and have more episodes of oxygen desaturation (5.3 vs 0.3/h; P < .005) than nonobese pregnant women.39 Snoring has also been associated with pregnancy-induced hypertension and fetal growth restriction.40 Indeed, in addition to advanced maternal age and low socioeconomic status, as discussed previously, the most prevalent risk factor for stillbirth is prepregnancy obesity.

**Thrombophilias**

Our understanding of the relationship between inherited abnormalities of blood clotting and stillbirth is seriously deficient, in that there have been no large population-based studies that have evaluated this association.41-44 The relationship between late fetal death and thrombophilia is more consistent than with early fetal losses,45 although the odds ratio ranges from as low as 1.8 to estimates as high as 12.46-50 A meta-analysis of smaller studies suggested that the presence of thrombophilias does increase the risk of stillbirth (OR = 3.6; 95% CI 1.4-9.4), with the analysis of specific defects limited by power.41 Martinelli et al51 found the prevalence of mutations either in factor V or prothrombin to be 16% in those pregnancies that ended in an unexplained loss, compared with 6% of normal pregnancies,51 although the value of placental disease to discriminate unexplained losses with and without a diagnosis of thrombophilia is in question. The authors found that 24% of the placentas were normal, whereas the remaining 76% showed intravascular thrombi, decidual vasculopathy, and ischemic necrosis with villous infarctions. The placentas were abnormal in 7 of 9 (78%) women with a mutation and in 40 of 53 (75%) stillbirths without a mutation so that the presence of a known mutation did not correlate with a specific placental histologic or biochemical abnormality. In another small study of 22 women with at least 1 unexplained loss, 4 of 9 placentas showed extensive infarcts in women who had documented thrombophilia, whereas none of the 8 without thrombophilia exhibited similar pathologic findings.47

**Systemic lupus erythematosus**

Systemic lupus erythematosus (SLE) complicates less than 1% of pregnancies but the risk of stillbirth in this population is disproportionately high, especially in women with preexisting renal disease.52 Hypertension, preeclampsia, and fetal growth restriction are common in these patients.53-55 Even when pregnancy is conceived during a relatively quiescent period in terms of disease activity, stillbirth can complicate up to 3% to 8% of pregnancies.53-55 The presence of a lupus anticoagulant has been reported to significantly increase the risk of a fetal loss after 20 weeks of gestation. The optimum management of patients with SLE is uncertain, but the use of heparin and aspirin was associated with an improved outcome in 1 small series.45

**Medical risk factors**

Hypertension and diabetes are 2 of the most common medical conditions to complicate pregnancy (7%-10% and 3%-5%, respectively).23,52,56-59 Historically, both of these conditions have been shown to be responsible for a significant proportion of fetal deaths. However, optimal management, including counseling, preconceptual care, and close medical management of these conditions, has been shown to reduce the risk for perinatal death to a level only marginally elevated over that of the general population.50 Management of patients remains a challenge, however, because of the increased risks of abruptio placenta, of intrauterine growth restriction, and of superimposed preeclampsia, which often necessitates early delivery.37,58,60 Other important medical conditions associated with an increased risk of stillbirth are listed in Table II.52

**Infection and immunologic exposure**

A significant proportion of perinatal morbidity and mortality is related to infection, which often leads to delivery of a premature liveborn or a stillborn infant. Despite the adoption of a strategy to reduce the risk of perinatal infection caused by group B streptococci, there has been little change in the risk of fetal death caused by infection because most of these deaths occur pre-term.10,61 Although there are some pathogens that are probable causes of stillbirth, such as parvovirus 19,
cytomegalovirus, toxoplasmosis, and listeria, there are others that may be associated with an increase in risk, but the evidence for which remains inconclusive. For example, colonization with *Ureaplasma urealyticum*, *Mycoplasma hominis*, and group B streptococci has all been associated with an increased risk of stillbirth, although colonization with these pathogens is also common among healthy women.

In recent reports, Refuerzo et al. and Blackwell et al. found that women who had had an unexplained stillbirth, without any evidence of obvious infection, had a higher number of “memory T cells” (CD45RO) than “naive T cells” (CD45RA) when compared with live-born controls. Although this finding suggests that, despite the absence of any overt evidence of clinically significant infection, these women had prior exposure to infectious agents. Froen et al. found, in an epidemiologic study of unexplained stillbirths, that bacteruria or symptomatic urinary tract infections during pregnancy were associated with a reduced risk of fetal death, a finding not fully explained by treatment with antibiotics. The role of the immune system has lately become a subject of considerable interest in perinatal birth injury. There is evidence that elevated inflammatory processes are associated with an increase in the risk of adverse outcomes in the premature neonate. Infected infants, both premature and term, were shown to exhibit a significant increase in interleukin 6 production, with C-reactive protein (CRP) increasing rapidly at the onset of infection and remaining elevated until the infection was cleared. Animal data suggest that the combination of subclinical infection and a fetal inflammatory response can both cause abnormalities of gas exchange that result in fetal hypoxia and decreased survival.

### Infertility

Because women who choose to delay their childbearing are also more likely to have a history of infertility and to conceive with the aid of reproductive technologies, it is important to evaluate the effect of infertility and infertility treatment on the risk of fetal death. Patients treated with advanced reproductive technologies experience excess perinatal mortality. Although the frequency of multiple gestations is responsible for a

<table>
<thead>
<tr>
<th>Table II</th>
<th>Estimates of maternal risk factors and risk of stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition</td>
<td>Prevalence</td>
</tr>
<tr>
<td>All pregnancies</td>
<td></td>
</tr>
<tr>
<td>Low-risk pregnancies</td>
<td></td>
</tr>
<tr>
<td>Hypertensive disorder</td>
<td></td>
</tr>
<tr>
<td>Chronic hypertension</td>
<td>6%-10%</td>
</tr>
<tr>
<td>Pregnancy-induced hypertension</td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>5.8%-7.7%</td>
</tr>
<tr>
<td>Severe</td>
<td>1.3%-3.3%</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Treated with diet</td>
<td>2.5%-5%</td>
</tr>
<tr>
<td>Treated with insulin</td>
<td>2.4%</td>
</tr>
<tr>
<td>SLE</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Renal disease</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Thyroid disorders</td>
<td>0.2%-2%</td>
</tr>
<tr>
<td>Thrombophilia</td>
<td>1%-5%</td>
</tr>
<tr>
<td>Cholestasis of pregnancy</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td>Smoking &gt; 10 cigarettes</td>
<td>10%-20%</td>
</tr>
<tr>
<td>Obesity (prepregnancy)</td>
<td></td>
</tr>
<tr>
<td>BMI 25-29.9 kg/m²</td>
<td>21%</td>
</tr>
<tr>
<td>BMI &gt; 30</td>
<td>20%</td>
</tr>
<tr>
<td>Low educational attainment (&lt;12 y vs. 12 y+)</td>
<td>30%</td>
</tr>
<tr>
<td>Previous growth-restricted infant (&lt;10%)</td>
<td>6.7%</td>
</tr>
<tr>
<td>Previous stillbirth</td>
<td>0.5%-1.0%</td>
</tr>
<tr>
<td>Multiple gestation</td>
<td>2%-3.5%</td>
</tr>
<tr>
<td>Twins</td>
<td>2.7%</td>
</tr>
<tr>
<td>Triplets</td>
<td>0.14%</td>
</tr>
<tr>
<td>Advanced maternal age (reference &lt;35 y)</td>
<td></td>
</tr>
<tr>
<td>35-39 y</td>
<td>15%-18%</td>
</tr>
<tr>
<td>40y +</td>
<td>2%</td>
</tr>
<tr>
<td>Black women compared with white women</td>
<td>15%</td>
</tr>
</tbody>
</table>

* OR of the factor present compared to the risk factor absent. Some estimates of medical conditions and stillbirth risk from Simpson. Other risk estimates from references 24, 25, 29, 33, 34, 35, 38, 55, 58, 68.
significant portion of this excess mortality, it also appears that women who undergo either in vitro fertilization (IVF) or ovarian stimulation and have a singleton gestation, also have a statistically increased risk of pretermaturity, low birth weight, and SGA fetuses.\textsuperscript{71-74} There have been no studies that have evaluated whether infertility itself is associated with an increase in unexplained fetal death. Nevertheless, many physicians who care for infertile patients perceive these pregnancies to be at “high risk” for adverse maternal and fetal outcomes.

**Multiple gestations**

Over the past 2 decades, the rate of pregnancies with twins has more than doubled, the rate of triplets has increased 6-fold, and the number of quadruplets has increased by 12-fold.\textsuperscript{68-70} With this increase in the number of multiple gestations, there has been a measurable increase in prenatal mortality and morbidity in industrialized countries. The main reason for this increase is the use of reproductive technologies and the associated increase in maternal age.\textsuperscript{75,76} It has been estimated that a strategy of lowering the transfer rate to 2 embryos during IVF could reduce the perinatal mortality rate by 45% in the case of limiting a triplet to twins, or 74% when limiting the quintuplet pregnancies to twins.\textsuperscript{70} The optimal duration of an otherwise uncomplicated pregnancy is shorter for multiple gestations. Kahn et al.\textsuperscript{77} found, for example, that it was safer for a twin pregnancy to be delivered than undelivered at 39 weeks, and for triplets who remain undelivered at 36 weeks, an elective delivery at this time minimized adverse fetal outcomes.

**Biologic markers of increased risk of stillbirth**

**Hemoconcentration**

Froen et al.\textsuperscript{64} from Norway have demonstrated that women with hemoconcentration, defined as the lowest hemoglobin measured during pregnancy greater that 13.0 g/dL, is associated with a 9-fold increase in the risk of unexplained fetal death. Stephansson et al.,\textsuperscript{78} using a Swedish database, found that both an initial elevated hemoglobin and the failure of significant hemodilution over the course of the pregnancy, increased the risk of stillbirth by 2-fold, even when women with preeclampsia and eclampsia were excluded.\textsuperscript{78} Plasma volume expansion and lowered hemoglobin concentration are normal physiologic responses to pregnancy. Plasma volume expansion appears to be important for fetal growth and failure of sufficient hemodilution is associated with an increased risk of stillbirth, even if the fetus is not growth restricted. Stephansson et al.\textsuperscript{78} suggest that those patients with high initial hemoglobin concentrations should be considered at high risk for adverse obstetric outcomes.

**Amniotic and serum markers**

Pregnancy-associated plasma protein A (PAPP-A) is a maternal serum marker used in combination with other tests to detect an increased risk of chromosomal abnormalities; it also appears to be of help in detecting, in the second trimester, pregnancies that might be at an increased risk for an adverse outcome. Smith et al.\textsuperscript{79} assessed adverse perinatal outcomes among the 8839 patients recruited into a multicenter study. Patients with serum markers in the lowest fifth percentile were found to have an increased risk of premature delivery (OR = 2.9, 95% CI 1.6-5.5), preeclampsia (OR = 2.3, 95% CI 1.6-3.3), and stillbirth (OR = 3.6, 95% CI 1.2-11.0).\textsuperscript{79} In growth-restricted fetuses, the maternal serum alpha-fetoprotein was not particularly helpful in identifying pregnancies that would later go on to an adverse perinatal outcome, but a combination of factors, an elevated HCG and a low unconjugated estriol, was 67% sensitive and 70% specific in predicting a composite “adverse perinatal outcome” metric, which included perinatal death and neonatal morbidity.\textsuperscript{80}

Amniotic fluid abnormalities also have been found to be associated with fetal demise. Florio et al.\textsuperscript{81} performed a case control study of women undergoing amniocentesis for routine reasons, in which 12 patients with a stillbirth all had elevated levels of S100B (a marker of brain damage in both adult and pediatric patients, but which is not specific for cerebral damage),\textsuperscript{32} but the 746 healthy controls did not. At least in this dataset, this test was perfect in predicting fetal death, a very rare finding in medicine, although these data will need to be replicated.\textsuperscript{81} The mechanisms linking most abnormal maternal serum and amniotic markers with adverse fetal outcomes are not known, but further study is required before recommendations for specific clinical applications can be considered.

**Prevention strategies**

The data available for cost-effective stillbirth prevention are limited. The remaining aspect of this review represents the author’s opinion based on the limited data available. In the absence of a prior obstetric history, the patient’s risk for stillbirth is related to her underlying health and lifestyle. Globally, one of the largest modifiable risk factors is smoking, as it is obviously tied to the pathophysiology of many diseases. Additional medical risk factors, as discussed previously, significantly impact both maternal and child health as well, and appropriate medical care for these conditions and preconception counseling can have a significant impact.
on outcome. The provider should perform a risk assessment for each individual patient and give realistic estimates of anticipated obstetric outcomes. Screening for hypertension and diabetes is essential to prevent poor pregnancy outcomes, but a number of other factors should be included in any risk assessment, including advanced maternal age, prepregnancy obesity, infertility, low educational attainment as a marker of lower socioeconomic status, and black race. Although the black race may be a proxy for socioeconomic factors, it is helpful to remember that black women 35 years or older have a risk of stillbirth 4 to 5 times higher than the national average and therefore deserve the same vigilance afforded to other groups at high risk for stillbirth.

A moderate proportion of stillbirths related to congenital anomalies could be reduced with preconceptual counseling and testing, adequate prenatal care, and prenatal diagnostic testing, with elective terminations for affected pregnancies. During pregnancy, patients with medical conditions need to be closely monitored to optimize their treatment and fitness for pregnancy and ensure fetal well-being.

In terms of reducing potentially preventable stillbirths, the Confidential Inquiry into Stillbirths and Infant Death (CISID) of Northern Ireland found that the failure to adequately diagnose and manage fetal growth restriction was the most common error, followed by failure to recognize additional maternal medical risk factors. Given that deaths of intrauterine growth-restricted fetuses represent 1 of the most common types of stillbirths, a significant opportunity remains to improve outcomes. Assessment of fetal growth by ultrasound should be considered in at-risk patients. A customized growth chart more readily identifies the growth-restricted fetus, and reduces "false alarms" in the constitutionally small fetus. Ideally, serial ultrasound reports should be reported together so that the history of intrauterine growth over time can be more readily appreciated. The threshold to perform an ultrasound in the obese patient should be low because fetal growth is often difficult to estimate clinically.

In women who have had a previous pregnancy, a previous preterm delivery, previous obstetric complication, delivery of a growth-restricted fetus, or a stillborn fetus, these events significantly increase their risk for adverse events in future pregnancies. There is some evidence, for example, that a previous cesarean section at term might reduce placental function and therefore increase the risk of a late antepartum unexplained stillbirth. Nevertheless, this association should be confirmed by other groups before it is considered an important risk factor.

Given all of the potential factors that influence the risk of stillbirth, it would be helpful to have an interactive model that would estimate the risk of a fetal demise in a manner similar to that used by physicians who care for patients with cardiovascular risk factors, who have a wealth of information to estimate the risk of myocardial infarction and death. A risk analysis should guide management policies and provide an evidence-based approach to alter the threshold at which antepartum testing and early delivery is considered. Until such evidence-based guidelines exist, the obstetric care provider must decide on the appropriate type of vigilance, and decide when expectant care increases the risk to the ongoing pregnancy to a degree that warrants intervention for delivery.

Fortunately, for the majority of obstetric patients who are at low risk, the incidence of a late stillbirth is a relatively low (1-2/1000). Still, there is a role for vigilance in these pregnancies. In a reanalysis of the results of a fetal movement counting study initially published by Grant et al, Froen has appropriately re-ignited the interest in fetal kick counting. Even low-risk pregnancies with decreased fetal movement are known to have a higher risk of fetal distress in labor, for being growth restricted, and for having an increased frequency of stillbirth.

The risk of stillbirth in late pregnancies has been appreciated by many authors, as discussed previously. Antepartum surveillance with judicious delivery of fetuses with poor fetal testing has been shown to improve outcomes in pregnancies with growth-restricted fetuses. Antepartum testing is also widely used in patients perceived to be at increased risk for fetal death, with the use of the testing related to the underlying risk of stillbirth. Randomized control trials of expectant versus induction of the postdates pregnancy are not large enough to detect a difference in the perinatal mortality. However, in an analysis of the effect of labor induction rates in the 41st week, Sue et al found that in Canada between 1980 and 1995 there was a marked decrease in the number of pregnancies at 41 or more weeks of gestation. The authors correlated the increase in the number of inductions after 41 weeks to a lowering of the stillbirth rate. Fretts et al, using the McGill Obstetrical Neonatal Database to obtain risk estimates, performed a decision-analysis of the risks and benefits of antepartum testing late in pregnancy for women 35 years or older. This decision analysis considered only late unexplained stillbirth, but this covers the majority of late stillbirths. For the neonate, there is no measurable long-term adverse effect of being born at 36 weeks of gestation, or later, so the analysis was begun starting during the 37th week. The major risk of antepartum testing after 36 weeks is induction of labor and its associated downstream effects, such as a potential for an increase in the cesarean delivery rate, and therefore a potential increase the maternal mortality rate. For multiparous patients, induction carries a lower risk, and although induction does probably increases the risk of cesarean delivery, it does so only
In the initial study by Fretts et al.\textsuperscript{93} on the risks and benefits of antepartum testing late in pregnancy for older women, they constructed a sensitivity analysis that applies to any condition associated with an increased risk of late stillbirth.\textsuperscript{93} Three strategies were compared: no testing, testing after the 36th week with induction for a positive test, and no testing with induction at 41 weeks. The number of fetal deaths averted and the number of tests, inductions, and additional cesarean deliveries per fetal death averted were calculated assuming antepartum testing to be 70% sensitive and 90% specific. The results for OR 1.0 to 5.0 are presented in Table III.

Although a strategy of antepartum testing is predicted to be most successful in reducing the number of unexplained stillbirths, it was also associated with the highest induction rate. For nulliparous women of advanced maternal age, predicted to have an OR of 3.3 over younger women, the number of additional cesarean deliveries per fetal death averted were calculated assuming antepartum testing to be 70% sensitive and 90% specific. The results for OR 1.0 to 5.0 are presented in Table III.

Management of stillbirth

The diagnosis of a singleton stillbirth must be confirmed with an ultrasound examination of the fetal heart. Most hospitals have instituted a program to help bereaved parents cope with their loss and follow good practice guidelines, which include the opportunity to see and hold their infant and obtain tokens of remembrance.\textsuperscript{107} A worksheet for both parents and providers help to streamline the management of these losses and can facilitate the optimal investigation for determining the cause of death. Delayed delivery after 24 hours of the diagnosis has been associated with an increased risk of anxiety years after the loss, when compared with women whose labors were induced within 6 hours.\textsuperscript{108} The expectant management of a stillbirth therefore should be discouraged, in addition to the fact that delayed delivery is also associated with increased maternal risks of consumptive coagulopathy.\textsuperscript{109,110} The availability of prostaglandins, in particular misoprostol, has made induction of stillbirth safer and more efficient in women without a previous cesarean delivery. For now, oxytocin will remain the main method of induction for women with a previous cesarean delivery.

After delivery, the parents and other family members should have the opportunity to spend as much time as needed with the deceased infant. Even in the scenario of obvious maceration of the infant, after initial anxiety, parents often find something to connect them to the infant. A recent study has questioned whether holding a stillborn child might increase the risk of later anxiety,\textsuperscript{111} this finding has not been duplicated to date.

One important aspect of a woman’s care after a stillbirth is an appropriate and comprehensive stillbirth assessment. It is unfortunate that the United States has 1 of the lowest rates of obtaining a comprehensive stillbirth assessment when compared with other developed countries. This may be in part due to an increased level of anxiety over litigation in the United States, but it may also reflect the absence of a nationally coordinated program to evaluate these deaths. Notwithstanding, there are centers within the United States that can serve as role models for a comprehensive approach to stillbirth such as those at the University of Southern California and the Wisconsin Stillbirth Service Program.\textsuperscript{112,113} Incerpi et al.\textsuperscript{113,114} have demonstrated that, within the context of developing a cost-effective stillbirth assessment program, the single most important test to determine the cause of a stillbirth is the autopsy, followed by an evaluation of the placenta. For some parents, a limited fetal evaluation will be more acceptable than a complete autopsy, and this option should be explored if a complete autopsy is not acceptable.\textsuperscript{115,116} An external

<table>
<thead>
<tr>
<th>Outcome</th>
<th>OR for unexplained stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>Fetal deaths per 1000</td>
<td>0.4</td>
</tr>
<tr>
<td>Tests per pregnancy</td>
<td>3.4</td>
</tr>
<tr>
<td>Inductions per fetal death</td>
<td>233</td>
</tr>
<tr>
<td>Cesarean deliveries per fetal</td>
<td>44</td>
</tr>
</tbody>
</table>

Assuming base-case test characteristics (70% sensitivity, 90% specificity).

* Outcomes from week 37 of gestation through week 41.
  † Unexplained fetal deaths averted per 1000 pregnancies compared to no testing.\textsuperscript{93}
physical examination and radiologic testing performed by the perinatal pathologist, with or without sampling fetal tissues in situ, can provide significant information. Although an autopsy is optimal, a postmortem magnetic resonance image (MRI) can provide useful additional information, although typically MRI staff are not used to receiving these requests.117

A genetic analysis of chromosomes will reveal abnormalities in between 5% and 10% of stillbirths.113 After a stillbirth, the highest yield for obtaining fluid for cytogenetic analysis will be at the time of amniocentesis at the time of the diagnosis of the stillbirth, but this has not been the usual practice at most centers of care within the United States. If amniotic fluid is unavailable, a sample of fetal blood, skin, or fascia lata will be best sources of tissue for culture. The use of a cytogenetic evaluation decreases with the duration of time that the infant has been dead, so reserving placental tissue for fluorescence in situ hybridization (FISH) in a buffered saline solution is an alternative method of determining whether the infant had a common chromosomal abnormality.116,119

With the use of a protocol of autopsy, evaluation of the cord/placenta and membranes, and laboratory tests of fasting glucose, a Kleihauer-Betke test, urine toxicology and hemoglobin A1c in selected cases, and a thrombophilia workup in normally formed infants, Incerti et al115 were able to attribute a primary cause of death in 72% of cases of stillbirth, leaving only 28% as “unexplained.” Notably absent in their protocol was the recommendation of obtaining TORCH titers, (ie, cytomegalovirus, toxoplasmosis, herpes simplex virus, and rubella) because these titers, in and of themselves, almost never aid in the diagnosis of a congenital infection in the absence of autopsy and placental findings of infection. Incerti et al120 found no significant association between antinuclear antibodies and stillbirth in the evaluation of 286 unexplained stillbirths. Parvovirus 19 is most commonly associated with a fetal death in the setting of nonimmune hydrops, but parvovirus 19 DNA can also be found in the placenta and fetus even in the nonhydropic infant.121,122

The value of a comprehensive stillbirth assessment cannot be underestimated, because the results are relevant to assess the risk of recurrence, the development of prenatal diagnostic recommendations for subsequent pregnancies. Pauli’s group at the Wisconsin Stillbirth Service, a model state-wide program for the prevention of stillbirth, estimated that in 2001, the real cost of a stillbirth assessment was approximately $1450 US or approximately $12 per cared-for pregnancy, and influenced subsequent perinatal care in 51% of cases.112

After studying 1631 stillbirths, the most significant consequence of this analysis was the change in the risk estimate of recurrence or stillbirth in 42% of cases. Other consequences were a change in the recommendations with respect to prenatal diagnosis in 22.2% and preconceptual management in 10.9% of subsequent pregnancies.

Summary

Clinicians need to be able to assess each patient’s risk for adverse outcomes, including stillbirth, and to have a low threshold to evaluate fetal growth in at-risk pregnancies. As reviewed previously, late pregnancy is also associated with progressively increasing risk of stillbirth, and although the strategy of antepartum testing in patients with increased risk will decrease the risk of late fetal loss, it is of necessity also associated with higher intervention rates.

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An Initiative to Improve the Quality of Care of Infants With Neonatal Abstinence Syndrome

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Dr Grossman conceptualized and designed the project, drafted the initial manuscript, and coordinated data collection; Drs Berkwitt and Osborn helped design the project, collected data, and critically reviewed the manuscript; Ms Xu and Dr Esserman carried out the statistical analysis and critically reviewed the manuscript; Dr Shapiro helped analyze data and critically reviewed the manuscript; Dr Bizzarro helped design the project and critically reviewed the manuscript; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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Infants exposed to opioids in utero may develop neonatal abstinence syndrome (NAS), a constellation of neurologic, gastrointestinal, and musculoskeletal disturbances associated with opioid withdrawal. At our institution, infants exposed to methadone in utero who developed signs of withdrawal were given a diagnosis of NAS. The number of infants at Yale New Haven Children’s Hospital (YNHCH) exposed to methadone in utero increased by 74% from 2003 to 2009, and the average length of stay (ALOS) for infants exposed to methadone in utero was 22.4 days before the start of our project. We aimed to reduce ALOS for infants with NAS by 50%.

METHODS: In 2010, a multidisciplinary team began several plan-do-study-act cycles at Yale New Haven Children’s Hospital. Key interventions included standardization of nonpharmacologic care coupled with an empowering message to parents, development of a novel approach to assessment, administration of morphine on an as-needed basis, and transfer of infants directly to the inpatient unit, bypassing the NICU. The outcome measures included ALOS, morphine use, and hospital costs using statistical process control charts.

RESULTS: There were 287 infants in our project, including 55 from the baseline period (January 2008 to February 2010) and 44 from the postimplementation period (May 2015 to June 2016). ALOS decreased from 22.4 to 5.9 days. Proportions of methadone-exposed infants treated with morphine decreased from 98% to 14%; costs decreased from $44,824 to $10,289. No infants were readmitted for treatment of NAS and no adverse events were reported.

CONCLUSIONS: Interventions focused on nonpharmacologic therapies and a simplified approach to assessment for infants exposed to methadone in utero led to both substantial and sustained decreases in ALOS, the proportion of infants treated with morphine, and hospital costs with no adverse events.
infants were occupying an increasing percentage of NICU beds and had an average cost of hospitalization of $44,800. From 2003 to 2009 at YNHCH, 98% of infants exposed to methadone in utero were treated with morphine, a higher percentage than in any published report.1

Previous initiatives at other institutions have successfully reduced ALOS for NAS. Holmes et al2 reported a reduction in ALOS from 17 to 12 days after adopting a rooming-in model focused on optimizing nonpharmacologic interventions. Asti et al3–5 reported a reduction in ALOS in a NICU of 36 to 18 days for infants with NAS after implementing a stringent weaning protocol and standardizing the scoring of the Finnegan Neonatal Abstinence Scoring System (FNASS), a tool that assigns a numerical score to 21 subjective clinical signs of NAS and is commonly used to guide pharmacologic management of NAS.

Despite the wide acceptance of the FNASS, its utility in improving outcomes for infants with NAS has not been formally evaluated.6 There is also no evidence that most infants with NAS require management in a NICU.6 In fact, the environment in some NICUs may impose barriers to implementing nonpharmacologic interventions, such as rooming-in. We set out to change the paradigm of how we approached the management of infants with NAS. We aimed to decrease our ALOS by 50% by focusing interventions on nonpharmacologic care. We also measured morphine use and hospital costs for infants with NAS born at our institution.

METHODS

Context

From March 2010 to June 2016, we conducted a quality improvement project at YNHCH, an academic medical center with ~4500 births and 850 NICU admissions annually. We applied our interventions to all infants with NAS (infants exposed in utero to opioids who developed signs of withdrawal), but we analyzed only those born at ≥35 weeks’ gestation whose mothers took methadone daily for at least 1 month before delivery. We considered this population to be the most likely to develop signs of withdrawal.6 We excluded infants with significant comorbidities, including sepsis and the need for either surgery or respiratory support (supplemental oxygen, noninvasive ventilation, and/or intubation for ≥2 days).

During the preintervention period (January 2008 to February 2010), all infants at risk for NAS were admitted directly to our NICU after birth, where signs of NAS were monitored by using the FNASS. Infants with either 3 FNASS scores ≥8 or 2 scores ≥12 in a 24-hour period were given morphine (starting at 0.05 mg/kg per dose every 3 hours and adjusted based on subsequent FNASS scores). Infants were initially managed in the NICU and then, at the discretion of the attending neonatologist, were either discharged from the NICU or transferred to the inpatient unit. In either unit, infants were discharged at day 5 of life (if no morphine was given) or 1 day after morphine was stopped.

Interventions

In 2009, we noted an increase in the number of infants with NAS and formed a multidisciplinary team that included attending physicians, residents, staff nurses, nursing leadership, child life specialists, and social workers to develop interventions aimed at improving care of these infants and reducing ALOS. We identified 4 key drivers of ALOS: nonpharmacologic interventions, simplified assessment of infants, decreased use of morphine, and communication between units (Fig 1). During the next 5 years, using plan-do-study-act cycle methodology, we developed and implemented 8 interventions (listed below their respective key driver) aimed at reducing the ALOS of infants with NAS. The chronology of the interventions is listed in Table 1.

Nonpharmacologic Interventions

Standardized Nonpharmacologic Care on the Inpatient Unit

We standardized 4 nonpharmacologic interventions. (1) Infants were placed in a low-stimulation environment with dimmed lights, muted televisions, and reduced noise. (2) Staff engaged...
parents continuously in the care of their infants (volunteers were used if a family member was not available); parents were strongly encouraged to room-in, to feed their infants on demand, and to tend to their infant if crying. (3) Staff were trained to view nonpharmacologic interventions as equivalent to medications; when increased intervention was warranted, the approach was to increase the involvement of the parents before using pharmacologic treatment. Finally, in conjunction with the well-baby nursery (WBN), we encouraged breast-milk feeding of all infants for whom there were no contraindications (ie, illicit drug use or HIV).

Prenatal Counseling of Parents
Several weeks before delivery, our outpatient care coordinator provided parents with informational handouts, told them that they would be expected to stay with their infant throughout the hospitalization, and answered questions.

Empowering Messaging to Parents
On the inpatient unit, we explained that our first-line and most important treatment would center around measures to comfort the infant and that these should be performed by a family member. Parents were told that they were the treatment of their infants and must be present as much as possible. Nurses and physicians focused on supporting and coaching parents on the care of their infants.

Simplified Assessment of Infants
We discontinued use of FNASS scores to guide pharmacologic management on the inpatient unit (FNASS was still used in the WBN and NICU). Instead, we developed and used our own functional assessment focused on 3 simple parameters: the infant’s ability to eat, to sleep, and to be consoled. If the infant was able to breastfeed effectively or to take ≥1 oz from a bottle per feed, to sleep undisturbed for ≥1 hour, and, if crying, to be consoled within 10 minutes, then morphine was neither started nor increased regardless of other signs of withdrawal. If the infant did not meet these criteria, staff first attempted to maximize nonpharmacologic interventions; if these attempts were unsuccessful, morphine was initiated or increased.

Decreased Use of Morphine

Rapid Morphine Weans
Our previous approach for infants with NAS had been to reduce the initial dose of morphine by not >10% every 24 to 48 hours. With the increase in nonpharmacologic management, we modified our approach to allow for decreases in the peak dose of morphine by 10% as often as 3 times a day.

Morphine Given as Needed
We noticed that signs of withdrawal were not always consistent throughout the day. In addition, sometimes we were unable to provide optimal nonpharmacologic care, such as when no parent, family member, or volunteer could be present. If maximal nonpharmacologic interventions were unsuccessful, we would give 1 dose of morphine (0.05 mg/kg per dose) and reassess the infant in 3 hours. If the infant was sleeping well, eating well, and consolable within 10 minutes, additional doses of morphine were not administered.

Communication Between Units

Transfer From WBN to the Inpatient Unit
Our level IV NICU housed infants with NAS in rooms with as many as 12 infants. Parents were not able to room-in and the ability to provide a low stimulation environment was extremely limited. We discontinued the practice of directly admitting infants at risk for NAS to the NICU after birth in an effort to keep the mother-infant dyad intact. Instead, these infants were brought to the WBN where FNASS scores were measured. If any score was ≥8, the neonates were preferentially transferred to the inpatient unit where the mothers could room-in. Neonates were admitted to the NICU only if an unforeseen medical problem arose or if there was no bed available on the inpatient unit. On the inpatient unit, nonpharmacologic interventions were initiated as soon as possible for all opioid-exposed infants, whether they had clinical signs of withdrawal or not.

Spread of Change Concepts to NICU
A focused educational session about our new approach to the management of infants with NAS was provided to NICU staff who were encouraged to transfer infants with NAS to the inpatient unit as soon as possible and, ideally, before starting morphine.

Study of the Intervention
We compared demographic features, including rates of polypharmacy (defined as methadone use in addition to mother’s use of cocaine,
selective serotonin reuptake inhibitors, benzodiazepines, or opioids other than methadone) and outcomes of infants in the baseline and postimplementation periods. P values (2-tailed) are reported from pairwise t tests for continuous variables and from either χ² tests or Fisher’s exact tests (if cell count <5) for categorical variables. Analyses were performed by using SAS version 9.3 (SAS Institute, Inc, Cary, NC).

Measures and Analysis

Our primary outcome measure was ALOS, calculated from date of birth, measured as day of life 0, until date of discharge. Secondary measures included the proportion of infants treated with morphine and the average total cost of hospitalization, including direct and indirect costs. Cost information was obtained from the YNHCH analytics department and adjusted for inflation (2016 dollars). Process measurements included the proportion of infants who were taking ≥50% of their feeds as breast milk at time of discharge and the proportion of infants initially admitted to the NICU for management of NAS. As balancing measures, we tabulated the number of infants transferred to an ICU from the inpatient unit, the number of infants with seizures, and readmissions within 30 days of discharge related to withdrawal. We compared measures after the interventions were fully implemented (May 2015 to June 2016) with the same measures during the baseline period (January 2008 to February 2010). There were no additional hospitalwide interventions to reduce ALOS in newborns ≥35 weeks’ gestational age during the study period. To ensure completeness of data, records of all patients with administrative codes for NAS (International Classification of Diseases, Ninth Revision: 779.5 and 760.72; International Classification of Diseases, 10th Revision: P04.49 and P96.1) were reviewed for inclusion criteria. We used statistical process control (SPC) charts to evaluate the impact of our interventions. SPC charts were developed by using Microsoft Excel QIMacros. SPC uses statistical methods to analyze common cause variability, to produce control limits to assess the process capability, and to identify special cause variation, or incidences of statistically significant (P < .01) variability.

Ethical Considerations

The Yale University Human Investigation Committee determined that this project was exempt from review. No interventions involved comparison of therapies and subjects were not randomized. All charts were accessed by quality team members and no personal health information was shared outside of the organization.

RESULTS

Of the 421 infants ≥35 weeks’ gestational age diagnosed with NAS from January 2008 to June 2016, 287 met inclusion criteria, including 55 in the baseline period, 188 during the intervention period, and 44 in the postimplementation period. Those excluded included 132 infants not exposed to methadone and 2 infants who had serious comorbid conditions. The characteristics and outcomes of the infants during the different time periods are presented in Table 2. The ALOS decreased from 22.4 days in the preimplementation period (January 2008 to February 2010) to 5.9 days (74% reduction) in the postimplementation period (May 2015 to June 2016) (P < .001). Special cause variation (8 consecutive points below the centerline) first occurred in March 2010, after standardization of nonpharmacologic interventions; it next occurred in December 2011, after implementation of direct transfer to the inpatient unit; it next occurred in January 2014, after implementation of novel approach to assess infants on the inpatient unit and spread of change concepts to the NICU; it next occurred in June 2015, after implementation of as-needed morphine dosing and empowering messaging to parents. There was narrowing of the control limits after each special cause variation (Figs 2 and 3).

The proportion of infants treated with morphine decreased from 98% to 14% (P < .001) and the average cost of hospitalization decreased from $44,824 to $10,289 (P < .001). For the infants transferred from the WBN to the inpatient unit without a NICU stay, only 6% (2/35) received treatment with morphine. The proportion of infants that took the majority of their feeds from breast milk increased from 20% to 45% (P = .01), and the proportion of infants admitted directly to the NICU decreased from 100% to 20% (P < .001).

No patient admitted to the inpatient unit required transfer to an ICU. There were no seizures reported in any patient. There were no readmissions within 30 days of discharge related to signs of withdrawal in either the baseline or the postimplementation periods.

DISCUSSION

The use of quality improvement methodology to improve the care of infants with NAS led to both substantial and sustainable decreases in ALOS, far beyond our goal of a 50% reduction. The use of morphine and the average cost of hospitalizations also were substantially reduced. Our 8-plan-do-study-act cycles led to an improvement in ALOS, well below that reported in any other published studies. There were no statistically significant differences in
the characteristics of infants in our baseline and postimplementation periods, and we are confident that our interventions directly resulted in the changes observed.

One of our study’s strengths was the inclusion of all methadone-exposed infants, which allowed us to fully measure the impact of our interventions. Many studies define infants with NAS as only those who receive pharmacologic treatment.9–12 However, requiring pharmacologic treatment for a diagnosis of NAS limits the ability to draw conclusions about the efficacy of nonpharmacologic interventions. The use of medication to treat clinical signs should not be the sole factor used to define the syndrome. Although we applied our interventions to all opioid-exposed infants, we focused our evaluation on the subset of opioid-exposed infants most likely to develop withdrawal, regardless of the eventual treatment received. Infants exposed to methadone are more likely to develop withdrawal,98% of infants exposed to methadone developed signs of withdrawal severe enough to receive pharmacologic treatment.

Another strength of our project was the development of novel criteria for the clinical assessment of infants with NAS. Criteria for either starting or altering treatment with opioids based on FNASS scores have never been validated.6 An FNASS score cannot be obtained without disturbing and unswaddling the baby, which increases the likelihood of high scores in many categories (eg, tremors, tone, and cry). Our approach encouraged providers to focus on a small number of clinically relevant factors to assess the need for treatment with morphine. Ideally, all infants should feed well, sleep well, and be easily consoled. We determined that if infants with NAS met these goals, then treatment was successful irrespective of the FNASS score.

When we began our initiative, all infants with NAS were admitted directly to the NICU, an environment that did not permit rooming-in and rarely provided consistent, nonpharmacologic interventions other than swaddling. In this setting, 98% of infants exposed to methadone developed signs of withdrawal severe enough to receive pharmacologic treatment. Our intervention changed the milieu in which these infants were managed from one with limited ability to optimize nonpharmacologic interventions to a low-stimulation environment with an intense focus on the involvement of parents and continuous assessment of the infant’s comfort. In the process, we were able to change a system in which parents were merely allowed to visit their infant to one in which they were empowered to be the most important part of their infant’s care. This approach employed the power of the maternal-infant bond to treat NAS.14, 15 After the implementation of these interventions, the use of morphine to treat NAS decreased to 14%.

In the United States from 2009 to 2012, the ALOS for all infants with NAS was 17 days; infants requiring pharmacologic interventions had an ALOS of 23 days.16 By changing the paradigm of how infants with NAS are treated and evaluated, we reduced our ALOS to 5.9 days. The potential savings in hospital costs from this approach is considerable. Based on the average cost of a hospital day for an infant with NAS at our institution in 2015 to 2016.

### TABLE 2 Characteristics and Outcomes of the Newborns and Their Mothers

<table>
<thead>
<tr>
<th>Characteristics of the Newborns</th>
<th>Baseline (N = 55)</th>
<th>Postimplementation (N = 44)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girl, no. (%)</td>
<td>31 (56)</td>
<td>25 (58)</td>
<td>.96</td>
</tr>
<tr>
<td>Race, no. (%)</td>
<td></td>
<td></td>
<td>.19</td>
</tr>
<tr>
<td>White</td>
<td>45 (85)</td>
<td>42 (95)</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>2 (4)</td>
<td>0 (0)</td>
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</tr>
<tr>
<td>Hispanic</td>
<td>6 (11)</td>
<td>2 (5)</td>
<td></td>
</tr>
<tr>
<td>Birth weight, kg /a</td>
<td>3.1 ± 0.6</td>
<td>3.1 ± 0.6</td>
<td>.72</td>
</tr>
<tr>
<td>Apgar score at 5 min /a</td>
<td>8.7 ± 0.8</td>
<td>8.8 ± 0.8</td>
<td>.92</td>
</tr>
<tr>
<td>Head circumference, cm /a</td>
<td>33.1 ± 1.8</td>
<td>32.8 ± 1.4</td>
<td>.44</td>
</tr>
<tr>
<td>Characteristics of the mothers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polypharmacy, no. (%) /b</td>
<td>18 (33)</td>
<td>16 (36)</td>
<td>.70</td>
</tr>
<tr>
<td>Cesarean delivery, no. (%)</td>
<td>24 (44)</td>
<td>13 (30)</td>
<td>.15</td>
</tr>
<tr>
<td>Cigarette smoking, no. (%)</td>
<td>30 (58)</td>
<td>26 (59)</td>
<td>.53</td>
</tr>
<tr>
<td>Alcohol, no. (%)</td>
<td>1 (2)</td>
<td>0 (0)</td>
<td>.36</td>
</tr>
<tr>
<td>Public insurance, no. (%)</td>
<td>48 (86)</td>
<td>42 (95)</td>
<td>.90</td>
</tr>
<tr>
<td>Mother’s age, ya</td>
<td>27.5 ± 5.8</td>
<td>29.1 ± 5.1</td>
<td>.16</td>
</tr>
<tr>
<td>Gestational age, wk /c</td>
<td>38.9 ± 1.8</td>
<td>38.4 ± 1.4</td>
<td>.09</td>
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<tr>
<td>Methadone dose, mg /d /c</td>
<td>85.6 ± 34.3</td>
<td>94.5 ± 37.8</td>
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<td>Gravida /d</td>
<td>3.2 ± 1.8</td>
<td>3.2 ± 1.9</td>
<td>.94</td>
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<tr>
<td>Outcomes</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hospital length of stay, d /f</td>
<td>22.4 ± 10.8</td>
<td>5.9 ± 1.9</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Treated with morphine, no. (%)</td>
<td>54 (98)</td>
<td>6 (14)</td>
<td>&lt;.001</td>
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<tr>
<td>Cost, US dollars /e /f</td>
<td>44 284 ± 23 726</td>
<td>10 289 ± 50 68</td>
<td>&lt;.001</td>
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<tr>
<td>Breast-milk fed at discharge, no. (%)</td>
<td>11 (20)</td>
<td>20 (45)</td>
<td>.01</td>
</tr>
<tr>
<td>NICU stay, no. (%) /d /f</td>
<td>55 (100)</td>
<td>9 (20)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

In the baseline period, data were unavailable for 5 patients for insurance, 3 patients for cigarette smoking, and 2 patients for ethnicity.

a Mean ± SD.

b Methadone use in addition to mother’s use of cocaine, selective serotonin reuptake inhibitors, benzodiazepines, or opioids other than methadone (determined either via history and/or urine testing of mother).

c Adjusted for inflation.

d Patients with any time spent in the NICU.

In the United States from 2009 to 2012, the ALOS for all infants with NAS was 17 days; infants requiring pharmacologic interventions had an ALOS of 23 days.16 By changing the paradigm of how infants with NAS are treated and evaluated, we reduced our ALOS to 5.9 days. The potential savings in hospital costs from this approach is considerable. Based on the average cost of a hospital day for an infant with NAS at our institution in 2015 to 2016.
We estimate a savings of $1.52 million in total hospital costs if the ALOS of infants with NAS had remained at baseline level (22.4 days). Applying this approach nationally could lead to substantial savings.

There are some limitations to our study. Implementation of our intervention bundle evolved over a 5-year period. Several of our interventions involved changes in the culture of how infants with NAS were managed, a process that takes time to implement, particularly when...
existing models of care have been ingrained for many years. During implementation of the intervention bundle, there were changes in both staffing models and hospital policies that may have affected our results. However, the proportional decrease in ALOS for all hospital patients during this period (9%) was far smaller than the proportional decrease in ALOS for infants with NAS (74%). Second, although rooming-in was an important component of the intervention, we do not have an estimate of the amount of time that a parent was with his/her child, so we could not assess whether there was a “dose-response” effect. Lastly, we do not know if any infants were readmitted to a different hospital. However, that is unlikely because most hospitals in the area transfer infants with NAS to YNHCH.

CONCLUSIONS

We demonstrated that supportive, nonpharmacologic interventions combined with assessments that focused on the functional well-being of infants with NAS, rather than on FNASS scores, dramatically and sustainably reduced ALOS below previously published levels. We reduced resource use, including less use of morphine and fewer NICU stays. Additional studies that assess effects on growth, development, and behavioral outcomes are needed as are studies that quantify the effect of the involvement of parents in the care of children with NAS.

ACKNOWLEDGMENTS

We thank the resident and nursing staff of the inpatient unit at YNHCH and Karrie Hendrickson, PhD, RN, from Yale New Haven Hospital and Deborah VandenBroek, RN, for data collection. We thank Yogangi Malhotra, MD, for her help in implementing some of our interventions. We also thank Alyssa Silver, MD, Paul Aronson, MD, Christine White, MD, and Emilia VandenBroek for assistance with the manuscript.

ABBREVIATIONS

ALOS: average length of stay
FNASS: Finnegan neonatal abstinence scoring system
NAS: neonatal abstinence syndrome
SPC: statistical process control
WBN: well-baby nursery
YNHCH: Yale New Haven Children’s Hospital

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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6. Hudak ML, Tan RG; Committee on Drugs; Committee on Fetus and Newborn; American Academy of Pediatrics. Neonatal drug withdrawal. Pediatrics. 2012;129(2). Available at: www.pediatrics.org/cgi/content/full/129/2/e540


An Initiative to Improve the Quality of Care of Infants With Neonatal Abstinence Syndrome


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Pediatrics; originally published online May 18, 2017;
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The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/early/2017/05/16/peds.2016-3360.full.html
Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome
A Systematic Review and Meta-analysis

Kathryn Dee L. MacMillan, MD; Cassandra P. Rendon, BA, BS; Kanak Verma, MPH; Natalie Riblet, MD, MPH; David B. Washer, MBA, MPH; Alison Volpe Holmes, MD, MPH

IMPORTANCE Rising incidence of neonatal abstinence syndrome (NAS) is straining perinatal care systems. Newborns with NAS traditionally receive care in neonatal intensive care units (NICUs), but rooming-in with mother and family has been proposed to reduce the use of pharmacotherapy, length of stay (LOS), and cost.

OBJECTIVE To systematically review and meta-analyze if rooming-in is associated with improved outcomes for newborns with NAS.

DATA SOURCES MEDLINE, CINAHL, The Cochrane Library, and clinicaltrials.gov were searched from inception through June 25, 2017.

STUDY SELECTION This investigation included randomized clinical trials, cohort studies, quasi-experimental studies, and before-and-after quality improvement investigations comparing rooming-in vs standard NICU care for newborns with NAS.

DATA EXTRACTION AND SYNTHESIS Two independent investigators reviewed studies for inclusion. A random-effects model was used to pool dichotomous outcomes using risk ratio (RR) and 95% CI. The study evaluated continuous outcomes using weighted mean difference (WMD) and 95% CI.

MAIN OUTCOMES AND MEASURES The primary outcome was newborn treatment with pharmacotherapy. Secondary outcomes included LOS, inpatient cost, and harms from treatment, including in-hospital adverse events and readmission rates.

RESULTS Of 413 publications, 6 studies (n = 549 [number of patients]) met inclusion criteria. In meta-analysis of 6 studies, there was consistent evidence that rooming-in is preferable to NICU care for reducing both the use of pharmacotherapy (RR, 0.37; 95% CI, 0.19-0.71; I² = 85%) and LOS (WMD, −10.41 days; 95% CI, −16.84 to −3.98 days; I² = 91%). Sensitivity analysis resolved the heterogeneity for the use of pharmacotherapy, significantly favoring rooming-in (RR, 0.32; 95% CI, 0.18-0.57; I² = 13%). Three studies reported that inpatient costs were lower with rooming-in; however, significant heterogeneity precluded quantitative analysis. Qualitative analysis favored rooming-in over NICU care for increasing breastfeeding rates and discharge home in familial custody, but few studies reported on these outcomes. Rooming-in was not associated with higher rates of readmission or in-hospital adverse events.

CONCLUSIONS AND RELEVANCE Opioid-exposed newborns rooming-in with mother or other family members appear to be significantly less likely to be treated with pharmacotherapy and have substantial reductions in LOS compared with those cared for in NICUs. Rooming-in should be recommended as a preferred inpatient care model for NAS.

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Neonatal abstinence syndrome (NAS) is a collection of signs and symptoms of newborn opioid withdrawal after intrauterine exposure. Other descriptions of the syndrome include neonatal opioid withdrawal syndrome and neonatal withdrawal syndrome. Neonatal abstinence syndrome manifests 24 to 96 hours after delivery with increased muscle tone, tremors, sweating, vomiting, diarrhea, and other symptoms. Between 1999 and 2013, the incidence of NAS in the United States increased from 1.5 to 6.0 cases per 1000 births, with a mean cost in 2012 of $93,400 per newborn stay.

While standardized approaches to pharmacologic treatment of NAS improve outcomes, the role of nonpharmacologic or “environmental” interventions in managing NAS is less clear. Opioid-exposed newborns are typically cared for in neonatal intensive care units (NICUs), and standardized scoring systems, such as the modified Finnegan system, are used to quantify NAS symptoms and to adjust medications used in treatment. Paradoxically, studies have found that opioid-exposed newborns in NICUs experience more severe withdrawal, longer length of stay (LOS), and increased pharmacotherapy compared with newborns who room in. In rooming-in care, infant and mother remain together 24 hours a day unless separation is indicated for medical reasons or safety concerns. More maternal time at the infant bedside improves NAS outcomes but is harder to accomplish in a typical NICU. Neonatal intensive care units may be poor settings for newborns with NAS because of increased sensitivity to high clinical activity levels. In settings where separation from mothers is inherent in a NICU admission, it can interfere with bonding and may contribute to maternal perceptions of guilt and stigma. While rooming-in may be effective for NAS, potential risks include unintentional suffocation, falling from an adult bed, or undertreated NAS after hospital discharge.

The benefits and harms of rooming-in for NAS have to date only been evaluated by single-center studies. We conducted a systematic review and meta-analysis to evaluate the benefits and harms of rooming-in compared with standard NICU care for management of NAS.

**Methods**

**Review Protocol**

We used Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines for reporting of methods and findings (Figure 1). We included randomized clinical trials, cohort studies, quasi-experimental studies, and before-and-after quality improvement (QI) investigations of rooming-in as an intervention for opioid-exposed newborns. Prenatal opioid exposure comprised maternal use of heroin, prescription opioids, and nonprescription opioids, as well as prescribed or illicit opioid replacement therapy. Polysubstance users were not excluded. We defined rooming-in as infant and mother remaining together 24 hours per day throughout the postpartum hospital stay unless separation was indicated for medical needs other than NAS symptoms. We included studies reporting on other interventions, such as increased skin-to-skin contact, swaddling, soothing, and breastfeeding support, because greater parental involvement in infant soothing is the primary plausible mechanism for rooming-in efficacy. We required reporting on at least the primary outcome of interest. Our systematic review protocol and search methods are available in the eMethods in the Supplement.

**Outcome Measures**

The primary outcome was the proportion of infants requiring pharmacologic treatment. Current treatment guidelines call for the use of oral morphine sulfate or methadone hydrochloride to relieve moderate or severe NAS symptoms. Therefore, the proportion of pharmacologically treated newborns was used as an adequate proxy for those with significant NAS. As secondary outcomes, we assessed the cumulative dose of opioid medication, duration of opioid treatment course, LOS, total cost of hospitalization, family satisfaction, breastfeeding incidence, and the proportion of infants discharged home in familial custody. To evaluate potential harms of rooming-in, we examined reports of adverse events and readmission rates.

**Search Strategy, Study Selection, and Data Collection**

We searched MEDLINE (1946 to June 25, 2017), CINAHL (1981-2016), and The Cochrane Library using keywords and Medical Subject Headings to generate sets for the themes of NAS and rooming-in. We used the Boolean term “AND” to find intersections. No limits were applied. In addition, we searched clinicaltrials.gov, reviewed references of included studies meeting inclusion criteria, and used the expertise of one of us (A.V.H.) in the field of NAS to identify any unpublished studies not identified by our principal electronic database search strategy. Complete search strategies for each database are included in the eMethods in the Supplement. Two of us (K.D.L.M. and C.P.R.) independently screened titles and abstracts. After the initial screening, these 2 authors independently assessed selected full texts to determine appropriateness for inclusion. They then independently used a standardized, piloted data collection form to extract data on key study components, including methods, participant characteristics, outcomes, and assessment techniques. Two independent reviewers (2 of us, K.V. and D.B.W.) then applied the Risk of Bias in Non-randomised Studies of Interventions (ROBINS-I) tool to each study. Studies were defined as having low risk of bias if...
allowing us to analyze the need for pharmacotherapy and LOS. We contacted the respective authors and received responses from 2, sufficient data to allow for quantitative analysis. We conducted multiple comparisons, only one group was selected for dichotomous variables. We assessed groupings for the heterogeneity using the $I^2$ statistic. This statistic evaluates the consistency of the results across studies. A notable advantage of the $I^2$ statistic is that it does not depend on the number of studies included in the meta-analysis and thus can be used even when the study sample size is small. We used the conventional threshold of $I^2$ exceeding 50% to define meaningful heterogeneity. In instances of heterogeneity, we first considered the contribution of study design or methodological flaws. We then performed sensitivity analyses to reanalyze outcomes, including the greatest possible number of homogeneous studies ($I^2$<50%). We performed sensitivity analyses based on each element of the ROBINS-I methodological quality assessment tool on the overall summary estimates, restricting analysis to only those studies deemed to have low risk of bias. We evaluated whether this restricted analysis affected the magnitude, direction, and statistical significance of the overall summary estimate. We also performed additional sensitivity analysis to account for the different types of study designs. First, we limited the summary estimates to the before-and-after studies. Second, we removed the study by Hüüseler et al.14 owing to high risk of bias in selection of participants (ie, mothers were encouraged to choose the intervention rather than systematically applying rooming-in to the entire population of interest). We then excluded 2 QI studies, by Holmes et al.18 and by Grossman et al.19 because during the implementation phase of the rooming-in intervention there were concurrent changes in how NAS scores affected the use of pharmacotherapy. For the outcomes not amenable to quantitative analysis, we provided a qualitative result summary, first assessing which group (rooming-in vs comparison group) was favored for each outcome and then considering potential methodological flaws influencing these results. We generated a summary assessment based on the overall trends in the results and categorized outcomes as favoring rooming-in, the comparison group, or neither group or as unclear. Statistical significance was determined using $P$ values calculated by 2-sided t tests.

## Results

The initial search identified 482 potentially eligible studies. After removing duplicates, we screened 413 studies and excluded 400 based on title and abstract. We performed full-text review of 13 publications, and 6 studies 7,18,19,22,23 (n = 549 [number of patients]) met our inclusion criteria (Figure 1 and Table). The included studies were published between 2007 and 2017 and were varied in sample size, geographic location, and clinical setting. In 3 included studies, 7,19,22 all infants in the comparison group were admitted to the NICU-level care. The reasons for exclusion of 7 studies after full-text review included overlapping populations across studies, institutional practices that limited pharmacologic treatment during the initial 36 to 72 hours of life, or insufficient data on rooming-in. There was strong and robust consistency in the results across included studies (eTable 1 in the Supplement). The most

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**Statistical Analysis**

To summarize the treatment effect, we measured risk ratio (RR) and 95% CI for dichotomous outcomes and weighted mean difference (WMD) and 95% CI for continuous outcomes. Some secondary outcomes were not amenable to quantitative analysis because either studies measured them in disparate manners that could not be mathematically resolved or too few studies reported on the primary outcome of interest. Therefore, we provided a qualitative summary for this subset of outcomes across studies.

Of the included publications, 3 studies7,18,19 provided insufficient data to allow for quantitative analysis. We contacted the respective authors and received responses from 2, allowing us to analyze the need for pharmacotherapy and LOS from these 2 studies.18,19 The third study7 was included in the systematic review but was excluded from the portion of the analysis associated with the missing data.

We used a software program (RevMan, version 5.3; The Cochrane Collaboration) to conduct the meta-analysis using a random-effects model by pooling study results for all outcomes to appropriately address expected heterogeneity. In the case of multiple comparison groups, only one group was selected for dichotomous variables. We assessed groupings for the heterogeneity using the $I^2$ statistic. This statistic evaluates the consistency of the results across studies. A notable advantage of the $I^2$ statistic is that it does not depend on the number of studies included in the meta-analysis and thus can be used even when the study sample size is small. We used the conventional threshold of $I^2$ exceeding 50% to define meaningful heterogeneity. In instances of heterogeneity, we first considered the contribution of study design or methodological flaws. We then performed sensitivity analyses to reanalyze outcomes, including the greatest possible number of homogeneous studies ($I^2$<50%). We performed sensitivity analyses based on each element of the ROBINS-I methodological quality assessment tool on the overall summary estimates, restricting analysis to only those studies deemed to have low risk of bias. We evaluated whether this restricted analysis affected the magnitude, direction, and statistical significance of the overall summary estimate. We also performed additional sensitivity analysis to account for the different types of study designs. First, we limited the summary estimates to the before-and-after studies. Second, we removed the study by Hüüseler et al.14 owing to high risk of bias in selection of participants (ie, mothers were encouraged to choose the intervention rather than systematically applying rooming-in to the entire population of interest). We then excluded 2 QI studies, by Holmes et al.18 and by Grossman et al.19 because during the implementation phase of the rooming-in intervention there were concurrent changes in how NAS scores affected the use of pharmacotherapy. For the outcomes not amenable to quantitative analysis, we provided a qualitative result summary, first assessing which group (rooming-in vs comparison group) was favored for each outcome and then considering potential methodological flaws influencing these results. We generated a summary assessment based on the overall trends in the results and categorized outcomes as favoring rooming-in, the comparison group, or neither group or as unclear. Statistical significance was determined using $P$ values calculated by 2-sided t tests.

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mon methodological concern was risk for confounding. In the 2 QI studies, clinical criteria for pharmacologic management were adjusted during implementation of the rooming-in intervention. Baseline study characteristics for the rooming-in vs control groups were not described in one study. Five studies provided data to support that there were no statistically significant differences between the rooming-in and comparison groups. Specifically, 4 studies reported on maternal type of specific drug abuse, with no statistically significant difference in rates of use between intervention and comparison groups. The use of the different patient samples as controls in the before-and-after studies and the historical controls in QI studies also raised concerns that the reported change in outcomes may have been due to secular trends rather than the rooming-in intervention. One study also included an external control group. In all included studies, outcomes were reported based on the initial assignment to intervention or comparison group, which was determined before birth.

**Need for Pharmacotherapy**

All 6 studies found that rooming-in was associated with a lower proportion of infants requiring pharmacotherapy compared with standard NICU care (RR, 0.37; 95% CI, 0.19-0.71). However, there was significant heterogeneity among the included studies ($I^2 = 85\%$). After removing 3 studies for simultaneously using multiple interventions or for allowing maternal group selection, the heterogeneity resolved, and rooming-in continued to be significantly favored (RR, 0.32; 95% CI, 0.18-0.57) ($I^2 = 13\%$) (Figure 2).

In the first sensitivity analysis, we examined the value of using a historical internal control group (vs an external control) for the study by Abrahams et al. This resulted in an unchanged RR of 0.37. In our second sensitivity analysis, we limited the investigation to 4 before-and-after studies. This resulted in an RR of 0.28, with significant heterogeneity ($I^2 = 62\%$). In our third sensitivity analysis, we removed the 2 QI studies. This resulted in an RR of 0.35, with an $I^2$ of 81%. Finally, we removed the QI studies and the study by Hünseler et al. This resulted in an RR of 0.32, with an $I^2$ of 13%. All sensitivity analyses demonstrated an association between rooming-in as an intervention and limiting pharmacotherapy, with statistically significant RRs between 0.27 and 0.37.

**Length of Stay**

All 6 studies found that LOS was significantly shorter with rooming-in vs standard NICU care (WMD, −10.41 days; 95% CI, −16.84 to −3.98 days). However, there was again significant heterogeneity among the included studies ($I^2 = 91\%$). After removing 3 studies for the same reasons related to study design noted above (see the Need for Pharmacotherapy subsection in this Results section), the heterogeneity resolved, and rooming-in continued to be favored (WMD, −12.84 days; 95% CI, −20.02 to −5.67 days) ($I^2 = 58\%$) (Figure 3).

In the first sensitivity analysis on LOS, we examined the value of using the historical internal control group (vs the external control) in the study by Abrahams et al and found an unchanged LOS (WMD, −10.41 days). In the second sensitivity analysis, we limited our investigation to 4 before-and-after studies. This resulted in a WMD of −10.84 days, with significant heterogeneity ($I^2 = 95\%$). In the third sensitivity analysis, we removed the 2 QI studies. This resulted in a WMD of −10.86 days, with significant heterogeneity ($I^2 = 95\%$). Finally, we removed the QI studies and the study by Hünseler et al. This resulted in a WMD of −12.84 days, with an $I^2$ of 58%. All sensitivity analyses demonstrated a strong association between rooming-in as an intervention and shortening LOS by approximately 10 to 12 days.

**Cost**

The results of the 3 studies reporting inpatient costs in US dollars suggested that rooming-in is associated with...
lower costs (eTable 2 in the Supplement). However, there was significant heterogeneity across studies ($I^2 = 97\%$), which precluded a formal meta-analysis.

**Qualitative Analysis**

None of the included studies reported any adverse events with rooming-in. Three studies\(^7,18,23\) reported on readmission rates, with no increase found (eTable 3 in the Supplement). Four studies\(^7,18,22,23\) reported on breastfeeding, with 2 studies noting an increase in breastfeeding with rooming-in and 2 studies reporting no difference (eTable 4 in the Supplement). Four studies\(^7,18,23,24\) reported on discharge home with mother or other family member; only one study\(^7\) showed a larger proportion of rooming-in infants remaining in familial custody. The remaining 3 studies\(^18,23,24\) all reported high rates of discharge with family, with no statistically significant difference in rates between study groups (eTable 5 in the Supplement).

Three studies\(^7,23,24\) reported on the mean length of opioid medication treatment, all of which identified a decrease in the number of days receiving pharmacotherapy, proportionate to the decrease in LOS seen above (see the Length of Stay subsection herein). Only one study\(^18\) reported on changes in the cumulative dose of opioid medication, and no included studies reported on patient satisfaction. We were unable to conduct a formal assessment for publication bias due to inclusion of only 6 studies in the meta-analysis.\(^25\)

**Discussion**

This systematic review and meta-analysis demonstrates that rooming-in is associated with decreased need for pharmacologic treatment of NAS and shorter LOS. The results of several included studies\(^18,19,24\) suggest that rooming-in is associated with reduced hospital costs, but the significant heterogeneity across studies precluded quantitative analysis. Because of variable reporting, we were unable to draw formal conclusions about the role of rooming-in on other secondary outcomes of interest. The findings of 2 studies\(^7,18\) suggested that breastfeeding increases with rooming-in. There was no evidence that rooming-in for NAS was associated with a significant increase in hospital readmission. Reporting of adverse events was insufficient to draw any conclusions about an association between rooming-in and these outcomes. Our findings agree with prior review articles\(^14,26,27\) of nonpharmacologic management of NAS, which also suggested that rooming-in is associated with decreased NAS severity and shorter LOS.

Our systematic review included studies from the United States, Canada, and Europe and covered a range of clinical settings. Therefore, rooming-in could be effective in diverse settings that manage neonates at risk for NAS. Our findings are relevant to current practice because implementing rooming-in for opioid-exposed newborns is straightforward and has clear benefits. It allows for greater parental involvement in-
Figure 3. Rooming-in vs Usual Care on Length of Stay

<table>
<thead>
<tr>
<th>Source</th>
<th>Rooming-in</th>
<th>Comparison Group</th>
<th>Mean Difference (Days), Random, (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrahams et al,7 2007</td>
<td>11.8 9.1 32</td>
<td>24.7 22.2 74</td>
<td>-12.90 (−18.86 to −6.94)</td>
</tr>
<tr>
<td>Grossman et al,15 2017</td>
<td>5.9 1.9 44</td>
<td>22.4 10.8 55</td>
<td>-16.50 (−19.41 to −13.59)</td>
</tr>
<tr>
<td>Holmes et al,16 2016</td>
<td>6.7 4.2 48</td>
<td>10.0 7.5 54</td>
<td>-3.30 (−5.63 to −0.97)</td>
</tr>
<tr>
<td>Hünse et al,24 2013</td>
<td>36.6 10.2 24</td>
<td>42.8 15.3 53</td>
<td>-6.20 (−12.00 to −0.40)</td>
</tr>
<tr>
<td>McKnight et al,22 2016</td>
<td>5 17.8 20</td>
<td>24 2.2 24</td>
<td>-19.00 (−26.85 to −11.15)</td>
</tr>
<tr>
<td>Saiki et al,23 2010</td>
<td>15.9 21.4 18</td>
<td>19.8 17.9 42</td>
<td>-3.90 (−15.17 to 7.37)</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>186 302</td>
<td>-10.41 (−16.84 to −3.98)</td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: τ² = 54.31, I² = 91%
Test for overall effect z = 3.17, P = .002

A, Meta-analysis, including 6 studies. B, Sensitivity analysis, including only the before-and-after studies that were not quality improvement investigations.

Increasing opportunities for families to provide nonpharmacologic treatment and permits more efficient use of institutional resources.

The quality of the included studies was high, and the results were consistent across them. Because most of the studies used a historical cohort, it is important to consider the observed results in light of secular trends. Studies that included a concurrent external control group also favored rooming-in and demonstrated no significant change in the findings. The risk for ascertainment bias in studies was low because the included studies used standardized definitions for rooming-in and the studied outcomes were objective (ie, the proportion treated with medications, LOS, and total cost). However, rooming-in is not an isolated intervention. In the 2 included QI studies, a number of cointerventions occurred during the course of the investigations, including changes to scoring practices that could have explained some of the observed improvement in outcomes. While the results of all included studies could be considered confounded by factors known to lessen NAS symptoms, such as increased skin-to-skin time, more opportunities for breastfeeding, and greater parental involvement and improved soothing techniques, we believe that these covariates are not confounders but rather are mediators that contribute to the benefits of rooming-in.

Strengths and Limitations

This study has a number of strengths, including strict adherence to The Cochrane Library and PRISMA guidelines for systematic review and meta-analysis conduct and reporting. We used a comprehensive search strategy that included multiple electronic databases and additional techniques to identify unpublished studies. Because rooming-in is a recent intervention for NAS, there is limited available literature. We believe that our search strategy comprehensively synthesized the available data.

First among the limitations of this systematic review and meta-analysis is the likely publication bias favoring rooming-in because it would be unlikely for researchers to publish their results with negative or insignificant findings. This is particularly concerning for QI studies because negative QI interventions are rarely published. We were unable to formally assess publication bias due to analyzing less than 10 studies. Second, to comprehensively identify negative or insignificant outcomes, we incorporated all reported outcome measures from each study, regardless of whether the measure was the intervention target. The included studies may have lacked sufficient power to fully evaluate secondary outcomes. Third, there was variable reporting of the secondary outcomes of this systematic review and meta-analysis across the included studies, particularly regarding adverse events and readmission rates. While the included studies measuring readmission demonstrated no increase among roomed-in infants, these events are rare, and it is possible that investigations lacked sufficient power to detect potential negative consequences of rooming-in. Fourth, we encountered significant heterogeneity among the included studies for the primary and secondary outcomes. This was anticipated given the varied nature of the study designs and settings and was particularly exacerbated by inclusion of 2 large QI studies that by virtue of their methods incorporated several staged interventions. Reassuringly, when we accounted for these
methodological issues in our sensitivity analysis, we were able to resolve the heterogeneity for our primary outcome, and rooming-in continued to show a statistically significant benefit over standard NICU care. The results of this systematic review and meta-analysis should be interpreted with careful consideration of the validity of the final estimations of intervention effect size.

As rooming-in interventions are implemented across a growing number of institutions, it will be important to monitor for potential adverse events of rooming-in, such as failure to thrive, accidental suffocation, and readmission rates. It will also be necessary to determine an association between rooming-in and breastfeeding and custody arrangements at discharge. While there is emerging evidence to suggest that rooming-in may also be associated with lower hospital costs, future studies should evaluate this in a systematic and standardized manner, allowing for adequate comparison across studies. Finally, future research should explore the possible long-term implications of rooming-in for infant health and development, strength of the mother-child bond, and potential to mitigate the risk of maternal relapse into active substance abuse.

Conclusions

There is consistent evidence supporting rooming-in as an effective strategy for managing NAS by reducing the need for pharmacotherapy and decreasing LOS. This systematic review and meta-analysis of the current literature demonstrates compelling data for rooming-in as beneficial for newborns with NAS or at risk for NAS. In clinical care settings where it is safe and feasible, we recommend that rooming-in be considered as a preferred management strategy for opioid-exposed newborns and for newborns with NAS.

ARTICLE INFORMATION

Accepted for Publication: November 9, 2017.

Author Contributions: Ms Verma had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: All authors.
Acquisition, analysis, or interpretation of data: MacMillan, Rendon, Verma, Washer.
Drafting of the manuscript: MacMillan, Rendon, Verma, Riblet, Washer.
Critical revision of the manuscript for important intellectual content: MacMillan, Rendon, Verma, Volpe Holmes.
Administrative, technical, or material support: Volpe Holmes.
Conflict of Interest Disclosures: None reported.

Additional Contributions: Elizabeth Nichols, MPH (The Dartmouth Institute for Health Policy and Clinical Practice), Shawn Ralston, MD, MS (Department of Pediatrics, Dartmouth-Hitchcock Medical Center), and Corinne Brooks, MD, MS, MPH (The Dartmouth Institute for Health Policy and Clinical Practice and Department of Pediatrics, Dartmouth-Hitchcock Medical Center) reviewed and revised the manuscript. Heather Blunt, Research and Education Librarian, Dartmouth Biomedical Libraries, Dartmouth College (Hanover, NH), assisted with the literature search. No compensation was received.

REFERENCES

Infant Race Affects Application of Clinical Guidelines When Screening for Drugs of Abuse in Newborns
Marc A. Ellsworth, Timothy P. Stevens and Carl T. D'Angio

*Pediatrics*; originally published online May 17, 2010;
DOI: 10.1542/peds.2008-3525

The online version of this article, along with updated information and services, is located on the World Wide Web at:

[http://pediatrics.aappublications.org/content/early/2010/05/17/peds.2008-3525](http://pediatrics.aappublications.org/content/early/2010/05/17/peds.2008-3525)
One of the causes of high-risk and premature infant deliveries is maternal abuse of illicit drugs such as cocaine during the prenatal period. Several prenatal factors, such as limited prenatal care and placental abruption, have been associated with a higher likelihood of drug abuse in mothers. Similarly, factors identified during the infant’s neonatal period have also been associated with maternal drug abuse. Because of the reported high incidence of intrauterine cocaine exposure (IUCE) among infants admitted to NICUs, including our own, our NICU uses specific guidelines for the screening of infant urine for a cocaine metabolite, a finding that suggests cocaine exposure in utero.

Drug screening in newborns entails significant privacy, social, and legal risks for families. In Monroe County, New York, IUCE may be used as grounds for reports to child protective services. Such reports, in the presence of other social risk factors, may result in removal of the child from parental care. In other states, positive results of drug screening have been used as a basis for alerting law-enforcement authorities, which has led to the arrest and imprisonment of mothers of newborns. In Pinellas County, Florida, which requires that findings of illicit drug use during pregnancy be reported to health authorities, discrepancies in reporting of findings that indicate maternal drug use have been described and attributed to the use of race as a factor in determining which mother-infant pairs to screen for illicit drugs. During a 6-month period, the proportion of white women reported for drug use was 1.1%, whereas that for black women was 10.7%. This discrepancy occurred despite similar rates of positive drug-screening results among white and black women (15.4% vs 14.1%) when universal drug screening was performed.

Although screening for in utero drug exposure may serve a legitimate purpose of facilitating identification of high-risk infants, the application of screening in a prejudicial manner places an unfair burden on patients subjected to screening by exposing them disproportionately to child-protective and law-enforcement actions. We pursued further research in this area by investigating the screening practices in an institution at which specific screening guidelines were in place. We explored the possibility that drug screening in our NICU might be applied in a manner that considers factors not included in our screening criteria, such as race, to determine whether an infant should be screened. We hypothesized that infants born to black mothers would be more likely than those born to white mothers to be screened for illicit drugs even if they did not meet the criteria for screening that have been specifically delineated at our institution.

**METHODS**

**Population**

The University of Rochester Medical Center NICU has ~1100 patient admissions per year. To include a minimum of 2000 mother-infant pairs in our study, we used data for all infants admitted to our NICU during the years 2005 and 2006. Because our institution performs standard maternal data collection on all patients, we were able to include mother-infant data for infants born at our institution (inborn) and for infants born at surrounding hospitals and then transferred to our NICU (outborn).

**Data Collection**

The protocol for record review was approved by the University of Rochester research subjects review board, which waived the requirement for patient consent. We used our NICU’s clinical database to identify all infants admitted from January 1, 2005, through December 31, 2006. This relational database contained demographic information concerning the mother-infant pair, including delivery statistics (including infant gestational age and weight), pregnancy and delivery complications, neonatal diagnoses, admission and discharge notes, and daily updates of the clinical course.

Maternal medical information was obtained from our clinical obstetrical database. The database contained maternal obstetric and demographic data on all obstetrical patients admitted to our hospital. For inborn patients, socioeconomic and clinical data were collected before delivery. Similar data for mothers of outborn patients were collected when these infants were admitted to our institution. Variables for which data were obtained included maternal race, level of maternal education, insurance status, number of prenatal visits, maternal drug and alcohol use, maternal history of sexually transmitted diseases, and delivery complications. Race information entered into the database was the choice selected by the mother from a menu on a questionnaire administered at the time of her admission to the hospital’s obstetrics unit.

Data on newborn and maternal toxicology screening were obtained from the hospital’s clinical information system. We examined only screening for cocaine use, because we wanted to eliminate possible false-positive results for opiates and benzodiazepines attributable to maternal medication and because marijuana reporting was not required by child protective services.

Infant urine was screened, and the presence of cocaine was confirmed by identification of the metabolite benzoylecgonine. Benzoylecgonine screening was accomplished by using a cloned enzyme-donor immunoassay.
TABLE 1 Demographic Characteristics of the Study Population (N = 2121)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (range) maternal age, y</td>
<td>29.19 (13-51)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>1412 (67.2)</td>
</tr>
<tr>
<td>Black</td>
<td>412 (19.6)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>189 (9.0)</td>
</tr>
<tr>
<td>Asian</td>
<td>76 (3.6)</td>
</tr>
<tr>
<td>Other</td>
<td>11 (0.5)</td>
</tr>
<tr>
<td>Unknown</td>
<td>21 (0.9)</td>
</tr>
<tr>
<td>Level of maternal education, n (%)</td>
<td></td>
</tr>
<tr>
<td>Less than high school diploma</td>
<td>319 (17.8)</td>
</tr>
<tr>
<td>High school diploma</td>
<td>380 (21.3)</td>
</tr>
<tr>
<td>Some college or more</td>
<td>1089 (60.9)</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>1265 (59.7)</td>
</tr>
<tr>
<td>Public</td>
<td>683 (32.7)</td>
</tr>
<tr>
<td>Self-pay</td>
<td>162 (7.6)</td>
</tr>
<tr>
<td>Median household income, n (%)</td>
<td></td>
</tr>
<tr>
<td>&lt;25th percentile*</td>
<td>404 (19.2)</td>
</tr>
<tr>
<td>25th-50th percentile</td>
<td>473 (22.4)</td>
</tr>
<tr>
<td>51st-75th percentile</td>
<td>371 (17.6)</td>
</tr>
<tr>
<td>&gt;75th percentile</td>
<td>861 (40.8)</td>
</tr>
<tr>
<td>Mean (range) No. of prenatal visits</td>
<td>10.1 (0-36)</td>
</tr>
<tr>
<td>Mean (range) gestational age of newborn, wk</td>
<td>35.8 (23.7-42.0)</td>
</tr>
<tr>
<td>Mean (range) birth weight of newborn, kg</td>
<td>2.7 (0.4-6.3)</td>
</tr>
<tr>
<td>Mother-infant pairs who met drug-screening criteria</td>
<td>585 (26.9)</td>
</tr>
<tr>
<td>Newborns screened for drug exposure, n (%)</td>
<td>153 (7.2)</td>
</tr>
<tr>
<td>Cocaine-positive screen results</td>
<td>13 (8.5%)</td>
</tr>
</tbody>
</table>

* Data are the median household income of the ZIP code of mother’s residence, expressed as percentiles of 2000 census data.
* Percentage of positive results among those who were screened.

study population, and these mothers were excluded from any analysis that used race as an independent variable. Of the infants evaluated, 153 (7.2%) were screened for exposure to an illicit drug, and test results were positive for 13 (8.5%).

Table 2 lists the individual screening criteria and the number of mother-infant pairs who had documented evidence of meeting each specific criterion. The number of infants whose urine was actually screened for drugs when the criterion was present is also shown. The highest rates of screening were found in infants with maternal drug-use history (47% screened) and infant pairs who did not have documented evidence of meeting screening criteria were screened. Among pairs that did not meet screening criteria, infants born to black mothers were fourfold more likely to be screened than those born to white mothers.

The results of the multivariate analysis (Table 4) demonstrated several characteristics independent of infants with drug screening. Among them, race was independently associated with screening of an infant. After we adjusted for other factors, infants born to black or Hispanic mothers were more than twice as likely to be screened for illicit drug use. Other factors independently associated with screening included maternal history of drug use, limited prenatal care, placental abruption, and IUGR. Conversely, as the level of maternal education increased, the likelihood of her infant being screened for drug exposure decreased.

Among our study population, 153 infants were screened for drug exposure, and positive test results indicating exposure to cocaine were found in 13 (8.5%). Among those infants whose urine test results were positive, 7 (12.3% of white infants screened) were white, 3 (4.2%) were black, and 3 (14.3%) were Hispanic (Table 5). Of the 13 infants whose test results were positive, 11 had mothers with a history of drug use. The other 2 positive results were obtained from infants who were limited prenatal care (39% screened).

The presence of factors such as repeated spontaneous abortions in the mother and neurologic complications and urogenital anomalies in the infant rarely resulted in screening of the infant.

We identified 585 mother-infant pairs as having documented evidence of meeting at least 1 screening criterion (Table 3). For those mother-infant pairs that met screening criteria, 117 (20.7%) of the infants were actually screened. Infants born to black mothers were threefold more likely than those born to white mothers to be screened if they met screening criteria. Thirty-four (2.2%) of the mother-infant pairs who did not have documented evidence of meeting screening criteria were screened. Among pairs that did not meet screening criteria, infants born to black mothers were fourfold more likely to be screened than those born to white mothers.

The results of the multivariate analysis (Table 4) demonstrated several characteristics independently associated with infant drug screening. Among them, race was independently associated with screening of an infant. After we adjusted for other factors, infants born to black or Hispanic mothers were more than twice as likely to be screened for illicit drug use. Other factors independently associated with screening included maternal history of drug use, limited prenatal care, placental abruption, and IUGR. Conversely, as the level of maternal education increased, the likelihood of her infant being screened for drug exposure decreased.

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TABLE 2 Presence of Screening Criteria

<table>
<thead>
<tr>
<th>Factor</th>
<th>No. of Pairs With Documented Evidence</th>
<th>No. (%) Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug history</td>
<td>148</td>
<td>70 (47.3)</td>
</tr>
<tr>
<td>Limited prenatal care</td>
<td>90</td>
<td>35 (38.9)</td>
</tr>
<tr>
<td>Sexually transmitted disease(s)</td>
<td>44</td>
<td>11 (25.0)</td>
</tr>
<tr>
<td>Placental abruption</td>
<td>104</td>
<td>33 (31.7)</td>
</tr>
<tr>
<td>Precipitous labor</td>
<td>57</td>
<td>10 (17.5)</td>
</tr>
<tr>
<td>Repeated spontaneous abortions</td>
<td>43</td>
<td>2 (4.7)</td>
</tr>
<tr>
<td>Neurologic complications</td>
<td>25</td>
<td>2 (8.0)</td>
</tr>
<tr>
<td>Evidence of drug withdrawal</td>
<td>65</td>
<td>14 (21.5)</td>
</tr>
<tr>
<td>IUGR*</td>
<td>138</td>
<td>15 (11.0)</td>
</tr>
<tr>
<td>Urogenital anomalies</td>
<td>35</td>
<td>1 (2.9)</td>
</tr>
</tbody>
</table>

No mother-infant pair had evidence of myocardial infarction, cerebrovascular accidents, severe mood swings, sudden hypertensive episodes (other than preeclampsia), or necrotizing enterocolitis in the first 2 days after birth.
* Birth weight <2.3rd percentile.

No mother-infant pair had evidence of maternal history of drug use, limited prenatal care, placental abruption, and IUGR. Conversely, as the level of maternal education increased, the likelihood of her infant being screened for drug exposure decreased.

Among our study population, 153 infants were screened for drug exposure, and positive test results indicating exposure to cocaine were found in 13 (8.5%). Among those infants whose urine test results were positive, 7 (12.3% of white infants screened) were white, 3 (4.2%) were black, and 3 (14.3%) were Hispanic (Table 5). Of the 13 infants whose test results were positive, 11 had mothers with a history of drug use. The other 2 positive results were obtained from infants who were

TABLE 3 Drug Screening Among Patients

<table>
<thead>
<tr>
<th>Race</th>
<th>At Least 1 Screening Criterion Documented</th>
<th>No Documented Screening Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>No. (%) Screened</td>
</tr>
<tr>
<td>White</td>
<td>342</td>
<td>44 (12.9)</td>
</tr>
<tr>
<td>Black</td>
<td>165</td>
<td>58 (35.1)*</td>
</tr>
<tr>
<td>Hispanic</td>
<td>49</td>
<td>14 (28.6)*</td>
</tr>
<tr>
<td>Asian</td>
<td>7</td>
<td>1 (14.3)</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Total</td>
<td>585</td>
<td>117 (20.7)</td>
</tr>
</tbody>
</table>

* Infants of black or Hispanic mothers were more likely to be screened than those born to white mothers regardless of whether screening criteria were met (P < .001 for both comparisons according to χ² test).
We found that even the established criteria in our institutional guidelines were not being applied equally in determining which infants were screened. Maternal drug history was the factor most commonly present among infants who were screened. Other factors associated with high rates of screening were limited prenatal care, placental abruption, and IUGR. However, other factors included in screening criteria, such as infant urogenital anomalies, almost never triggered screening.

This study had several limitations. Urine testing was the method used for detecting IUCE in infants at our institution. Meconium testing is a more accurate way to detect cocaine exposure, and some reports have suggested that urine screens may miss up to 40% of positive results.11,18 However, unless we assume that in our study meconium testing of infants would have differentially revealed false-negative screens for black patients, the type of testing would not affect our conclusion regarding factors associated with screening.

The use of electronic records and the lack of complete electronic data on some infants may also be considered a weakness of this study. Because we obtained data exclusively by searching electronic records we may have missed screening indications found only in patient data recorded on paper. However, the use of uniform coding and ability to perform field text searches allowed us to more completely evaluate a larger number of records than if we had reviewed paper charts. Unless incomplete data were distributed unevenly among racial groups, the inclusion of data from this additional source would not have affected our conclusions. Furthermore, the largest disparity in our study was seen with providers who did not screen infants of mother-infant pairs who were documented to have met screening criteria, a finding unaffected by incomplete risk data.

The ultimate goal of screening for IUCE in the newborn is to effectively identify and treat those infants who are at the highest risk for complications. This goal might best be accomplished if only specific risk factors that have been proven to predict both positive screening results and poorer outcomes were applied strictly and universally. Results of some studies have suggested that only a few screening criteria are actually useful in the prediction of poorer neonatal outcomes.19,20 Similarly, certain studies have shown that only a few screening criteria are associated with positive drug-screening results.15,16,21–23 The 2 most commonly identified criteria that may be useful for predicting both poorer outcomes and positive screens are maternal history of drug use and limited prenatal care.16,19,20 Additional research is needed to better identify specific criteria that would help providers more accurately achieve the aims of neonatal drug screening. This goal might be most effectively accomplished by use of protocols that include consistent screening of infants who meet defined, limited criteria and the use of both urine and meconium testing to detect drug exposure.

CONCLUSIONS

Screening infants for IUCE is an important component of optimal care for at-risk infants. However, we found that at our institution many infants who met specified criteria were not being screened and that differences in screening decisions made by providers were associated with maternal race. Lack of training and inclusion of several largely ignored (and possibly clinically insignificant) criteria in the screening protocol may have contributed to inequitable application of the screening criteria. A more effective screening protocol might contain fewer criteria, with an emphasis on maternal drug history and prenatal care, factors that are associated with high risks of poor neonatal outcomes.

ACKNOWLEDGMENTS

This work was supported in part by a Strong Children’s Research Center summer fellowship. We thank Ken Edel for help in obtaining the maternal medical records and Dr Sanjiv Amin for assistance with the statistical software.

REFERENCES

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Legal Interventions During Pregnancy
Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women

ORDINARILY, the pregnant woman, in consultation with her physician, acts in all reasonable ways to enhance the health of her fetus. Indeed, clinicians are frequently impressed with the amount of personal health risk undertaken and voluntary self-restraint exhibited by the pregnant woman for the sake of her fetus and to help ensure that her child will be as healthy as possible. In a limited number of situations, however, a pregnant woman may reject a medical treatment or procedure that her physician believes would benefit the health of her fetus. For instance, she may refuse to submit to a cesarean section when her physician believes that a cesarean is in the best interests of the fetus. Or, a pregnant woman may behave in ways that are potentially detrimental to fetal well-being, for example, taking illegal drugs while pregnant.

Increasingly, legal interventions are being sought in cases in which the decisions or actions of pregnant women do not accord with medical recommendations that could benefit fetal health. Physicians have sought, and some courts have granted, permission to override refusals of pregnant women to submit to medical procedures. Public officials have tried to impose legal penalties on women whose behavior is not in the best interest of the fetus. This work, which is based on the deliberations of the Committee of Medical Legal Problems, discusses the various legal and policy concerns and makes recommendations regarding legal interventions in pregnancy.

SEEKING COURT ORDERS TO OVERRIDE THE MEDICAL PREFERENCES OF PREGNANT WOMEN
Recent Medical Advances Enable Physicians to Address the Health of the Fetus More Directly

Until recently, promoting fetal well-being was generally not a separate endeavor from promoting the health of the pregnant woman. Advances in medicine and surgery, however, have increased the ability of physicians to direct medical procedures specifically at the fetus. Diagnostic tools, such as ultrasound, amniocentesis, and chorionic villus sampling, can be used to detect fetal abnormalities that, in some cases, may be treated through prenatal therapy or surgery. The ability to treat the fetus more directly than in the past has given rise to the question of whether a pregnant woman has a legal obligation to undergo medical treatments that could benefit the fetus. When a pregnant woman refuses treatment or procedures that could benefit fetal health, a conflict arises between her right to make medical decisions that affect the health of her fetus and herself and the state's desire to intervene on behalf of the fetus.

Questions and concerns over a pregnant woman's legal obligations to accept medical care are exacerbated by the unique physical relationship that exists between a pregnant woman and her fetus. Invariably, one cannot be treated without affecting the other. Performing medical procedures against the pregnant woman's will violates her right to informed consent and her constitutional right to bodily integrity. These rights are among the most basic and are well established in both society and medicine. However, preservation of these rights may come at the risk of preventable fetal impairment or death.

Moral and Legal Responsibilities of the Pregnant Woman Toward Her Fetus

A woman who chooses to carry her pregnancy to term has a moral responsibility to make reasonable efforts toward preserving fetal health. This moral responsibility, however, does not necessarily imply a legal duty to accept medical procedures or treatments in order to benefit the fetus.

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Legal Precedent.—Several courts have considered the issue of legal interventions to impose medical treatments on pregnant women. However, few requests for court-ordered obstetrical interventions have been reviewed by appellate courts. Only two appellate courts have considered a decision to override a pregnant woman’s refusal of a blood transfusion. In 1964, the New Jersey Supreme Court ordered a blood transfusion for a pregnant woman who refused the transfusion on religious grounds. Also in 1964, an appeals court in the District of Columbia ruled that a pregnant woman could be forced to undergo a blood transfusion for the sake of her fetus. However, both of these cases were decided in the early 1960s, before the current legal emphasis on the integrity of the individual and the right to refuse treatment.

Approximately two dozen courts have been asked to order cesarean sections. Only two of these cases have reached the appellate level. In one, a trial court judge in the District of Columbia ordered a cesarean section on a woman who was terminally ill. The woman’s treatment desires and her competency were major points of controversy in this case. The District of Columbia Court of Appeals, en banc, ruled that the lower court was in error for ordering the cesarean section. The court of appeals ruled that rather than weighing the interests of the state (in destroying the potential life of the fetus) against the interests of the pregnant woman, the lower court should have used “substituted” judgment and proceeded according to what could best ascertain the pregnant woman’s wishes had been.

In 1951, a trial court in Georgia ordered a cesarean section performed on a woman who had refused the operation for religious reasons. The physician involved diagnosed placenta previa, with a 99% to 100% chance of fetal demise if vaginal delivery occurred. The Georgia Supreme Court, with minimal explanation or policy discussion, refused to stay the trial court’s order. A few days after the court’s denial of a stay, the woman had a safe vaginal delivery.

The remainder of this section of the report provides an analysis of relevant law and policy considerations and recommendations on the extent to which a pregnant woman’s moral duties toward the fetus should be legally enforced. Distinctions Between Moral and Legal Responsibilities.—Society places a positive moral value on those who may need help or be in danger, yet it does not ordinarily impose a legal duty on specific individuals to render that needed assistance. This reluctance to impose a legal duty on the individual is especially strong where rendering aid would pose a risk to the health of the individual or would require an invasion of his or her bodily integrity.

There is also no legal duty for an individual to render aid even if a life would be saved and the assistance rendered would incur minimal risk to the health of the person providing the aid. For example, a person need not donate bone marrow to a cousin who is dying of aplastic anemia.

Yet the responsibility of a pregnant woman to her fetus is stronger than that of one individual to another. The duty of a pregnant woman to her fetus is more akin to the obligations of a parent to his or her child. And in fact, a parent’s duty to his or her child is enforced with legal sanctions. The parent-child relationship is considered a “special relationship” under “Samaritan law.” Samaritan law, which applies to duties to render aid, provides that those people who have a special relationship to another person, such as innkeeper to guest or common carrier to passenger, have a legal obligation to come to the aid of that person.

Even in cases of special relationships, however, the obligation to render aid is minimal and cannot require the rescuer to endanger him or herself. For example, if a child needed a bone marrow transplant, but the only compatible donor was the child’s father, the father would not be legally required to donate his bone marrow to his child.

There are other situations in which a pregnant woman’s obligation to her or her child is legally enforced. Parents clearly have both a moral and legal duty to provide reasonable medical care for their children. All states legally require parents to provide such care. A pregnant woman who refuses a surgical intervention, treatment, or therapy that might benefit fetal health is, in practical terms, witholding medical care from her fetus. However, in the case of a pregnant woman, in order for her not to withhold medical treatment, she generally must accept a risk to her life or health, as well as bodily invasion of her person. Just as parental legal obligations to provide medical care to children do not include compelled acceptance of risk to life or health, neither should a pregnant woman’s obligations to her fetus include the acceptance of such risk.

Current conclusive law reflects this principle. Under Roe v. Wade, the state’s interest in potential life becomes compelling at the point of viability. It is at that point, therefore, that the state may prevent a woman from having an abortion. Nevertheless, the state may not adopt postviability abortion regulations that trade off risks to the health of the pregnant woman against benefits to the health of her fetus.

In addition, legally enforcing a pregnant woman’s moral obligation to the fetus creates a burden or penalty on pregnancy itself. The right to bear a child is constitutionally protected. Forcing a pregnant woman to undertake a health risk or to accept an invasive procedure against her will burdens her decision to have a child.

Even a viable fetus does not generally receive the same legal recognition as a child. Consequently, the legal enforcement of a pregnant woman’s moral responsibility to her fetus should not exceed the legal enforcement of a parent’s moral duty to his or her child. Society does not legally require parents to undertake a risk of life, health, or bodily invasion in order to carry out their moral obligations to provide medical care for their children. Few, if any, medical procedures meant to benefit the fetus would entail no risk to a pregnant woman’s health. Thus, while a pregnant woman should be scrupulously encouraged to fulfill her moral responsibilities to her fetus, a legal duty to accept medical procedures meant to benefit her fetus generally should not be imposed.

Ethical Obligations of the Physician in Instances of Treatment Refusal

A physician’s ethical duty toward the pregnant woman clearly requires the physician to act in the interest of the fetus as well as the woman. Arguably, adherence to a pregnant woman’s refusal of treatment that is intended to benefit the fetus would violate that ethical obligation, particularly when the physician believes that the potential benefit to the fetus outweighs the health risk to the mother. While some physicians find adherence to a pregnant woman’s wishes morally untenable in situations of fetal endangerment, the duty to protect the health of both the pregnant woman and the fetus precedes balancing one against the other. The physician’s
responsibilities in other settings provide a useful analogy, eg, there is no situation (other than perhaps the case of conjoint twins) when it is appropriate for a physician to impose a medical risk on one patient in order to preserve the health of another. A physician cannot force one patient to donate blood to another patient, even if the donation would save the second patient’s life. Similarly, such a balancing should generally not be undertaken in the context of pregnancy.

The doctrine of informed consent also indicates that a pregnant woman’s refusal of treatment should not be overridden for the benefit of the fetus. Principles of informed consent require a physician to respect the wishes of a mentally competent adult in situations of medical decision making. These principles recognize that decisions that would result in health risks are properly made only by the individual who must bear the risk. Considerable uncertainty can surround medical evaluations of the risks and benefits of obstetrical interventions. Through a court-ordered intervention, a physician deprives a pregnant woman of her right to reject personal risk and replaces it with the physician’s evaluation of the amount of risk that is properly acceptable. This undermines the very concept of informed consent.

**Adverse Consequences of Seeking Court-Ordered Obstetrical Interventions in Instances of Treatment Refusal**

There are additional reasons why seeking a court order is not necessarily an appropriate response to a pregnant woman’s treatment refusal.

A Court Is an Inappropriate Forum for Resolving Treatment Disputes.—Courts are ill-equipped to resolve conflicts concerning obstetrical interventions. The judicial system ordinarily requires that court decisions be based on careful, focused deliberation and the cautious consideration of all facts and related legal concerns. In addition, there is always an opportunity for review on appeal. Court-ordered obstetrical interventions, on the other hand, are likely to be requested on extremely short notice and require immediate judicial action. A study done of court-ordered obstetrical interventions reported that in 70% of cases in which orders were considered, hospital administrators and attorneys were aware of the situation only a day or less before seeking a court order; 86% of the orders were obtained in less than 6 hours, and in 19%, less than an hour. It is unlikely that most judges would already be familiar with the policy concerns or relevant legal precedents required to make a carefully considered decision on such short notice. Decisions made under these immediate deadlines and intense pressures are likely to be hasty and lack reasoned conclusions. In the case of an improperly reached conclusion, there is no meaningful appeal available.

In addition, such court proceedings may be unfairly weighted against the pregnant woman. A woman in such a situation is probably under considerable psychological stress and may be suffering from substantial physical pain as well. Her ability to articulate her interests may be seriously impaired. It is further unlikely that the woman will be able to find adequate counsel on such short notice, and it is even more unlikely that counsel will have time to prepare properly for the hearing. When a decision must be rendered almost immediately, there will be little or no time to obtain the full range of medical opinions or facts. The inability of a court to understand the full range of the relevant medical evidence may lead to error with serious and irreversible consequences.

The Bases for Selecting Cases for a Court Order May Result in the Inconsistent Application of Compelled Treatment.—A physician’s decision to pursue a court order reflects his or her personal evaluation of the importance of a pregnant woman’s autonomy vis-à-vis the importance of fetal health. Accordingly, whether a woman must undergo judicial review of her decision regarding medical care will vary from physician to physician.

A troubling fact is that court-ordered obstetrical interventions seem to be sought more often in cases where the woman is either a member of a minority group or of a lower economic background. According to an initial study, in 81% of the instances in which a court-ordered intervention was sought, the woman belonged to a minority group. Every request for a court order involved a woman who had received care at a teaching hospital or who had received public assistance.

Women from lower socioeconomic groups and from differing ethnic backgrounds may have religious and other personal beliefs or circumstances that vary greatly from those of their physicians or the judges who decide their cases. A woman’s reasons for refusing care may be misunderstood or disregarded by the physician seeking the court-ordered override of her decision or by the judge who decides the case.

Creating Impermissible Legal Obligations for the Physician.—An important consideration for physicians is the extent to which they should encourage or contribute to state or court intervention in the medical decision-making process in general. Physicians have traditionally rejected outside intrusion into the physician-patient relationship. Imposing legal duties to accept medical care on pregnant women may result in concomitant legal duties for the physician. Such duties may require the physician to act as an agent of the state rather than as an independent patient counselor.

Judicial intervention is often sought in part to minimize either physician or hospital liability. However, seeking such interventions could ultimately serve to expand rather than limit liability. The tendency to resort to judicial intervention in cases of treatment refusal may create an obligation for the physician to obtain a court order in any situation in which a pregnant woman’s preferences does not accord with the physician’s evaluation of the fetus’ needs. If a pregnant woman’s obligations to the fetus become legally enforceable, then it is up to the physician to decide on which situations a woman is shirking her legal obligations by rejecting proposed care. Courts may therefore consider a physician negligent for not seeking a court order in situations where a pregnant woman’s decision led to fetal impairment.

Another consideration is the extent to which a physician would be required to participate in the practical aspects of enforcing an override of a pregnant woman’s treatment decision. In one case in which a court granted permission to a hospital to perform an unwanted cesarean section, the pregnant woman left the hospital before delivery. Should a court choose to enforce an override by compelling the woman to accept treatment, severe methods of restraint may be required. A pregnant woman may have to be forcibly restrained to prevent her from leaving the hospital or physical force may have to be used in order to administer a particular medicine to her. Inviting the state to override a pregnant woman’s decision legally may also be inviting government-mandated participation by physicians in administering the treatment. The
Physician-patient relationship would certainly be damaged by physician participation in the forcible administration of medical care. A physician’s role is as a medical advisor and counselor. Physicians should not be responsible for policing the decisions that a pregnant woman makes that affect the health of herself and her fetus, nor should they be liable for respecting an informed, competent refusal of medical care. In the interest of preserving fetal health, the physician must ensure that a pregnant woman’s decision is fully informed, competent, and considered decision. A physician should make sure that the pregnant woman understands the nature of the proposed treatment and the implications of treatment and non-treatment for both herself and her fetus. A physician may encourage the pregnant woman to consult other sources, such as family members, health professionals, social welfare workers, or the clergy, to provide her with additional information regarding her decision. When a pregnant woman makes an informed refusal of a procedure meant to benefit fetal health, the physician cannot be held morally responsible for the consequences of the pregnant woman’s decision.

Adverse Effects on the Physician-Patient Relationship.—Requests for court intervention may interfere with the physician-patient relationship in other ways. The physician’s willingness to override a woman’s refusal of treatment can create an adversarial relationship between physician and patient. In specific cases, the damage to the physician-patient relationship may appear to be outweighed in relation to the benefit to the fetus. However, it may also precipitate general distrust of physicians on the part of pregnant women. Once it becomes known that a physician or physicians in general are willing to override a woman’s refusal of treatment for both herself and her fetus. While the health of a few infants may be preserved by overriding a woman’s decision, the health of a great many more may be sacrificed.

Conclusions

The Physician’s Professional Duty. — The physician’s duty is to ensure that the pregnant woman makes an informed and thoughtful decision, not to dictate the woman’s decision.

Physicians Should Not Have a Legal Duty to Seek Court-Ordered Obstetrical Interventions.—There may be no other case where patient rejection of medical advice is as frustrating as when a pregnant woman rejects a procedure designed to benefit her fetus. Yet, physicians should refrain from using the courts to impose personal value judgments on a pregnant woman who refuses medical advice meant to benefit her fetus. As a corollary, a physician should not be liable for injuries sustained as a result of honoring a pregnant woman’s informed refusal of treatment designed to benefit the fetus.

Justification for Seeking Court-Ordered Interventions May Be Permissible Only In Exceptional Circumstances. — An absolute rule that a pregnant woman has no legal duty to accept any medical treatment that would substantially benefit her fetus would be problematic. For example, a woman conceivably could refuse oral administration of a drug that would cause no ill effects in her own body but would almost certainly prevent a substantial and irreversible injury to her fetus. Given the current state of medical technology, it is unlikely that such a situation would occur. In addition, as a practical matter, it is unlikely that a woman would refuse treatment in that situation.

If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should be a control in all cases that do not present such exceptional circumstances.

RESPONSES TO HARMFUL BEHAVIOR BY THE PREGNANT WOMAN

Alarm at the Rising Percentages of Infants Exposed to Harmful Substances in Utero

Currently, attention is increasingly being drawn to instances where the behavior of pregnant women is potentially harmful to fetal well-being. There has been particular great concern with the incidence of babies born with cocaine in their systems as a result of cocaine use by pregnant women. Hospitals are reporting an alarming rise in the number of births of those drug-exposed infants. The unpreparedness of infants born of cocaine use appears among women of childbearing age primarily due to the current popularity of the use of "crack," a concentrated, inexpensive, and highly addictive form of cocaine. Experts estimate that as many as 11% of pregnant women have used an illegal drug during pregnancy, and of those women, 75% have used cocaine. The American Medical Association (AMA) Board of Trustees profiled the current problem of substance abuse among pregnant women and discussed the clinical challenges involved in identifying and providing comprehensive treatment for these women.

The alarm with which these figures have been met is not unwarranted. The effects of cocaine use by a pregnant woman on her fetus and subsequently on her infant can be severe. Cocaine can cause in utero stroke, spontaneous abortion, and abruptio placenta. It also results in increased infant mortality. On the average, cocaine-exposed babies have lower birth weights, shorter birth lengths, and smaller head circumferences than normal infants. They also have a higher incidence of physical abnormalities, including deformed kidneys and neural tube defects. Cocaine-exposed babies often experience withdrawal symptoms that make them more irritable and resistant to bonding than other babies. Researchers believe that cocaine-exposed babies will be more likely to experience learning disabilities.

Although drug and other substance abuse by the pregnant woman attracts intense media attention, there are actually a large variety of behaviors that can adversely affect the fetus. Cigarette smoking by pregnant women results in higher rates of spontaneous abortion, premature birth, increased perinatal mortality, low birth weight, and negative effects on later growth and development in infants. Many prescription and over-the-counter medicines will cross the placenta and affect fetal health. Exposure to hazardous chemicals heightens the risk for spontaneous abortion, premature birth, stillbirths, low birth weight, and birth defects.

Special mention should be made of alcohol use. Many studies have confirmed the dangerous effects of alcohol use by pregnant women. Alcohol not only can retard the individual's physical and mental development, it can also affect the health of the mother and her fetus. It is not uncommon for infants born to alcoholics to be born with alcohol withdrawal syndrome or Fetal Alcohol Syndrome. These conditions can cause lifelong disabilities and complications.

Legal Action by
The rise of substances involving the problem of drug use and abuse in the state of California has been of great concern to many. The de facto legalization of marijuana and the proliferation of drug use has increased the number of drug-related problems in the state. The state has been forced to adopt new laws to address the problem.

Some provisions will be seen by many to be as harsh as new sanctions. The sanctions could have a serious impact on the state of prenatal care. Incarceration means of the state to adopt a new law that serves to protect the state from future harm. Any at-large harmful condition is likely to result in the medicating actions of the state. A report was issued by the state that the reports and liabilities are on the rise. It is no wonder w
pregnant women on their infants. Babies born with fetal alcohol syndrome suffer from prenatal and postnatal growth retardation; cardiovascular, limb, skull, and facial defects; impaired fine- and gross-motor function; and impaired intellectual function. Despite the serious health effects of alcohol consumption, the legal and social acceptance of alcohol make its use particularly difficult to prevent. Further, while excessive alcohol use during pregnancy certainly can cause serious fetal harm, no minimum level of alcohol use has yet been established as safe. The AMA, former Surgeon General Koop, and a number of other experts have concluded that total abstinence is the only way to ensure no ill effects from alcohol consumption during pregnancy.

**Legal Penalties as a Response to Substance Abuse by Pregnant Women**

The rising percentage of babies born with cocaine in their systems has been matched by the rising frustration of the health care and legal communities in finding ways to prevent the problem. A growing number of jurisdictions have tried to impose legal penalties, often criminal sanctions, in an attempt to deter drug use by pregnant women. Women have been charged under statutes against child abuse and neglect and the delivery of a controlled substance to a minor, or given special penalties for an unrelated conviction because they were pregnant and suspected of cocaine use. Evidence of drug abuse by pregnant women is being used as grounds for the state’s assuming immediate custody of newborns. In addition, other legal interventions, such as civil detention, have been sought in order to monitor or control the behavior of a pregnant woman when her behavior was considered potentially dangerous to her fetus. For the most part, these attempts to criminalize or legally penalize behavior by pregnant women have been unsuccessful. Several courts have ruled that existing statutes against child abuse and neglect cannot be applied to the fetus.

Some public officials believe that imposing criminal sanctions will deter substance abuse by pregnant women. However, many health and social welfare experts feel that the problem is more effectively addressed as a health concern rather than as a legal problem. They further maintain that criminal sanctions will not only fail to deter pregnant women from substance abuse, they will in fact prevent them from seeking prenatal care or medical help for their dependency.

**Incarceration or Detention During Pregnancy.** Incarceration or detention might seem to be the most effective means of preventing a specific harmful behavior. Ostensibly, the state could force an incarcerated or detained woman to adopt behavior that would promote the health of her fetus. However, incarcerating pregnant women in order to preserve fetal health may prove counterproductive.

Any attempt at detecting and managing the potentially harmful behavior of pregnant women through legal intervention is likely to require substantial participation on the part of the medical community. For instance, if a pregnant woman’s actions are classified as child abuse, legal obligations are created for the physician. All states require physicians to report suspected abuse. Most, in fact, hold health care personnel liable for failure to report, and some states even maintain liability for failure to diagnose child abuse properly.

It is not unreasonable to assume that at-risk pregnant women would be deterred from seeking contact with those people or institutions who might take action leading to their incarceration. 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. This fear is not unfounded; recently, a pregnant woman who sought medical care for injuries received as a result of a spousal beating was reported to the authorities, arrested, and charged with criminal child abuse for drinking during her pregnancy. The case was subsequently dismissed. In addition, the number of women who are convicted and incarcerated for potentially harmful behavior is likely to be relatively small in comparison with the number of women who would be prompted to avoid medical care altogether. As a result, the potential well-being of many infants may be sacrificed in order to preserve the health of a few.

Imposing criminal or civil sanctions on pregnant women for potentially harmful behavior may also encourage women to seek abortions in order to avoid legal repercussions. In addition, incarceration would be of only limited value since a considerable amount of damage could be done to the fetus before a woman even realized she was pregnant.

Further, while the incarceration of pregnant women would be intended to benefit the fetus, the reality of the environment in which pregnant women would be placed would do little to ensure fetal health. Prisoners in general have inadequate health care resources. Moreover, prison health experts warn that prisoners are “shockingly deficient” in attending to the health care needs of pregnant women. Most prisons have inadequate protocol, staff, or training to properly attend to the special needs of pregnant prisoners. The result has been widespread deficiencies in prenatal diet, nutrition, and exercise and seriously inadequate, if any, prenatal care. Pregnant women in jail are routinely subject to conditions that are hazardous to fetal health, such as gross overcrowding, 24-hour lock-up with no access to exercise or fresh air, exposure to tuberculosis, measles, and hepatitis, and a generally filthy and unsanitary environment. Additionally, it is unclear that incarceration would prevent drug use by pregnant women because drugs are readily available in prison.

**Legal Penalties Imposed After Birth.**—Criminal Sanctions. The most compelling reason that has been proposed for instituting postnatal criminal sanctions in cases of substance abuse by pregnant women is to prevent damage to fetal health. The actual efficacy of criminal sanctions as a method for preventing substance abuse is difficult, however. Obviously, fetal harm caused by substance abuse is averted only by effecting abstinence from harmful substances by pregnant women. Punishing a person who abuses drugs or alcohol is not generally an effective way of curing their dependency or preventing future abuse. The AMA has stated that “it is clear that addiction is not simply the product of a failure of individual willpower.” Substance abuse is caused by complex hereditary, environmental, and social factors. Individuals who are substance-dependent have impaired competence in making decisions about the use of that substance.

Punishing a person for substance abuse is generally ineffective because it ignores the impaired capacity of substance-abusing individuals to make decisions for themselves. In all but a few cases, taking a harmful substance such as cocaine is not meant to harm the fetus but to satisfy an acute psychological and physical need for that particular substance. If preg-
nant woman suffers from a substance dependency, it is the physical impossibility of avoiding an impact on fetal health that causes severe damage to the fetus, not an intentional or malicious wish to cause harm.

A woman's socioeconomic position may further affect her ability to carry out her moral responsibility to provide reasonable care in preserving fetal health. The women most likely to be prosecuted for exposing their fetuses to harmful substances are those from the lower economic levels. These women are more likely to lack access to both prenatal care and substance abuse treatment because of financial barriers. They are often uninsured or underinsured. Even when Medicaid is available, women may still lack access to medical care because of inadequate system capacity.

Access to care does not guarantee that pregnant women will receive drug treatment; one of the most commonly missed diagnoses in obstetric and pediatric medicine is drug abuse. Additionally, many prenatal care facilities do not have the capacity to treat substance abuse.

Pregnant substance abusers also tend to have other severe life stresses that may contribute to their substance abuse. An AMA Board of Trustees report states that female substance abusers tend to have more dysfunction in their families than nonabusers. They have high levels of depression, anxiety, sense of powerlessness, and low levels of self-esteem and self-confidence. A study done by a center that treats female substance abusers found that 70% of them were sexually abused as children, as compared with 15% of nonsubstance abusers. Eighty-three percent had had a chemically dependent parent, as opposed to 35% of the nonabusers. Seventy percent of female substance abusers report being beaten. Ten percent of female substance abusers in one study were homeless, while 50% had occasional housing problems.

Substance dependence and contributing factors cannot be used as an excuse for disregarding the consequences of dependent behavior on fetal and infant health. However, the magnitude of the problem and the influence of aggravating factors may preclude criminal sanctions from being an effective deterrent. For example, the use of illegal substances already incurs criminal penalties. Pregnant women who use illegal substances are obviously not deterred by existing sanctions; the reasons that prompt them to ignore existing penalties might also prompt disregard for any additional penalties. Furthermore, in ordinary instances, concern for fetal health prompts the great majority of women to refrain from potentially harmful behavior. If that concern, generally a strong impetus for avoiding certain actions, is not sufficient to prevent harmful behavior, then it is questionable that criminal sanctions would provide the additional motivation needed to avoid behavior that may cause fetal harm.

Civil Liability as a Remedy for Harmful Behavior by Pregnant Women.—Regardless of the inefficiency of criminal sanctions, a woman who uses harmful substances during her pregnancy often gives birth to a child who is either impaired or less healthy than the child would have been had the mother abstained from substance abuse. It is widely accepted that if a person other than the pregnant woman acts in such a way that fetal health, and consequently a child's health, is impaired, then that person can be held civilly liable for the impairment. While recovery in such situations is meant to compensate the parents of the impaired child, it may also be used to compensate the subsequent child for injuries resulting from negligent actions during the prenatal period.

The consequences of harm may be similar regardless of whether the responsible party is the pregnant woman herself or another person (a third party). Some commentators have stated that to punish third parties but not pregnant women for actions that result in harm to the fetus would be inconsistent. However, a pregnant woman and her fetus share a physical interdependency that a third-party tort-feasor and the fetus do not. The nature of the relationship between the pregnant woman and her fetus makes problematic tort liability against the mother for prenatal injuries.

Third-party liability protects both the pregnant woman and her fetus from behavior that is normally unacceptable under any circumstances. For instance, a drunk driver is liable for his actions because they are a menace to all, the born and unborn alike. However, every action on the part of a pregnant woman can have substantial impact on fetal health. Maternal liability would severely restrict a pregnant woman's freedom to act in even normally innocuous ways.

Causes of action would arise much more frequently than instances where the mother would actually be at fault. The difficulty in determining the cause of infant impairment could give rise to numerous unfounded claims of maternal liability. Many women who behaved in an acceptable manner during pregnancy would be unfairly subjected to liability proceedings, just as presently many physicians who practice good obstetrical medicine are subjected to unfounded liability claims.

Even if it could be proven that a pregnant woman's behavior caused infant impairment, intense scrutiny of the most intimate details of a pregnant woman's life would be required to evaluate the extent to which she could be held responsible for her actions. A judicial investigation to determine which action caused the harm and its reasonableness would have to include a determination of whether the harm was caused before or after the woman realized she was pregnant and whether she realized the behavior could affect fetal health. The court would also have to determine whether she could have reasonably prevented the harm or whether the action taken was reasonable in the context of other circumstances.

Even the most insignificant decision on the part of the pregnant woman could be subsequently called into question. The imposition of civil liability on women whose infants are born impaired would pose too great a burden and too great an intrusion into the lives of innocent women to justify it as a remedy to harmful behavior by the pregnant woman.

The Most Effective Method of Preventing Harmful Behavior by Pregnant Women Is Through Treatment and Education

Many health and public welfare officials feel that the most effective way of preventing substance abuse in pregnant women is through education about potential harms and the provision of comprehensive treatment for their abuse. Important methods of preventing or minimizing fetal harm due to substance abuse by pregnant women include identification of women who are at high risk for being substance abusers, early medical and psychotherapeutic intervention in the pregnancies of substance-abusing women, and access to programs that address the full range of social and health care needs associated with substance abuse. The National Association for Perinatal Addiction Education and Research has docu-
Deliberate, less of oneself's have women conceived or and then a лиability is under able for the born act of a health amount by the. Then the could ability during ooced e good liability behav the most quired mobile which have to caused nt and health, could action ances, are rest as it as a

In contrast, criminal penalties may exacerbate the harm done to fetal health by deterring pregnant substance abusers from obtaining help or care from either the health or public welfare professions, the very people who are best able to prevent future abuse. The California Medical Association has noted:

While unhealthy behavior cannot be condoned, to bring criminal charges against a pregnant woman for activities which may be harmful to her fetus is inappropriate. Such prosecution is counterproductive to the public interest as it may discourage a woman from seeking prenatal care or dissuade her from providing accurate information to health care providers out of fear of self-incrimination. This failure to seek proper care or to withhold vital information concerning her health could increase the risks to herself and her baby.

Florida's secretary of Health and Rehabilitative Services has also observed that potential prosecution under existing child abuse or drug use statutes already "makes many potential reporters reluctant to identify women as substance abusers."

It may seem that a pregnant substance abuser has an obligation to obtain treatment for her dependence. However, obtaining treatment is not currently a practical alternative for pregnant substance abusers. Even the most persistent woman is likely to fail to find a treatment program for her substance dependence. Rehabilitative centers for substance abusers are in short supply. The majority of those facilities that do treat substance abuse refuse to accept pregnant women, in part due to concerns over liability. Of the few centers that do treat pregnant women, most have long waiting lists.

Further, the majority of substance abuse treatment facilities operate on an adult-male centered model. They are not designed to address problems specific to women's psychological or physiological needs. Nor are they equipped to handle other problems that substance-dependent women often have, such as how to arrange day-care for older children or counseling for a woman who is abused by a spouse or partner. This would be an injustice to punish a pregnant woman for not receiving treatment for her substance abuse when treatment is not an available option to her.

Finally, societal efforts to educate pregnant women and provide accessible treatment for those who may be substance abusers promote relationships and attitudes that are beneficial to fetal health in general. Criminal penalties levied against pregnant women for their actions would politicize government agents with enforcement responsibilities rather than as concerned patient advocates. Criminal penalties would also emphasize conflict between the pregnant woman and her fetus, which does not encourage a healthy relationship between the pregnant woman and her future child. On the other hand, providing education and treatment emphasizes cooperation and trust between the pregnant woman and her physician and facilitates more emotionally positive relationship after birth.

State-Assumed Custody of Exposed Infants

Another response to harmful behavior by pregnant women is taking the woman's baby into state custody after birth. Probably the most widely accepted action for preterm substance abuse is state-assumed custody of infants who show signs of prenatatal exposure to harmful substances. Legal penalties for behavior while pregnant are problematic be-cause a pregnant woman and her fetus cannot practically be treated as separate entities. Once an infant is born, this is not a consideration. In addition, evidence shows that parental substance abuse and child abuse are highly correlated. Children who have been impaired due to in utero exposure to harmful substances are likely to be especially difficult to care for, requiring above normal parenting skills. Courts have ruled that the potential for abuse implied by substance abuse by a woman while pregnant is adequate justification for allowing the state to assume at least temporary custody of these infants.

Ordinarily, the state cannot impose punishment for potential, rather than actual, actions. Presumably, the termination or suspension of parental rights is an exception because it is primarily a protection for the child and not a penalty directed at the parent. In the interest of preserving family unity wherever reasonably possible, courts should be careful to ensure that such actions are actually protective of the child.

Consideration of Criminal or Civil Sanctions in Exceptional Cases

Some commentators have argued that legal penalties or state intrusion into the lives of pregnant women are legally justifiable because once a pregnant woman forgoes her right to have an abortion she has a "legal . . . duty to bring the child into the world as healthy as is reasonably possible." This duty includes restrictions that "may significantly limit a woman's freedom of action and even lead to forced bodily intrusion." The implication is that once a woman has become pregnant and does not take affirmative steps to terminate her pregnancy, then she has forfeited her constitutional rights to bodily integrity and privacy.

However, this legal argument has been criticized as misplaced. One commentator notes that such a waiver of constitutional rights never actually takes place because "women do not appear before judges to waive their rights at any time during pregnancy." The fact that a woman does not abort her fetus cannot be construed as the willing forfeiture of her constitutional rights. Further, if the decision to have a child automatically precipitates a waiver of constitutional rights, then the state has created a penalty for choosing to bear a child. The right to procreate is constitutionally protected and its exercise cannot be penalized. In addition, state-imposed penalties upon the decision to bear children would be troubling as a policy matter.

Absolutely prohibiting legal penalties for all potentially harmful actions by a pregnant woman may seem extreme. For instance, if a situation arose in which a woman willingly engaged in an elective behavior that would clearly cause severe and irreparable injury to the future child, it seems incongruous to suggest that society should have no legal recourse for such behavior.

Yet, it is difficult to imagine that such circumstances might occur in significant numbers, if at all. More important, the conscious infliction of certain and severe harm to the fetus would generally pose a serious risk of harm to the pregnant woman as well. Therefore, counseling, psychiatric treatment, or other support services would probably be a more appropriate response than criminal punishment. In addition, it is difficult to imagine a situation in which legal rules would be the best policy choice as legal penalties or liability may be ultimately detrimental, rather than beneficial, to fetal health.
RECOMMENDATIONS

The AMA Board of Trustees recommends adoption of the following statement:

1. Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.

2. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases that do not present such exceptional circumstances.

3. The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.

4. A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.

5. Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.

6. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.

7. To minimize the risk of legal action by a pregnant patient or an injured child or fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendations.

References

24. Amos GJ. Forced cesareans: the most undiscovered of all. Hastings Cent
STATE OF NORTH DAKOTA

COUNTY OF CASS

State of North Dakota,

Plaintiff,

vs.

Martina Greywind,

Defendant(s).


MOTION TO DISMISS
WITH PREJUDICE

Comes now Stephen R. Dawson, Assistant Cass County States
Attorney, on behalf of Plaintiff in the above-entitled action,
and moves this Court pursuant to North Dakota Rules of Criminal
Procedure 48(a), to dismiss the Complaint against the defendant.

On February 10, 1992 the above-named defendant was charged
with the offense of Reckless Endangerment, a class A misdemeanor.
The defendant has recently undergone treatment at the North Dakota
State Hospital and is presently in custody at the Cass County Jail
on a subsequent and pending charge of Inhalation of Volatile
Chemicals in violation of N.D.C.C. Section 12.1-31-06. Defendant
has made it known to the State that she has terminated her
pregnancy. Consequently, the controversial legal issues presented
are no longer ripe for litigation. Further, the likelihood of this
extreme factual situation recurring is limited. In the interest of
preserving limited prosecutorial and judicial resources, Plaintiff
hereby moves to dismiss the Complaint in this action with
prejudice.

Dated this 10th day of April, 1992.
ORDER

After reviewing Plaintiff's Motion to Dismiss in the above-entitled action and after reviewing the records and files herein,

IT IS HEREBY ORDERED that the above-entitled action is dismissed with prejudice.

Dated this __ th day of April, 1992.

Stephen R. Dawson
Assistant States Attorney
Cass County Courthouse
P.O. Box 2806
Fargo, ND 58108-2806

County Judge
195 A.3d 567
Superior Court of Pennsylvania.

COMMONWEALTH of Pennsylvania, Appellant
v.
Kasey Rose DISCHMAN

No. 1615 WDA 2017
| Submitted June 18, 2018.
| Filed August 29, 2018

Synopsis
Background: Commonwealth appealed from decision of the Court of Common Pleas, Criminal Division, Butler County, No. CP-10-CR-0001495-2017, William R. Shaffer, J., dismissing one count of aggravated assault of an unborn child.

The Superior Court, No. 1615 WDA 2017, Nichols, J., held that, as matter of first impression, liability would not be imposed upon pregnant defendant in regard to crimes against her unborn child.

Affirmed.

Appeal from the Order Entered October 19, 2017, In the Court of Common Pleas of Butler County Criminal Division at No(s): CP-10-CR-0001495-2017, WILLIAM R. SHAFFER, J.

Attorneys and Law Firms
Laura D. Pitchford, Assistant District Attorney, Butler, for Commonwealth, appellant.

Joseph L. Smith, Public Defender, Butler, for appellee.

Sara J. Rose, Pittsburgh, for ACLU, amicus curiae.

Susan Frietsche, Pittsburgh, and Margaret H. Zhang, Philadelphia, for Women’s Law Project, amicus curiae.

BEFORE: BOWES, J., NICHOLS, J., and STRASSBURGER, J.*

OPINION

OPINION BY NICHOLS, J.:

*568 The Commonwealth appeals from the order dismissing one count of aggravated assault of an unborn child under 18 Pa.C.S. § 2606(a) against Appellee Kasey Rose Dischman. The Commonwealth claims that the trial court erred in holding that the nonliability provision in 18 Pa.C.S. § 2608(a)(3) barred the Commonwealth's prosecution of Appellee for the crime against her unborn child. 1 We affirm.

On June 23, 2017, Appellee was transported to the hospital due to a drug-related overdose. N.T., 7/11/17, at 3. Further testing at the hospital revealed that the overdose was due to opioids in Appellee's system. Id. at 4, 6. At the time, Appellee was approximately thirty weeks' pregnant. Id. at 4. Appellee went into cardiac arrest and an emergency Cesarean section had to be performed on June 24, 2017 “because of [her] condition of being on a ventilator and the risk to the child.” Id.

Appellee was initially charged with one count of aggravated assault of an unborn child. The magisterial district court held a preliminary hearing on July 11, 2017. The court denied Appellee's motion to dismiss and held the matter over for trial in the court of common pleas. See N.T., 7/11/17, at 12.

On July 17, 2017, Appellee filed a combined petition for a writ of habeas corpus and motion to prohibit the Commonwealth's criminal prosecution. On July 21, 2017, the trial court dismissed Appellee's petition without prejudice for failure to comply with Rule 578 of the Pennsylvania Rules of Criminal Procedure, which governs the filing of omnibus pretrial motions.

On August 2, 2017, the Commonwealth filed a motion to amend the information to include charges of endangering the welfare of children, corruption of minors, and possession of drug paraphernalia. 2 On August 23, 2017, the trial court granted the Commonwealth's motion.

On August 29, 2017, Appellee filed an omnibus pre-trial motion, seeking, in relevant part, dismissal of the count of aggravated assault of an unborn child. Appellee claimed that section 2608(a)(3) expressly prohibits the prosecution of a pregnant woman for crimes against her own unborn

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child. Appellee also challenged the propriety of the count of possession of drug paraphernalia.

On October 19, 2017, following the hearing, the trial court granted in part and denied in part Appellee’s omnibus pre-trial motion. The court found that although Appellee “is alleged to have done a senseless, selfish, and heinous act that, allegedly, resulted in devastating and permanent injuries to her unborn child,” it was constrained by the clear, plain, and unambiguous language of 18 Pa.C.S. § 2608(a)(3), and the Pennsylvania Supreme Court’s decision in [Commonwealth v. Bullock, 590 Pa. 480, 913 A.2d 207 (2006)], to find that our legislature intended for prosecution under the Crimes Against the Unborn Child Act to be barred as to [Appellee], a pregnant woman, for crimes committed against her then unborn child.

*569 Order, 10/19/17 at 3 (unpaginated). The court thus dismissed the one count of aggravated assault of an unborn child and held the remaining charges for trial. Id.

On October 30, 2017, the Commonwealth filed a timely appeal and a court-ordered Pa.R.A.P. 1925(b) statement. The trial court filed an opinion relying on the reasoning set forth in its October 19, 2017 order.

The Commonwealth raises the following issues on appeal:

1. Whether the trial court erred in applying [Bullock] as precedent in the case at bar as it is inapplicable to the case at bar and serves no purpose to determine legislative intent for 18 Pa.C.S.[ ] § 2608(a)(3) as well as 18 Pa.C.S.[ ] § 2606(a)[.]

2. Whether the trial court erred in ruling that the language of 18 Pa.C.S.[ ] § 2608(a)(3) is clear and free of ambiguity[.]

3. In the alternative, if this Court were to determine that the language of 18 Pa.C.S.[ ] § 2608(a)(3) is clear and free of ambiguity, whether the trial court erred in determining that it was the intent of the legislature to prohibit prosecution under the facts of this particular case[.]

Commonwealth’s Brief at 1 (full capitalization omitted).

The Commonwealth claims that the trial court erred in its interpretation and application of the nonliability provision in section 2608(a)(3). According to the Commonwealth, section 2608 does not limit the prosecution of a pregnant woman who inflicts harm upon her unborn child “through the intentional and reckless use of an illegal substance known to cause death.” Id. at 7. In support, the Commonwealth advances three arguments, which we address jointly.

First, the Commonwealth begins with the premise that the General Assembly enacted Chapter 26 of the Crimes Code to protect unborn children. Id. at 10. The Commonwealth asserts that before the enactment of Chapter 26, the term “child” or “person” did not extend to a fetus. Id. Thus, the enactment of Chapter 26 recognized “the rights of an unborn child within the criminal realm to receive justice as a victim” of certain crimes. Id.

Second, the Commonwealth argues that section 2608 is ambiguous when read in isolation. Id. at 9. The Commonwealth asserts that section 2608 contains two additional subsections that prohibit prosecutions under Chapter 26 in instances of abortion and other legally protected medical procedures. Id. at 8-9. The Commonwealth thus contends that section 2608, when read as a whole, protects “a pregnant woman from prosecution for engaging in otherwise legal activities such as abortion and medical procedures.” Id. The Commonwealth concludes that it would be absurd and contrary to the intent of Chapter 26 to interpret section 2608(a)(3) in a carte blanche manner to prevent prosecution of a pregnant woman engaged in illegal and reckless behavior such as drug use. 6 Id. at 8-9, 11-12.

*570 Third, the Commonwealth asserts that the trial court erred in relying on Bullock. Id. at 5. The Commonwealth notes that the discussion of the potential nonliability of a pregnant woman in Bullock was dicta. Id. at 6. The Commonwealth instead suggests that the decision of In the Interest of L.B., a Minor, 177 A.3d 308 (Pa. Super. 2017), appeal granted, 183 A.3d 971 (Pa. 2018),
is more instructive because it addresses “the illegal opiate
drug use by a pregnant mother that results in harm to her
unborn child.” Id. at 7.

Appellee and the amici curiae 7 assert that the trial court
properly construed the nonliability provision of section
2608(a)(3) as clear and unambiguous. Appellee's Brief
at 14-15; ACLU’s Amicus Brief at 2; Women's Law
Project's Amicus Brief at 5-6. They assert that the statutory
text of section 2608(a)(3) precludes the Commonwealth's
suggested distinction between a pregnant woman's legal
acts and illegal acts that harm her unborn child. Appellee's
Brief at 14-15; ACLU’s Amicus Brief at 2; Women's Law
Project's Amicus Brief at 5-6. Moreover, they assert that
because section 2608(a)(3) is unambiguous, there is no
need to examine the policy considerations underlying
Chapter 26 as a whole. Appellee's Brief at 14-15; ACLU’s
Amicus Brief at 2; Women's Law Project's Amicus Brief at
5-6. The ACLU further asserts that the Commonwealth's
suggested construction of section 2608(a)(3) raises serious
constitutional concerns. See ACLU’s Amicus Brief.

The Commonwealth's claim requires us to interpret the
statutory language in section 2608(a)(3), which raises a
59, 99 A.3d 416, 420 (2014). Thus, our standard of review
is de novo and our scope of review is plenary. See id.

Our Supreme Court has stated that in construing a statute,
we rely on the Statutory Construction Act, 1 Pa.C.S. §§
1501-1991. The Court further explained:

The objective of all interpretation and construction of
statutes is to ascertain and effectuate the intention of the
indication of the legislature's intent is the plain language
of the statute. When considering statutory language,
“[w]ords and phrases shall be construed according to
rules of grammar and according to their common and
approved usage.” Id. § 1903(a). Further, when the
words of a statute are clear and unambiguous, there is
no need to go beyond the plain meaning of the
language of the statute “under the pretext of pursuing
its spirit.” Id. § 1921(b). Thus, only when the words of
a statute are ambiguous, should a reviewing court seek
to ascertain the intent of the General Assembly through
considerations of the various factors found in Section
1921(c). [8] Id. § 1921(c); see generally *571 Bayada

Nurses Inc. v. Com. Dept. Labor and Indus., [607 Pa. 527,

Rushing, 99 A.3d at 423. When reviewing a statute, “we
may not render language superfluous or assume language
to be mere surplusage.” Commonwealth v. Durso, 86 A.3d
865, 867 (Pa. Super. 2013) (citation omitted).

Chapter 26 of the Crimes Code, 9 also referred as the
Crimes Against the Unborn Child Act (Act), defines
several crimes against unborn children, 10 including
murder, voluntary manslaughter, and aggravated assault.
See 18 Pa.C.S. §§ 2604-2606. Section 2606(a) provides
that a “person commits aggravated assault of an unborn
child if he attempts to cause serious bodily injury to
the unborn child or causes such injury intentionally,
knowingly or recklessly under circumstances manifesting
extreme indifference to the life of the unborn child.” 18
Pa.C.S. § 2606(a).

Section 2608, in turn, enumerates “nonliability” and
“defenses” under Chapter 26. Specifically, section 2608(a)
states as follows:

(a) Nonliability.—Nothing in this chapter shall impose
criminal liability:

(1) For acts committed during any abortion or
attempted abortion, whether lawful or unlawful, in
which the pregnant woman cooperated or consented.

(2) For the consensual or good faith performance
of medical practice, including medical procedures,
diagnostic testing or therapeutic treatment, the use of
an intrauterine device or birth control pill to inhibit
or prevent ovulation, fertilization or the implantation
of a fertilized ovum within the uterus.

(3) Upon the pregnant woman in regard to crimes
against her unborn child.

18 Pa.C.S. § 2608(a). 11

There is no dispute that the purposes of Chapter 26 include
the recognition of unborn children as victims of certain
crimes, including aggravated assault. Nevertheless, the
text of the nonliability provision in section 2608(a)(3) is
clear and unambiguous. 12 The General Assembly chose
not to hold a pregnant woman culpable for “crimes”

Thus, we discern no textual support for the Commonwealth's argument that a pregnant woman's illegal action resulting in harm to the unborn child may give rise to liability under Chapter 26. See *572 Rushing, 99 A.3d at 423; Durso, 86 A.3d at 867. Moreover, the Commonwealth's suggested construction of section 2608(a)(3) asks that we depart from the plain meaning of the text to pursue the broader policy goals of Chapter 26 and to find ambiguity where none actually exists. This we cannot do under the guise of statutory interpretation. See Rushing, 99 A.3d at 423.

Accordingly, we agree with the trial court and hold that the unambiguous language of section 2608(a)(3) dictates that a pregnant woman cannot be held liable under Chapter 26 for crimes against her unborn child.

Although the plain language of section 2608(a)(3) is dispositive, a review of the legislative history of Chapter 26 further establishes that the result reached here is neither unintended nor absurd. As noted by the Women's Law Project, Representative Dennis O'Brien was one of the principal drafters of the statute. Women's Law Project's Amicus Brief at 9-11. During an exchange between Representative O'Brien and Representative Babette Joseph, the following occurred:

Ms. JOSEPHS. Thank you, Mr. Speaker. For instance, a woman named Pamela Rae Stewart was prosecuted in California for not getting to her doctor fast enough when she went into labor and for having intercourse too late in her pregnancy. A woman in Wisconsin named Deborah Zimmerman was prosecuted for attempted homicide because she drank alcohol shortly before giving birth. In Florida, a woman named Kawana Ashley was prosecuted for manslaughter felony murder because she shot herself in the stomach when she was 25 to 26 weeks pregnant. In almost every case of this nature, the courts have thrown out the prosecutions. Sometimes after the woman has already spent time in prison, the courts usually base their conclusion on an interpretation that the State legislature could not possibly have meant to criminalize pregnant women's prenatal conduct. I am worried, in passing SB 45, Pennsylvania will be encouraging the prosecution of pregnant women who engage in arguably unhealthy behavior during their pregnancies. Is it the intention of

the Senate language to this bill or the bill that it should be used against pregnant women in any way? That is my question.

Mr. O'BRIEN. The answer to that question is, nothing in this chapter shall impose criminal liability upon the pregnant woman in regard to crimes against her unborn child.

Ms. JOSEPHS. That is civil liability. What about civil liability? Is there any possibility we are going to have somebody step in, say they are representing the fetus, and getting an injunction against certain kinds of behavior that the pregnant woman might engage in?

Mr. O'BRIEN. Not by virtue of this specific legislation.
respects these types of situations. While this does result in the mother being treated more leniently under the Act as regards crimes against her unborn child, such a result would only be constitutionally problematic if it stemmed from an arbitrary classification, which, as noted, it does not.

This Court need not presently opine regarding the legal propriety of a hypothetical criminal prosecution of the mother in such circumstances.  

Id. at 216 (some citations omitted and emphases added).

Taken together, the legislative history of Chapter 26 and the dicta in Bullock suggest that the General Assembly was aware of the unique relationship between a pregnant woman and her unborn child, as well as the special constitutional issues surrounding the pregnant woman's liberty interests. In crafting section 2608(a)(3), the General Assembly chose a particular balance of its recognition of the unborn child as a victim of certain crimes and the interests of the pregnant mother. Given the unambiguous language of section 2608(a)(3), as well as the persuasive authority of the General Assembly's intent, we reject the Commonwealth's attempts to alter that balance.  

*574 In sum, we discern no error of law with the trial court's holding that liability under Chapter 26 will not be imposed upon a pregnant woman in regard to crimes against her unborn child. Absent ambiguity in the statutory text, this Court cannot accept the Commonwealth's argument. Accordingly, we affirm the order dismissing the charge of aggravated assault against an unborn child.

Order affirmed. Application for admission pro hac vice granted.

All Citations
195 A.3d 567, 2018 PA Super 238

Footnotes
* Retired Senior Judge assigned to the Superior Court.
1 Section 2608(a)(3) states: "Nothing in [Chapter 26 of the Crimes Code] shall impose criminal liability ... [u]pon the pregnant woman in regard to crimes against her unborn child." 18 Pa.C.S. § 2608(a)(3).
2 18 Pa.C.S. § 4304(a)(1), 18 Pa.C.S. § 6301(a)(1)(i), and 35 P.S. § 780-113(a)(32), respectively.
3 The Commonwealth certified that the trial court's ruling would terminate or substantially handicap the prosecution. See Pa.R.A.P. 311(d); Commonwealth v. Karetny, 583 Pa. 514, 880 A.2d 505, 512-13 (2005).
4 The Commonwealth notes that this is a case of first impression.
5 We have reordered the Commonwealth's arguments for the purposes of this appeal.
6 In further support of its argument that the trial court's interpretation of section 2608(a)(3) could result in an absurd result, the Commonwealth poses a hypothetical. See Commonwealth's Brief at 12. It suggests that if another person injected a pregnant woman with an illegal substance that harmed her child, that person could be charged under Chapter 26, even if the pregnant woman consented to the injection. Id. However, under the trial court's interpretation of section 2608(a)(3), the pregnant woman could not be charged for a Chapter 26 offense. Id.
7 The American Civil Liberties Union of Pennsylvania (ACLU) and the Women's Law Project have filed amicus briefs in this appeal. Additionally, the Women's Law Project has filed an application to admit Christine Castro, Esq., pro hac vice. We grant that application.
8 Section 1921(c) states:
   (c) When the words of the statute are not explicit, the intention of the General Assembly may be ascertained by considering, among other matters:
      (1) The occasion and necessity for the statute.
      (2) The circumstances under which it was enacted.
      (3) The mischief to be remedied.
      (4) The object to be attained.
      (5) The former law, if any, including other statutes upon the same or similar subjects.
      (6) The consequences of a particular interpretation. (7) The contemporaneous legislative history.
      (8) Legislative and administrative interpretations of such statute.
   1 Pa.C.S. § 1921(c).
Chapter 26 adopts the Abortion Control Act's definition of unborn child as meaning “an individual organism of the species homo sapiens from fertilization until live birth.” See 18 Pa.C.S. §§ 2602, 3203.

Section 2608(b) enumerates defenses based on justification. 18 Pa.C.S. § 2608. Section 2609 states: “The provisions of this chapter shall not be construed to prohibit the prosecution of an offender under any other provision of law.” 18 Pa.C.S. § 2609.

Indeed, the Commonwealth does not contend that a word or phrase in section 2608(a)(3) is ambiguous or open to multiple interpretations.

In Bullock, our Supreme Court addressed a male appellant's equal protection challenge to Chapter 26 based on the nonliability provision in section 2608(a)(3). In that case, the appellant was living with his pregnant girlfriend. Id. at 210. On New Year's Eve, they were both drinking and ingesting cocaine. Id. The appellant asked her to stop ingesting cocaine for the remainder of the night due to her pregnancy, which she did not do. Id. They argued and the appellant “blacked out.” Id. When he awoke, he was on top of her, strangling her. Id. When she was nearly unconscious, he wrapped her feet, hands, and mouth with masking tape. Id. at 210-11. The appellant then continued to strangle her until she was unconscious and then dragged her body into the closet. Id. at 211. On January 6, 2003, the appellant confessed to the police, who found her partially-decomposed body in the closet. Id. The appellant was convicted of murder of his girlfriend and with criminal homicide of her unborn child pursuant to the Chapter 26. Id.

Additionally, we find the Commonwealth's reliance on L.B. unavailing. L.B. was a dependency case that addressed section 6303 of the Child Protective Services Law, in which this Court held that drug use while pregnant may constitute child abuse. See generally In the Interest of L.B., a Minor, 177 A.3d 308 (Pa. Super. 2017). While L.B. stands for the proposition that a pregnant mother’s use of illicit narcotics may result in consequences under the Child Protective Services Law, L.B. provides no support for the Commonwealth’s suggested interpretation of section 2608(a)(3).
IN THE SUPERIOR COURT OF PENNSYLVANIA

1615 WDA 2017

COMMONWEALTH OF PENNSYLVANIA,

Appellant,

v.

KASEY ROSE DISCHMAN,

Appellee.

On appeal from the Order dated October 19, 2017, of the Court of Common Pleas of Butler County, Pennsylvania, CP-10-CR-1495-2017

BRIEF OF AMICI CURIAE WOMEN’S LAW PROJECT, ET AL., IN SUPPORT OF APPELLEE AND FOR AFFIRMANCE

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STATEMENT OF INTEREST OF THE AMICI CURIAE

Amici curiae are non-profit organizations and individuals\(^1\) concerned about the public health implications of applying punitive sanctions against pregnant women who use drugs while pregnant. Amici include women’s health advocates and organizations that have participated as counsel or amici curiae in cases challenging illegal discrimination in the provision of substance use disorder treatment for pregnant women and in cases involving the criminal prosecution of pregnant women for behavior alleged to be harmful to their fetuses. Amici also include health care professionals and providers who treat patients who use drugs while pregnant, including pregnant women battling substance use disorders.

Amici share a common interest in improving maternal and fetal health. They seek to supplement the parties’ briefs by providing this Court with information relating to drug use during pregnancy and the importance of making appropriate and accessible prenatal care and substance use disorder treatment more widely available to pregnant and parenting women.

\(^1\) Statements of interest for each amicus are included as an appendix to this brief.
*Amici* submit this brief in support of Appellee Dischman because they believe that interpreting Pennsylvania law to allow for the prosecution of pregnant women for alleged drug use will adversely affect the health and well-being of women and their families, and would be contrary to legislative intent. Accordingly, *amici* respectfully urge this Court to affirm the order of the Court of Common Pleas dismissing the aggravated assault charge against Dischman.
SUMMARY OF ARGUMENT

The prosecution of Dischman for alleged conduct affecting her pregnancy is without any basis in law. The Pennsylvania legislature has explicitly limited a pregnant woman’s liability for offenses against her so that she cannot be prosecuted for allegedly unhealthy conduct. 18 Pa. C.S. § 2608(a)(3). The plain language of the nonliability provision compels this result and confirms that the lower court’s ruling should be affirmed.

Even if the statutory language were ambiguous, which it is not, tenets of statutory construction strongly support affirming the ruling below. The legislative history of the statute, the presumption that statutes should not be interpreted to advance an absurd or unreasonable result, and the rule of lenity in criminal statutes all indicate that the nonliability provision means precisely what it says.

Prosecuting pregnant women for conduct alleged to harm their fetus undermines public health, maternal and fetal well-being, and women’s equality and autonomy. The practical effect of the Commonwealth’s novel reading of 18 Pa. C.S. § 2606 would be to drive pregnant women who use drugs out of the health care system and away from treatment and prenatal care, and punish them for communicating openly with their health care providers. Some women may even end wanted pregnancies in order to avoid punishment.
In addition to having a harmful public health impact, applying criminal fetal assault laws to pregnant women’s conduct is profoundly unjust. It punishes pregnant women for failing to undergo or successfully complete treatment that is largely unavailable or inaccessible to them. It also infringes upon pregnant women’s privacy and autonomy, and could have far-reaching consequences outside the context of drug use. In light of the host of factors that can adversely affect maternal and fetal health, the sweeping expansion of the criminal laws urged by the Commonwealth opens the door to highly intrusive and coercive policing of pregnant women’s behavior. The brunt of this policy would fall most heavily on poor women and women of color, who are already at higher risk of experiencing pregnancy complications and adverse outcomes, compared to the general population.

For these reasons, as well as those set forth in the Brief for Appellee, the order of the Court of Common Pleas should be affirmed.
ARGUMENT

I. THE LOWER COURT CORRECTLY APPLIED THE UNAMBIGUOUS LANGUAGE OF 18 PA. C.S. § 2608(a)(3) IN RULING THAT DISCHMAN COULD NOT BE HELD LIABLE FOR ALLEGED CONDUCT AFFECTING HER FETUS.

The Butler County Court of Common Pleas correctly held that the nonliability provision at 18 Pa. C.S. § 2608(a)(3) applies where, as here, a pregnant woman engages in conduct alleged to harm her own pregnancy. The court dismissed the charge of aggravated assault of a fetus under 18 Pa. C.S. § 2606 against Dischman, because the plain language of Section 2608 precludes prosecution under these circumstances. See R.R. 2-3. The nonliability provision states that criminal liability for aggravated assault under Section 2606 cannot attach “[u]pon the pregnant woman in regard to crimes against” the fetus. 18 Pa. C.S. § 2608(a)(3). This provision is plain and clear: in all circumstances, a pregnant woman cannot be liable for aggravated assault against her fetus.

It is hornbook law that “[w]hen the language of a statute is plain and unambiguous and conveys a clear and definite meaning, there is no occasion for resorting to the rules of statutory interpretation and construction; the statute must be given its plain and obvious meaning.” Davis v. Sulcowe, 205 A.2d 89, 92 (Pa. 1964) (quoting Commonwealth ex rel. Cartwright v. Cartwright, 40 A.2d 30, 33 (Pa. 1944)); accord Commonwealth v. Empfield, 585 A.2d 442, 444 (Pa. 1991). Here, because Dischman was charged with aggravated assault against her fetus
under Section 2606, and because the nonliability provision plainly precludes her
criminal liability, the charge was correctly dismissed. The Statutory Construction
Act requires that the analysis end there, see 1 Pa. C.S. § 1921(b) (“When the words
of a statute are clear from all ambiguity, the letter of it is not to be disregarded
under the pretext of pursuing its spirit.”), and the order of the Court of Common
Pleas should be affirmed.

II. EVEN IF 18 PA. C.S. § 2608(a)(3) IS AMBIGUOUS, WHICH IT IS
NOT, THE LOWER COURT RULING THAT DISCHMAN
COULD NOT BE HELD LIABLE FOR CONDUCT AFFECTING
HER FETUS IS SUPPORTED BY CANONS OF STATUTORY
INTERPRETATION.

The Commonwealth seeks to avoid the plain reading of the statute by
insisting that the nonliability provision is ambiguous. See Appellant’s Br. 7-9.
The Commonwealth would restrict the exemption to situations involving
“otherwise legal activities such as abortion and medical procedures,” but to do so
requires rewriting the statute. Appellant’s Br. 9. No words in the nonliability
provision or in the statute it circumscribes indicate that the nonliability provision is
limited to “otherwise legal activities.” Id. Indeed, the subsection providing that
abortion does not constitute aggravated assault of a fetus specifies that there is no
liability regardless of whether an abortion or attempted abortion is otherwise
“lawful or unlawful.” 18 Pa. C.S. § 2608(a)(1).
Even if the nonliability provision were ambiguous, which it is not, binding principles of statutory interpretation would preclude this prosecution. First, penal provisions such as Sections 2606 and 2608 must be strictly construed, 1 Pa. C.S. § 1928(b)(1); accord Commonwealth v. Hall, 80 A.3d 1204, 1212 (Pa. 2013), and must be “interpreted in the light most favorable to the accused,” Hall, 80 A.3d at 1212. Moreover, as discussed below, courts must interpret a statute so that “the entire statute” is “effective” and no parts are superfluous, the result is not “absurd, impossible . . . or unreasonable,” the interpretation accords with legislative intent, and where possible, the statute does not “violate the Constitution of the United States or of this Commonwealth.” 1 Pa. C.S. §§ 1921, 1922(1)–(3).

To give effect to “every word, sentence, and provision of [the nonliability] statute” and to avoid rendering portions of it “mere surplusage,” Allegheny Cty. Sportsmen’s League v. Rendell, 860 A.2d 10, 19 (Pa. 2004), the nonliability provision for pregnant women must apply to any “pregnant woman in regard to crimes against” the fetus, 18 Pa. C.S. § 2608(a)(3), not only to pregnant women “engaging in otherwise legal activities.” Appellant’s Br. 9. This provision speaks of nonliability for “crimes” against the fetus: for the Commonwealth to suggest that the word “crimes” really means “otherwise legal activities” is nonsense. And to the extent that the Commonwealth suggests that the nonliability provision applies only to “abortion and medical procedures,” Appellant’s Br. 9, that reading
“would result in duplicate [provisions] which would render [the nonliability provision for pregnant women] meaningless, and not give full effect to the plain language of [all] Sections.” Rendell, 860 A.2d at 19. For “the entire statute . . . to be certain and effective, not superfluous and without import,” the nonliability provision must apply to pregnant women in all circumstances. Rossi v. Commonwealth, 860 A.2d 64, 66 (Pa. 2004).

The Commonwealth’s reading of this provision is also absurd and unreasonable, and hence insupportable. 1 Pa. C.S. § 1922(1); see Zimmerman v. O’Bannon, 442 A.2d 674, 676-77 (Pa. 1982) (“[T]he General Assembly does not intend a result that is absurd or unreasonable.”). Indeed, an attempted prosecution of a pregnant woman under Pennsylvania’s criminal child endangerment statute for her conduct while pregnant failed for just this reason. Commonwealth v. Kemp, 18 Pa. D. & C. 4th 53, 63 (C.P. 1992). In the words of the trial court, “the dangerous policy of criminally prosecuting pregnant women for their alleged drug use threatens such serious health consequences for pregnant addicts and their fetuses that the Legislature could not possibly have intended such an unreasonable application of this penal law.” Id. As discussed in more detail below, see infra Part III, “[c]riminal prosecution cruelly severs women from the health care system, thereby increasing the potential for harm to both mother and fetus” and “endanger[ing] both [of them].” Id. at 63-64. The statute “should not be
interpreted to create more harm than it seeks to prevent.” *Id.* at 64. As in *Kemp*, charging Dischman with aggravated assault of her fetus threatens far more harm than it seeks to prevent; by refusing to eviscerate the nonliability statute, the court below correctly avoided this unreasonable and absurd result.

The legislative history of the relevant statute likewise confirms that the nonliability provision was intended to apply without limitation to pregnant women’s prenatal conduct. The aggravated assault of a fetus statute, 18 Pa. C.S. § 2606, and its related nonliability provision, 18 Pa. C.S. § 2608(a)(3), were sponsored by Representative Dennis O’Brien, who authored the statute as an amendment to a separate bill pending in the Pennsylvania House of Representatives.2 Senator Melissa Hart later crafted subsequent amendments passed in the Pennsylvania Senate.3 Throughout the legislative process, both Representative O’Brien and Senator Hart repeatedly emphasized that the bill was


not focused on abortion.\textsuperscript{4} Furthermore, immediately before final passage, Representative O’Brien made clear that the nonliability provision applied broadly and was plainly intended to preclude prosecutions such as Dischman’s.

Just prior to final passage, Representative Babette Josephs pointedly asked Representative O’Brien how the law would apply to pregnant women:

Pregnant women all over the country are being inappropriately prosecuted for behavior that somebody considers unhealthy for their fetuses . . . For instance, a woman named Pamela Rae Stewart was prosecuted in California for not getting to her doctor fast enough when she went into labor and for having intercourse too late in her pregnancy. A woman in Wisconsin named Deborah Zimmerman was prosecuted for attempted homicide because she drank alcohol shortly before giving birth. In Florida, a woman named Kawana Ashley was prosecuted for manslaughter felony murder because she shot herself in the stomach when she was 25 to 26 weeks pregnant. In almost every case of this nature, the courts have thrown out the prosecutions\textsuperscript[s] sometimes after the woman has already spent time in prison\. [T]he courts usually base their conclusion on an interpretation that the State legislature could not possibly have meant to criminalize pregnant women’s prenatal conduct.

I am worried [that], in passing SB 45, Pennsylvania will be encouraging the prosecution of pregnant women who engage in arguably unhealthy behavior during their pregnancies. Is it the intention of . . . the bill that it should be used against pregnant women in any way? That is my question.\textsuperscript{5}

\textsuperscript{4} See Pa. Legis. J., 1997 Sess., No. 28 (Apr. 29, 1997), at 871, 874-75; see also id. at 878 (discussing a non-abortion hypothetical situation involving a bartender serving a woman a drink); Pa. Legis. J., 1997 Sess., No. 37 (June 10, 1997), at 732-33 (same, involving an intentional physical assault on a pregnant woman).

Representative O’Brien swiftly referred to the nonliability provision for pregnant women and emphasized that no criminal liability under the bill would be possible in these circumstances:

The answer to that question is, nothing in this chapter shall impose criminal liability upon the pregnant woman in regard to crimes against her unborn child.\(^6\)

In quoting verbatim from the nonliability provision, Representative O’Brien confirmed the plain meaning of the statutory text. Simply put, it “does not impose any criminal penalty for the mother,”\(^7\) regardless of whether her actions were abortion-related, not abortion-related, lawful or unlawful. 18 Pa. C.S. § 2608.

Finally, this Court should be wary of adopting the Commonwealth’s interpretation of the statute because doing so would raise grave questions of constitutional magnitude. One of the basic principles of statutory interpretation is the “canon of constitutional avoidance.” Under this canon, “when a statute is susceptible of two constructions, by one of which grave and doubtful constitutional questions arise and by the other of which such questions are avoided, our duty is to adopt the latter.” \textit{MCI WorldCom, Inc. v. Pa. Pub. Util. Comm’n}, 844 A.2d 1239, 1249-50 (Pa. 2004).

\(^6\) \textit{Id.} at 1541.

As stated above, amici do not believe this statute is “susceptible of two constructions.” *Id.* However, if this Court believes otherwise, adopting the Commonwealth’s position here would raise serious issues of due process notice, reproductive privacy, and equal protection.

Because the nonliability provision plainly exempts any pregnant woman from being prosecuted for aggravated assault of her fetus, interpreting it nonetheless to allow prosecution for substance use would not “give the person of ordinary intelligence a reasonable opportunity to know what is prohibited,” and thus would raise serious questions about whether it is void for vagueness under the due process clause of the federal Constitution. *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972); see U.S. Const. amend. XIV, § 1.

It would also penalize a pregnant woman using drugs for carrying a pregnancy to term, thereby raising the issue of whether the statute violates her due process liberty interest in procreation under the federal and state constitutions. *See, e.g., Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632 (1974); *Roe v. Wade* 410 U.S. 113 (1973); see *In re “B,”* 394 A.2d 419, 425 (Pa. 1978) (explaining that Pennsylvania constitution “parallel[s]” U.S. Constitution, or “provides more rigorous and explicit protection for a person’s right to privacy”).
Furthermore, because the statute would criminalize only pregnant women’s substance use, without criminalizing paternal substance use despite evidence that either can affect fetal health, it would raise equal protection concerns under the federal and state constitutions. See U.S. Const. amend. XIV, § 1; Pa. Const. art. I, § 28.

As recognized by the Pennsylvania Supreme Court, in exempting pregnant women from liability under Section 2608(a)(3), the legislature reasonably sought to avoid the constitutional implications of allowing prosecution of Dischman for crimes against her fetus. See Commonwealth v. Bullock, 913 A.2d 207, 216 (Pa. 2006) (noting that “there are various situations,” including drug use, for which “[pregnant women] alone . . . bear an increased risk of criminal prosecution were it not for the (a)(3) exception”). Rather than confront these grave constitutional issues, this Court should apply the canon of constitutional avoidance and rule in Dischman’s favor.

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III. SUBSTANCE USE DURING PREGNANCY IS A HEALTH CONDITION APPROPRIATELY ADDRESSED BY TREATMENT AND PRENATAL CARE, NOT PUNISHMENT.

a. Threats of state intervention and control lead women to forego treatment and prenatal care and undermine maternal and fetal health.

Virtually all major medical and public health organizations have recognized that punishing women for substance use during pregnancy is counterproductive to public and private health. This is because women with a substance use disorder during pregnancy need prenatal care and treatment. The threat of serious negative consequences for coming forward for treatment drives women away from medical care, thus risking their own and their child’s health.

9 Prenatal care is necessary to prevent negative birth outcomes: regular OB/GYN visits during pregnancy allow for screening and detection of numerous adverse health conditions, and they can lower incidences of stillbirth, newborn death, and maternal mortality. See Nagahawatte, & Goldenberg, Poverty, Maternal Health, and Adverse Pregnancy Outcomes, 1136 ANNALS N.Y. ACADEMY SCIENCES 80 (June 17, 2008), https://nyaspubs.onlinelibrary.wiley.com/doi/epdf.

10 Amici note that not all drug use during pregnancy rises to the level of substance use disorder. Some women use drugs while pregnant and do not have substance use disorders. Nonetheless, punishing pregnant women who use drugs deters them from getting treatment they may need. Substance use disorder treatment can markedly reduce adverse birth outcomes even when the pregnant woman does not entirely abstain from substance use during her pregnancy. See Center on Addiction, Punishments Don’t Help Pregnant Women and New Mothers with Addiction (Feb. 22, 2017), https://www.centeronaddiction.org/the-buzz-blog/punishments-don%e2%80%99t-help-pregnant-women-and-new-mothers-addiction.

11 See Subbaraman et al., Associations Between State-Level Policies Regarding Alcohol Use Among Pregnant Women, Adverse Birth Outcomes, and Prenatal Care Utilization: Results from 1972-2013 Vital Statistics, 42 ALCOHOLISM: CLINICAL & EXPERIMENTAL RESEARCH (forthcoming June 2018) (concluding that states with policies that consider prenatal alcohol use a form of child abuse have worse outcomes than states that do not, that newborns in those states are at greater risk of low birth weight and prematurity, and that pregnant women in those states
For example, the Pennsylvania Department of Health, the state agency charged with overseeing programs combatting the opioid crisis in Pennsylvania, issued guidance on suggested approaches to opioid use during pregnancy:

“Attempts to criminalize [opioid use disorder] in pregnancy should be avoided, as this may deter that patient from obtaining adequate prenatal care for herself and the fetus.”

Other public health authorities agree that the threat of punitive sanctions places pregnant women in an impossible situation, forcing them to choose between risking punishment for seeking health care and managing pregnancy on their own. For instance, the March of Dimes, one of the leading non-profit organizations committed to the health of mothers and babies, has stated unequivocally: “The March of Dimes opposes policies and programs that impose punitive measures on pregnant women who use or abuse drugs.”

are less likely to utilize prenatal care). The article is not yet available publicly, but a presentation about the findings from the authors is available at http://files.www.alcoholpolicyconference.org/presentations/C-9_AP18_-_ROBERTS__SUBBARAMAN.pdf.


Pregnant women who are addicted to opioids often do not seek prenatal care until late in pregnancy because they are worried that they will be stigmatized or that their newborn will be taken away. The March of Dimes supports policy interventions that enable women to access services in order to promote a healthy pregnancy and build a healthy family.\(^{14}\)

The American Academy of Pediatrics (AAP) also made a clear statement about this issue in response to the recent increase in opioid use: “The AAP reaffirms its position that punitive measures taken toward pregnant women are not in the best interest of the health of the mother-infant dyad.”\(^{15}\) The AAP opposes punitive responses because they “are ineffective and may have detrimental effects on both maternal and child health.”\(^{16}\)

The National Perinatal Association is the leading voice of professionals who care for newborns immediately after birth. This organization has also cautioned against a punitive approach through either the criminal or child welfare system because of its adverse effect on maternal and child health:

Treating this personal and public health issue [perinatal substance use] as a criminal issue—or a deficiency in parenting that warrants child welfare intervention—results in pregnant and parenting people avoiding prenatal and obstetric care and putting the health of

\(^{14}\) Id.


\(^{16}\) Id. at 3.
themselves and their infants at increased risk. Parents are rightly and understandably fearful that seeking prenatal care, disclosing substance use, and initiating treatment for a Substance Use Disorder may result in harmful and punitive child welfare involvement. This, unfortunately, increases the risk of obstetrical complications, preterm birth, and delivery of low birth weight infants.\footnote{National Perinatal Association, \textit{Position Statement 2017: Perinatal Substance Use 2}, http://www.nationalperinatal.org/resources/Documents/Position\%20Papers/2017_Perinatal\%20Substance\%20Use_NPA\%20Position\%20Statement.pdf.}

The American College of Obstetricians and Gynecologists, the leading organization of women’s health care physicians, has taken a position that explicitly denounces both criminal and civil sanctions for pregnant women:

> Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing. Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes.\footnote{Committee on Health Care for Underserved Women, Am. Coll. of Obstetricians & Gynecologists, \textit{Committee Opinion 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist} (2011, reaffirmed 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co473.pdf?dmc=1&ts=20151215T1226107964.}

The American Medical Association, perhaps the leading generalist medical organization in the country, agrees. In a revised 2017 policy statement, the organization wrote that “[t]ransplacental drug transfer should not be subject to
criminal sanctions or civil liability.”19 Instead, the organization recommends that “[p]regnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation.”20

The American Society of Addiction Medicine, a professional medical society representing health care professionals in the field of addiction medicine, opposes state punitive measures against women for taking drugs while pregnant. In a statement that focuses on opioid use, the organization concludes: “State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as ‘child abuse or maltreatment,’ and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care services for these women.”21

Indeed, there is virtual unanimity among national public health authorities that the criminalization of drug use during pregnancy is counterproductive. The


20 Id.

American Academy of Family Physicians, the American Public Health Association, the American Nurses Association, the American Psychiatric Association, and the American Psychological Association are among these organizations.22

The criminalization of pregnancy would worsen an already dire state of maternal and fetal health by driving more women away from health care, and it would discourage them from communicating honestly with their health care providers. It is increasingly dangerous to be pregnant and give birth in the United States. In fact, women in the United States are less likely to survive pregnancy than women in other developed countries.23 Alarmingingly, the number of women dying due to complications from pregnancy and childbirth is rising in the United States, whereas maternal mortality rates are decreasing elsewhere.24 In the United States, maternal mortality more than doubled between 2000 and 2014, increasing


23 See MacDorman et al., Recent Increases in the U.S. Maternal Mortality Rate, 128 OBSTETRICS & GYNECOLOGY 447 (2016).

24 Id. (finding that 157 of 183 countries studied had decreases in maternal mortality rates from 2000 to 2013).
from 9.8 maternal deaths per 100,000 live births to 21.5 maternal deaths.\textsuperscript{25} By 2016, this rate has risen to 28 maternal deaths.\textsuperscript{26} In fact, the Centers for Disease Control and Prevention reports approximately 700 women are dying of pregnancy complications each year.\textsuperscript{27} Driving pregnant and parenting people away from prenatal and obstetric care will worsen this public health crisis.

The implications of criminalizing drug use during pregnancy extend beyond immediate health concerns, including devastating effects on a woman and her family’s safety and financial security. For example, prior criminal history may result in restrictions on child custody or ability to adopt\textsuperscript{28} or in the inability to find employment, housing, and receive student financial aid.\textsuperscript{29}

\textsuperscript{25} \textit{Id.}


Moreover, the risk of dying from pregnancy or childbirth does not fall equally on all women. Women of color are more likely to die from pregnancy-related causes than their white counterparts. \textit{See infra} Part III.b.


Criminalizing pregnancy is not only counterproductive public health policy; it also serves no criminal justice purpose. See Commonwealth v. Heck, 491 A.2d 212, 224 (Pa. Super. Ct. 1985) (noting that “principal preferred purposes” of criminal justice are deterrence, rehabilitation, and incapacitation). Punitive measures typically do not cure individuals with substance use disorders or deter them from using drugs. Moreover, punitive measures fail to prevent further harm to the fetus, because measures that hurt the woman also hurt the fetus she is carrying.

Because prosecuting women for their conduct during pregnancy fulfills neither a public health nor a criminal justice purpose, this Court should affirm the ruling below.


b. Punishing women for their conduct during pregnancy will disproportionately harm poor women and women of color.

It is no coincidence that the criminalization of pregnant women’s conduct would have its harshest impact on poor women and women of color. The intersection of gender, race, and poverty creates conditions that exacerbate risk factors for pregnant women. 32 Black women are three times as likely as white women to die during pregnancy. 33 They are twice as likely to experience stillbirth, nearly twice as likely to deliver preterm (i.e., before 37 weeks). 34

Infant mortality in America for Black infants is now more than double that of white infants. 35 In Pennsylvania, compared to white infants, Black infants are


33 Ctrs. for Disease Control & Prevention, Pregnancy Mortality Surveillance System, (updated Nov. 2017), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html (reporting the Black maternal mortality rate at 43.5 deaths per 100,000 live births compared to 12.7 for white women and 14.4 for other races).

34 Ctrs. for Disease Control & Prevention, Preterm Birth (updated Apr. 24, 2018), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm (showing that, in 2016, the rate of preterm birth among Black women (14%) was approximately 50 percent higher than the rate of preterm birth among white women (9%)).

35 Ctrs. for Disease Control & Prevention, Infant Mortality (updated Jan. 2018), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (reporting the Black infant mortality rate at 11.3% per 1,000 live births compared to 4.9% among white infants).
2.4 times as likely to die before their first birthday.⁶⁶ These findings hold across socioeconomic strata, even comparing births among low-income white parents without a high school education to births among educated middle-class Black parents.⁶⁷ Moreover, racial disparities in infant mortality rates also persist for Latino babies: in Pennsylvania, compared to a rate of 5.21 in 1,000 live births for white infants, the Latino infant mortality rate is nearly 7 in 1,000 live births.⁶⁸

Tragically, the very populations that suffer the greatest risk of maternal and infant mortality also experience the worst barriers to prenatal care and substance use disorder treatment. Poor women and women of color are more likely to encounter multiple barriers to prenatal care, including lack of insurance or transportation, depression, fear of reprisal, social stigma, and other poverty-related barriers.⁶⁹ Women in these populations may underutilize substance use disorder treatment for a number of reasons, such as lack of available treatment programs⁷⁰.

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⁶⁷ See Reeves & Matthew, 6 Charts Showing Race Gaps Within the American Middle Class (Oct. 21, 2016), https://www.brookings.edu/blog/social-mobility-memos/2016/10/21/6-charts-showing-race-gaps-within-the-american-middle-class.

⁶⁸ Mathews et al., supra note 36, at 17, tbl.2.

⁶⁹ Nagahawatte & Goldenberg, supra note 9.

⁷⁰ Data from the 2012 National Survey of Substance Abuse Treatment Services indicate that only 13% of outpatient substance-use treatment facilities and 13% of residential treatment
or treatment facilities’ refusal to allow children to remain at the treatment facility with their mother, which forces women to choose between inpatient treatment and custody of their children.\footnote{Based on 2012 data, only about 1 in 5 (18\%) outpatient treatment facilities with specialized programs for pregnant or postpartum women offered child care services. Smith & Lipari, \textit{supra} note 40. The numbers were lower for inpatient programs, with 15\% offering child care services and 12\% reporting residential beds for children. \textit{Id.}}

The stigma that already functions as a barrier to prenatal care and substance use disorder treatment would be enormously compounded if pregnant women’s conduct is criminalized.\footnote{See \textit{Stone, Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care}, 3 \textit{Health & Justice} No. 2, at 7 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5151516/pdf/40352_2015_Article_15.pdf (“The most common strategy employed by women afraid of detection was avoidance of medical care . . . ”).} The very women at highest risk of pregnancy-related morbidity and mortality would be driven away from care. The honest and open flow of information between patient and clinician would be shut down. Furthermore, poor, Black, and Latina women, disproportionately suffering the worst pregnancy outcomes, would also be disproportionately subject to investigation and prosecution for fetal abuse.
Indeed, where such prosecutions have been attempted, it is striking how frequently the defendants are poor women and women of color. To date, pregnancy criminalization laws have been disproportionately enforced against poor women, Black women, and other women of color.\textsuperscript{43} The largest systematic study of these cases, analyzing 413 arrests and forced interventions over 30 years, found that 71\% of cases were brought against low-income women who qualified for indigent defense.\textsuperscript{44} Of the 368 cases where race information was available, 59\% involved women of color, most of which were Black women (52\% of the 368 cases).\textsuperscript{45}

There is ample evidence that racial bias has played a significant role in whether pregnant patients are reported by medical providers to authorities for perceived substance use violations. One study found that during a six-month period, despite Black women having the same incidence of substance use during

\textsuperscript{43} Amnesty Int’l, supra note 29, at 10. For example, after Tennessee in 2014 became the first state to criminalize giving birth to a baby showing signs of narcotic exposure, most convictions under that law occurred in rural eastern Tennessee—an area with high poverty and lacking drug treatment facilities—and in Memphis, which has a high Black population. \textit{Id.} at 7. Along similar lines, since the enactment of a similar law in Alabama in 2006, 89\% of the 479 women prosecuted under that law were unable to afford legal representation. \textit{Id.} at 8.


\textsuperscript{45} \textit{Id} at 311.
pregnancy as white women, Black women were reported to health authorities ten
times more often than white women.\footnote{Chasnoff et al., \textit{The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida}, 322 NEW ENGLAND J. MED. 1202, 1202 (1990), https://www.nejm.org/doi/pdf/10.1056/NEJM199004263221706.} Similar racial bias in reporting occurred in \textit{Ferguson v. City of Charleston}, where Medical University of South Carolina hospital patients sued the hospital for colluding with police and prosecutors to conduct warrantless drug searches on pregnant women’s body fluids, the results of which the hospital then disclosed to law enforcement authorities. 532 U.S. 67, 22 (2001). Black women comprised of all but one of the women prosecuted under this unconstitutional policy. \textit{Id.} at 23.\footnote{The one white patient resided with her Black boyfriend—a fact noted in her medical records. Goodwin, \textit{How the Criminalization of Pregnancy Robs Women of Reproductive Autonomy}, 47 HASTINGS CTR. REPORT, No. 6, at 19, 23 https://onlinelibrary.wiley.com/doi/epdf/10.1002/hast.791.} Should the Court adopt the Commonwealth’s interpretation of Section 2606, there is every reason to expect that poor women, Black women, and Latinas—the very people most at risk for catastrophic pregnancy outcomes—will be deterred from seeking life-saving medical care.
IV. APPLYING SECTION 2606(a) TO PREGNANT WOMEN’S CONDUCT WILL IMPROPERLY INVOLVE THE STATE IN INTRUSIVE POLICING OF PREGNANT WOMEN.

In Pennsylvania between 2014 and 2016, 8.2% of all infants were born with low birth weight and 9.4% of all infants were born preterm. Birth defects—structural changes present at birth, ranging from mild to severe—are common in the United States. If Section 2606(a) is construed to impose criminal liability on a pregnant woman for conduct alleged to have harmed her fetus, any woman with a negative birth outcome could be subject to criminal investigation.

An array of factors beyond the pregnant woman’s control may contribute to adverse birth outcomes: certain health conditions, social and economic circumstances, and environmental factors. Several studies show that pregnant women who are exposed to tobacco smoke or lead are at risk for preterm birth, low birth weight, and possibly fetal death or miscarriage.


The Commonwealth’s reassurance that pregnant women would not be prosecuted for otherwise legal but unhealthy conduct is misguided. There is no reason to doubt that the Commonwealth’s interpretation of 18 Pa. C.S. § 2606(a) could lead to prosecuting pregnant women for engaging in legal activity if it caused, or was perceived to have caused, harm to the fetus. In fact, pregnant women across the country have faced criminal charges for engaging in non-criminal activity alleged to have harmed the fetus.51

Adopting the Commonwealth’s expansive reading of the statute would infringe the fundamental constitutional right of reproductive autonomy. The U.S. Supreme Court has long recognized that the Due Process Clause protects the right “to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”


51 See Amnesty International, _supra_ note 29, at 18 (reporting that pregnant women have been charged under fetal assault and fetal endangerment laws for driving without a seatbelt, falling down stairs, attempting suicide, and refusing medical interventions).
chooses to avoid prosecution by terminating her pregnancy, because continuing her pregnancy would be a criminal act, her reproductive choice is no choice at all. Ironically, the very statutes created to protect fetuses could, if turned against pregnant women, create a powerful incentive for termination of wanted pregnancies.

This unintended consequence is a real concern. In North Dakota, a woman obtained an abortion in order to moot a criminal prosecution for her substance use during pregnancy. *State v. Greywind*, No. CR-92-447 (N.D. Cass County Ct. Apr. 10, 1992). After Tennessee passed a “fetal assault” law, which criminalized giving birth to a child with symptoms of prenatal exposure to narcotics, Tenn. Code Ann. § 39-13-107 (2015), Amnesty International reported that a Tennessee woman battling substance use disorder had an abortion, partly motivated by her “[f]ear that a rogue prosecutor could prosecute her.”\(^{52}\) Concern that “[p]rosecution of pregnant women for engaging in activities harmful to their fetuses or newborns may also unwittingly increase the incidence of abortion” led the Florida Supreme Court to reject an effort to criminalize pregnancy in that state. *Johnson v. State*, 602 So. 2d 1288, 1296 (Fla. 1992).

\(^{52}\) Amnesty International, *supra* note 29, at 34.
The choice between, on the one hand, giving birth and being criminally charged, or, on the other, terminating a pregnancy, is no choice at all. Criminal prosecution in this case would serve as a powerful deterrent to carrying a wanted pregnancy to term. For that reason, the Commonwealth’s interpretation of Section 2606(a) would violate a pregnant woman’s fundamental right to decide if, when, and how to form a family. Because both legal and illegal behavior that could adversely affect a fetus would be subject to state scrutiny and regulation, the Commonwealth’s interpretation would open the door to a nightmarish loss of autonomy for pregnant people.
CONCLUSION

For these reasons, as well as those set forth in the Brief for Appellee, amici respectfully urge the Court to affirm the ruling below.

Respectfully submitted,

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CERTIFICATE OF WORD COUNT COMPLIANCE

Pursuant to Pa. R. App. P. 2135, the text of this *amicus curiae* brief consists of 6,658 words as determined by the Microsoft Word word-processing program used to generate this document.

Dated: June 4, 2018

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CERTIFICATE OF COMPLIANCE WITH PUBLIC ACCESS POLICY

I certify that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

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APPENDIX OF INDIVIDUAL STATEMENTS OF AMICI CURIAE

ORGANIZATIONS

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN—PENNSYLVANIA

In 1881, the American Association of University Women (AAUW) was founded by like-minded women who defied society’s conventions by earning twenty-seven college degrees. Since then it has worked to increase women’s access to higher education through research, advocacy, and philanthropy. Today, AAUW-Pennsylvania has more than 5,000 members and supporters, 36 branches, and 50 college and university partners statewide. AAUW-Pennsylvania plays a major role in mobilizing advocates statewide on AAUW’s public policy goals to educate citizens about the impact of public policies on women and girls and to advocate for policies that will advance equity for women and girls. In adherence with its member-adopted Public Policy Priorities, AAUW Pennsylvania is a staunch advocate for measures that guarantee equality, individual rights and social justice including self-determination of one's reproductive health decisions.

CALIFORNIA WOMEN’S LAW CENTER

The California Women’s Law Center (CWLC) is a statewide, nonprofit law and policy center dedicated to advancing the civil rights of women and girls through impact litigation, policy advocacy and education. CWLC’s issue priorities include gender discrimination, reproductive justice, violence against women, and women’s health. Since its inception in 1989, CWLC has placed an emphasis on eliminating all forms of gender discrimination, including discrimination against pregnant women. CWLC is committed to addressing the disparities facing incarcerated women, with an emphasis on the inequities facing pregnant women in incarceration.

COMMUNITY LEGAL SERVICES, INC.

Community Legal Services, Inc. (CLS) has served the legal needs of low-income Philadelphia residents by providing them with advice and representation in civil matters, advocating for their legal rights, and conducting community education about legal issues for over 50 years. The Family Advocacy Unit (FAU) is a unit within CLS which provides high quality representation to hundreds of parents each year in Philadelphia dependency and termination of
parental rights proceedings. As part of its mission, the FAU works to ensure that low-income vulnerable families involved with the child welfare system receive the due process to which they are entitled and have meaningful access to justice in these extremely important proceedings. In addition to individual client representation, the FAU engages in policy advocacy and continuing legal education at both a statewide and local level to improve outcomes for children and families.

DELAWARE COUNTY WOMEN’S CENTER

Delaware County Women’s Center (DCWC) is a state licensed private doctor’s office that has a professional medical team specializing in medication abortion services up to ten weeks of pregnancy. We provide compassionate abortion care and reproductive health services, inspired by our belief in the autonomy of the individual, and our commitment to strengthening communities and building a better future. We believe that threatening policies against substance-using women will discourage them from seeking medical care or treatment during their pregnancy for fear of facing legal penalization. No one should have to sacrifice their health in order to avoid punitive action.

DRUG POLICY ALLIANCE

The Drug Policy Alliance (DPA) is a 501(c)(3) nonprofit organization that leads the nation in promoting drug policies that are grounded in science, compassion, health, and human rights. Established in 1994, DPA is a nonprofit, non-partisan organization with more than 20,000 members nationwide. DPA is dedicated to advancing policies that reduce the harms of drug use and drug prohibition, and seeking solutions that promote public health and public safety. DPA is actively involved in the legislative process across the country and strives to roll back the excesses of the drug war, block new, harmful initiatives, and promote sensible drug policy reforms. The organization also regularly files legal briefs as amicus curiae, including in other cases pertaining to pregnant women who use drugs. See, e.g., In the Interest of: L.J.B., a Minor, No. 10 MAP 2018 (Pa. 2018).

FAMILIES FOR SENSIBLE DRUG POLICY

Families for Sensible Drug Policy (FSDP), a 501(c)(3) nonprofit organization cofounded by Barry Lessin and Carol Katz Beyer, is a global coalition of families, professionals, and organizations representing the voice of the family impacted by substance use and the harms of existing drug policies. We empower families by advancing and implementing a new paradigm of comprehensive care
and progressive solutions for family support based on science, compassion, public health and human rights.

We support existing criminal statutes that provide immunity protecting pregnant women from prosecution for conduct during their pregnancy, as well as existing public health policies designed to protect pregnant women based on evidence that punishing them can prevent them from getting the care they need. We also know that punitive measures disproportionately harm poor women and women of color.

GENDER JUSTICE

Gender Justice is a nonprofit legal advocacy organization based in the Midwest that eliminates gender barriers through impact litigation, policy advocacy, and education. As part of its impact litigation program, Gender Justice acts as counsel in cases involving gender equality in the Midwest region, including advocating for abortion rights and reproductive justice for all. Gender Justice also participates as amicus curiae in cases that have an impact in the region. The organization has an interest in protecting the legal rights of pregnant persons.

LEGAL VOICE

Legal Voice is a non-profit public interest organization that works in the Pacific Northwest to advance the legal rights of women through public impact litigation, legislation, and legal rights education. Since its founding in 1978 (as the Northwest Women’s Law Center), Legal Voice has been dedicated to protecting and expanding women’s legal rights. Toward that end, Legal Voice has advocated for legislation protecting pregnant persons' rights, including their rights to be free from shackling if they are incarcerated and pregnant or in labor. In addition, Legal Voice has participated as counsel and as amicus curiae in the Pacific Northwest and across the country in numerous cases involving the rights of pregnant and birthing women. Legal Voice opposes, and has successfully challenged, prosecutions of women for their pregnancy outcomes and works to end punitive measure that undermine the humanity and legal rights of all pregnant people.

MATERNITY CARE COALITION

Since 1980, Maternity Care Coalition (MCC) has assisted more than 100,000 families throughout Southeastern Pennsylvania, focusing particularly on neighborhoods with high rates of poverty, infant mortality, health disparities, and changing immigration patterns. We know a family’s needs change as they go
through the pregnancy and their child’s first years and we offer a range of services and programs for every step along the way including helping families dealing with substance use disorder and child abuse. MCC works with families on the frontline starting with our home visiting programs that help parents with programs which strengthens families, promotes positive parenting practices and encourages early learning. Evidence-based parenting skills are taught that help reduce child abuse and neglect. In addition MCC has programs working with high risk women suffering from behavioral health issues including substance use disorder. MCC works with babies diagnosed with neonatal abstinence syndrome providing home visiting support, which is part of the plan of safe care for the baby. MCC engages in advocacy supporting regional and state efforts addressing the opioid epidemic.

MEDIA MOBILIZING PROJECT

The Media Mobilizing Project helps to support and organize with myriad low income community members and organizations in our home city of Philadelphia. We also organize directly with groups who try to reduce harm in neighborhoods struggling with live drug addiction. Women struggling with drug addiction need support to preserve their health and that of their families. Prosecuting women in the throes of addiction and poverty hurts them, their families, and our entire community.

NATIONAL ADVOCATES FOR PREGNANT WOMEN

National Advocates for Pregnant Women (NAPW) is a non-profit organization that advocates for the rights, health, and dignity of all women, focusing particularly on pregnant and parenting women, and those who are most likely to be targeted for state control and punishment. Through litigation, representation of medical and public health organizations and experts as amicus, and through public education, NAPW works to ensure that women do not lose their constitutional, civil, and human rights as a result of pregnancy. The organization also conducts research, and has published a peer-reviewed study on prosecutions of and forced medical interventions on pregnant women. NAPW believes that health and welfare should be addressed as health issues, not as crimes, and promotes policies that actually protect maternal, fetal, and child health.

NEW VOICES FOR REPRODUCTIVE JUSTICE

New Voices for Reproductive Justice is a Human Rights and Reproductive Justice advocacy organization with a mission to build a social change movement dedicated to the full health and well-being of Black women, femmes, and girls in
Pennsylvania and Ohio. Since 2004, the organization has served over 75,000 women of color and LGBTQIA+ people of color, through community organizing, grassroots activism, civic engagement, youth mentorship, leadership development, culture change, public policy advocacy and political education. New Voices defines Reproductive Justice as the human right of all people to have full agency over their bodies, gender identity and expression, sexuality, work, reproduction and the ability to form and raise families. New Voices stands in staunch opposition to laws, policies, decisions, and actions that criminalize birth outcomes and pregnant women who have used substances during pregnancy. Such criminalization deters mothers who may be struggling with addiction from seeking care and unequally harms women of color and poor women who are disproportionately punished by the criminal justice system and who are uniquely affected by roadblocks to treatment and care. Women of color, furthermore, experience higher rates of pregnancy-related maternal deaths and infant mortality for a number of reasons, including the pervasive effects of institutional racism, stress, and barriers to comprehensive reproductive healthcare. For example, in Pennsylvania, Black women comprise 11% of the population and yet account for 31% of all pregnancy-related maternal deaths. Additionally, Black infants in Pennsylvania are 2.4 times as likely to die before their first birthday than white children. For Black women, these adverse outcomes exist across income brackets and regardless of education level. New Voices firmly believes that rather than criminalizing mothers, lawmakers should work to increase access to a full range of pregnancy-related and maternal care, including substance treatment care.

Pennsylvania Coalition Against Domestic Violence

The Pennsylvania Coalition Against Domestic Violence (PCADV) is a private nonprofit organization working at the state and national levels to eliminate domestic violence, secure justice for victims, enhance safety for families and communities, and create lasting systems and social change. PCADV was established in 1976 as the nation’s first domestic violence coalition, and is now comprised of 60 funded community-based domestic violence programs across Pennsylvania, providing a range of life-saving services, including shelters, hotlines, counseling programs, safe home networks, medical advocacy projects, transitional housing and civil legal services for victims of abuse and their children. Current PCADV initiatives provide training and support to further advocacy on behalf of victims of domestic violence and their children.
PENNSYLVANIA RELIGIOUS COALITION FOR REPRODUCTIVE JUSTICE

The mission of the Pennsylvania Religious Coalition for Reproductive Justice is to educate, serve, witness and advocate for reproductive justice as a spiritual and moral issue of our day. We support reproductive justice because of our faith. Accordingly, we are called to support this amicus brief in Commonwealth v. Dischman because Dischman deserves our support as a child of God, created in the likeness and image of God.

PENNSYLVANIA STATE NURSES ASSOCIATION

The Pennsylvania State Nurses Association (PSNA) is a nursing professional organization that advocates on behalf of over 212,000 registered nurses in Pennsylvania. PSNA believes that jeopardizing policies against substance-using women will discourage them from seeking medical care or treatment during their pregnancy for fear of facing legal penalization. Penalizing women would increase the risk of poor health outcomes for themselves and their children. No one should have to sacrifice their health in order to avoid punitive action.

PHILADELPHIA WOMEN’S CENTER

Philadelphia Women’s Center (PWC) has been continually meeting the needs of women and families by providing professional, confidential and compassionate abortion care since 1972. PWC provides compassionate abortion care and reproductive health services, inspired by our belief in the autonomy of the individual, and our commitment to strengthening communities and building a better future. We believe that threatening policies against substance-using women will discourage them from seeking medical care or treatment during their pregnancy for fear of facing legal penalization. No one should have to sacrifice their health in order to avoid punitive action.

PLANNED PARENTHOOD PENNSYLVANIA ADVOCATES

In partnership with the three Planned Parenthood affiliates in Pennsylvania, Planned Parenthood Pennsylvania Advocates, the state public affairs office in Harrisburg, works to achieve maximum public, governmental and media support for reproductive health care by developing, implementing and facilitating a statewide strategy. Planned Parenthood Pennsylvania Advocates supports the Women’s Law Project’s amicus brief in Commonwealth v. Dischman. We believe that pregnant people should always be encouraged to seek treatment throughout
their pregnancies. Punishing pregnant people for certain conduct during a pregnancy only deters them from seeking medical care for themselves and increases the risk of poor health outcomes for themselves and their children. We also know that punitive measures disproportionately harm poor women and women of color, groups that already face higher barriers to accessing healthcare.

**SUPPORT CENTER FOR CHILD ADVOCATES**

Support Center for Child Advocates ("Child Advocates") provides legal assistance and social service advocacy for abused and neglected children in Philadelphia, Pennsylvania. Representing more than 1,000 children each year, Child Advocates protects children by securing social services, finding alternative homes, and helping children testify in court. Respected for diligent and effective advocacy throughout more than 40 years, Child Advocates works to ensure safety, health, education, family permanency and access to justice for all children committed to their care. Systemically, Child Advocates promotes collaborative, multi-disciplinary casework, and solutions to recurrent problems.

**WOMEN AND GIRLS FOUNDATION**

The Women and Girls Foundation (WGF) is a non-profit organization with expertise in the economic security of women and vulnerable families. For over a dozen years, WGF has been involved in publishing research on the status of women in Pennsylvania. WGF is especially focused on working with community leaders to create informed policies which can help strengthen the health and economic security of vulnerable families, such as those struggling with substance use disorders.

**WOMEN’S LAW CENTER OF MARYLAND, INC.**

The Women’s Law Center of Maryland, Inc. is a nonprofit, public interest, membership organization of attorneys and community members with a mission of improving and protecting the legal rights of women. Established in 1971, the Women’s Law Center achieves its mission through direct legal representation, research, policy analysis, legislative initiatives, education and implementation of innovative legal-services programs to pave the way for systematic change. The Women’s Law Center is participating as an amicus in Commonwealth v. Dischman because, in particular, the Women’s Law Center seeks to ensure the physical safety, economic security, and autonomy of women, and that goal cannot be achieved unless all women have full sovereignty related to their reproductive choices.
WOMEN’S LAW PROJECT

The Women’s Law Project (WLP) is a non-profit public interest law firm with offices in Philadelphia and Pittsburgh, Pennsylvania. Founded in 1974, the WLP is dedicated to creating a more just and equitable society by advancing the rights and status of women through high-impact litigation, advocacy, and education. Throughout its history, the WLP has played a leading role in the struggle to eliminate discrimination against women based on pregnancy and reproductive capacity, representing women and amici curiae in a number of cases involving the improper application of state criminal, child abuse, and drug delivery statutes to pregnant women and to new mothers who have given birth while suffering from a substance use disorder. The WLP believes that it is both unjust and counterproductive to impose criminal sanctions on pregnant women with untreated substance use issues. Instead of prosecuting and incarcerating these women, the WLP believes that it is fairer and more effective to make appropriate treatment, including prenatal care and supportive services, available to women throughout their pregnancies.

WOMEN’S MEDICAL FUND

Women’s Medical Fund ensures and expands abortion access for low-income women and teens through direct service and community mobilization. Attempts to criminalize drug use during pregnancy under the guise of promoting maternal and child health are violent. When we threaten to punish people for drug use during pregnancy, we jeopardize their health by deterring them from accessing care—including prenatal care and drug treatment. From other similar attempts to police pregnancy, we know that enforcement of such laws falls disproportionately on low-income women and women of color. Rather than attempting to punish and control drug use during pregnancy, Women’s Medical Fund calls on Pennsylvania officials to work harder to ensure access to all reproductive health care services—including prenatal healthcare and drug treatment programs.
AVIK CHATTERJEE, MD, MPH

Avik Chatterjee, MD, MPH, is a physician at Boston Health Care for the Homeless Program and Instructor at Harvard Medical School. He is board-certified in pediatrics, internal medicine, and addiction medicine. He works with men and women, including mothers and pregnant women, with opioid use disorder. He has published papers about opioid use disorder in top-tier journals, and he has presented at regional and national conferences on this topic as well. Engaging pregnant women in treatment for substance use disorders is incredibly important, because treatment of substance use disorders during pregnancy can help both the mother and the future child. But stigma is a major barrier for individuals who use substances seeking treatment. Dr. Chatterjee believes that allowing prosecution of women for overdosing during pregnancy as a criminal act against their fetus would drive many vulnerable women away from lifesaving prenatal and addiction care—and this sort of penalty would result in untold harm to mothers (and their future babies) by driving them away from seeking help when they most need it.

HENDRÉE JONES, PhD

Hendrée Jones, PhD, is a Professor in the Department of Obstetrics and Gynecology, School of Medicine, University of North Carolina, Chapel Hill and Executive Director of Horizons, a comprehensive drug treatment program for pregnant and parenting women and their drug-exposed children. She is also an Adjunct Professor in the Department of Psychiatry and Behavioral Sciences and in the Department of Obstetrics and Gynecology, School of Medicine, Johns Hopkins University. Dr. Jones is an internationally recognized expert in the development and examination of both behavioral and pharmacologic treatments of pregnant women and their children in risky life situations. Dr. Jones has received continuous funding from the United States National Institutes of Health since 1994 and has published over 190 peer-reviewed publications, two books on treating substance use disorders (one for pregnant and parenting women and the other for a more general population of patients), several book and textbook chapters, and multiple editorial letters and non-peer reviewed articles for clinicians. She is a consultant for The Substance Abuse and Mental Health Services Administration,

53 The individual amici’s views do not represent those of their respective institutions. Institutional affiliations are included for identification purposes only.
the United Nations, and the World Health Organization. Dr. Jones leads or is involved in projects in Afghanistan, India, the Southern Cone, the Republic of Georgia, South Africa, and the United States that are focused on improving the lives of children, women, and families.

STEPHEN R. KANDALL, MD, FAAP

Stephen Kandall, MD, FAAP, graduated from Harvard College *magna cum laude* and from New York University School of Medicine. He is board-certified in Pediatrics and Neonatal-Perinatal Medicine and ended his academic career as Chief of Neonatology at Beth Israel Medical Center in New York and Professor of Pediatrics at the Albert Einstein College of Medicine. He served as President of the New York Pediatric Society, the New York Perinatal Society, and his 2100 pediatrician chapter of the American Academy of Pediatrics. Dr. Kandall also chaired the Federal panel on “Improving Treatment for Drug-Exposed Infants.” Most of Dr. Kandall’s 90 articles and textbook chapters deal with perinatal drug issues, and his own history text, “Substance and Shadow: Women and Addiction in the United States,” was published by Harvard University Press. Dr. Kandall has lectured throughout the United States, Europe and Australia. His many radio and television appearances include the Oprah Winfrey Show and the Joan Lunden Show. He remains extremely active in advocacy, and continues to serve on local, statewide and national advisory groups on perinatal drug issues.

MISHKA TERPLAN, MD, MPH, FACOG, DFASAM

Mishka Terplan, MD, MPH, FACOG, DFASAM, is a Professor of Obstetrics & Gynecology and Psychiatry, Associate Director of Addiction Medicine, and Medical Director of MOTIVATE (an outpatient office-based opioid-treatment clinic) at Virginia Commonwealth University. He is board-certified in both OB/GYN and Addiction Medicine, the Addiction Medicine Consultant for Virginia Medicaid and a consultant for the National Center on Substance Abuse and Child Welfare. He has published over 70 peer-review articles and several book chapters and has active grant funding most focused along the intersections of reproductive and behavioral health. For almost two decades, he has worked with pregnant women with addiction, and he has never met a pregnant woman who displayed no concern for the health of her baby-to-be. Addiction is a brain-centered condition for which evidence-based treatment exists and works. Relapse rates for addiction treatment are similar to other chronic conditions including hypertension, diabetes, asthma and depression. Treatment success is arguably the greatest during pregnancy due both to increased health
insurance coverage and maternal motivation for change. Hence the salient public health and clinical distinction is between treated and untreated addiction. It appears that Ms. Dischman had untreated (or undertreated) addiction. People who use heroin have no control over the quality of the product which they use. Almost all overdoses are unintentional and result from heroin that has been contaminated with fentanyl and other potent synthetic opioids. Prosecuting Ms. Dischman for the disease of addiction is discriminatory, immoral and ineffective.

BRUCE TRIGG, MD

Bruce Trigg, MD, is a pediatrician and public health physician who has worked in the field of addiction medicine for the past decade. He is currently a consultant on the treatment of opioid use disorder with medications for addiction treatment for the New York State Department of Health; the AIDS Institute; and Office of Drug User Health in the Montana Department of Health and Human Services. Dr. Trigg is also the Interim Medical Director for the Harm Reduction Coalition, a national advocacy and training organization.

TRICIA D. WRIGHT, MD, MS

Tricia D. Wright, MD, MS, is a specialist in treating pregnant women with substance use disorders. Over forty years of research shows that punitive measures—such as those used in this case—serve to worsen prenatal outcomes for women and children, by preventing women from obtaining prenatal care and addiction treatment. The best outcomes for women and children are when women are treated in a comprehensive care environment without judgment and allowed to parent their children. Women who use substances during pregnancy are much more likely to be victims themselves of childhood sexual assault and interpersonal violence, and they do not deserve to be further victimized by our court system.
Women increasingly face criminal charges for giving birth to infants who test positive for drugs. Most of the women prosecuted are poor, Black, and addicted to crack cocaine. In this Article, Professor Roberts seeks to add the perspective of poor Black women to the current debate over protecting fetal rights at the expense of women's rights. Based on the presumption that Black women experience several forms of oppression simultaneously, the author argues that the punishment of drug addicts who choose to carry their pregnancies to term violates their constitutional rights to equal protection and privacy regarding their reproductive choices. She begins by placing these prosecutions in the context of the historical devaluation of Black women as mothers. After presenting her view of the prosecutions as punishing drug-addicted women for having babies, the author argues that this punishment violates the equal protection clause because it stems from and perpetuates Black subordination. Finally, Professor Roberts argues that the prosecutions violate women's constitutional rights to autonomy and freedom from invidious government standards for childbearing. In presenting her view that the prosecutions violate women's privacy rights, the author critiques the liberal, “negative” conception of privacy rooted in freedom from government constraints. She concludes by advocating a progressive concept of privacy that places an affirmative obligation on the government to guarantee individual rights and recognizes the connection between the right of privacy and racial equality.
I. INTRODUCTION

A growing number of women across the country have been charged with criminal offenses after giving birth to babies who test positive for drugs. The majority of these women, like Jennifer Johnson, are poor and Black. Most are addicted to crack cocaine. The prosecution of drug-addicted mothers is part of an alarming trend towards greater state intervention into the lives of pregnant women under the rationale of protecting the fetus from harm. This intervention has included compelled medical treatment, greater restrictions on abortion, and increased supervision of pregnant women’s conduct.

*1422 Such government intrusion is particularly harsh for poor women of color. They are the least likely to obtain adequate prenatal care, the most vulnerable to government monitoring, and the least able to conform to the white, middle-class standard of motherhood. They are therefore the primary targets of government control.

The prosecution of drug-addicted mothers implicates two fundamental tensions. First, punishing a woman for using drugs during pregnancy pits the state’s interest in protecting the future health of a child against the mother’s interest in autonomy over her reproductive life — interests that until recently had not been thought to be in conflict. Second, such prosecutions represent one of two possible responses to the problem of drug-exposed babies. The government may choose either to help women have healthy pregnancies or to punish women for their prenatal conduct. Although it might seem that the state could pursue both of these avenues at once, the two responses are ultimately irreconcilable. Far from deterring injurious drug use, prosecution of drug-addicted mothers in fact deters pregnant women from using available health and counseling services because it causes women to fear that, if they seek help, they could be reported to government authorities and charged with a crime. Moreover, prosecution blinds the public to the possibility of nonpunitive solutions and to the inadequacy of the nonpunitive solutions that are currently available.

The debate between those who favor protecting the rights of the fetus and those who favor protecting the rights of the mother has been extensively waged in the literature. This Article does not repeat the theoretical arguments for and against state intervention. Rather, this Article suggests that both sides of the debate have largely overlooked a critical aspect of government prosecution of drug-addicted mothers. Can we determine the legality of the prosecutions simply by weighing the state’s abstract interest in the fetus against the mother’s abstract interest in autonomy? Can we determine whether the prosecutions are fair simply by deciding the duties a pregnant woman owes to her fetus and then assessing whether the defendant has met them? Can we determine the constitutionality of the government’s actions without considering the race of the women being singled out for prosecution?

Before deciding whether the state’s interest in preventing harm to the fetus justifies criminal sanctions against the mother, we must first understand the mother’s competing perspective and the reasons for the state’s choice of a punitive response. This Article seeks to illuminate the current debate by examining the experiences of the class of women who are primarily affected — poor Black women.

Providing the perspective of poor Black women offers two advantages. First, examining legal issues from the viewpoint of those whom they affect most helps to uncover the real reasons for state action and to explain the real harms that it causes. It exposes the way in which the prosecutions deny poor Black women a facet of their humanity by punishing their reproductive choices. The government’s choice of a punitive response perpetuates the historical devaluation of Black women as mothers. Viewing the legal issues from the experiential standpoint of the defendants enhances our understanding of the constitutional dimensions of the state’s conduct.
Second, examining the constraints on poor Black women's reproductive choices expands our understanding of reproductive freedom in particular and of the right of privacy in general. Much of the literature discussing reproductive freedom has adopted a white middle-class perspective, which focuses narrowly on abortion rights. The feminist critique of privacy doctrine has also neglected many of the concerns of poor women of color.  

My analysis presumes that Black women experience various forms of oppression simultaneously, as a complex interaction of race, gender, and class that is more than the sum of its parts. It is impossible to isolate any one of the components of this oppression or to separate the experiences that are attributable to one component from experiences attributable to the others. The prosecution of drug-addicted mothers cannot be explained as simply an issue of gender inequality. Poor Black women have been selected for punishment as a result of an inseparable combination of their gender, race, and economic status. Their devaluation as mothers, which underlies the prosecutions, has its roots in the unique experience of slavery and has been perpetuated by complex social forces.

Thus, for example, the focus of mainstream feminist legal thought on gender as the primary locus of oppression often forces women of color to fragment their experience in a way that does not reflect the reality of their lives. Angela Harris and others have presented a racial critique of this gender essentialism in feminist legal theory. By introducing the voices of Black women, these critics have begun to reconstruct a feminist jurisprudence based on the historical, economic, and social diversity of women's experiences. This new jurisprudence must be used to reconsider the more particular discourse of reproductive rights.

This Article advances an account of the constitutionality of prosecutions of drug-addicted mothers that explicitly considers the experiences of poor Black women. The constitutional arguments are based on theories of both racial equality and the right of privacy. I argue that punishing drug addicts who choose to carry their pregnancies to term unconstitutionally burdens the right to autonomy over reproductive decisions. Violation of poor Black women's reproductive rights helps to perpetuate a racist hierarchy in our society. The prosecutions thus impose a standard of motherhood that is offensive to principles of both equality and privacy. This Article provides insight into the particular and urgent struggle of women of color for reproductive freedom. Further, I intend my constitutional critique of the prosecutions to demonstrate the advantages of a discourse that combines elements of racial equality and privacy theories in advocating the reproductive rights of women of color.

Although women accused of prenatal crimes can present their defenses only in court, judges are not the only government officials charged with a duty to uphold the Constitution. Given the Supreme Court's current hostility to claims of substantive equality and reproductive rights, my arguments might be directed more fruitfully to legislatures than to the courts. Robin West, among others, has persuasively recharacterized the progressive interpretation of the constitutional guarantees of liberty and equality — such as the redistributive directive embodied in the fourteenth amendment — as “political ideals to guide legislation, rather than as legal restraints on legislation.” Legislatures may be more receptive than courts to the claim that punitive policies contribute to the subordinate status of Black women. They can serve as a forum for presenting both a vision of a community free from racist standards of motherhood and as a means of collectively implementing that vision. This Article translates the dehumanization that Black women experience so that lawmakers may understand and reverse — or at least must confront — the injustice of the prosecutions.

Part II of this Article presents background information about the recent prosecutions of drug-addicted mothers and explains why most of the defendants are poor and Black. Part III sets out the context in which the prosecutions must be understood: the historical devaluation of Black women as mothers. I discuss three aspects of this social phenomenon
— the control of Black women's reproductive lives during slavery, the abusive sterilization of Black women and other women of color during this century, and the disproportionate removal of Black children from their families. I also describe how a popular mythology denigrating Black motherhood has reinforced and legitimated this devaluation. Part IV characterizes the prosecutions as punishing drug-addicted women for having babies. This approach exposes the impact that the government's punitive policy has on the devaluation of Black women as mothers. Part V argues that the prosecutions violate the equal protection clause because they are rooted in and perpetuate Black subordination. Part VI examines the legal scholarship opposing state intervention in the lives of pregnant women. I show that the typical arguments advanced against intervention are inadequate to explain or challenge the criminal charges brought against drug-addicted mothers.

Finally, Part VII argues that punishing women for having babies violates their constitutional right of privacy for two reasons: it violates the right of autonomy of women over their reproductive decisions, and it creates an invidious government standard for childbearing. I discuss two benefits of privacy doctrine for advocating the reproductive rights of women of color: its emphasis on the value of personhood, *1428 and its protection against the abuse of government power. I argue, however, that the liberal interpretation of privacy is inadequate to eliminate the subordination of Black women. I therefore suggest that a progressive understanding of privacy must acknowledge government's affirmative obligation to guarantee the rights of personhood and must recognize the connection between the right of privacy and racial equality.

II. BACKGROUND: THE STATE'S PUNITIVE RESPONSE TO DRUG-ADDICTED MOTHERS

A. The Crack Epidemic and the State's Response

Crack cocaine appeared in America in the early 1980s, and its abuse has grown to epidemic proportions. Crack is especially popular among inner-city women. Indeed, evidence shows that, in several urban areas in the United States, more women than men now smoke crack. Most crack-addicted women are of childbearing age, and many are pregnant. This phenomenon has contributed to an explosion in the number of newborns affected by maternal drug use. Some experts estimate that as many as 375,000 drug-exposed infants are born every year. In many urban hospitals, the number of these newborns has quadrupled in the last five years. A widely cited 1988 study conducted by the National Association for Perinatal Addiction Research and Education (NAPARE) found that eleven percent of newborns in thirty-six hospitals surveyed were affected by their mothers' illegal-drug use during pregnancy. In several hospitals, the proportion of drug-exposed infants was as high as fifteen and twenty-five percent.

Babies born to drug-addicted mothers may suffer a variety of medical, developmental, and behavioral problems, depending on the nature of their mother's substance abuse. Immediate effects of cocaine exposure can include premature birth, low birth weight, and withdrawal symptoms. Cocaine-exposed children have also exhibited neurobehavioral problems such as mood dysfunction, organizational deficits, poor attention, and impaired human interaction, although it has not been determined whether these conditions are permanent. Congenital disorders and deformities have also been associated with cocaine use during pregnancy. According to NAPARE, babies exposed to cocaine have a tenfold greater risk of suffering sudden infant death syndrome (SIDS).

Data on the extent and potential severity of the adverse effects of maternal cocaine use are controversial. The interpretation of studies of cocaine-exposed infants is often clouded by the presence of other fetal risk factors, such as the mother's use of additional drugs, cigarettes, and alcohol and her socioeconomic status. For example, the health prospects of an infant are significantly threatened because pregnant addicts often receive little or no prenatal care and may be malnourished. Moreover, because the medical community has given more attention to studies showing
adverse effects of cocaine exposure than to those that deny these effects, the public has a distorted perception of the risks of maternal cocaine use. Researchers have not yet authoritatively determined the percentage of infants exposed to cocaine who actually experience adverse consequences.

The response of state prosecutors, legislators, and judges to the problem of drug-exposed babies has been punitive. They have punished women who use drugs during pregnancy by depriving these mothers of custody of their children, by jailing them during their pregnancy, and by prosecuting them after their babies are born.

The most common penalty for a mother's prenatal drug use is the permanent or temporary removal of her baby. Hospitals in a number of states now screen newborns for evidence of drugs in their urine and report positive results to child welfare authorities. Some child protection agencies institute neglect proceedings to obtain custody of babies with positive toxicologies based solely on these tests. More and more government authorities are also removing drug-exposed newborns from their mothers immediately after birth pending an investigation of parental fitness. In these investigations, positive neonatal toxicologies often raise a strong presumption of parental unfitness, which circumvents the inquiry into the mother's ability to care for her child that is customarily necessary to deprive a parent of custody.

A second form of punishment is the “protective” incarceration of pregnant drug addicts charged with unrelated crimes. In 1988, a Washington, D.C. judge sentenced a thirty-year-old woman named Brenda Vaughn, who pleaded guilty to forging $700 worth of checks, to jail for the duration of her pregnancy. The judge stated at sentencing that he wanted to ensure that the baby would be born in jail to protect it from its mother's drug abuse. Although the Vaughn case has received the most attention, anecdotal evidence suggests that defendants' drug use during pregnancy often affects judges' sentencing decisions.

Finally, women have been prosecuted after the birth of their children for having exposed the fetuses to drugs or alcohol. Creative statutory interpretations that once seemed little more than the outlandish concoctions of conservative scholars are now used to punish women. Mothers of children affected by prenatal substance abuse have been charged with crimes such as distributing drugs to a minor, child abuse and neglect, manslaughter, and assault with a deadly weapon.

This Article considers the constitutional implications of criminal prosecution of drug-addicted mothers because, as Part IV explains, this penalty most directly punishes poor Black women for having babies. When the government prosecutes, its intervention is not designed to protect babies from the irresponsible actions of their mothers (as is arguably the case when the state takes custody of a pregnant addict or her child). Rather, the government criminalizes the mother as a consequence of her decision to bear a child.

B. The Disproportionate Impact on Poor Black Women

Poor Black women bear the brunt of prosecutors' punitive approach. These women are the primary targets of prosecutors, not because they are more likely to be guilty of fetal abuse, but because they are Black and poor. Poor women, who are disproportionately Black, are in closer contact with government agencies, and their drug use is therefore more likely to be detected. Black women are also more likely to be reported to government authorities, in part because of the racist attitudes of health care professionals. Finally, their failure to meet society's image of the ideal mother makes their prosecution more acceptable.
To charge drug-addicted mothers with crimes, the state must be able to identify those who use drugs during pregnancy. Because poor women are generally under greater government supervision — through their associations with public hospitals, welfare agencies, and probation officers — their drug use is more likely to be detected and reported. Hospital screening practices result in disproportionate reporting of poor Black women. The government's main source of information about prenatal drug use is hospitals' reporting of positive infant toxicologies to child welfare authorities. Hospitals serving poor minority communities implement this testing almost exclusively. Private physicians who serve more affluent women perform less of this screening both because they have a financial stake both in retaining their patients' business and securing referrals from them and because they are socially more like their patients.

Hospitals administer drug tests in a manner that further discriminates against poor Black women. One common criterion triggering an infant toxicology screen is the mother's failure to obtain prenatal care, a factor that correlates strongly with race and income. Worse still, many hospitals have no formal screening procedures, relying solely on the suspicions of health care professionals. This discretion allows doctors and hospital staff to perform tests based on their stereotyped assumptions about drug addicts.

Health care professionals are much more likely to report Black women's drug use to government authorities than they are similar drug use by their wealthy white patients. A study recently reported in The New England Journal of Medicine demonstrated this racial bias in the reporting of maternal drug use. Researchers studied the results of toxicologic tests of pregnant women who received prenatal care in public health clinics and in private obstetrical offices in Pinellas County, Florida. Little difference existed in the prevalence of substance abuse by pregnant women along either racial or economic lines, nor was there any significant difference between public clinics and private offices. Despite similar rates of substance abuse, however, Black women were ten times more likely than whites to be reported to public health authorities for substance abuse during pregnancy. Although several possible explanations can account for this disparate reporting, both public health facilities and private doctors are more inclined to turn in pregnant Black women who use drugs than pregnant white women who use drugs.

It is also significant that, out of the universe of maternal conduct that can injure a fetus, prosecutors have focused on crack use. The selection of crack addiction for punishment can be justified neither by the number of addicts nor the extent of the harm to the fetus. Excessive alcohol consumption during pregnancy, for example, can cause severe fetal injury, and marijuana use may also adversely affect the unborn. The incidence of both these types of substance abuse is high as well. In addition, prosecutors do not always base their claims on actual harm to the child, but on the mere delivery of crack by the mother. Although different forms of substance abuse prevail among pregnant women of various socioeconomic levels and racial and ethnic backgrounds, inner-city Black communities have the highest concentrations of crack addicts. Therefore, selecting crack abuse as the primary fetal harm to be punished has a discriminatory impact that cannot be medically justified.

Focusing on Black crack addicts rather than on other perpetrators of fetal harms serves two broader social purposes. First, prosecution of these pregnant women serves to degrade women whom society views as undeserving to be mothers and to discourage them from having children. If prosecutors had instead chosen to prosecute affluent women addicted to alcohol or prescription medication, the policy of criminalizing prenatal conduct very likely would have suffered a hasty demise. Society is much more willing to condone the punishment of poor women of color who fail to meet the middle-class ideal of motherhood.
In addition to legitimizing fetal rights enforcement, the prosecution of crack-addicted mothers diverts public attention from social ills such as poverty, racism, and a misguided national health policy and implies instead that shamefully high Black infant death rates are caused by the bad acts of individual mothers. Poor Black mothers thus become the scapegoats for the causes of the Black community's ill health. Punishing them assuages any guilt the nation might feel at the plight of an underclass with infant mortality at rates higher than those in some less developed countries. Making criminals of Black mothers apparently helps to relieve the nation of the burden of creating a health care system that ensures healthy babies for all its citizens.

For a variety of reasons, then, an informed appraisal of the competing interests involved in the prosecutions must take account of the race of the women affected. Part III examines a significant aspect of Black women's experience that underlies the punishment of crack-addicted mothers.

III. THE DEVALUATION OF BLACK MOTHERHOOD

The systematic, institutionalized denial of reproductive freedom has uniquely marked Black women's history in America. An important part of this denial has been the devaluation of Black women as mothers. A popular mythology that degrades Black women and portrays them as less deserving of motherhood reinforces this subordination. This mythology is one aspect of a complex set of images that deny Black humanity in order to rationalize the oppression of Blacks.

In this Part, I will discuss three manifestations of the devaluation of Black motherhood: the original exploitation of Black women during slavery, the more contemporary, disproportionate removal of Black children from their mothers' custody, and sterilization abuse. Throughout this Part, I will also show how several popular images denigrating Black mothers — the licentious Jezebel, the careless, incompetent mother, the domineering matriarch, and the lazy welfare mother — have reinforced and legitimated their devaluation.

A. The Slavery Experience

The essence of Black women's experience during slavery was the brutal denial of autonomy over reproduction. Female slaves were commercially valuable to their masters not only for their labor, but also for their capacity to produce more slaves. Henry Louis Gates, Jr., writing about the autobiography of a slave named Harriet A. Jacobs, observes that it “charts in vivid detail precisely how the shape of her life and the choices she makes are defined by her reduction to a sexual object, an object to be raped, bred or abused.” Black women's childbearing during slavery was thus largely a product of oppression rather than an expression of self-definition and personhood.

The method of whipping pregnant slaves that was used throughout the South vividly illustrates the slaveowners' dual interest in Black women as both workers and childbearers. Slaveowners forced women to lie face down in a depression in the ground while they were whipped. This procedure allowed the masters to protect the fetus while abusing the mother. It serves as a powerful metaphor for the evils of a fetal protection policy that denies the humanity of the mother. It is also a forceful symbol of the convergent oppressions inflicted on slave women: they were subjugated at once both as Blacks and as females.

From slavery on, Black women have fallen outside the scope of the American ideal of womanhood. Slave owners forced slave women to perform strenuous labor that contradicted the Victorian female roles prevalent in the dominant white society. Angela Davis has observed: “judged by the evolving nineteenth-century ideology of femininity, which emphasized women's roles as nurturing mothers and gentle companions and housekeepers for their husbands, Black
women were practically anomalies.”  

Black women's historical deviation from traditional female roles has engendered a mythology that denies their womanhood.

One of the most prevalent images of slave women was the character of Jezebel, a woman governed by her sexual desires. As early as 1736, the South Carolina Gazette described “African Ladies” as women “of ‘strong robust constitution’ who were ‘not easily jaded out’ but able to serve their lovers ‘by Night as well as Day.’” This ideological construct of the licentious Jezebel legitimated white men's sexual abuse of Black women. The stereotype of Black women as sexually promiscuous helped to perpetuate their devaluation as mothers.

The myth of the “bad” Black woman was deliberately and systematically perpetuated after slavery ended. For example, historian Philip A. Bruce's book, The Plantation Negro as a Freeman, published in 1889, strengthened popular views of both Black male and Black female degeneracy. Bruce traced the alleged propensity of the Black man to rape white women to the “wantonness of the women of his own race” and “the sexual laxness of plantation women as a class.” This image of the sexually loose, impure Black woman that originated in slavery persists in modern American culture.

Black women during slavery were also systematically denied the rights of motherhood. Slave mothers had no legal claim to their children. Slave masters owned not only Black women, but also their children. They alienated slave women from their children by selling them to other slaveowners and by controlling childrearing. In 1851, Sojourner Truth reminded the audience at a women's rights convention that society denied Black women even the limited dignity of Victorian womanhood accorded white women of the time, including the right of mothering:

Dat man ober dar say dat women needs to be helped into carriages, and lifted ober ditches, and to have de best place every whar. Nobody eber help me into carriages, or ober mud puddles, or gives me any best place . . . and ar'n't I a woman? Look at me! Look at my arm! . . . I have plowed, and planted, and gathered into barns, and no man could head me — and ar'n't I a woman? I could work as much and eat as much as a man (when I could get it), and bear de lash as well — and ar'n't I a woman? I have borne thirteen children and seen em mos' all sold off into slavery, and when I cried out with a mother's grief, none but Jesus heard — and ar'n't I a woman?

Black women struggled in many ways to resist the efforts of slave masters to control their reproductive lives. They used contraceptives and abortives, escaped from plantations, feigned illness, endured severe punishment, and fought back rather than submit to slave masters' sexual domination. Free Black women with the means to do so purchased freedom for their daughters and sisters. Black women, along with Black men, succeeded remarkably often in maintaining the integrity of their family life despite slavery's disrupting effects.

B. The Disproportionate Removal of Black Children

The disproportionate number of Black mothers who lose custody of their children through the child welfare system is a contemporary manifestation of the devaluation of Black motherhood. This disparate impact of state intervention results in part from Black families' higher rate of reliance on government welfare. Because welfare families are subject to supervision by social workers, instances of perceived neglect are more likely to be reported to governmental authorities than neglect on the part of more affluent parents. Black children are also removed from their homes in
part because of the child welfare system's cultural bias and application of the nuclear family pattern to Black families. Black childrearing patterns that diverge from the norm of the nuclear family have been misinterpreted by government bureaucrats as child neglect. For example, child welfare workers have often failed to respect the longstanding cultural tradition in the Black community of shared parenting responsibility among blood-related and non-blood kin. The state has thus been more willing to intrude upon the autonomy of poor Black families, and in particular of Black mothers, while protecting the integrity of white, middle-class homes.

This devaluation of Black motherhood has been reinforced by stereotypes that blame Black mothers for the problems of the Black family. This scapegoating of Black mothers dates back to slavery, when mothers were blamed for the devastating effects on their children of poverty and abuse of Black women. When a one-month-old slave girl named Harriet died in the Abbeville District of South Carolina on December 9, 1849, the census marshal reported the cause of death as “‘[s]mothered by carelessness of [her] mother.’” This report was typical of the United States census mortality schedules for the southern states in its attribution of a Black infant death to accidental suffocation by the mother. Census marshal Charles M. Pelot explained: “‘I wish it to be distinctly understood that nearly all the accidents occur in the negro population, which goes clearly to prove their great carelessness & total inability to take care of themselves.’” It now appears that the true cause of these suffocation deaths was Sudden Infant Death Syndrome. Black children died at a dramatically higher rate because of the hard physical work, poor nutrition, and abuse that their slave mothers endured during pregnancy.

The scapegoating of Black mothers has manifested itself more recently in the myth of the Black matriarch, the domineering female head of the Black family. White sociologists have held Black matriarchs responsible for the disintegration of the Black family and the consequent failure of Black people to achieve success in America. Daniel Patrick Moynihan popularized this theory in his 1965 report, The Negro Family: The Case for National Action. According to Moynihan:

At the heart of the deterioration of the fabric of the Negro society is the deterioration of the Negro family. It is the fundamental cause of the weakness of the Negro community . . . . In essence, the Negro community has been forced into a matriarchal structure which, because it is so out of line with the rest of the American society, seriously retards the progress of the group as a whole.

Thus, Moynihan attributed the cause of Black people's inability to overcome the effects of racism largely to the dominance of Black mothers.

C. The Sterilization of Women of Color

Coerced sterilization is one of the most extreme forms of control over a woman's reproductive life. By permanently denying her the right to bear children, sterilization enforces society's determination that a woman does not deserve to be a mother. Unlike white women, poor women of color have been subjected to sterilization abuse for decades. The disproportionate sterilization of Black women is yet another manifestation of the dominant society's devaluation of Black women as mothers.

Sterilization abuse has taken the form both of blatant coercion and trickery and of subtle influences on women's decisions to be sterilized. In the 1970s, some doctors conditioned delivering babies and performing abortions on Black women's consent to sterilization. In a 1974 case brought by poor teenage Black women in Alabama, a federal district court
found that an estimated 100,000 to 150,000 poor women were sterilized annually under federally-funded programs. Some of these women were coerced into agreeing to sterilization under the threat that their welfare benefits would be withdrawn unless they submitted to the operation. Despite federal and state regulations intended to prevent involuntary sterilization, physicians and other health care providers continue to urge women of color to consent to sterilization because they view these women's family sizes as excessive and believe these women are incapable of effectively using other methods of birth control.

Current government funding policy perpetuates the encouragement of sterilization of poor, and thus of mainly Black, women. The federal government pays for sterilization services under the Medicaid program, while it often does not make available information about and access to other contraceptive techniques and abortion. In effect, sterilization is the only publicly-funded birth control method readily available to poor women of color.

Popular images of the undeserving Black mother legitimate government policy as well as the practices of health care providers. The myth of the Black Jezebel has been supplemented by the contemporary image of the lazy welfare mother who breeds children at the expense of taxpayers in order to increase the amount of her welfare check. This view of Black motherhood provides the rationale for society's restrictions on Black female fertility. It is this image of the undeserving Black mother that also ultimately underlies the government's choice to punish crack-addicted women.

*1445 IV. PROSECUTING DRUG ADDICTS AS PUNISHMENT FOR HAVING BABIES

Informed by the historical and present devaluation of Black motherhood, we can better understand prosecutors' reasons for punishing drug-addicted mothers. This Article views such prosecutions as punishing these women, in essence, for having babies; judges such as the one who convicted Jennifer Johnson are pronouncing not so much “I care about your baby” as “You don't deserve to be a mother.”

It is important to recognize at the outset that the prosecutions are based in part on a woman's pregnancy and not on her illegal drug use alone. Prosecutors charge these defendants not with drug use, but with child abuse or drug distribution — crimes that relate to their pregnancy. Moreover, pregnant women receive harsher sentences than drug-addicted men or women who are not pregnant.

The unlawful nature of drug use must not be allowed to confuse the basis of the crimes at issue. The legal rationale underlying the prosecutions does not depend on the illegality of drug use. Harm to the fetus is the crux of the government's legal theory. Criminal charges have been brought against women for conduct that is legal but was alleged to have harmed the fetus.

When a drug-addicted woman becomes pregnant, she has only one realistic avenue to escape criminal charges: abortion. Thus, she is penalized for choosing to have the baby rather than having an abortion. In this way, the state's punitive action may coerce women to have abortions rather than risk being charged with a crime. Thus, it is the choice of carrying a pregnancy to term that is being penalized.

*1446 There is also good reason to question the government's justification for the prosecutions — the concern for the welfare of potential children. I have already discussed the selectivity of the prosecutions with respect to poor Black women. This focus on the conduct of one group of women weakens the state's rationale for the prosecutions.

The history of overwhelming state neglect of Black children casts further doubt on its professed concern for the welfare of the fetus. When a society has always closed its eyes to the inadequacy of prenatal care available to poor Black women,
its current expression of interest in the health of unborn Black children must be viewed with suspicion. The most telling
evidence of the state's disregard of Black children is the high rate of infant death in the Black community. In 1987, the
mortality rate for Black infants in the United States was 17.9 deaths per thousand births — more than twice that for
white infants (8.6). In New York City, while infant mortality rates in upper- and middle-income areas were generally
less than nine per thousand in 1986, the rates exceeded nineteen in the poor Black communities of the South Bronx and
Bedford-Stuyvesant and reached 27.6 in Central Harlem.

The main reason for these high mortality rates is inadequate prenatal care. Most poor Black women face financial
and other barriers to receiving proper care during pregnancy. In 1986, only half of all pregnant Black women
in America received adequate prenatal care. It appears that in the 1980s Black women's access to prenatal care has
actually declined. The government has chosen to punish poor Black women rather than provide the means for them
to have healthy children.

The cruelty of this punitive response is heightened by the lack of available drug treatment services for pregnant
drug addicts. Protecting the welfare of drug addicts' children requires, among other things, adequate facilities for
the mother's drug treatment. Yet a drug addict's pregnancy serves as an obstacle to obtaining this treatment. Treatment
centers either refuse to treat pregnant women or are effectively closed to them because the centers are ill-equipped to meet
the needs of pregnant addicts. Most hospitals and programs that treat addiction exclude pregnant women because
their babies are more likely to be born with health problems requiring expensive care. Program directors also feel
that treating pregnant addicts is worth neither the increased cost nor the risk of tort liability.

Moreover, there are several barriers to pregnant women who seek to use centers that will accept them. Drug treatment
programs are generally based on male-oriented models that are not geared to the needs of women. The lack of
accommodations for children is perhaps the most significant obstacle to treatment. Most outpatient clinics do not provide
child care, and many residential treatment programs do not admit children. Furthermore, treatment programs have
traditionally failed to provide the comprehensive services that women need, including prenatal and
gynecologic care, contraceptive counseling, appropriate job training, and counseling for sexual and physical abuse.
Predominantly male staffs and clients are often hostile to female clients and employ a confrontational style of therapy
that makes many women uncomfortable.

Finally, and perhaps most importantly, ample evidence reveals that prosecuting addicted mothers may not achieve
the government's asserted goal of healthier pregnancies; indeed, such prosecutions will probably lead to the opposite
result. Pregnant addicts who seek help from public hospitals and clinics are the ones most often reported to government
authorities. The threat of prosecution based on this reporting forces women to remain anonymous and thus has the
pervasive effect of deterring pregnant drug addicts from seeking treatment. For this reason, the government's decision
to punish drug-addicted mothers is irreconcilable with the goal of helping them.

Pregnancy may be a time when women are most motivated to seek treatment for drug addiction and make positive
lifestyle changes. The government should capitalize on this opportunity by encouraging drug-addicted women to
seek help and providing them with comprehensive treatment. Punishing pregnant women who use drugs only exacerbates
the causes of addiction — poverty, lack of self-esteem, and hopelessness. Perversely, this makes it more likely that
poor Black women's children — the asserted beneficiaries of the prosecutions — will suffer from the same hardships.
V. PUNISHING BLACK MOTHERS AND THE PERPETUATION OF RACIAL HIERARCHY

The previous Part showed how recent prosecutions have penalized Black women for their reproductive choices based in part on society's devaluation of Black motherhood. This analysis implicates two constitutional protections: the equal protection clause of the fourteenth amendment and the right of privacy. These two constitutional challenges appeal to different but related values. They are related in the sense that underlying the protection of the individual's autonomy is the principle that all individuals are entitled to equal dignity. A basic premise of equality doctrine is that certain fundamental aspects of the human personality, including decisional autonomy, must be respected in all persons. Theories of racial equality and privacy can be used as related means to achieve a common end of eliminating the legacy of racial discrimination that has devalued Black motherhood. Both aim to create a society in which Black women's reproductive choices, including the decision to bear children, are given full respect and protection.

The equal protection clause embodies the Constitution's ideal of racial equality. State action that violates this ideal by creating classifications based on race must be subjected to strict judicial scrutiny. The equal protection clause, however, does not explicitly define the meaning of equality or delineate the nature of prohibited government conduct. As a result, equal protection analyses generally have divided into two visions of equality: one that is informed by an antidiscrimination principle, the other by an antisubordination principle.

The antidiscrimination approach identifies the primary threat to equality as the government's “failure to treat Black people as individuals without regard to race.” The goal of the antidiscrimination principle is to ensure that all members of society are treated in a color-blind or race-neutral fashion. Under this view of equality, the function of the equal protection clause is to outlaw specific acts committed by individual government officials that discriminate against individual Black complainants because of their race. Thus, this approach judges the legitimacy of government action from the perpetrator's perspective. The analysis focuses on the process by which government decisions are made and seeks to purge racial classifications from that process.

The Supreme Court's current understanding of the equal protection clause is based on a narrow interpretation of the antidiscrimination principle. The Court has confined discrimination prohibited by the Constitution to state conduct performed with a discriminatory intent. State conduct that disproportionately affects Blacks violates the Constitution only if it is accompanied by a purposeful desire to produce this outcome. Although recognized violations are not limited to explicit racial classifications, an invidious purpose cannot be inferred solely from the adverse consequences of racially neutral policies. A Black complainant, therefore, need not produce a law that expressly differentiates between whites and Blacks; but neither can she simply demonstrate that a color-blind law has a clearly disproportionate impact on Blacks. As one commentator has noted, “the Justices have demanded proof . . . that officials were ‘out to get’ a person or group on account of race.”

Black women prosecuted for drug use during pregnancy nevertheless may be able to make out a prima facie case of discriminatory purpose. The Court has recognized that a selection process characterized by broad government discretion that produces unexplained racial disparities may support the presumption of discriminatory purpose. In Castaneda v. Partida, for example, the Court held that the defendant demonstrated a prima facie case of intentional discrimination in grand jury selection by showing a sufficiently large statistical disparity between the percentage of Mexican-Americans in the population (seventy-nine percent) and the percentage of those summoned (thirty-nine percent), combined with a selection procedure that relied on the discretion of jury commissioners.
Similarly, a Black mother arrested in Pinellas County, Florida could make out a prima facie case of unconstitutional racial discrimination by showing that a disproportionate number of those chosen for prosecution for exposing newborns to drugs are Black. In particular, she could point out the disparity between the percentage of defendants who are Black and the percentage of pregnant substance abusers who are Black. The New England Journal of Medicine study of pregnant women in Pinellas County referred to earlier found that only about twenty-six percent of those who used drugs were Black. Yet over ninety percent of Florida prosecutions for drug abuse during pregnancy have been brought against Black women. The defendant could buttress her case with the study's finding that, despite similar rates of substance abuse, Black women were ten times more likely than white women to be reported to public health authorities for substance abuse during pregnancy. In addition, the defendant could show that both health care professionals and prosecutors wield a great deal of discretion in selecting women to be subjected to the criminal justice system. The burden would then shift to the state “to dispel the inference of intentional discrimination” by justifying the racial discrepancy in its prosecutions.

The antisubordination approach to equality would not require Black defendants to prove that the prosecutions are motivated by racial bias. Rather than requiring victims to prove distinct instances of discriminating behavior in the administrative process, the antisubordination approach considers the concrete effects of government policy on the substantive condition of the disadvantaged. This perspective recognizes that racial subjugation is not maintained solely through the racially antagonistic acts of individual officials. It instead views social patterns and institutions that perpetuate the inferior status of Blacks as the primary threats to equality. The goal of antisubordination law is a society in which each member is guaranteed equal respect as a human being. Under this conception of equality, the function of the equal protection clause is to dismantle racial hierarchy by eliminating state action or inaction that effectively preserves Black subordination.

The prosecution of drug-addicted mothers demonstrates the inadequacy of antidiscrimination analysis and the superiority of the antisubordination approach. Rather than conform Black women's experiences to the intent standard, we can use those experiences to reveal the narrowmindedness of the Court's view of equality. First, the antidiscrimination approach may not adequately protect Black women from prosecutions' infringement of equality, because it is difficult to identify individual guilty actors. Who are the government officials motivated by racial bias to punish Black women? The hospital staff who test and report mothers to child welfare agencies? The prosecutors who develop and implement policies to charge women who use drugs during pregnancy? Legislators who enact laws protecting the unborn? It is unlikely that any of these individual actors intentionally singled out Black women for punishment based on a conscious devaluation of their motherhood. The disproportionate impact of the prosecutions on poor Black women does not result from such isolated, individualized decisions. Rather, it is a result of two centuries of systematic exclusion of Black women from tangible and intangible benefits enjoyed by white society. Their exclusion is reflected in Black women's reliance on public hospitals and public drug treatment centers, in their failure to obtain adequate prenatal care, in the more frequent reporting of Black drug-users by health care professionals, and in society's acquiescence in the government's punitive response to the problem of crack-addicted babies.

More generally, the antidiscrimination principle mischaracterizes the role of social norms in perpetuating inequality. This view of equality perceives racism as disconnected acts by individuals who operate outside of the social fabric. The goal of the equal protection clause under this world view is “to separate from the masses of society those blameworthy individuals who are violating the otherwise shared norm.”

The prosecutions of drug-addicted mothers demonstrate how dramatically this perspective departs from reality. It is precisely a shared societal norm — the devaluation of Black motherhood — that perpetuates the social conditions
discussed above and explains why Black women are particularly susceptible to prosecution. The Court's vision of equality
acquiesces in racist norms and institutions by exempting them from a standard that requires proof of illicit motive on
the part of an individual governmental actor. The inability to identify and blame an individual government actor allows
society to rationalize the disparate impact of the prosecutions as the result of the mothers' own irresponsible actions.
Formal equality theory thus legitimates the subordination of Black women.

In contrast to the antidiscrimination approach, antisubordination theory mandates that equal protection law concern
itself with the concrete ways in which government policy perpetuates the inferior status of Black women. The law should
listen to the voices of poor Black mothers and seek to eliminate their experiences of subordination. From this perspective,
the prosecutions of crack-addicted mothers are unconstitutional because they reinforce the myth of the undeserving
Black mother by singling out — whether intentionally or not — Black women for punishment. The government's punitive
policy reflects a long history of denigration of Black mothers dating back to slavery, and it serves to perpetuate that
legacy of unequal respect. The prosecutions should therefore be upheld only if the state can demonstrate that they serve
a compelling interest that could not be achieved through less discriminatory means.\(^{189}\)

Although the state's asserted interest in ensuring the health of babies is substantial, prosecution does not advance that
interest in a sufficiently narrow fashion. First, as I have noted, the government's punitive course of action
is inimical to the goal of healthier pregnancies because it deters women from seeking help.\(^{190}\) In addition, even if
the prosecutions could be proved to further the state's interest in children's welfare, they would not survive the “least
restrictive alternative” standard. That standard requires that “even though the governmental purpose be legitimate and
substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end
can be more narrowly achieved.”\(^{191}\) A public commitment to providing adequate prenatal care for poor women and
drug treatment programs that meet the needs of pregnant addicts would be a more effective means for the state to address
the problem of drug-exposed babies.\(^{192}\)

By prosecuting crack-addicted mothers, the government helps to perpetuate the dominant society's devaluation of Black
motherhood. The antisubordination analysis better uncovers this institutional, rather than individualistic, mechanism
for maintaining racial inequality. The government's policy cannot withstand the scrutiny of an equality jurisprudence
dedicated to eradicating hierarchies of racial privilege. Still, the focus purely on equality does not address the unique
significance of punishing the decision to bear a child. The remainder of this Article examines how the prosecutions violate
Black women's right of privacy and the relationship between that privacy analysis and the goal of racial equality.

VI. A CRITICAL ASSESSMENT OF ARGUMENTS AGAINST INTERVENTION

There is now a substantial body of scholarship challenging state intervention in pregnant women's conduct.\(^{193}\) Yet much
of the literature has not sufficiently taken into account the experience of poor Black women, the very women who are
most affected. In addition, the literature has failed to address adequately the arguments on behalf of fetal protection.
In this Part, I will critique various reproductive rights theories that have been used to challenge the control of pregnant
women and show why they are not helpful in addressing the prosecution of drug-addicted mothers. In Part VII, I will
present a privacy argument that more effectively confronts the government's policy. That analysis better explains the
constitutional injury caused by the prosecutions because it recognizes race as a critical factor.

\(^{1457}\) A. Bodily Autonomy and Integrity

Much of the discourse challenging state intervention in the decisions of pregnant women has occurred in the context
of forced medical treatment.\(^{194}\) Many commentators have argued that judicial decisions that allow doctors to perform
surgery and other procedures on a pregnant woman without her consent violate women's right to bodily autonomy and
integrity. It is difficult, however, to transfer the scholarship addressing compelled medical procedures to the issue of drug-addicted mothers.

The interests of the drug-addicted mother appear to be weaker for three reasons. First, unlike forced medical treatment, punishing the pregnant drug addict does not require her to take affirmative steps to benefit the fetus. She is not asked to be a good samaritan; rather, she is punished for affirmatively doing harm to the fetus. Second, the prosecution of drug-addicted mothers involves no direct physical intrusion. Nor do prosecutions deprive women of control over their bodies by directly compelling them to undergo an unwanted biological process, as is the case with the prohibition of abortion. On this level, punishing drug-addicted mothers does not seem to implicate a mother's right to bodily integrity at all.

Third, the mother's drug use has potentially devastating effects on the fetus and lacks any social justification. Indeed, forcing a woman to refrain from using harmful drugs through incarceration or court order may be seen as a benefit to the women herself, whereas forced medical procedures often aid the fetus only at the expense of the mother's health or her deeply held religious beliefs. It is therefore harder to identify how the government's action infringes a constitutionally protected interest. Consequently, some commentators who oppose the regulation of some potentially harmful conduct during pregnancy at the same time justify punishment of pregnant drug users. We must therefore draw on another principle of autonomy to describe the infringement caused by these prosecutions: the right to make decisions about reproduction (here, the choice of carrying a pregnancy to term).

In addition, many of the issues raised by forced medical treatment seem disconnected from the experiences of poor women of color. For example, much of the literature focuses on ethical issues arising from treating the fetus as a patient and its impact on the relationship between the pregnant woman and her physician. This debate is largely irrelevant to poor Black women, the majority of whom receive inadequate prenatal care. Their major concern is not having an ethical conflict with their doctor, but affording or finding a doctor in the first place. The issue of whether intricate fetal surgery may be performed against a mother's will is far removed from the urgent needs of poor women who may not have available to them the most rudimentary means to ensure the health of the fetus.

Forced treatment decisions equate women with inert vessels, disregard their own choices, and value them solely for their capacity to nurture the fetus. Although this view of women is reflected as well in the prosecution of drug-addicted mothers, it does not grasp the full indignity of the state's treatment of poor Black women. Government control of pregnancy perpetuates stereotypes that value women solely for their procreative capacity. But the prosecutions of crack addicts deny poor Black women even this modicum of value. By punishing them for having babies, they are deemed not even worthy of the dignity of childbearing. Thus, the prosecutions debase Black women even more than forced medical treatment's general devaluation of women.

B. The Right to Make Medical and Lifestyle Decisions

A second approach challenges restrictions on maternal conduct during pregnancy by advocating a woman's right to make medical and lifestyle decisions. Rather than focus on a woman's right to protect her body from physical intrusion, this approach focuses on a woman's right to engage in activities of her choice free from government interference. This argument also loses its force in the context of maternal drug addiction. While the danger of government restrictions on a pregnant woman's normal conduct may be apparent, drug use during pregnancy arguably belongs in a separate category. The pregnant drug addict is not asked to refrain from generally acceptable behavior, such as sexual intercourse, work, or exercise. Rather, society demands only that she cease conduct that it already deems illegal and reprehensible.
Arguments based on a woman's right to make decisions about her pregnancy and her fetus also appear weak in the context of maternal drug addiction. Unlike healthy mothers, pregnant drug addicts are not better able to make lifestyle and medical decisions that affect the fetus than the state or physicians. Nor can we say that a decision to carry a fetus to term automatically demonstrates that a drug-addicted mother cares deeply for it and is in a better position to monitor her own conduct during pregnancy than the state. Most would agree that the pregnant drug addict has exercised poor judgment in caring for herself and her fetus. The state should not substitute its judgment for that of the “normal” mother, but intervention in the case of the drug addict seems more justified.

Although the government is arguably better able to make decisions about the care of the fetus than the drug-addicted mother, it is quite a different matter to allow the government to determine who is entitled to be a mother. State interference in the decision to bear a child is constitutionally more significant than state control of lifestyle decisions.

The interference-in-women's-lifestyles approach also neglects the concerns of poor women of color. A common criticism of the prosecution of drug-addicted mothers is that the imposition of maternal duties will lead to punishment for less egregious conduct. Commentators have predicted government penalties for cigarette smoking, consumption of alcohol, strenuous physical activity, and failure to follow a doctor's orders. Although valid, this argument ignores the reality of poor Black women whom are currently being arrested. The reference to a parade of future horribles to criticize the fetal rights doctrine belittles the significance of current government action. It seems to imply that the prosecution of Black crack addicts is not enough to generate concern and that we must postulate the prosecution of white middle-class women in order for the challenge to be meaningful.

C. The Focus on Abortion

Another aspect of the reproductive rights literature that limits our understanding of reproductive choice is its focus on abortion rights. One problem is that this focus provides an inadequate response to a central argument in support of the regulation of pregnancy. John Robertson, for example, has contended that if a woman forgoes her right to an abortion, she forfeits her right to autonomy and choice. If abortion is the heart of women's reproductive rights, then state policies that do not interfere with that right are acceptable. Similarly, if the full extent of reproductive freedom is the right to have an abortion, then a policy that encourages abortion — such as the prosecution of crack-addicted mothers — does not interfere with that freedom.

As in the previous approaches, the emphasis on abortion fails to incorporate the needs of poor women of color. The primary concern of white, middle-class women are laws that restrict choices otherwise available to them, such as statutes that make it more difficult to obtain an abortion. The main concern of poor women of color, however, are the material conditions of poverty and oppression that restrict their choices. The reproductive freedom of poor women of color, for example, is limited significantly not only by the denial of access to safe abortions, but also by the lack of resources necessary for a healthy pregnancy and parenting relationship. Their choices are limited not only by direct government interference with their decisions, but also by government's failure to facilitate them. The focus of reproductive rights discourse on abortion neglects this broader range of reproductive health issues that affect poor women of color.

Addressing the concerns of women of color will expand our vision of reproductive freedom to include the full scope of what it means to have control over one's reproductive life.

VII. CLAIMING THE RIGHT OF PRIVACY FOR WOMEN OF COLOR
A. Identifying the Constitutional Issue

In deciding which of the competing interests involved in the prosecution of drug-addicted mothers prevails — the state's interest in protecting the health of the fetus or the woman's interest in preventing state intervention — it is essential as a matter of constitutional law to identify the precise nature of the woman's right at stake. In the Johnson case, the prosecutor framed the constitutional issue as follows: “What constitutionally protected freedom did Jennifer engage in when she smoked cocaine?” That was the wrong question. Johnson was not convicted of using drugs. Her “constitutional right” to smoke cocaine was never at issue. Johnson was prosecuted because she chose to carry her pregnancy to term while she was addicted to crack. Had she smoked cocaine during her pregnancy and then had an abortion, she would not have been charged with such a serious crime. The proper question, then, is “What constitutionally protected freedom did Jennifer engage in when she decided to have a baby, even though she was a drug addict?”

Understanding the prosecution of drug-addicted mothers as punishment for having babies clarifies the constitutional right at stake. The woman's right at issue is not the right to abuse drugs or to cause the fetus to be born with defects. It is the right to choose to be a mother that is burdened by the criminalization of conduct during pregnancy. This view of the constitutional issue reveals the relevance of race to the resolution of the competing interests. Race has historically determined the value society places on an individual's right to choose motherhood. Because of the devaluation of Black motherhood, protecting the right of Black women to choose to bear a child has unique significance. In the following section, I argue that the prosecutions of addicted mothers violate traditional liberal notions of privacy. I also demonstrate how the issue of race informs the traditional analysis and calls for a reassessment of the use of privacy doctrine in the struggle to eliminate gender and racial subordination.

B. Overview of Privacy Arguments

Prosecutions of drug-addicted mothers infringe on two aspects of the right to individual choice in reproductive decisionmaking. First, they infringe on the freedom to continue a pregnancy that is essential to an individual's personhood and autonomy. This freedom implies that state control of the decision to carry a pregnancy to term can be as pernicious as state control of the decision to terminate a pregnancy. Second, the prosecutions infringe on choice by imposing an invidious government standard for the entitlement to procreate. Such imposition of a government standard for childbearing is one way that society denies the humanity of those who are different. The first approach emphasizes a woman's right to autonomy over her reproductive life; the second highlights a woman's right to be valued equally as a human being. In other words, the prosecution of crack-addicted mothers infringes upon both a mother's right to make decisions that determine her individual identity and her right to be respected equally as a human being by recognizing the value of her motherhood.

Inherent in the thesis of this Article is a tension between the reliance on the liberal rhetoric of choice and an acknowledgement of the fallacy of choice for poor women of color. This Article also seeks to incorporate liberal notions of individual autonomy while acknowledging the collective injury perpetrated by racism. This tension may be an example of what Mari Matsuda calls “multiple consciousness.” Professor Matsuda observes that “outsider” lawyers and scholars must often adopt a “dualist approach” that incorporates an elitist legal system and the concept of legal rights while seeing the world from the standpoint of the oppressed. “Unlike the post-modern critics of the left . . . outsiders, including feminists and people of color, have embraced legalism as a tool of necessity, making legal consciousness their own in order to attack injustice.”

This internal struggle between the embrace of legalism and the recognition of oppression characterizes a process of enlightenment. Working through the privacy analysis from the perspective of poor Black women uncovers
unexplored benefits to be gained from liberal doctrine while revealing liberalism's inadequacies. This process of putting forth new propositions for challenge and subversion will produce a better understanding of the law and the ways in which it can be used to pursue social justice.

C. The Right to Choose Procreation

Punishing drug-addicted mothers unconstitutionally burdens the right to choose to bear a child. Certain interests of the individual — *1465 generally called “rights” — are entitled to heightened protection against government interference under the due process clause of the fourteenth amendment. 223 The right of privacy is recognized as one cluster of such interests, implicit in the “liberty” that the fourteenth amendment protects. 224 The right of privacy has been interpreted to include the “interest in independence in making certain kinds of important decisions.” 225 This concept of decisional privacy 226 seeks to protect intimate or personal affairs that are fundamental to an individual's identity and moral personhood from unjustified government intrusion. 227 At the forefront of the development of the right of privacy has been the freedom of personal choice in matters of marriage and family life. 228 Once an interest has been deemed part of the right of privacy, the government needs a compelling reason to intervene to survive constitutional scrutiny. 229

Considerable support exists for the conclusion that the decision to procreate 230 is part of the right of privacy. The decision to bear *1466 children is universally acknowledged in the privacy cases as being “at the very heart” of these constitutionally protected choices. 231 In Eisenstadt v. Baird, 232 for example, the Court struck down a Massachusetts statute that prohibited the distribution of contraceptives to unmarried persons. Although the case was decided on equal protection grounds, the Court recognized the vital nature of the freedom to choose whether to give birth to a child: “If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.” 233

The right of privacy protects equally the choice to bear children and the choice to refrain from bearing them. 234 The historical experiences of Black women illustrate the evil of government control over procreative decisions. Their experiences demonstrate that the dual *1467 nature of the decisional right recognized in the privacy cases goes beyond the logical implications of making a choice. The exploitation of Black women's foremothers during slavery to breed more slaves and the sterilization abuse that they have suffered reveal society's pervasive devaluation of Black women as mothers.

Burdening both the right to terminate a pregnancy and the right to give birth to a child violates a woman's personhood by denying her autonomy over the self-defining decision of whether she will bring another being into the world. Furthermore, criminalizing the choice to give birth imposes tangible burdens on women, as well as the intangible infringement on personhood. Punishing women for having babies is in this sense at least as pernicious as forced maternity at the behest of the state. 235

If a woman's decision to bear a child is entitled to constitutional protection, it follows that the government may not unduly burden that choice. In Cleveland Board of Education v. LaFleur, 236 the Court invalidated mandatory maternity leave policies that had the effect of burdening the choice to procreate. The Court viewed the school board's policy of forced maternity leave as a form of penalty imposed on pregnant teachers for asserting their right to decide to have children. 237 Although the Court applied a rational basis test to the maternity leave policies in LaFleur, 238 the more drastic burden of criminal punishment should warrant strict scrutiny. 239 Even under the *1468 Court's current analysis, which distinguishes between direct and indirect governmental interference in reproductive decisionmaking, 240
government intrusion as extreme as criminal prosecution would unduly infringe on protected autonomy. The Court has expressly distinguished, for example, the government's refusal to subsidize the exercise of the abortion right from the infliction of criminal penalties on the exercise of that right. Criminal prosecutions of drug-addicted mothers do more than discourage a choice; they exact a severe penalty on the drug user for choosing to complete her pregnancy.

These privacy concepts have two benefits for advocating the reproductive rights of women of color in particular: the right of privacy stresses the value of personhood, and it protects against the totalitarian abuse of government power. First, affirming Black women's constitutional claim to personhood is particularly important because these women historically have been denied the dignity of their full humanity and identity. The principle of self-definition has special significance for Black women. Angela Harris recognizes in the writings of Zora Neale Hurston an insistence on a “conception of identity as a construction, not an essence . . . . B lack women have had to learn to construct themselves in a society that denied them full selves.” Black women's willful self-definition is an adaptation to a history of social denigration. Rejected from the dominant society's norm of womanhood, Black women have been forced to resort to their own internal resources. Harris contrasts this process of affirmative self-definition with the feminist paradigm of women as passive victims. Black women willfully create their own identities out of “fragments of experience, not discovered in one's body or unveiled after male domination is eliminated.”

The concept of personhood embodied in the right of privacy can be used to affirm the role of will and creativity in Black women's construction of their own identities. Relying on the concept of self-definition celebrates the legacy of Black women who have survived and transcended conditions of oppression. The process of defining one's self and declaring one's personhood defies the denial of self-ownership inherent in slavery. Thus, the right of privacy, with its affirmation of personhood, is especially suited for challenging the devaluation of Black motherhood underlying the prosecutions of drug-addicted women.

Another important element of the right of privacy is its delineation of the limits of governmental power. Poor women of color are especially vulnerable to government control over their decisions. The government's pervasive involvement in Black women's lives illustrates the inadequacy of the privacy critique presented by some white feminist scholars. Catharine MacKinnon, for example, argues that privacy doctrine is based on the false liberal assumption that government nonintervention into the private sphere promotes women's autonomy. The individual woman's legal right of privacy, according to MacKinnon, functions instead as “a means of subordinating women's collective needs to the imperatives of male supremacy.”

This rejection of privacy doctrine does not take into account the contradictory meaning of the private sphere for women of color. Feminist legal theory focuses on the private realm of the family as an institution of violence and subordination. Women of color, however, often experience the family as the site of solace and resistance against racial oppression. For many women of color, the immediate concern in the area of reproductive rights is not abuse in the private sphere, but abuse of government power. The prosecution of crack-addicted mothers and coerced sterilization are examples of state intervention that pose a much greater threat for women of color than for white women.

Another telling example is the issue of child custody. The primary concern for white middle-class women with regard to child custody is private custody battles with their husbands following the termination of a marriage. But for women of color, the dominant threat is termination of parental rights by the state. Again, the imminent danger faced by poor women of color comes from the public sphere, not the private. Thus, the protection from government interference that privacy doctrine affords may have a different significance for women of color.
D. Unconstitutional Government Standards for Procreation: The Intersection of Privacy and Equality

The equal protection clause and the right of privacy provide the basis for two separate constitutional challenges to the prosecution of drug-addicted mothers. The singling out of Black mothers for punishment combines in a single government action several wrongs prohibited by both constitutional doctrines. Black mothers are denied autonomy over procreative decisions because of their race. The government's denial of Black women's fundamental right to choose to bear children serves to perpetuate the legacy of racial discrimination embodied in the devaluation of Black motherhood. The full scope of the government's violation can better be understood, then, by a constitutional theory that acknowledges the complementary and overlapping qualities of the Constitution's guarantees of equality and privacy. Viewing the prosecutions as imposing a racist government standard for procreation uses this approach.

Poor crack addicts are punished for having babies because they fail to measure up to the state's ideal of motherhood. Prosecutors have brought charges against women who use drugs during pregnancy without demonstrating any harm to the fetus. Moreover, a government policy that has the effect of punishing primarily poor Black women for having babies evokes the specter of racial eugenics, especially in light of the history of sterilization abuse of women of color. These factors make clear that these women are not punished simply because they may harm their unborn children. They are punished because the combination of their poverty, race, and drug addiction is seen to make them unworthy of procreating.

This aspect of the prosecutions implicates both equality and privacy interests. The right to bear children goes to the heart of what it means to be human. The value we place on individuals determines whether we see them as entitled to perpetuate themselves in their children. Denying someone the right to bear children — or punishing her for exercising that right — deprives her of a basic part of her humanity. When this denial is based on race, it also functions to preserve a racial hierarchy that essentially disregards Black humanity.

The abuse of sterilization laws designed to effect eugenic policy demonstrates the potential danger of governmental standards for procreation. During the first half of the twentieth century, the eugenics movement embraced the theory that intelligence and other personality traits are genetically determined and therefore inherited. This hereditarian belief, coupled with the reform approach of the progressive era, fueled a campaign to remedy America's social problems by stemming biological degeneracy. Eugenicists advocated compulsory sterilization to prevent reproduction by people who were likely to produce allegedly defective offspring. Eugenic sterilization was thought to improve society by eliminating its “socially inadequate” members. Many states around the turn of the century enacted involuntary sterilization laws directed at those deemed burdens on society, including the mentally retarded, mentally ill, epileptics, and criminals.

In a 1927 decision, Buck v. Bell, the Supreme Court upheld the constitutionality of a Virginia involuntary sterilization law. The plaintiff, Carrie Buck, was described in the opinion as “a feeble minded white woman” committed to a state mental institution who was “the daughter of a feeble minded mother in the same institution, and the mother of an illegitimate feeble minded child.” The Court approved an order of the mental institution that Buck undergo sterilization. Justice Holmes, himself an ardent eugenicist, gave eugenic theory the imprimatur of constitutional law in his infamous declaration: “Three generations of imbeciles are enough.”

The salient feature of the eugenic sterilization laws is their brutal imposition of society's restrictive norms of motherhood. Governmental control of reproduction in the name of science masks racist and classist judgments about who deserves to
bear children. It is grounded on the premise that people who depart from social norms do not deserve to procreate. Carrie Buck, for example, was punished by sterilization not because of any mental disability, but because of her deviance from society's social and sexual norms.

Explanations of the eugenic rationale reveal this underlying moral standard for procreation. One eugenicist, for example, justified his extreme approach of putting the socially inadequate to death as “the surest, the simplest, the kindest, and most humane means for preventing reproduction among those whom we deem unworthy of the high privilege.” Dr. Albert Priddy, the superintendent of the Virginia Colony, similarly explained the necessity of eugenic sterilization in one of his annual reports: the “sexual immorality” of ‘anti-social’ ‘morons' rendered them ‘wholly unfit for exercising the right of motherhood.”

Fourteen years after Buck v. Bell, the Court acknowledged the danger of the eugenic rationale. Justice Douglas recognized both the fundamental quality of the right to procreate and its connection to equality in a later sterilization decision, Skinner v. Oklahoma. Skinner considered the constitutionality of the Oklahoma Habitual Criminal Sterilization Act authorizing the sterilization of persons convicted two or more times for “felonies involving moral turpitude.” An Oklahoma court had ordered Skinner to undergo a vasectomy after he was convicted once of stealing chickens and twice of robbery with firearms. The statute, the Court found, treated unequally criminals who had committed intrinsically the same quality of offense. For example, men who had committed grand larceny three times were sterilized, but embezzlers were not. The Court struck down the statute as a violation of the equal protection clause. Declaring the right to bear children to be “one of the basic civil rights of man,” the Court applied strict scrutiny to the classification and held that the government failed to demonstrate that the statute's classifications were justified by eugenics or the inheritability of criminal traits.

Skinner rested on grounds that linked equal protection doctrine and the right to procreate. Justice Douglas framed the legal question as “a sensitive and important area of human rights.” The reason for the Court's elevation of the right to procreate was the Court's recognition of the significant risk of discriminatory selection inherent in state intervention in reproduction. The Court also understood the genocidal implications of a government standard for procreation: “In evil or reckless hands the government's power to sterilize can cause races or types which are inimical to the dominant group to wither and disappear.” The critical role of procreation to human survival and the invidious potential for government discrimination against disfavored groups makes heightened protection crucial. The Court understood the use of the power to sterilize in the government's discrimination against certain types of criminals to be as invidious “as if it had selected a particular race or nationality for oppressive treatment.”

Although the reasons advanced for the sterilization of chicken thieves and the prosecution of drug-addicted mothers are different, both practices are dangerous for similar reasons. Both effectuate ethnocentric judgments by the government that certain members of society do not deserve to have children. As the Court recognized in Skinner, the enforcement of a government standard for childbearing denies the disfavored group a critical aspect of human dignity.

The history of compulsory sterilization demonstrates that society deems women who deviate from its norms of motherhood — in 1941, teenaged delinquent girls like Carrie Buck who bore illegitimate children, today, poor Black crack addicts who use drugs during pregnancy — “unworthy of the high privilege” of procreation. The government therefore refuses to affirm their human dignity by helping them overcome obstacles to good mothering. Rather, it punishes them by sterilization or criminal prosecution and thereby denies them a basic part of their humanity. When this denial is based on race, the violation is especially serious. Governmental policies that perpetuate racial subordination
through the denial of procreative rights, which threaten both racial equality and privacy at once, should be subject to the highest scrutiny.

E. Toward a New Privacy Jurisprudence

Imagine that courts and legislatures have accepted the argument that the prosecution of crack-addicted mothers violates their right of privacy. All pending indictments for drug use during pregnancy are dismissed and bills proposing fetal abuse laws are discarded. Would there be any perceptible change in the inferior status of Black women? Pregnant crack addicts would still be denied treatment, and most poor Black women would continue to receive inadequate prenatal care. The infant mortality rate for Blacks would remain deplorably high. In spite of the benefits of privacy doctrine for women of color, liberal notions of privacy are inadequate to eliminate the subordination of Black women. In this section, I will suggest two approaches that I believe are necessary in order for privacy theory to contribute to the eradication of racial hierarchy. First, we need to develop a positive view of the right of privacy. Second, the law must recognize the connection between the right of privacy and racial equality.

The most compelling argument against privacy rhetoric, from the perspective of women of color, is the connection that feminist scholars have drawn between privacy and the abortion funding decisions. Critics of the concept of privacy note that framing the abortion right as a right merely to be shielded from state intrusion into private choices provides no basis for a constitutional claim to public support for abortions. As the Court explained in Harris v. McRae, “although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation.” MacKinnon concludes that abortion as a private privilege rather than a public right only serves to perpetuate inequality:

Privacy conceived as a right from public intervention and disclosure is the opposite of the relief that Harris sought for welfare women. State intervention would have provided a choice women did not have in [the] private [realm]. The women in Harris, women whose sexual refusal has counted for particularly little, needed something to make their privacy effective. The logic of the Court's response resembles the logic by which women are supposed to consent to sex. Preclude the alternatives, then call the sole remaining option “her choice.” The point is that the alternatives are precluded prior to the reach of the chosen legal doctrine. They are precluded by conditions of sex, race, and class — the very conditions the privacy frame not only leaves tacit but exists to guarantee.

This critique is correct in its observation that the power of privacy doctrine in poor women's lives is constrained by liberal notions of freedom. First, the abstract freedom to choose is of meager value without meaningful options from which to choose and the ability to effectuate one's choice. The traditional concept of privacy makes the false presumption that the right to choose is contained entirely within the individual and not circumscribed by the material conditions of the individual's life. Second, the abstract freedom of self-definition is of little help to someone who lacks the resources to realize the personality she envisions or whose emergent self is continually beaten down by social forces. Defining the guarantee of personhood as no more than shielding a sphere of personal decisions from the reach of government — merely ensuring the individual's “right to be let alone” — may be inadequate to protect the dignity and autonomy of the poor and oppressed.

The definition of privacy as a purely negative right serves to exempt the state from any obligation to ensure the social conditions and resources necessary for self-determination and autonomous decisionmaking. Based on this narrow view of liberty, the Supreme Court has denied a variety of claims to government aid. MacKinnon notes
that “it is apparently a very short step from that which the government has a duty not to intervene in to that which it has no duty to intervene in.”

An evolving privacy doctrine need not make the step between these two propositions. Laurence Tribe, for example, has suggested an alternative view of the relationship between the government's negative and affirmative responsibilities in guaranteeing the rights of personhood: “Ultimately, the affirmative duties of government cannot be severed from its obligations to refrain from certain forms of control; both must respond to a substantive vision of the needs of human personality.”

This concept of privacy includes not only the negative proscription against government coercion, but also the affirmative duty of government to protect the individual's personhood from degradation and to facilitate the processes of choice and self-determination. This approach shifts the focus of privacy theory from state nonintervention to an affirmative guarantee of personhood and autonomy. Under this post-liberal doctrine, the government is not only prohibited from punishing crack-addicted women for choosing to bear children; it is also required to provide drug treatment and prenatal care. Robin West has eloquently captured this progressive understanding of the due process clause in which privacy doctrine is grounded: “The ideal of due process, then, is an individual life free of illegitimate social coercion facilitated by hierarchies of class, gender, or race. The goal is an affirmatively autonomous existence: a meaningfully flourishing, independent, enriched individual life.”

This affirmative view of privacy is enhanced by recognizing the connection between privacy and racial equality. The government's duty to guarantee personhood and autonomy stems not only from the needs of the individual, but also from the needs of the entire community. The harm caused by the prosecution of crack-addicted mothers is not simply the incursion on each individual crack addict's decisionmaking; it is the perpetuation of a degraded image that affects the status of an entire race. The devaluation of a poor Black addict's decision to bear a child is tied to the dominant society's disregard for the motherhood of all Black women. The diminished value placed on Black motherhood, in turn, is a badge of racial inferiority worn by all Black people. The affirmative view of privacy recognizes the connection between the dehumanization of the individual and the subordination of the group.

Thus, the reason that legislatures should reject laws that punish Black women's reproductive choices is not an absolute and isolated notion of individual autonomy. Rather, legislatures should reject these laws as a critical step towards eradicating a racial hierarchy that has historically demeaned Black motherhood. Respecting Black women's decision to bear children is a necessary ingredient of a community that affirms the personhood of all of its members. The right to reproductive autonomy is in this way linked to the goal of racial equality and the broader pursuit of a just society. This broader dimension of privacy's guarantees provides a stronger claim to government's affirmative responsibilities.

Feminist legal theory, with its emphasis on the law's concrete effect on the condition of women, calls for a reassessment of traditional privacy law. It may be possible, however, to reconstruct a privacy jurisprudence that retains the focus on autonomy and personhood while making privacy doctrine effective. Before dismissing the right of privacy altogether, we should explore ways to give the concepts of choice and personhood more substance. In this way, the continuing process of challenge and subversion — the feminist critique of liberal privacy doctrine, followed by the racial critique of the feminist analysis — will forge a finer legal tool for dismantling institutions of domination.

**VIII. CONCLUSION**

Our understanding of the prosecutions of drug-addicted mothers must include the perspective of the women whom they most directly affect. The prosecutions arise in a particular historical and political context that has constrained reproductive choice for poor women of color. The state's decision to punish drug-addicted mothers rather than help them stems from the poverty and race of the defendants and society's denial of their full dignity as human beings. Viewing
the issue from their vantage point reveals that the prosecutions punish for having babies women whose motherhood has historically been devalued.

A policy that attempts to protect fetuses by denying the humanity of their mothers will inevitably fail. We must question such a policy's true concern for the dignity of the fetus, just as we question the motives of the slave owner who protected the unborn slave child while whipping his pregnant mother. Although the master attempted to separate the mother and fetus for his commercial ends, their fates were inextricably intertwined. The tragedy of crack babies is initially a tragedy of crack-addicted mothers. Both are part of a larger tragedy of a community that is suffering a host of indignities, including, significantly, the denial of equal respect for its women's reproductive decisions.

It is only by affirming the personhood and equality of poor women of color that the survival of their future generation will be ensured. The first principle of the government's response to the crisis of drug-exposed babies should be the recognition of their mothers' worth and entitlement to autonomy over their reproductive lives. A commitment to guaranteeing these fundamental rights of poor women of color, rather than punishing them, is the true solution to the problem of unhealthy babies.

Footnotes

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had been brought nationwide in the three months following the Supreme Court's decision in Webster v. Reproductive Health Servs., 109 S.Ct. 3040 (1989).


According to a memorandum prepared by the ACLU Reproductive Freedom Project, of the 52 defendants, 35 are African-American, 14 are white, 2 are Latina, and 1 is Native American. See State Case Summary, supra note 2; Telephone interviews with Joseph Merkin, Attorney for Sharon Peters (Jan. 7, 1991), James Shields, North Carolina ACLU (Jan. 7, 1991), and Patrick Young, Attorney for Brenda Yurchak (Jan. 7, 1991); see also Kolata, Bias Seen Against Pregnant Addicts, N.Y. Times, July 20, 1990, at A13, col. 1 (indicating that of 60 women charged, 80% were minorities). The disproportionate prosecution of poor Black women can be seen most clearly in the states that have initiated the most cases. In Florida, where two women have been convicted for distributing drugs to a minor, 10 out of 11 criminal cases were brought against Black women. See State Case Summary, supra note 2, at 3-5. Similarly, of 18 women in South Carolina charged since August 1989 with either criminal neglect of a child or distribution of drugs to a minor, 17 have been Black. See id. at 12.

See Hoffman, supra note 5, at 35 (noting that “with the exception of a few cases, prosecutors have not gone after pregnant alcoholics”).

In addition to prosecuting women after the birth of a baby for prenatal crimes, the range of state intrusions on pregnant women's autonomy includes jailing pregnant women, see infra notes 54-56 and accompanying text; placing the child in protective custody, see N.J. REV. STAT. § 30:4C-11 (West 1981); allowing tort suits by children against their mothers for negligent conduct during pregnancy, see Grodin v. Grodin, 102 Mich. App. 396, 301 N.W.2d 869 (1980); ordering forced medical treatment performed on pregnant women, see In re A.C., 573 A.2d 1235 (D.C. 1990); depriving mothers of child custody based on acts during pregnancy, see infra notes 48-53 and accompanying text; upholding employer policies excluding fertile women from the workplace, see UAW v. Johnson Controls, Inc., 886 F.2d 871 (7th Cir. 1989), rev'd, 111 S.Ct. 1196 (1991); and placing greater restrictions on access to abortion, see Webster v. Reproductive Health Servs., 109 S.Ct. 3040 (1989). For general theoretical treatments of the issues involved in state intervention during pregnancy, see Gallagher, Prenatal Invasions & Interventions: What's Wrong with Fetal Rights, 10 HARV. WOMEN'S L.J. 9 (1987); Goldberg, Medical Choices During Pregnancy: Whose Decision Is It Anyway?, 41 Rutgers L. Rev. 591 (1989); McNulty, Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses, 16 N.Y.U. REV. L. & SOC. CHANGE 277, 279-90 (1988); and Note, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection, 95 YALE L.J. 599 (1986).

I use the term “women of color” to refer to non-white women in America, including Black, Latina, Asian, and Native American women. Recognizing the diversity of historical and cultural backgrounds among women of color, this Article focuses particularly on the experience of Black women in America. When women of color are united in a common experience of oppression and poverty, however, I draw more general conclusions about constraints on their reproductive autonomy.


See infra notes 156-157 and accompanying text.

See infra notes 87-89 and accompanying text.


The scholarship of people of color is a more recent variety of alternative jurisprudence. See, e.g., D. BELL, AND WE ARE NOT SAVED (1987); Cook, Beyond Critical Legal Studies: The Reconstructive Theology of Dr. Martin Luther King, Jr., 103 HARV. L. REV. 985 (1990); Crenshaw, Race, Reform, and Retrenchment: Transformation and Legitimation in Antidiscrimination Law, 101 HARV. L. REV. 1331 (1988). Among this latter group are scholars who, like me, are particularly concerned with the legal problems and concrete experiences of Black women. Their work has informed and inspired me. See, e.g., Austin, Sapphire Bound!, 1989 WIS. L. REV. 539; Harris, Race and Essentialism in Feminist Legal Theory, 42 STAN. L. REV. 581 (1990); Scales-Trent, Black Women and the Constitution: Finding Our Place, Asserting Our Rights, 24 HARV. C.R.-C.L. L. REV. 9 (1989).

For a description and critique of feminist standpoint epistemology, see Bartlett, Feminist Legal Methods, 103 HARV. L. REV. 829, 872-77 (1990). Bartlett criticizes feminist standpoint epistemology because it tends to standardize women's characteristics, it denies the significance of the viewpoints of non-victims, it does not explain differences of perception among women, and it engenders adversarial politics. See id. at 873-75. These criticisms have merit. Notwithstanding the problems inherent in adopting a general feminist standpoint epistemology, I believe there is value in the limited project of focusing on the perspective of Black women, especially because that perspective has traditionally been ignored.

See infra notes 197-214, 248-257 and accompanying text.

See Harris, supra note 14, at 604 (“Far more for black women than for white women, the experience of self is precisely that of being unable to disentangle the web of race and gender — of being enmeshed always in multiple, often contradictory, discourses of sexuality and color.”); Kline, Race, Racism, and Feminist Legal Theory, 12 HARV. WOMEN'S L.J. 115, 121 (1989); Scales-Trent, supra note 14, at 9. The theme of the simultaneity of multiple forms of oppression is common in Black feminist writings. See, e.g., Combahee River Collective, A Black Feminist Statement, in THIS BRIDGE CALLED MY BACK: WRITINGS BY RADICAL WOMEN OF COLOR 210, 213 (C. Moraga & G. Anzaldua eds. 1981); B. HOOKS, AIN'T I A WOMAN: BLACK WOMEN AND FEMINISM 12 (1981) (“[A]t the moment of my birth, two factors determined my destiny, my having been born black and my having been born female.”).

See Scales-Trent, supra note 14, at 9 & n.2 (noting that “race and sex interact to magnify the effect of each independently”).

Angela Harris notes the fragmentation produced by an arithmetic approach to multiple oppression: “‘The result of essentialism is to reduce the lives of people who experience multiple forms of oppression to addition problems: ‘racism + sexism = straight black women's experience . . . .’’” Harris, supra note 14, at 588.

White feminist scholars do not completely ignore diversity among women. Catharine MacKinnon, for example, acknowledges the experiences of women of color and recognizes that feminist theory must take race into account. See, e.g., C. MACKINNON, FEMINISM UNMODIFIED 2 (1987) (“[G]ender . . . . appears partly to comprise the meaning of, as well as bisect, race and class, even as race and class specificities make up, as well as cross-cut, gender.”).

Professor Harris defines gender essentialism as “‘the notion that a unitary, ‘essential’ women's experience can be isolated and described independently of race, class, sexual orientation, and other realities of experience.’” Harris, supra note 14, at 585. She observes that this tendency toward gender essentialism results in the silencing of the very same voices ignored by mainstream legal jurisprudence — including the voices of women of color. See id. To claim the existence of a monolithic, universal “woman's voice” is in fact to claim that the voice of white, heterosexual, socioeconomically privileged women can speak for all other women. See id. at 588; see also E. SPELMAN, INESSENTIAL WOMAN: PROBLEMS OF EXCLUSION IN FEMINIST THOUGHT 4 (1988) (“[T]he real problem has been how feminist theory has confused the condition of one group of women with the condition of all.”); Crenshaw, Demarginalizing the Intersection of Race and Sex: A Black Feminist
Critique of Antidiscrimination Doctrine, Feminist Theory and Racist Politics, 1989 U. CHI. LEGAL F. 139, 152-60 (arguing that feminist theory has been built only upon the experiences of white women).

21 See A. LORDE, Age, Race, Class, and Sex: Women Redefining Difference, in SISTER OUTSIDERS 114, 122 (1984) (“Now we must recognize differences among women who are our equals, neither inferior nor superior, and devise ways to see each others’ difference to enrich our visions and our joint struggles.”); Harris, supra note 14, at 585-86; Kline, supra note 17, at 150 (“It is imperative that white feminist legal theorists problematize and complicate our analyses by taking into account the real and contradictory differences of interest and power between women that are generated by, and generate, racism.”); see also Cain, Feminist Jurisprudence: Grounding the Theories, 4 BERKELEY WOMEN'S L.J. 191, 204-05 (1990) (“Good feminist thought ought to reflect the real differences in women's realities, in our lived experiences. These include differences of race, class, age, physical ability and sexual preference.”) (citation omitted)).

22 The fourteenth amendment, for example, explicitly gives Congress the power to enforce the equal protection clause. See U.S. CONST. amend. XIV, § 5.


24 See, e.g., Hodgson v. Minnesota, 110 S.Ct. 2926, 2969-70 (1990) (upholding state statute requiring notification of two parents before a minor may obtain an abortion unless she secures a court order); Webster v. Reproductive Health Servs., 109 S.Ct. 3040, 3052 (1989) (permitting state restrictions on abortion, including a ban on the use of public facilities for performing some abortions); Harris v. McRae, 448 U.S. 297, 326 (1980) (upholding version of Hyde Amendment that withheld federal Medicaid funds used to reimburse costs of abortion not necessary to save the mother's life); Maher v. Roe, 432 U.S. 464, 480 (1977) (permitting states to deny welfare payments for nontherapeutic abortions).

25 Professor West argues that “for both strategic and theoretical reasons, the proper audience for the development of a progressive interpretation of the Constitution is Congress rather than the courts.” West, Progressive and Conservative Constitutionalism, supra note 14, at 650 (emphasis in original). Alan Freeman has expressed a similar sentiment in more blunt terms: “If the federal courts are to become, as they were in the past, little more than reactionary apologists for the existing order, we should treat them with the contempt they deserve. One can only hope that other political institutions will be reinvigorated.” Freeman, Antidiscrimination Law: The View from 1989, 64 TUL. L. REV. 1407, 1441 (1990). I do not advocate abandoning litigation as a strategy for challenging government abuses. Rather, I am suggesting the exploration of other forums for taking collective action to implement visions of a just society. State courts and state constitutions may also provide a more progressive understanding of equal protection and privacy rights. See Brennan, State Constitutions and the Protection of Individual Rights, 90 HARV. L. REV. 489 (1977); Developments in the Law — The Interpretation of State Constitutional Rights, 95 HARV. L. REV. 1324, 1442-43 (1982). State courts, for example, have interpreted the right of teenagers to obtain an abortion without parental consent more broadly under the state constitution's right of privacy than the Supreme Court has under the federal Constitution. Compare American Academy of Pediatrics v. Van de Kamp, 263 Cal. Rptr. 46, 55 (Cal. Ct. App. 1989) (affirming the issuance of a preliminary injunction of law that prohibited minors from obtaining abortions without parental consent or court order as violating state constitutional right of privacy) and In re T.W., 551 So. 2d 1186, 1194 (Fla. 1989) (holding that a Florida statute requiring minors to obtain parental consent or court order prior to obtaining abortion violated the right of privacy guaranteed by Florida's constitution) with Hodgson v. Minnesota, 110 S.Ct. 2926, 2969-70 (1990) (holding that a parental notification requirement with judicially granted exception does not violate the Constitution).

26 See West, Progressive and Conservative Constitutionalism, supra note 14, at 715.

27 Id. at 717.
Professor Ball argues that some minority scholars are engaged in translating, or making visible, their world so that they may influence and eventually transform the world of conventional academia. See Ball, The Legal Academy and Minority Scholars, 103 HARV. L. REV. 1855, 1857-60 (1990).


Approximately half of the nation's crack addicts are women. See Alters, Women and Crack: Equal Addiction, Unequal Care, Boston Globe, Nov. 1, 1989, at 1, col. 1. Some have theorized that women are attracted to crack because they can be smoked rather than injected. See Teltsch, In Detroit, a Drug Recovery Center that Welcomes the Pregnant Addict, N.Y. Times, Mar. 20, 1990, at A14, col. 1. The highest concentrations of crack addicts are found in innercity neighborhoods. See Malcolm, Crack, Bane of Inner City, Is Now Gripping Suburbs, N.Y. Times, Oct. 1, 1989, § 1, at 1, col. 1.


Many crack-addicted women become pregnant as a result of trading sex for crack or turning to prostitution to support their habit. See Alters, supra note 30, at 1, col. 1; Kolata, supra note 6, at A13, col. 1. Crack seems to encourage sexual activity, in contrast to the passivity induced by heroin addiction. See Alters, supra note 30, at 1, col. 1.


The number of babies born to cocaine-addicted mothers in New York City, for example, has more than quadrupled since 1985. See More Births to Cocaine Users, N.Y. Times, Apr. 7, 1990, at B30, col. 2.


See id.


See Koren, Graham, Shear & Einarsen, Bias Against the Null Hypothesis: The Reproductive Hazards of Cocaine, LANCET, Dec. 16, 1989, at 1440, 1440; Blakeslee, Child-Rearing Is Stormy when Drugs Cloud Birth, N.Y. Times, May 19, 1990, § 1, at 1, col. 3.
44 See Koren, Graham, Shear & Einarson, supra note 43, at 1441.


46 See Koren, Graham, Shear & Einarson, supra note 43, at 1440-41.

47 See Nolan, supra note 33, at 14.


49 Several states have enacted statutes that require the reporting of positive newborn toxicologies to state authorities. See MASS. GEN. L. ch. 119, § 51A (Supp. 1990); MINN. STAT. ANN. § 626.556(2)(c) (West Supp. 1991); OKLA. STAT. ANN. tit. 21, § 846 (West Supp. 1991); UTAH CODE ANN. § 62A-4-504 (1989). Many hospitals also interpret state child abuse reporting laws to require them to report positive results. For a discussion of the constitutional and ethical issues raised by the drug screening of postpartum women and newborns, see Moss, Legal Issues: Drug Testing of Postpartum Women and Newborns as the Basis for Civil and Criminal Proceedings, 23 CLEARINGHOUSE REV. 1406, 1409-13 (1990); Moss, supra note 2, at 292-96.


55 At Vaughn's sentencing, Judge Peter Wolf stated: “I'm going to keep her locked up until the baby is born because she's tested positive for cocaine when she came before me. . . . She's apparently an addictive personality, and I'll be darned if I'm going to have a baby born that way.” Moss, supra note 54, at 20.
See Davidson, supra note 35, at 19, col. 1.

See supra notes 2 & 5.

See, e.g., Parness, The Duty to Prevent Handicaps: Laws Promoting the Prevention of Handicaps to Newborns, 5 W. NEW ENG. L. REV. 431, 442-52 (1983); Parness & Pritchard, supra note 13, at 270 (advocating that states “promote the unborn's potentiality for life by outlawing fetus endangerment, abandonment, neglect and nonsupport”) (citations omitted).

See supra note 6.

Black women are five times more likely to live in poverty, five times more likely to be on welfare, and three times more likely to be unemployed than are white women. See UNITED STATES COMM'N ON CIVIL RIGHTS, THE ECONOMIC STATUS OF BLACK WOMEN 1 (1990).

See infra notes 70-78 and accompanying text.

See McNulty, supra note 8, at 319; see also Faller & Ziefert, Causes of Child Abuse and Neglect, in SOCIAL WORK WITH ABUSED AND NEGLECTED CHILDREN 32, 46-47 (K. Faller ed. 1981) (providing a similar explanation of why poor parents are more likely to be reported for child neglect).

See Note, supra note 51, at 753, 782 n.157; Kolata, supra note 31, at A13, col. 3.

See Note, supra note 51, at 753.


See Note, supra note 51, at 753, 798-99.

See Moss, supra note 49, at 1412; infra notes 143-146 and accompanying text.

See Note, supra note 51, at 753.

See Chasnoff, Landress & Barrett, supra note 65, at 1206; Note, supra note 51, at 754 & n.36; see also Faller & Ziefert, supra note 62, at 47 (noting that professionals are more likely to report child abuse by poor parents because of their disbelief in abuse by their own socioeconomic class).

See Note, supra note 51, at 754 & n.36; Chasnoff, Landress & Barrett, supra note 65, at 1205.

See Chasnoff, Landress, & Barrett, supra note 65, at 1205 (table 3).

See id. at 1203. The researchers tested urine samples from 715 pregnant women who enrolled for prenatal care in the county during a one-month period. Three hundred eighty women at five public health clinics and 335 women at 12 private obstetrical offices were screened for alcohol, opiates, cocaine and its metabolites, and cannabinoids between January 1 and June 30, 1989.

See id. at 1204. The rate of positive results on toxicologic testing for white women (15.4%) was slightly higher than that for Black women (14.1%). See id. at 1204 (table 2).

“The frequency of a positive result was 16.3% for women seen at the public clinics and 13.1% for women seen at the private offices.” Id. at 1203 (table 1).

In March 1987, the Florida Department of Health and Rehabilitative Services adopted a policy requiring hospitals to report to local health departments evidence of drug and alcohol use during pregnancy. See id. at 1202-03.

See id. at 1204.

The authors of the Pinellas County study suggest several reasons for the discrepancy in reporting. Physicians may have been prompted to test Black women and their infants more frequently because the infants displayed more severe symptoms or
because Black women intoxicated from smoking crack are more readily identified than white women intoxicated from smoking marijuana. See id. at 1205. Additionally, the disproportionate reporting of Black women may result from socioeconomic factors and the mistaken preconception that substance abuse during pregnancy is predominantly an inner-city, minority group problem. See id. at 1206. The second explanation does not negate the racist nature of the rate of reporting and subsequent prosecution of women who use drugs during pregnancy, however. Even if physicians do not consciously decide to report Black women rather than white women, their testing and reporting practices unjustifiably discriminate against Black women and thus demonstrate their unconscious racism. See Lawrence, The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism, 39 STAN. L. REV. 316, 328-44 (1987).

The striking degree of difference between the reporting rate of drug use by Black women and that of white women and the similarity in their rates of substance abuse strongly suggests that racial prejudice and stereotyping must be a factor.

Numerous maternal activities are potentially harmful to the developing fetus, including drinking alcohol, taking prescription and nonprescription drugs, smoking cigarettes, failing to eat properly, and residing at high altitudes for prolonged periods. See, e.g., INSTITUTE OF MED., PREVENTING LOW BIRTHWEIGHT 65-72 (1985); Berkowitz, Holford & Berkowitz, Effects of Cigarette Smoking, Alcohol, Coffee and Tea Consumption on Preterm Delivery, 7 EARLY HUM. DEV. 239 (1982); Note, Parental Liability for Prenatal Injury, 14 COLUM. J.L. & SOC. PROBS. 47, 73-75 (1978). Conduct by people other than the pregnant woman can also threaten the health of the fetus. A pregnant woman's exposure to secondary cigarette smoke, sexually transmitted and other infectious diseases, environmental hazards such as radiation and lead, and physical abuse can harm the fetus. See CHILDREN'S DEFENSE FUND, THE HEALTH OF AMERICA'S CHILDREN 35-37 (1989); Note, supra note 8, at 606-07.


Marijuana use during pregnancy has been associated with impaired fetal development and reduced gestational length. See, e.g., Fried, Watkinson & Willan, Marijuana Use During Pregnancy and Decreased Length of Gestation, 150 AM. J. OBSTETRICS & GYN. 23 (1984); Zuckerman, Frank, Hingson, Amaro, Levenson, Kayne, Parker, Vinci, Abaogye, Fried, Cabral, Timperi & Bauchner, Effects of Maternal Marijuana and Cocaine Use on Fetal Growth, 320 NEW ENG. J. M. ED. 762 (1989) [hereinafter Effects of Maternal Marijuana].

Approximately 6000 to 8000 newborns each year suffer from fetal alcohol syndrome. See Nolan, supra note 33, at 15. An additional 35,000 infants experience less severe effects of maternal drinking. See Doctors Criticized on Fetal Problem, N.Y. Times, Dec. 11, 1990, at B10, col. 6. A study of 2200 women who gave birth at the University of Washington Hospital in Seattle from March 1989 to March 1990 and who used drugs during or immediately before pregnancy revealed that 20% smoked marijuana, 16% used cocaine, and 9% used either heroin, methadone, or amphetamines. See Blakeslee, Parents Fight for a Future for Infants Born to Drugs, N.Y. Times, May 19, 1990, at A1, col. 3; see also Effects of Maternal Marijuana, supra note 81, at 762 (noting that in 1985, 31% of American women in their late teens and early twenties reported using marijuana within the past year).

See State Case Summary, supra note 2; infra note 260.

See Chasnoff, Landress & Barrett, supra note 65, at 1204; Malcolm, supra note 30, at 1, col. 1. A 1989 study of 2278 highly educated women found that 30% consumed more than one drink per week while pregnant. See Rosenthal, supra note 80, at 49. Furthermore, despite the media's depiction of crack addiction as an exclusively inner-city problem, crack use among middle-class and affluent people is on the rise. See Elmer-DeWitt, A Plague Without Boundaries: Crack, Once a Problem of the Poor, Invades the Middle Class, TIME, Nov. 6, 1989, at 97; Malcolm, supra note 30, at 1, col. 1.

See Malcolm, supra note 30, at 1, col. 1. The Pinellas County study, for example, found that Black women tested positive more frequently for cocaine use during pregnancy (7.5% versus 1.8% for white women), whereas white women tested positive...
more frequently for the use of marijuana (14.4% versus 6.0% for Black women). See Chasnoff, Landress & Barrett, supra note 65, at 1204 (table 2).


In 1987, the mortality rate for Black infants was 17.9 deaths per 1000, compared to a rate of 8.6 deaths per 1000 for white infants. See U.S. DEPT OF COMMERCE, BUREAU OF CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 77 (table 110) (1990).

In 1986, the Black infant mortality rate (18 deaths per 1000 live births) was higher than the infant mortality rate in Bulgaria, Costa Rica, Cuba, and Singapore. See CHILDREN'S DEFENSE FUND, supra note 79, at 14 (table 1.8) (1989). A Black infant born in the inner city has an even greater chance of dying before reaching his first birthday. See id. at 23 (table 1.10).


See, e.g., id. at 120 (describing the dominant society's resistance to the concept of Black people as “vulnerable human beings”). For a discussion of the hegemonic function of racist ideology, see Crenshaw, supra note 14, at 1370-81 (1988). See generally G. FREDRICKSON, THE BLACK IMAGE IN THE WHITE MIND 256-82 (1971) (discussing the propagation of theories of Black inferiority and degeneracy at the turn of the century); J. WILLIAMSON, THE CRUCIBLE OF RACE: BLACK-WHITE RELATIONS IN THE AMERICAN SOUTH SINCE EMANCIPATION 111-51 (1984) (discussing the prevalence of theories near the turn of the century that Blacks, freed from slavery, were returning to their “natural state of bestiality”).


White masters controlled their slaves' reproductive capacity by rewarding pregnancy with relief from work in the field and additions of clothing and food, punishing slave women who did not give birth, manipulating slave marital choices, forcing them to breed, and raping them. See J. JONES, supra, at 34-35; WE ARE YOUR SISTERS: BLACK WOMEN IN THE NINETEENTH CENTURY 24-26 (D. Sterling ed. 1984); Clinton, Caught in the Web of the Big House: Women and Slavery, in THE WEB OF SOUTHERN SOCIAL RELATIONS 19, 23-28 (W. Raser, R. Saunders & J. Wakelyn eds. 1985).

Gates, To be Raped, Bred or Abused, N.Y. TIMES BOOK REV., Nov. 22, 1987, at 12 (reviewing H. JACOBS, INCIDENTS IN THE LIFE OF A SLAVE GIRL (J. Yellin ed. 1987)).

See J. JONES, supra note 91, at 20; Johnson, supra note 1, at 513.


Kimberlé Crenshaw describes how racist ideology reflects an “oppositional dynamic, premised upon maintaining Blacks as an excluded and subordinated ‘other.’” Crenshaw, supra note 14, at 1381. Under this pattern of oppositional categories, whites are associated with positive characteristics (industrious, intelligent, responsible); Blacks are associated with the opposite, aberrational qualities (lazy, ignorant, shiftless). See id. at 1370-71 & n.151.

A. DAVIS, supra note 91, at 7.

See D. WHITE, supra note 94, at 28-29.

Id. at 30.
See E. FOX-GENOVESE, supra note 94, at 292; D. WHITE, supra note 94, at 61.

See BLACK WOMEN IN WHITE AMERICA 163-71 (G. Lerner ed. 1973); P. GIDDINGS, supra note 91, at 85-89; B. HOOKS, supra note 17, at 55-60.

See Gresham, supra note 89, at 117.


See B. HOOKS, supra note 17, at 65-68; Omolade, Black Women, Black Men and Tawana Brawley: The Shared Condition, 12 HARV. WOMEN'S L.J. 12, 16 (1989).

See Allen, Surrogacy, Slavery, and the Ownership of Life, 13 HARV. J.L. & PUB. POL'Y 139, 140 n.9 (1990). Professor Allen tells the story of Polly, a woman wrongfully held in slavery, who successfully sued a white man in 1842 for the return of her daughter Lucy. Polly used slave law to prove unlawful possession. She argued that, because she was not in fact a slave at the time of Lucy's birth, she was the rightful owner of her daughter. See id. at 142-44.

See id. at 140 n.9; Burnham, Children of the Slave Community in the United States, 19 FREEDOMWAYS 75, 75-77 (1979).

O. GILBERT, NARRATIVE OF SOJOURNER TRUTH 133 (1878).

See P. GIDDINGS, supra note 91, at 46; WE ARE YOUR SISTERS, supra note 91, at 25-26, 58-61; D. WHITE, supra note 94, at 76-90.

See BLACK WOMEN IN WHITE AMERICA, supra note 99, at 40-42. This practice is poignantly described in the words of a former slave named Anna Julia Cooper in a speech given in 1893 to the Congress of Representative Women:
Yet all through the darkest period of the colored women's oppression in this country her yet unwritten history is full of heroic struggle, a struggle against fearful and overwhelming odds, that often ended in horrible death, to maintain and protect that which woman holds dearer than life. The painful, patient, and silent toil of mothers to gain a fee simple title to the bodies of their daughters, the despairing fight, as of an entrapped tigress, to keep hallowed their own persons, would furnish material for epics.


See Gray & Nybell, Issues in African-American Family Preservation, 69 CHILD WELFARE 513, 513 (1990) (noting that about half of the children in foster care are Black); Hogan & Sin, Minority Children and the Child Welfare System: An Historical Perspective, 33 SOC. WORK 493 (1988). Once Black children enter foster care, they remain there longer and receive less desirable placements than white children; they are also less likely than white children to be returned home or adopted. See B. MANDELL, WHERE ARE THE CHILDREN? A CLASS ANALYSIS OF FOSTER CARE AND ADOPTION 36 (1973); Gray & Nybell, supra, at 513-14; Stehno, Differential Treatment of Minority Children in Service Systems, 27 SOC. WORK 39, 39-41 (1982). These realities have led some Blacks to deem foster care a system of legalized slavery. See B. MANDELL, supra, at 60. Malcolm X described the state's disruption of his own family in these terms:

Soon the state people were making plans to take over all of my mothers' children. . . . A Judge . . . in Lansing had authority over me and all of my brothers and sisters. We were “state children,” court wards; he had the full say-so over us. A white man in charge of a black man's children! Nothing but legal, modern slavery — however kindly intentioned . . .
I truly believe that if ever a state social agency destroyed a family, it destroyed ours.


See Wald, supra note 53, at 629 n.22.
See Faller & Ziefert, supra note 62, at 47; Wald, supra note 53, at 629 n.21. For a discussion of the connection between the child welfare system and poverty, see Jenkins, Child Welfare as a Class System, in CHILDREN AND DECENT PEOPLE 3-4 (A. Schorr ed. 1974).


See Gray & Nybell, supra note 109, at 515-17; Stack, supra note 112, at 541. For descriptions of childrearing patterns in the Black community that are considered deviant, such as extended kin networks, see R. HILL, INFORMAL ADOPTION AMONG BLACK FAMILIES (1977); and C. STACK, ALL OUR KIN: STRATEGIES FOR SURVIVAL IN A BLACK COMMUNITY 62-107 (1974).

See Stack, supra note 112, at 539-43.

See id. at 547.

Johnson, supra note 1, at 493 (quoting S. Carolina Mortality Schedules, 1850, Abbeville District).

See id. at 493-96.

Id. at 495 (quoting S. Carolina Mortality Schedules, 1850, Abbeville District).

See id. at 496-508; Savitt, Smothering and Overlaying of Virginia Slave Children: A Suggested Explanation, 49 BULL. HIST. MED. 400, 400 (1975).

See Johnson, supra note 1, at 508-20.

See P. GIDDINGS, supra note 91, at 325-35; B. HOOKS, supra note 17, at 70-83; R. STAPLES, THE BLACK WOMAN IN AMERICA 10-34 (1976); Bennett & Gresham, supra note 89, at 117-18.


Id. at 5.

“Sterilization abuse occurs whenever the sterilization procedure is performed under conditions that . . . pressure an individual into agreeing to be sterilized, or obscure the risks, consequences, and alternatives associated with sterilization.” Petchesky, Reproduction, Ethics, and Public Policy: The Federal Sterilization Regulations, 9 HASTINGS CENTER REP. 29, 32 (1979); see also Note, Sterilization Abuse: Current State of the Law and Remedies for Abuse, 10 GOLDEN GATE U.L. REV. 1147, 1152-53 (1980) (listing many common situations of sterilization abuse).

See A. DAVIS, supra note 91, at 215-21; Nsiah-Jefferson, Reproductive Laws, Women of Color, and Low-Income Women, in REPRODUCTIVE LAWS FOR THE 1990S, at 46-47 (S. Cohen & N. Taub eds. 1988). One study found that 43% of women sterilized in 1973 under a federally funded program were Black, although only 33% of the patients were Black. See Note, supra note 124, at 1153 n.30, Spanish-speaking women are twice as likely to be sterilized as those who speak English. See Levin & Taub, Reproductive Rights, in WOMEN AND THE LAW § 10A.07[3][b], at 10A-28 (C. Lefcourt ed. 1989). The racial disparity in sterilization cuts across economic and educational lines, although the frequency of sterilization is generally higher among the poor and uneducated. Another study found that 9.7% of college-educated Black women had been sterilized, compared to 5.6% of college-educated white women. Among women without a high school diploma, 31.6% of Black women and 14.5% of white women had been sterilized. See id.

See Clarke, Subtle Forms of Sterilization Abuse: A Reproductive Rights Analysis, in TEST-TUBE WOMEN 120, 120-32 (R. Arditti, R. Klein & S. Minden eds. 1984); Nsiah-Jefferson, supra note 125, at 44-45; Petchesky, supra note 124, at 32.

See Nsiah-Jefferson, supra note 125, at 46-47.

See id.

See *Nsiah-Jefferson*, supra note 125, at 47-48; see also Note, supra note 124, at 1159-60 (noting the lack of any sanctions for noncompliance with federal sterilization regulations). In contrast to the encouragement of minority sterilization, our society views childbearing by white women as desirable. Ruth Colker tells the story of a classmate of hers in law school who decided to be sterilized. The university physician refused to allow her to undergo the procedure unless she agreed to attend several sessions with a psychiatrist, presumably to dissuade her from her decision. See *Colker, Feminism, Theology, and Abortion: Toward Love, Compassion, and Wisdom*, 77 CALIF. L. REV. 1011, 1067 n.196 (1989). Colker recognizes that the "physician's actions reflect the dominant social message — that a healthy (white) woman should want to bear a child." Id.


See *Nsiah-Jefferson*, supra note 125, at 45-46; *Petchesky*, supra note 124, at 39; Note, supra note 124, at 1154.

See *Harrington*, Introduction to S. SHEEHAN, A WELFARE MOTHER at x-xi (1976); MILWAUKEE COUNTY WELFARE RIGHTS ORG., WELFARE MOTHERS SPEAK OUT 72-92 (1972). In a chapter entitled “Welfare Mythology,” the Milwaukee County Welfare Rights Organization portrays a common image of welfare mothers: You give those lazy, shiftless good-for-nothings an inch and they'll take a mile. You have to make it tougher on them. They're getting away with murder now. You have to catch all those cheaters and put them to work or put them in jail. Get them off the welfare rolls. I'm tired of those niggers coming to our state to get on welfare. I'm tired of paying their bills just so they can sit around home having babies, watching their color televisions, and driving Cadillacs.

Id. at 72. Writers in the 1980s claimed that welfare induces poor Black women to have babies. See, e.g., C. MURRAY, LOSING GROUND 154-66 (1984). Other researchers have refuted this claim. See, e.g., Darity & Myers, Does Welfare Dependency Cause Female Headship? The Case of the Black Family, 46 J. MARRIAGE & FAM. 765, 773 (1984) (concluding that “[t]he attractiveness of welfare and welfare dependency exhibit no effects on black female family heads”).

This thinking was reflected in a recent newspaper editorial suggesting that Black women on welfare should be given incentives to use Norplant, a new contraceptive. See Poverty and Norplant: Can Contraception Reduce the Underclass?, Phila. Inquirer, Dec. 12, 1990, at A18, col. 1. On January 2, 1991, a California judge ordered a Black woman on welfare who was convicted of child abuse to use Norplant for three years as a condition of probation. See Lev, Judge Is Firm on Forced Contraception, but Welcomes an Appeal, N.Y. Times, Jan. 11, 1991, at A17, col. 1; see also *Lewin*, Implanted Birth Control Device Renews Debate over Forced Contraception, N.Y. Times, Jan. 10, 1991, at A20 col. 1 (reviewing the debate on forced use of Norplant). The condemnation of single mothers can also be seen as penalizing poor Black women for departing from white middle-class norms of motherhood. Cf. *Chambers v. Omaha Girls Club*, 834 F.2d 697 (8th Cir. 1987) (affirming dismissal of title VII action brought by an unmarried Black staff member of a private girls' club who was fired because she became pregnant). Regina Austin suggests that “young, single, sexually active, fertile, and nurturing black women are being viewed ominously because they have the temerity to attempt to break out of the rigid economic, social, and political categories that a racist, sexist, and class-stratified society would impose upon them.” Austin, supra note 14, at 555.

At Jennifer Johnson's sentencing, the prosecutor made clear the nature of the charges against her: “About the end of December 1988, our office undertook a policy to begin to deal with mothers like Jennifer Johnson . . . as in the status of a child abuse case, Your Honor. . . . We have never viewed this as a drug case.” Motion for Rehearing and Sentencing at 12, State v. Johnson, No. E89-890-CFA (Fla. Cir. Ct. Aug. 25, 1989) (emphasis added).

The drug user's pregnancy not only greatly increases the likelihood that she will be prosecuted, but also greatly enhances the penalty she faces upon conviction. In most states, drug use is a misdemeanor, while distribution of drugs is a felony. See Hoffman, supra note 5, at 44.

Pamela Rae Stewart, for example, was charged with criminal neglect in part because she failed to follow her doctor's orders to stay off her feet and refrain from sexual intercourse while she was pregnant. See *People v. Stewart*, No. M508197, slip op. at 4 (Cal. Mun. Ct. Feb. 26, 1987); *Bonavoglia*, The Ordeal of Pamela Rae Stewart, Ms., Jul./Aug. 1987, at 92, 92.
Seeking drug treatment is not a viable alternative. First, it is likely that the pregnant addict will be unable to find a drug treatment program that will accept her. See infra notes 151-155 and accompanying text. Second, even if she successfully completes drug counseling by the end of her pregnancy, she may still be prosecuted for her drug use that occurred during pregnancy before she was able to overcome her addiction.

I recognize that both becoming pregnant and continuing a pregnancy to term are not necessarily real “choices” that women — particularly women of color and addicted women — make. Rape, battery, lack of available contraceptives, and prostitution induced by drug addiction may lead a woman to become pregnant without exercising meaningful choice. Similarly, coercion from the father or her family, lack of money to pay for an abortion, or other barriers to access to an abortion may force a woman to continue an unwanted pregnancy. See infra note 211. Nevertheless, these constraints on a woman's choice do not justify the government's punishment of the reproductive course that she ultimately follows. While we work to create the conditions for meaningful reproductive choice, it is important to affirm women's right to be free from unwanted state intrusion in their reproductive decisions.

See supra pp. 1432-36.

See U.S. DEPT OF COMMERCE, BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 77 (table 110) (1990). This means that in 1987, Black children were 2.08 times more likely than white children to die before reaching one year of age. This is the largest gap between Black and white infant mortality rates since 1940, when infant mortality data were first reported by race. See CHILDREN'S DEFENSE FUND, supra note 79, at 3.


One of the most significant obstacles to receiving prenatal care is the inability to pay for health care services. See CHILDREN'S DEFENSE FUND, supra note 79, at 43-48; McNulty, supra note 8, at 295-97. Most poor women depend on overextended public hospitals for prenatal care because of the scarcity of neighborhood physicians who accept Medicaid. See id. Institutional, cultural, and educational barriers also deter poor women of color from using the few available services. See generally F. CARO, D. KALMUSS & I. LOPEZ, supra note 142 (discussing institutional and cultural barriers to prenatal care among low-income women in New York City); Curry, Nonfinancial Barriers to Prenatal Care, 15 WOMEN & HEALTH 85-87 (1989) (discussing accessibility problems to needed health care sites); Zambrana, A Research Agenda on Issues Affecting Poor and Minority Women: A Model for Understanding Their Health Needs, 14 WOMEN & HEALTH 137, 148-50 (1988) (discussing cultural barriers to prenatal care). A Haitian woman's explanation of why she discontinued prenatal care illustrates these obstacles to the use of public health facilities:

My friend say go to doctor and get checked. . . . My friend be on the phone much time before they make appointment. They no have space for 30 days.
When I go to hospital, it confusing. . . . I go early, and see doctor late in the afternoon. . . . I wait on many long lines and take lots of tests. I no understand why so many test every time. No one explain nothing. No one talk my language. I be tired, feel sick from hospital. I go three times, but no more. Too much trouble for nothing.
F. CARO, D. KALMUSS & I. LOPEZ, supra note 142, at 75-76.

See CHILDREN'S DEFENSE FUND, supra note 79, at 4 (table 1.1). The percentage of white women receiving adequate prenatal care was 72.6. See id.

See Hughes, Johnson, Rosenbaum & Simons, supra note 143, at 473-74; McNulty, supra note 8, at 293-94.
The percentage of Black women receiving prenatal care in the first three months of pregnancy declined from a high of 62.7 in 1980 to 61.1 in 1988. See Hilts, Life Expectancy for Blacks in U.S. Shows Sharp Drop, N.Y. Times, Nov. 29, 1990, at B17, col. 1. The percentage of babies born to Black women getting no prenatal care increased from 8.8 in 1980 to 11.0 in 1988. See id. The number of Black infant deaths could be reduced significantly by a national commitment to ensuring that all pregnant women receive high-quality prenatal care. See generally Leu, Legislative Research Bureau Report: A Proposal to Strengthen State Measures for the Reduction of Infant Mortality, 23 HARV. J. LEGIS. 559 (1986) (proposing methods for delivering prenatal care services to poor women). A recently revealed confidential draft of a report by the White House Task Force on Infant Mortality recommends 18 specific measures costing a total of $480 million per year to reduce infant mortality. “The steps include expansion of Medicaid to cover 120,000 additional pregnant women and children in low-income families, an increase in Federal spending on prenatal care and a requirement for states to provide a uniform set of Medicaid benefits to pregnant women.” Pear, Study Says U.S. Needs to Attack Infant Mortality, N.Y. Times, Aug. 6, 1990, at B9, col. 3. Programs specifically designed to provide prenatal care to low-income, high-risk women have succeeded in substantially reducing the rates of low birth-weight and high infant mortality. See F. CARO, D. KALMUSS & I. LOPEZ, supra note 142, at 3-5. For discussions of recommendations of measures to increase the use of prenatal care by poor women, see id. at 85-99; and Poland, Ager & Olson, supra note 45, at 303.

See Chavkin, Drug Addiction and Pregnancy: Policy Crossroads, 80 AM. J. PUB. HEALTH 483, 485 (1990); McNulty, supra note 8, at 301-02. A 1979 national survey by the National Institute on Drug Abuse found only 25 drug treatment programs that described themselves as specifically geared to female addicts. See Chavkin, supra, at 485. The lack of facilities for pregnant addicts in two cities illustrates the problem. A recent survey of 78 drug treatment programs in New York City revealed that 54% denied treatment to pregnant women, 67% refused to treat pregnant addicts on Medicaid, and 87% excluded pregnant women on Medicaid addicted specifically to crack. Less than half of those programs that did accept pregnant addicts provided prenatal care, and only two provided child care. See Chavkin, Help, Don't Jail, Addicted Mothers, N.Y. Times, July 18, 1989, at A21, col. 2. Similarly, drug-addicted mothers in San Diego must wait up to six months to obtain one of just 26 places in residential treatment programs that allow them to live with their children. See Schachter, Help Is Hard to Find for Addict Mothers: Drug Use “Epidemic” Overwhelms Services, L.A. Times, Dec. 12, 1986, pt. 2, at 1, col. 1; Substance Abuse Treatment for Women: Crisis in Access, Health Advoc., Spring 1989, at 9, col. 1. Furthermore, because Medicaid covers only 17 days of a typical 28-day program, poor women may not be able to afford full treatment even at centers that will accept them. See Hoffman, supra note 5, at 44.


See McNulty, supra note 8, at 301; Teltsch, supra note 30, at A14, col. 1.


See Cuskey, Berger & Densen-Gerber, supra note 148, at 312-14; Alters, supra note 30, at 1, col. 1.

See McNulty, supra note 150, at 22; Substance Abuse Treatment for Women: Crisis in Access, supra note 147, at 9.


See Chavkin, Drug Addiction and Pregnancy: Policy Crossroads, supra note 147, at 485; see also NATIONAL INSTITUTE ON DRUG ABUSE, DRUG DEPENDENCY IN PREGNANCY 46 (1978) (describing pervasive negative attitudes toward pregnant addicts).

The experience of one Black pregnant drug addict, whom I will call Mary, exemplifies the barriers to care. Mary needed to find a residential drug treatment program that provided prenatal care and accommodations for her two children, ages three and eight. She tried to get into H.U.G.S. (Hope, Unity and Growth), the sole residential treatment program for women with
children in Detroit, but there was no vacancy. Mary's only source of public prenatal care was Eleanor Hutzel Hospital, which has a clinic for high risk pregnancies. She was also able to receive drug counseling on an outpatient basis from the adjacent Eleanor Hutzel Recovery Center. But Mary encountered an eight-week waiting list at the hospital, and inadequate public transportation made it extremely difficult for her to get there. In the end, she received deficient care for both her addiction and her pregnancy. Telephone Interview with Adrienne Edmonson-Smith, Advocate with the Maternal-Child Health Advocacy Project, Wayne State University (July 25, 1990).


The government learned of Jennifer Johnson's crack addiction only because she confided her addiction to the obstetrician who delivered her baby at a public hospital. Her trust in her doctor prompted the hospital to test Johnson and her baby for drugs. See Brief of American Public Health Association and Other Concerned Organizations as Amici Curiae in Support of Appellant at 2, Johnson v. State, No. 89-1765 (Fla. Dist. Ct. App. Dec. 28, 1989). Moreover, the state's entire proof of Johnson's criminal intent was based on the theory that Johnson's attempts to get help for her addiction showed that she knew that her cocaine use harmed the fetus. The key evidence against her was that, a month before her daughter's birth, Johnson had summoned an ambulance after a crack binge because she was worried about its effect on her unborn child. See Trial Transcript, supra note 4, at 144.

See American Medical Association, Report of the Board of Trustees on Legal Interventions During Pregnancy: Court Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 J. A.M.A. 2663, 2669 (1990). The reaction of pregnant women in San Diego to the 1987 arrest of Pamela Rae Stewart for harming her unborn child illustrates the deterrent effect of prosecution. Health care professionals reported that their pregnant clients' fear of prosecution for drug use made some of them distrustful and caused others to decline prenatal care altogether. See Moss, supra note 49, at 1411-12.

See Note, supra note 51, at 766 & n.84; Chavkin, Help, Don't Jail, Addicted Mothers, supra note 147 at A21, col. 2.

See Escamilla-Mondanaro, Women: Pregnancy, Children and Addiction, 9 J. PSYCHEDELIC DRUGS 59, 59-60 (1977); see also Zuckerman, Amaro, Bauchner & Cabral, Depressive Symptoms During Pregnancy: Relationship to Poor Health Behaviors, 160 AM. J. OBSTETRICS & GYN. 1107, 1109 (1989) (stating that poor health behavior in pregnancy correlates with such characteristics as “being single, older, unemployed, and having a lower income”).


The fourteenth amendment provides, in relevant part, that “[n]o State shall make or enforce any law which shall . . . deny to any person within its jurisdiction the equal protection of the laws.” U.S. CONST. amend. XIV, § 1.


These competing views of equal protection law have been variously characterized by commentators. See, e.g., L. TRIBE, supra note 164, § 16-21, at 1514-21 (describing the “antidiscrimination” and “antisubjugation” principles); Brest, The Supreme Court, 1975 Term — Foreword: In Defense of the Antidiscrimination Principle, 90 HARV. L. REV. 1, 5 (1976) (advocating the antidiscrimination principle as a theory of racial justice); Colker, Anti-Subordination Above All: Sex, Race,


Commentators have noted that the Court adopted the discriminatory intent rule not because this standard is inherently required by the equal protection clause, but because it feared the remedies a discriminatory impact rule would entail. See, e.g., Binion, Intent and Equal Protection: A Reconsideration, 1983 SUP. CT. REV. 397, 404-08; Kennedy, supra note 142, at 1414 (noting Justice Brennan’s derision of the Court’s “fear of too much justice”); Schwemm, From Washington to Arlington Heights and Beyond: Discriminatory Purpose in Equal Protection Litigation, 1977 U. ILL. L.F. 961, 1050.

170 Freeman recognizes in the Court's discriminatory intent standard the twin notions of “fault” and “causation”: proof of an equal protection violation requires identification of a blameworthy perpetrator whose actions can be linked to the victim's injury. See Freeman, supra note 167, at 1054-56; see also Sullivan, The Supreme Court, 1985 Term — Comment: Sins of Discrimination: Last Term's Affirmative Action Cases, 100 HARV. L. REV. 78, 80 (1986) (arguing that “the Court has approved affirmative action only as precise penance for the specific sins of racism a government, union, or employer has committed in the past”).

171 See Personnel Adm'r v. Feeney, 442 U.S. 256, 279 (1979); Kennedy, supra note 142, at 1404.

172 Kennedy, supra note 142, at 1405.


174 See Kennedy, supra note 142, at 1425-27. See generally Note, To Infer or Not to Infer a Discriminatory Purpose: Rethinking Equal Protection Doctrine, 61 N.Y.U. L. REV. 334, 351-62 (1986) (discussing the impact-inference standard as applied to jury selection and advocating its extension to death penalty cases and other contexts). The cases in which the Supreme Court has applied this reasoning involve challenges to the racial composition of juries. See, e.g., Castaneda v. Partida, 430 U.S. 482, 500-01 (1977); Turner v. Fouche, 396 U.S. 346, 360-61 (1970). The Court has not been willing to extend this reasoning to other claims of racial discrimination in the administration of criminal justice. See Cardinale & Feldman, The Federal Courts and the Right to Nondiscriminatory Administration of the Criminal Law: A Critical View, 29 SYRACUSE L. REV. 659, 662-64 (1978); Kennedy, supra note 142, at 1402 (observing that “no defendant in state or federal court has ever successfully challenged his punishment on grounds of racial discrimination in sentencing”) (emphasis in original).


176 See id. at 494-97.

177 See McCleskey v. Kemp, 481 U.S. 279, 349-61 (1987) (Blackmun, J., dissenting) (applying the Castaneda test to a claim of discriminatory prosecution); Developments, supra note 173, at 1552-54 (advocating use of an impact-inference standard in the racial prosecution context).

178 See Chasnoff, Landress & Barrett, supra note 65, at 1204 (table 2).

179 See State Case Summary, supra note 2, at 3-5.
180 See supra p. 1434.
181 See supra p. 1433.
183 See Binion, supra note 169, at 407-08.
184 See Kennedy, supra note 142, at 1424-25.
185 See L. Tribe, supra note 164, § 16-21, at 1518, 1520-21.
186 See West, Progressive and Conservative Constitutionalism, supra note 14, at 693-94. Professor Tribe and others have argued that the antisubordination view of equality is more faithful to the historical origins of the Civil War amendments, which were drafted specifically to eradicate racial hierarchy. See L. Tribe, supra note 164, § 16-21, at 1516; Freeman, supra note 167, at 1061. In the Civil Rights Cases, 109 U.S. 3 (1883), for example, the Court asserted that the thirteenth amendment abolishes “all badges and incidents of slavery.” Id. at 20. In the Slaughter-House Cases, 83 U.S. (16 Wall.) 36 (1873), the Court identified as the “one pervading purpose” of the amendments “the freedom of the slave race, the security and firm establishment of that freedom, and the protection of the newly-made freeman and citizen from the oppressions of those who had formerly exercised unlimited dominion over him.” Id. at 71.
187 See Freeman, supra note 167, at 1054. Kimberlé Crenshaw similarly demonstrates how the “restrictive view” of antidiscrimination law assumes that a racially equitable society already exists. Crenshaw, supra note 14, at 1344.
188 Freeman, supra note 167, at 1054.
189 See Binion, supra note 169, at 447-48.
190 See supra notes 156-157 and accompanying text.
192 See supra notes 143-155 and accompanying text.
193 See sources cited supra note 8.
197 This is not to say that forced medical treatment has no relevance to the lives of poor women of color. In fact, court-ordered medical procedures are performed disproportionately on pregnant minority women. A study of 15 court-ordered cesarians published in 1987 found that 80% involved women of color; 27% of the women were not native English speakers. See Kolder, Gallagher & Parsons, Court-Ordered Obstetrical Interventions, 316 New Eng. J. Med. 1192, 1193 (1987); see also Daniels, Court-Ordered Cesareans: A Growing Concern for Indigent Women, 21 Clearinghouse Rev. 1064, 1065 (1988) (comparing the general distribution of cesarian sections with that of cesarians performed pursuant to court order); Gallagher, Fetus as Patient, in Reproductive Laws for the 1990s, supra note 125, at 157, 183-84 (discussing the discriminatory impact of forced medical treatment).
199 See supra notes 147 & 148.

200 The punishment of drug-addicted mothers raises ethical issues affecting poor women of color, however, because drug-addicted mothers are often reported to government authorities by their own physicians. In the Johnson trial, for example, Johnson's obstetricians provided the most damaging evidence against her by testifying that Johnson had admitted to them that she had smoked crack soon before both of her children were delivered. See Trial Transcript, supra note 4, at 15, 70. Punishing pregnant women based on information from their doctors undermines the confidential doctor-patient relationship and deters women from sharing important information with health care providers or even from obtaining prenatal care. See Berrien, supra note 156, at 247; Moss, supra note 49, at 1411-12; Roberts, supra note 2, at 60-61.

201 See, e.g., Annas, Predicting the Future of Privacy in Pregnancy: How Medical Technology Affects the Legal Rights of Pregnant Women, 13 NOVA L. REV. 329, 345 (1989) (“Treating the fetus against the will of the mother requires us to degrade and dehumanize the mother and treat her as an inert container.”); Gallagher, supra note 8, at 27 (“The individual women themselves become invisible or viewed only as vessels — carriers of an infinitely more valuable being.”).

202 See supra notes 94-95 and accompanying text.

203 See, e.g., Goldberg, supra note 8, at 601-04; King, Should Mom Be Constrained in the Best Interests of the Fetus?, 13 NOVA L. REV. 393, 397 (1989); Note, supra note 8, at 613; Note, supra note 196, at 998-1002.

204 See, e.g., Note, supra note 8, at 613 (“[B]ecause the decisions a woman makes throughout her pregnancy depend on her individual values and preferences, complicated sets of life circumstances, and uncertain probabilities of daily risk, the woman herself is best situated to make these complex evaluations.”); Note, Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy, 103 HARV. L. REV. 1325, 1339-41 (1990) (arguing that “the pregnant woman's physical and psychological position with respect to the fetus makes her a uniquely appropriate decisionmaker”).

205 See, e.g., Moss, supra note 2, at 288-89; Note, supra note 8, at 606-07.

206 I recognize, however, the tactical benefit of demonstrating that the prosecution of pregnant crack addicts should be the concern of all women. It may be more effective politically to convince affluent women that such government policies also jeopardize their lifestyles.

207 See Robertson, supra note 13, at 437-38, 445-47 (“[T]he woman] waived her right to resist bodily intrusions made for the sake of the fetus when she chose to continue the pregnancy.”); Robertson, The Right to Procreate and In Utero Fetal Therapy, 3 J. LEGAL MED. 333, 359 (1982); see also Shaw, Conditional Prospective Rights of the Fetus, 5 J. LEGAL MED. 63, 88 (1984) (arguing that the mother's duty to protect the fetus from harm increases after viability “because she has forgone her right to choose abortion”).

208 See, e.g., Mathieu, Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice, 8 HARV. J.L. & PUB. POL’Y 19, 32-37 (1985) (arguing that the right to an abortion is not inconsistent with the duty to prevent or not cause harm to the fetus); Walker & Puzder, State Protection of the Unborn After Roe v. Wade: A Legislative Proposal, 13 STETSON L. REV. 237, 241, 253 (1984) (arguing that extending the fourteenth amendment's protection to unborn children would not impair women's right to abortion).

209 The prosecution of drug-addicted mothers can be seen as encouraging abortion because pregnant drug-addicts may feel pressure to abort the fetus rather than risk being charged with a crime.

210 See Stearns, supra note 196, at 604 (“It is inconsistent to argue that a [pre-natal duty] rule unconstitutionally removes the right to abort if in fact the rule actually encourages women to exercise that very right.”).

211 If the facilities necessary to effectuate a reproductive decision cost money, poor women may not be able to afford to take advantage of them. Prenatal care, abortion services, artificial insemination, fetal surgery, contraceptives, and family planning counseling are some examples of the means to realize a reproductive choice that may be financially inaccessible to low-income women. See generally Gertner, Interference with Reproductive Choice, in REPRODUCTIVE LAWS FOR THE 1990S, supra note 125, at 307, 307-12 (discussing economic and legal obstacles to reproductive choice); Nsiah-Jefferson, supra note 125, at 20-23, 50-51 (discussing limitations on access to abortion services and new reproductive technology).
In Roberts, The Future of Reproductive Choice for Poor Women and Women of Color, 12 WOMEN'S RTS. L. REP. 59 (1990), I describe the constraints on the reproductive choices available to a hypothetical pregnant young woman in the inner city. See id. at 62-64.

212 See supra note 144.

213 An example of how the unilateral focus on abortion has neglected — and even contradicted — the interests of poor women of color is the pro-choice opposition to sterilization reform in the 1970s. In 1977, the Committee to End Sterilization Abuse introduced the New York City Council guidelines to prevent sterilization abuse, an important issue for women of color. See supra notes 124-130. The Department of Health, Education, and Welfare also considered the guidelines in 1979. The guidelines had two key provisions: they required informed consent in the preferred language of the patient and a 30-day waiting period between the signing of the consent form and the sterilization procedure. Representatives of the National Abortion Rights Action League and Planned Parenthood testified against the New York and national guidelines as restrictions on women's access to sterilization. See Tax, Tax Replies, NATION, July 24/31, 1989, at 110, 148 (1989) (letter to the editor); see also Petchesky, supra note 124, at 35-39 (discussing arguments asserted by opponents of the federal sterilization regulations).

The abortion rights of women of color have also been overlooked. One example is the belated political mobilization on the part of the pro-choice movement triggered by the Supreme Court's decision in Webster v. Reproductive Health Servs., 109 S.Ct. 3040 (1989). There was no similar response to the Court's decisions in Maher v. Roe, 432 U.S. 464 (1977), and Harris v. McRae, 448 U.S. 297 (1980), which allowed the government to deny poor women public funding for abortions. The pro-choice movement was relatively complacent about the Court's effective denial of access to abortions for poor women until the reproductive rights of affluent women were also threatened. See Stearns, Roe v. Wade: Our Struggle Continues, 4 BERKELEY WOMEN'S L.J. 1, 7 (1989).

214 The struggle for abortion rights nevertheless continues to play a critical role in advancing women's reproductive autonomy. Expanding the scope of reproductive rights beyond abortion to include the right to bear healthy children may also help pro-choice advocates in the abortion debate. One of the tactics of the right-to-life movement is to characterize the pro-choice movement as people who do not care about children. I participated in a panel discussion in which the right-to-life participants brought along a contingent of supporters — all with young children on their laps. A more complete view of reproductive choice may help to dispel this image. See Colker, Reply to Sarah Burns, 13 HARV. WOMEN'S L.J. 207, 212 n.31 (1990). I do not, however, advocate transforming reproductive freedom from a women's rights issue into a children's rights issue. See Burns, Notes from the Field: A Reply to Professor Colker, 13 HARV. WOMEN'S L.J. 189, 205-06 (1990).

215 Trial Transcript, supra note 4 at 364.

216 The Supreme Court privacy analysis has similarly mischaracterized the fundamental right at issue in other contexts. The Court has typically identified the constitutional question as whether there is a fundamental right to engage in the conduct forbidden by the law at issue (for example, abortion, adultery, contraception, or homosexual activity). See, e.g., Michael H. v. Gerald D., 109 S.Ct. 2333, 2343 (1989) (identifying the right at issue as “specifically the power of the natural father to assert parental rights over a child born into a woman's existing marriage with another man”); Bowers v. Hardwick, 478 U.S. 186, 190 (1986) (“The issue presented is whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy.”). Jed Rubenfeld has observed that this approach obscures the real danger of laws that abridge the right of privacy — their use as a means for government to control critical aspects of our lives and identity. See Rubenfeld, The Right of Privacy, 102 HARV. L. REV. 737, 739 (1989). Rubenfeld writes that “[t]he fundament of the right to privacy is not to be found in the supposed fundamentality of what the law proscribes. It is to be found in what the law imposes.” Id.; see also Tribe & Dorf, supra note 160, at 1065-71 (describing the enterprise of designating fundamental rights as a question of the proper level of abstraction at which to portray those rights).

217 Ohio Senate Bill No. 324, which would create a new crime of “prenatal child neglect,” forces drug-addicted mothers to choose between going to jail and giving up their right to bear children. See S.B. No. 324, § 2919.221(B), 118th Ohio General Assembly, Regular Session 1989-90. A repeat offender must elect either to undergo tubal ligation or to participate in a five-year contraception program. If she fails to remain drug-free during the five-year program, the judge must sentence her to be sterilized. See S.B. No. 324 § 2919.221(B)(2)(c). If she refuses to make the required election, she will be held guilty of “aggravated prenatal child neglect,” a first degree felony carrying a possible 25-year prison sentence. S.B. No. 324, §§ 2919.221(E), 2929.11(B).
Both aspects of the constitutional protection of the individual's personhood satisfy Martin Luther King Jr.'s test for the legitimacy of man-made laws: “Any law that uplifts human personality is just. Any law that degrades human personality is unjust.” M. L. KING, JR., WHY WE CAN'T WAIT 85 (1963) (Letter from Birmingham Jail); accord West, Progressive and Conservative Constitutionalism, supra note 14, at 686-87.

Kimberlé Crenshaw has argued that, although liberal legal ideology has served important functions in Blacks' struggle against racial domination, it is important to develop strategies that minimize the costs of engaging in legitimating liberal discourse. See Crenshaw, supra note 14, at 1384-87. She suggests that such strategies must have a community perspective: “History has shown that the most valuable political asset of the Black community has been its ability to assert a collective identity and to name its collective political reality. Liberal reform discourse must not be allowed to undermine the Black collective identity.” Id. at 1336.

Matsuda, When the First Quail Calls: Multiple Consciousness as Jurisprudential Method, II WOMEN'S RTS. L. REP. 7, 8 (1989).


223 See Roe v. Wade, 410 U.S. 113 (1973) (right to choose whether to terminate a pregnancy); Loving v. Virginia, 388 U.S. 1 (1967) (right to choose one's spouse); Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (right to decide whether to use contraceptives); Skinner v. Oklahoma, 316 U.S. 535 (1942) (right to procreate); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (right to select the schooling of children under one's control); Meyer v. Nebraska, 262 U.S. 390 (1923) (right to determine the language taught to one's children).

224 See Roe v. Wade, 410 U.S. at 155.

225 Exploiting the contours of the right to procreate is beyond the scope of this Article. I focus on the aspect of the right of privacy that guarantees the choice to carry a pregnancy to term. I want to protect the individual from punishment for making a reproductive decision rather than to fulfill the individual's desire to have children. The value at the heart of my argument is not procreation, but autonomy. See L. TRIBE, supra note 164, § 15-23, at 1423 (“As the Court itself stressed in Carey, the constitutional principle of 'individual autonomy' affirmed in these cases protected not procreation, but the individual's 'right of decision' about procreation.”) (quoting Carey v. Population Servs. Int'l, 431 U.S. 678, 687-89 (1977)) (emphasis in original)). Delineating the right to procreate is difficult indeed. It involves defining the procreative activities encompassed by the right, as well as the limits on government interference with those activities. New developments in reproductive technology have complicated the problem by allowing people to procreate in ways current law does not contemplate. See, e.g., Andrews, Alternative Modes of Reproduction, in REPRODUCTIVE LAWS FOR THE 1990S, supra note 125, at 259; Developments in the Law — Medical Technology and the Law, 103 HARV. L. REV. 1519, 1525-56 (1990); Special Project: Legal Rights and

231 Carey v. Population Servs. Int'l, 431 U.S. 678, 685 (1977). Although dicta in many of the privacy decisions include the decision to bear a child among those protected by the right of privacy, the holdings of the cases concern the freedom not to procreate — the right to avoid unwanted pregnancy through contraception or abortion. See Carey, 431 U.S. at 694 (holding that a state law limiting minors' access to contraceptives violated fourteenth amendment); Roe v. Wade, 410 U.S. 113, 153 (1973); Eisenstadt v. Baird, 405 U.S. 438, 443 (1972) (striking down a state law limiting unmarried people's access to contraceptives), Griswold v. Connecticut, 381 U.S. 479, 485 (1965). By contrast, the Supreme Court has hardly addressed the right to bear a child. Its only decision upholding the right to procreate is Skinner v. Oklahoma, 316 U.S. 535 (1942). See infra pp. 1475-76.


233 Id. at 453 (emphasis omitted).

234 Support for the right to procreate can be found in the language of Roe v. Wade, in which the Court held that the constitutional “right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.” 410 U.S. at 153 (emphasis added). The Court made the woman's choice — either to terminate her pregnancy or complete it — the crux of the privacy right it recognized. Because it is the woman's choice that is guaranteed, the alternative to the abortion decision — the decision to carry the fetus to term — must also be protected. See Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 778 n.6 (1986) (Stevens, J., concurring); L. TRIBE, supra note 164, § 15-10, at 1340 (arguing that the meaning of the privacy cases is that "whether one person's body shall be the source of another life must be left to that person and that person alone to decide") (emphasis omitted); cf. Tribe, The Curvature of Constitutional Space: What Lawyers Can Learn from Modern Physics, 103 HARV. L. REV. 1, 14 (1989) (noting the difficulty in justifying any constitutional distinction between "the state's power to require an abortion in certain circumstances and the state's power to forbid one" (emphasis in original)).

235 But see Rubenfeld, supra note 216, at 796-97 (arguing that laws limiting family size and laws prohibiting abortion are “enormously different in their real, material effect on individuals' lives” and cautioning against being “misled by their formal similarities”). Rubenfeld finds that, although both laws impinge on the child-bearing decision, a law that in effect requires women to bear children takes over women's lives far more than a law that forbids them from having more than a prescribed number of children. See id. at 797; see also R. PETCHESKY, ABORTION AND WOMAN'S CHOICE 387-90 (1984) (criticizing the assumption of "a mistaken symmetry between 'the right to have children' and 'the right . . . not to have them'"). Petchesky postulates that in a society where gender, class, and racial equality have been achieved, the state might be justified in denying individuals a right to procreate. Unlike Petchesky, I have endeavored to analyze the political implications of the punishment of drug-addicted mothers only in the context of the current and historical conditions of gender, class, and racial inequality. Petchesky presents just such an analysis of abortion. See id. at 12-13. Rubenfeld also may have reached a different conclusion if he had considered the real, material effects on women of color created by the state's interference in the decision to procreate. Of course, the consequences of compelling childbirth and of prohibiting it are not identical, and the government's asserted justifications for intervention are not always of equal weight.


237 See McNulty, supra note 8, at 315; Note, supra note 8, at 618.

238 LaFleur, 414 U.S. at 639-48.

239 Under Roe v. Wade, laws allowing the prosecution of drug-addicted mothers would have to meet a strict scrutiny test. As the Court stated in Roe, “[W]here certain ‘fundamental rights’ are involved, the Court has held that regulation limiting these rights may be justified only by a ‘compelling state interest,’ and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake.” 410 U.S. at 113 (citations omitted). I have already demonstrated that laws punishing drug-addicted mothers do not meet this test. See supra notes 190-192 and accompanying text.


Patricia Williams has explored the differing perspectives on "rights" held by Blacks and whites — in this case the predominantly white critical legal studies movement. She explains that, for Blacks, the stereotyping of human experience created by rights discourse (the focus of the critical legal studies critique) is a lesser historical evil than having been ignored altogether. See Williams, Alchemical Notes: Reconstructing Ideals from Deconstructed Rights, 22 HARV. C.R.-C.L. L. REV. 401, 414 (1987) ("The black experience of anonymity, the estrangement of being without a name, has been one of living in the oblivion of society's inverse, beyond the dimension of any consideration at all. Thus, the experience of rights-assertion . . . has been a process of finding the self.") Similarly, Kimberlé Crenshaw observes that dispossessed people use rights rhetoric "to redeem some of the rhetorical promises" of popular political discourse by forcing society to live up to its deepest commitments. See Crenshaw, supra note 14, at 1366.

Harris, supra note 14, at 613 (citing Hurston, How It Feels to Be Colored Me, in I LOVE MYSELF WHEN I AM LAUGHING . . . AND THEN AGAIN WHEN I AM LOOKING MEAN AND IMPRESSIVE 152, 155 (A. Walker ed. 1979)).

Id.


See Allen, supra note 103, at 141.

Rubenfeld, for example, proposes an interpretation of the right of privacy that focuses on the affirmative consequences of laws challenged on the basis of privacy claims. See Rubenfeld, supra note 216, at 782-84. It is the "totalitarian" intervention of government into a person's life that the right of privacy protects against. Id. at 787. The right of privacy, then, means "the right not to have the course of one's life dictated by the state." Id. at 807.

Protection from government power need not be the full extent of the Constitution's guarantee of autonomy and personhood. See infra pp. 1478-80. Recognizing that "[a]s long as a state exists and enforces any laws at all, it makes political choices," Frances Olsen argues that the distinction between state intervention and nonintervention is a myth. Olsen, The Myth of State Intervention in the Family, 18 U. MICH. J.L. REF. 835, 836 (1985). Olsen further argues that the poor have the least to gain from the rhetoric of nonintervention: "The attempt to criticize state 'intervention' instead of criticizing the particular policies
pursued may be especially limiting for poor people, who often have to rely on various government programs and are thus less likely to benefit from any political strategy based on the myth of nonintervention.” Id. at 863.

250 See supra pp. 1432-34.


For a dialogue concerning the use of equality doctrine versus privacy doctrine to advocate abortion rights, see Colker, Feminist Litigation: An Oxymoron? — A Study of the Briefs Filed in William L. Webster v. Reproductive Health Services, 13 HARV. WOMEN'S L.J. 137 (1990); Burns, Notes from the Field: A Reply to Professor Colker, 13 HARV. WOMEN'S L.J. 189 (1990); and Colker, Reply to Sarah Burns, 13 HARV. WOMEN'S L.J. 207 (1990). In her response to Ruth Colker's criticism of the emphasis on privacy doctrine in feminist litigation, Sarah Burns raises several important questions:

Why should we not insist that the question whether to have an abortion is a woman's private moral decision outside the public realm and beyond public interference? Why is arguing for equality necessarily more 'radical' and less 'liberally co-opted' than arguing for fundamental liberty and autonomy for women? Are not equality concepts co-opted by liberal interpretation? Can equality work as a concept without the concepts of liberty and autonomy?

Burns, supra, at 193. I attempt to answer some of these questions in this Article, especially as they relate to women of color.

For a defense of privacy that responds to the feminist critique, see A. ALLEN, supra note 160, at 57 (arguing that the “solution to the privacy problem women face begins with promoting greater emphasis on opportunities for individual forms of privacy, rather than in rejecting privacy”); and Olsen, The Supreme Court, 1988 Term — Comment: Unraveling Compromise, 103 HARV. L. REV. 105, 117 (1989) (arguing the importance of extending privacy doctrine equally to women and men, “even as we pursue efforts to dismantle the false dichotomies underlying it”).

252 See MacKinnon, supra note 251, at 51-53.

253 Id. at 49.

254 “[T]he legal concept of privacy can and has shielded the place of battery, marital rape, and women's exploited labor; has preserved the central institutions whereby women are deprived of identity, autonomy, control and self-definition; and has protected the primary activity through which male supremacy is expressed and enforced.” Id. at 53 (emphasis in original).

255 See Jones, supra note 108, at 237; Kline, supra note 17, at 122-23. Patricia Cain observes that lesbians' experiences of the private sphere may also differ from MacKinnon's description: “lesbians who live our private lives removed from the intimate presence of men do indeed experience time free from male domination. When we leave the male-dominated public sphere, we come home to a woman-identified private sphere.” Cain, supra note 21, at 212.

256 See Kline, supra note 17, at 129.

257 See id. at 128-31 (criticizing a feminist analysis of child custody law that neglects the experiences of Black and Native American women); supra notes 109-115 and accompanying text.

258 See L. TRIBE, supra note 164, § 16-9, at 1458-60 (discussing the intersection of “preferred rights” and “equality of rights”).

259 The issue of the constitutionality of a government standard for procreation raises the question of whether the right to procreate is limited and therefore implies certain requirements for entitlement. Elizabeth Scott, for example, defines the right to procreate as “the right to produce one's own children to rear.” Scott, supra note 230, at 829. She argues that constitutional protection extends only to the reproductive interests of prospective rearing parents, because it is the objective of rearing the child that elevates the interest in procreation to the status of a fundamental right. The right to procreate, therefore, “requires an intention as well as an ability to assume the role of parent.” Id. Thus, a retarded person who is “so severely and irremediably impaired that she could never provide a child with minimally adequate care . . . has no [constitutionally] protectable interest in procreation.” Id. at 833. The irremedible nature of the retarded person's impairment distinguishes her from a drug addict
who is judged to be an unfit parent. Cf. id. at 833 n.91 (distinguishing on the basis of irremediability retarded people from those who have previously failed at parenting).

In the Johnson trial, for example, the prosecution introduced no evidence that Johnson's children were adversely affected by their mother's crack use. Indeed, there was testimony that the children were healthy and developing normally. See Trial Transcript, supra note 4, at 46-47, 120 (testimony of Dr. Randy Tompkin and Clarice Johnson, Jennifer's mother). A law proposed in Ohio makes drug use during pregnancy grounds for sterilization. See supra note 217. Similarly, several states have enacted statutes that make a woman's drug use during pregnancy by itself grounds to deprive her of custody of her child. See supra note 50.

See supra pp. 1442-43.

See Karst, supra note 161, at 32; Stefan, Whose Egg Is It Anyway? Reproductive Rights of Incarcerated, Institutionalized and Incompetent Women, 13 NOVA L. REV. 405, 454 (1989) (discussing the systematic barriers to motherhood imposed on incarcerated women as a part of the process of dehumanization); see also Asch, Reproductive Technology and Disability, in REPRODUCTIVE LAWS FOR THE 1990S, supra note 125, at 106-07 (discussing the importance of the right to choose childbearing for disabled women).

I recognize that there are women who choose not to have children or are incapable of having children and that this choice or inability does not make them any less human. See Cain, supra note 21, at 201, 205 n.96 (criticizing feminist discourse that privileges the experience of motherhood over other experiences of female connection). It is not the act of having children that makes an individual fully human; it is society's view of whether she deserves to have children.


The discrediting of eugenic theory, the development of the constitutional doctrine of reproductive autonomy, and the changing view of mental retardation have all spurred a major reform of sterilization law in the last two decades. Reports of Nazi Germany's program of racial eugenics achieved through widespread sterilization precipitated the modern rejection of these laws. See Scott, supra note 230, at 811-12.

For a description of the origins of eugenic theory, see Cynkar, supra note 263, at 1420-25.

One report written by a leading scholar of the eugenic movement defined the “socially inadequate” as:

“(1) feeble-minded; (2) insane (including the psychopathic); (3) criminalistic (including the delinquent and wayward); (4) epileptic; (5) inebriate (including drug-habitués); (6) diseased (including the tuberculous, the syphilitic, the leprous, and others with chronic, infectious and legally segregable diseases); (7) blind (including those with seriously impaired vision); (8) deaf (including those with seriously impaired hearing); (9) deformed (including the crippled); and (10) dependent (including orphans, ne'er-do-wells, the homeless, tramps and paupers).”

Cynkar, supra note 263, at 1428 (quoting H. LAUGHLIN, THE LEGAL STATUS OF EUGENICAL STERILIZATION 65 (1929)).

As late as 1966, 26 states still had eugenic sterilization laws. See Scott, supra note 230, at 809 n.11. It has been estimated that over 70,000 persons were involuntarily sterilized under these statutes. See Smith, supra note 263, at 77 n.35. For a discussion of the eugenic sterilization statutes, see Ferster, Eliminating the Unfit — Is Sterilization the Answer?, 27 OHIO ST. L.J. 591 (1966).

274 U.S. 200 (1927).

The Court rejected arguments that the Virginia sterilization law violated the equal protection clause because it applied only to institutionalized persons and that it violated the due process clause because it exceeded the legitimate power of the state. See id. at 207-08.
The continued authority of Buck v. Bell is highly doubtful in light of the development of reproductive privacy doctrine in the last 30 years. Because sterilization laws infringe what is now acknowledged as a fundamental right, they are subject to strict scrutiny rather than the rational-basis analysis applied in Bell. See Murdock, Sterilization of the Retarded: A Problem or a Solution?, 62 CALIF. L. REV. 917, 921-24 (1974); Sherlock & Sherlock, Sterilizing the Retarded: Constitutional, Statutory and Policy Alternatives, 60 N.C.L. REV. 943, 953-54 (1982).


Bell, 274 U.S. at 205. Subsequent research has revealed that the Court's factual statement was erroneous. Although Carrie Buck became pregnant out of wedlock, the finding that she was “feeble minded” was based on insubstantial testimony. See Gould, Carrie Buck's Daughter, 2 CONST. COMMENTARY 331, 336 (1985); Lombardo, supra note 269, at 52.

See Holmes, Ideals and Doubts, 10 ILL. L. REV. 1, 3 (1915) (“I believe that the wholesale social regeneration . . . cannot be affected appreciably by tinkering with the institution of property, but only by taking in hand life and trying to build a race.”); Rogat, Mr. Justice Holmes: A Dissenting Opinion, 15 STAN. L. REV. 254, 282 (1963) (referring to Buck v. Bell as “a judicial manifestation of [Holmes's] intense eugenic views”).

The distinction I make between punitive and eugenic motive does not depend on the specific provisions of the statute, but on the moralistic versus biological impulse underlying the statute. Compulsory sterilization laws — whether criminal or therapeutic — were often based on punitive motivations disguised as a eugenic rationale. See R. PETCHESKY, supra note 235, at 85. Petchesky asserts that the sterilization laws were punitive because “[t]heir aim was not only to reduce numbers or root out ‘defective genes’ but also to attack and punish sexual ‘promiscuity’ and the sexual danger thought to emanate from the lower classes, especially lower-class women.” Id. at 88. My focus is on the statutes' punishment of deviance from the standard for motherhood rather than for sexual deviance alone.

Apparently, Carrie was sterilized because she was poor and had been pregnant out of wedlock. See Lombardo, supra note 269, at 51. The deposition testimony of the state mental institution's trial expert, the famed eugenicist Harry Laughlin, implies this underlying motivation: “These people belong to the shiftless, ignorant, and worthless class of anti-social whites of the South.” Id. After reviewing the record of the case, Professor Gould concluded: “Her case never was about mental deficiency; it was always a matter of sexual morality and social deviance. . . . Two generations of bastards are enough.” Gould, supra note 270, at 336.


Lombardo, supra note 269, at 46 (quoting REPORT OF THE VIRGINIA STATE EPILEPTIC COLONY 27 (1922-23)) (emphasis added).

316 U.S. 535 (1942).


Id. § 173.

See Skinner, 316 U.S. at 537.

Id. at 541.

See id. at 541.

See id. at 542.

Id. at 536 (emphasis added). The right of procreation is also considered a human right under international law. See Universal Declaration of Human Rights, art. 16 § 1, G.A. Res. 217 (III), at 74, U.N. Doc. A/810 (1948) (“Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family.”).
See L. TRIBE, supra note 164, § 15-10, at 1339, § 16-12, at 1464.

Skinner, 316 U.S. at 541.

Id.

See id.

See supra note 275 and accompanying text.

See supra notes pp. 1448-50.

See supra notes 213 & 240.

448 U.S. 297 (1980).

Id. at 316.

C. MACKINNON, supra note 19, at 101 (emphasis in original). Rhonda Copelon and Rosalind Petchesky draw similar conclusions about the limits of liberal privacy theory in the abortion funding context. See R. PETCHESKY, supra note 235, at 295-302; Copelon, supra note 251, at 322-25.

See supra note 211. Dependence on public largesse, for example, means that the government can determine which reproductive decisions indigent women may carry out. The Supreme Court erroneously reasoned in the abortion funding decisions that the denial of public funding imposes no new obstacle to reproductive choice. If an indigent woman is unable to effectuate her decision to have an abortion, the Court argued, her inability is due to her poverty and not the government's funding policy. See Maher v. Roe, 432 U.S. 464, 474 (1977); Harris, 448 U.S. at 314-15. But the Court's reasoning ignores the real-life effect of the government's funding choices on poor women. An indigent woman who is unable to pay for either childbirth or abortion has no choice but to accept the government's determination. By funding only one option, the government has really made the woman's choice for her. See Binion, supra note 230, at 19; Goldstein, A Critique of the Abortion Funding Decisions: On Private Rights in the Public Sector, 8 HASTINGS CONST. L. Q. 313, 315-17 (1981); Tribe, The Abortion Funding Conundrum: Inalienable Rights, Affirmative Duties, and the Dilemma of Dependence, 99 HARV. L. REV. 330, 336-37 (1985).

See R. PETCHESKY, supra note 235, at 295-302; Copelon, supra note 251, at 322-23.

Thomas Grey notes the distinction between the civil rights and civil liberties perceptions of the personality: “The former tend to see the personality as more socially-constructed, hence socially destructible; the latter see it as more naturally self-reliant and autonomous.” T. Grey, Civil Rights vs. Civil Liberties: The Case of Discriminatory Verbal Harassment 1-2 (Mar. 1990) (unpublished manuscript on file at the Harvard Law School Library); see also Colker, supra note 130, at 1019-21 (describing a group-based and individual-based concept of the “authentic self”). While relying on the right to individual autonomy, I am suggesting that the legal doctrine that protects it should adopt what Professor Grey calls the civil rights perspective of personhood. This concept of autonomy protects the right to make certain choices but recognizes that choices are made in the context of a community and in relation to others. See T. Grey, supra, at 1. I also recognize that the individual's personhood may be denied as a means of attacking the community as a whole and that the community's support may be necessary for nurturing the individual's personhood. I do not believe that the recognition of these connections between the individual and the community are inherently inconsistent with the notion of autonomy.


See, e.g., DeShaney v. Winnebago County Dep't of Social Servs., 489 U.S. 189, 196 (1989) (“[O]ur cases have recognized that the Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual.”).

C. MACKINNON, supra note 19, at 96 (emphasis in original); see also Copelon, supra note 251, at 316 (observing the “sharp tension between the liberal idea of privacy as the negative and qualified right to be let alone as long as nothing too
significant is at stake and the more radical idea of privacy as an affirmative liberty of self-determination and an aspect of equal personhood’’); West, Progressive and Conservative Constitutionalism, supra note 14, at 646-47 (“[P]rogressives tend to support an ‘affirmative’ understanding of the liberty protected by the due process clause of the fourteenth amendment . . . while conservatives read the clause as protecting ‘negative liberty’ only, i.e., the right to be free from certain defined interferences.”).

301 L. TRIBE, supra note 164, § 15-2, at 1305.

302 Clearly the affirmative guarantee of personhood and autonomy must have boundaries. We cannot expect the government to provide every means necessary to fulfill each individual's sense of identity. Moreover, increased government involvement in the processes of individual choice and self-determination may create new dangers. Finally, there may be advantages to using privacy doctrine to protect against the government's abuse of power and using other concepts, such as equality, to achieve more affirmative goals. It is beyond the scope of this Article to explore all of the questions raised by the new privacy jurisprudence. My point here is to acknowledge the limitations of current privacy doctrine and to suggest the ingredients of a doctrine that overcomes them. Others have explored the scope of the positive role of government in correcting material inequalities. See, e.g., Michelman, The Supreme Court, 1968 Term — Foreword: On Protecting the Poor Through the Fourteenth Amendment, 83 HARV. L. REV. 7, 9-13 (1969) (proposing a vision of social justice in which citizens are entitled to “minimum protection against economic hazard”); Tribe, Unraveling National League of Cities: The New Federalism and Affirmative Rights to Essential Government Services, 90 HARV. L. REV. 1065, 1090-96 (1977) (interpreting National League of Cities as a recognition of affirmative rights).

303 West, Progressive and Conservative Constitutionalism, supra note 14, at 707.

304 The word “privacy” may be too imbued with limiting liberal interpretation to be a useful descriptive term. “Privacy” connotes shielding from intrusion and thus may be suitable to describe solely the negative proscription against government action. Moreover, the word conjures up the public-private dichotomy. “Liberty,” on the other hand, has more potential to include the affirmative duty of government to ensure the conditions necessary for autonomy and self-definition. In reconstructing the constitutional guarantees I have been discussing, it may be more appropriate to rely on the broader concept of “liberty.” See A. ALLEN, supra note 160, at 98-101 (discussing the differences between the “liberty” and “privacy”).

305 In answering the critical legal studies' critique of rights, Patricia Williams notes that oppression is the result not of “rights-assertion,” but of a failure of “rights-commitment.” Williams, supra note 243, at 424 (emphasis in original). In the same way, the concepts of choice, personhood, and autonomy that are central to privacy doctrine are not inherently oppressive, any more than is the concept of equality (which has also been interpreted in ways that perpetuate hierarchy and domination). It is the “constricted referential universe,” id. at 424, of liberal notions — such as negative rights, neutral principles, the public-private dichotomy, and formal equality — that have limited privacy's usefulness for attaining reproductive freedom. See Matsuda, Looking to the Bottom: Critical Legal Studies and Reparations, 22 HARV. C.R.-C.L. L. REV. 323, 334-35 (1987) (demonstrating how women and people of color can adopt and transform constitutional text for radical objectives).

306 See supra p. 1464.

307 I hear this false dichotomy in the words of Muskegon, Michigan, narcotics officer Al Van Hemert: “‘If the mother wants to smoke crack and kill herself, I don't care.’ . . . ‘Let her die, but don't take that poor baby with her.’” Hoffman, supra note 5, at 34.

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