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PUNITIVE POLICIES: CONSTITUTIONAL HAZARDS OF NON-CONSENSUAL TESTING OF WOMEN FOR PRENATAL DRUG USE

Derk B.K. VanRaalte IV†

WOMEN'S ADVOCATES SEEK $3 MILLION AND END TO ARRESTS OF PREGNANT WOMEN AT SOUTH CAROLINA HOSPITAL

Press Conference 1:00 P.M.
171 Church Street, Charleston, South Carolina

CHARLESTON, Oct. 5, 1993 - In the first case of its kind in the nation, the Center for Reproductive Law and Policy today urged the federal district court in South Carolina to enjoin a racially discriminatory program that threatens prosecution of pregnant women or women in labor who test positive for cocaine. The $3 million class action lawsuit asserts that the Charleston Interagency Policy — implemented in October 1989 . . . violates a number of constitutional guarantees, including the right to privacy, the right to refuse medical treatment, and the right to procreate. Under the policy, women suspected of using cocaine while pregnant are [tested without their knowledge] and referred to inappropriate or inaccessible drug treatment and told they will be arrested if they do not comply with the treatment ordered.¹

INTRODUCTION

IN THE MIDST OF AMERICA'S "War on Drugs," the realm of maternal-fetal rights has developed into a constitutional battleground. With a rising incidence of cocaine use by women of child-bearing age, some studies have shown as many as 10% of infants may have faced exposure to some form of

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illegal drugs while in the womb. These statistics, obviously of concern to the medical community, have brought the issue of maternal drug use to the forefront of legal and political debate.

Governmental and professional responses to the problem of maternal drug use have differed vastly. While all agree that drug use is undesirable during pregnancy, proposals to remedy the problem have ranged from education, counseling, and voluntary treatment to more controversial means such as involuntary civil commitment or criminal prosecution. Focusing on the recent trend toward treatment by criminal prosecution, this Note explores (1) the nature and extent of the harm caused by drug use during pregnancy; and (2) the medical efficacy and constitutional concerns implicated by punitive policies. In conclusion, proposals for a more medically effective, yet legally permissible, plan will be proffered.

I. SOCIETAL AND PERSONAL COSTS OF DRUG USE DURING PREGNANCY

Considering the vast array of illicit drugs in common use, little more than generalities can be drawn without first narrowing the range of inquiry. Within the confines of this Note, the primary medical focus will be limited to the costs associated with prenatal exposure to cocaine. Although the documented medical information on the subject arises from current studies, statistical problems still plague this budding area of research. In particular, difficulty has been encountered in isolating the effects of cocaine use on fetal outcome from common environmental factors such as poor maternal nutrition, inadequate prenatal care, and the use of alcohol and tobacco.


3. This focus on cocaine appears warranted, for the same studies showing that up to 11% of pregnant women have used drugs during pregnancy, also suggest that 75% of these same women used cocaine. Helen M. Cole, Legal Interventions During Pregnancy: Court-ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663, 2666 (1990).

A. Health Risks Incurred By Pregnant Women

Women who abuse cocaine face a variety of risks. Even exclusive of pregnancy, cocaine use creates significant health risks. These risks include dysrhythmias, hypertension, myocardial infarction, angina, hyperthermia, chest pains, and cerebral vascular accidents.\

Additional complications arise when cocaine use accompanies pregnancy. The American Public Health Association (APHA) attributes drug use to an increased incidence of spontaneous abortion and abruptio placentae. Even if these conditions are successfully avoided, the addicted woman still faces a magnified risk of premature labor and delivery.

The health risks, however, are hardly confined to the expectant mother. The fetus also may face a number of increased risks. Given the prevalence of premature birth in these cases, it is not surprising that the American Medical Association (AMA) chronicled a problem of low birth weight. Further developmental defects may surface in the form of below average head circumference. Other, potentially more catastrophic, risks include an increased chance of stroke, increased risk of Sudden Infant Death Syndrome, and the possibility of seizures in the infant.

The impact on the quality of the infant’s future life also may be affected. The developmental retardation resulting in low birth weight and small head circumference is often accom-
panied by later emotional and behavioral abnormalities. The South Carolina State Council on Maternal, Infant and Child Health (MICH) found learning disabilities and lack of mother-child bonding often plagued these children long after birth. Notably absent, however, has been any conclusive evidence that the oftentimes feared and much publicized “cocaine-withdrawal syndrome” is present in newborns.

Cocaine use by expectant mothers imposes costs which ripple outward until they are eventually borne by society as a whole. Some of these costs are unsurprising. For instance, infants who experienced low birth weight and poor nutrition require greatly increased levels of intensive, expensive health care.

Other societal costs are equally troubling, yet less palatable. Maternal drug use has been linked to lack of maternal bonding and increased intra-family stress. Rather than remaining a problem only in the abstract, this fundamental failure within the family rapidly transforms into problems for the community. In its study *Drug Exposed Infants: A Generation at Risk*, the General Accounting Office (GAO) concluded that infants born to drug abusing mothers were more likely to enter foster care programs, more likely to require special education services, and more likely to be underachievers with respect to both educational and occupational goals.

This litany of horrors, however, has not been universally accepted in the scientific community. Dr. Barry Zuckerman fears that “Valid concern about the high rate of cocaine use among pregnant women has resulted in an apparent rush to judg-

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15. Telephone Interview with Dr. William C. MacLean, Jr., Vice President of Pediatric Nutritional Research and Development of Ross (Abbott) Laboratories (Mar. 30, 1994). In some infants, irritability, lethargy, and other symptoms have been observed. “Many [infants], however, seem to have no specific clinical manifestations [of withdrawal] in the early neonatal period.” *Pediatrics, supra* note 2, at 640. However, Dr. MacLean has suggested that statistical data in this field may lag behind common experience. Dr. MacLean reflected that although thorough statistical studies may not exist to demonstrate these carryover effects, it would not surprising to find experts willing to testify to the manifestation.
17. *Id.* at 11.
ment about the extent and permanency of specific effects of intrauterine cocaine exposure on newborns. Predictions of an adverse developmental outcome for these children are being made despite a lack of supportive scientific evidence.\textsuperscript{19}

Behavioral and psychological abnormalities might arguably be as related to environmental factors surrounding the family as to the physiological effects of cocaine. But, in the final analysis, these distinctions may be spurious. Whether the burdens thrust upon society result from the drug culture or from cocaine itself, removing women from the grasp of addiction will invariably be beneficial.\textsuperscript{20}

B. Factors Affecting Drug Use Among Women

1. Demographics in General

Drug abuse as a whole is not confined to minorities, to the inner city, or to the poor. Studies have demonstrated that, while the drug of choice may vary based on demographic factors, overall drug use tends to be roughly equal among the races.\textsuperscript{21} However, race and income are predictors of cocaine usage. The MICH study found that women on Medicaid were over seventeen times more likely than women with private insurance to use cocaine as the drug of choice.\textsuperscript{22} Comparisons made by race were also telling. Blacks studied in South Carolina were 5.7 times more likely than whites to use cocaine.\textsuperscript{23}

\begin{itemize}
\item[20.] This suggestion is one harkening back to "family values." Politicians can talk about family values and promise to improve education. However, such efforts will be futile unless maternal drug use is first addressed. Even if problems in the family remain, at least they will be more manageable. By creating positive family role models, there may also be some spillover benefits as well.
\item[21.] MICH 1 Study, supra note 10, at 24.
\item[22.] Id.
\item[23.] Id. This is not to suggest that other races use fewer drugs; overall, drug usage is roughly equal. However, these statistics provide a foundation for the attack on punitive policies as "underinclusive." See infra note 78.
\end{itemize}

Although statistics seem to suggest correlation between poverty and overall drug use, it is unclear why African-Americans display a higher incidence of cocaine use. What is clear is that blacks use cocaine approximately six times more frequently than other races. \textit{Id.} at 7, 25.
2. Women Have Distinct Needs In Treatment

Drug addiction may not discriminate between the sexes, but it does appear to have different causes. Since the motivations driving women to drug abuse are often distinct from those prompting men, successful attempts to treat female addiction must cater to different needs. Depression, high stress, and low self-esteem are strikingly common among addicted women. These coping problems are further compounded by the poverty and homelessness often faced by the poor of both sexes.

Perhaps the single most telling similarity among drug abusing women is a history of victimization. Childhood rape and incest, battery, and exposure to alcoholic lifestyles characterize the experiences of a vast majority of drug abusing women. Noting that as many as 90% of women addicts faced such lives, Lynn Paltrow concluded that "[d]rug abuse for these women [w]as not a self-indulgent pastime, but rather a form of self-medication in lives filled with pain and abuse."26

Women also face unique obstacles and have special needs in the context of treatment. Most services, designed to treat drug use by men, "are not responsive to the psychological, social, and economic conditions in women's lives."27 One of the most obvious needs is that of child care. The general shortage of drug-treatment facilities is exacerbated by the fact that few facilities accept pregnant women and even fewer offer child care. Should a woman find treatment at all, it often necessitates that she leave her children in the hands of relatives or relatives or


25. Id.; see also Study Examines Access to Substance Abuse Treatment for Women, SPECIAL DELIVERY (Southern Regional Project on Infant Mortality, Washington, D.C.), Fall 1993, at 1, 1 [hereinafter SPECIAL DELIVERY NEWSLETTER] (stating that one study concluded that "[w]omen in rural areas were also much more likely to express shame over their addiction and experience domestic violence and sexual abuse.")

26. Paltrow, supra note 24, at 86.

27. Id. at 86.

28. COALITION ON ALCOHOL AND DRUG DEPENDENT WOMEN AND THEIR CHILDREN, STATEMENT ON ACCESS TO ALCOHOLISM AND DRUG DEPENDENCY TREATMENT (Dec. 1990) [hereinafter ADDWTC] (stating that "[C]urrently there are only a few treatment centers which either provide childcare services or assist women in finding such services. . . . Alcohol and drug dependent women who are pregnant face even greater barriers to obtaining treatment. Many programs refuse to provide services to pregnant women because of concerns about
foster care.29 Forcing women to surrender their children in order to pursue recovery effectively serves as a barrier to women seeking treatment.30

C. Addiction Is A Disease

Health care professionals and the courts have both recognized addiction to be a legitimate disease. Medical and social organizations including the Association of Maternal and Child Health (AMCH), the March of Dimes, the National Association for Perinatal Addiction Research and Education (NAPARE), the American Society of Addiction Medicine (ASAM), the APHA, and the National Council on Alcoholism and Drug Dependence (NCADD) concur in characterizing addiction as an illness or disease. The AMCH even specifically states that “addiction is an illness and [it] has been shown to persist despite adverse consequences.”31

The United States Supreme Court has long accepted that addiction is a medical condition beyond the control of the individual. As early as 1924, the Court announced in Linder v. United States that addicts “are diseased and proper subject for such treatment.”32 Later, the Court in Robinson v. California emphatically affirmed this characterization by holding unconstitutional a California penal statute making addiction a continuing offense.33 Analogizing the punishment of addiction to punishment for being a leper, the Court accepted that addic-

legal and financial liability or because they lack the services necessary to meet the special needs of pregnant women.”)
29. Paltrow, supra note 24, at 86.
30. SPECIAL DELIVERY NEWSLETTER, supra note 25 (listing the “fear that their children will be taken away” as a major barrier for women seeking treatment).
31. ASSOCIATION OF MATERNAL AND CHILD HEALTH, STATEMENT SUBMITTED TO THE SENATE FINANCE COMM. CONCERNING VICTIMS OF DRUG ABUSE (1990) [hereinafter AMCH]; for similar statements, see also MARCH OF DIMES, STATEMENT ON MATERNAL SUBSTANCE ABUSE (1990) [hereinafter MARCH OF DIMES]; NATIONAL ASS’N FOR PERINATAL ADDICTION RESEARCH AND EDUCATION, NAPARE POLICY STATEMENT No. 1, CRIMINALIZATION OF PRENATAL DRUG USE: PUNITIVE MEASURES WILL BE COUNTERPRODUCTIVE (1990) [hereinafter NAPARE]; AMERICAN SOCIETY OF ADDICTION MEDICINE, INC., PUBLIC POLICY STATEMENT ON CHEMICALLY DEPENDENT WOMEN AND PREGNANCY (1989) [hereinafter ASAM]; NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, POLICY STATEMENT, WOMEN, ALCOHOL, OTHER DRUGS, AND PREGNANCY (1990) [hereinafter NCADD].
32. 268 U.S. 5, 18 (1924).
tion "is apparently an illness which may be contracted innocently or involuntarily."34

II. CURRENT TREND IN POLICY

The states have taken a variety of approaches. Education, voluntary treatment, and other low-key responses have all been attempted.35 Growth in research and service efforts continues. A new, more aggressive policy, however, has come to the forefront. The new approach, in which individual prosecutors actively utilize the power of the state to compel treatment even in the absence of a statewide mandate, has included such policies as involuntary civil commitment and criminal prosecution of pregnant women.

A. Criminalization Of The Issue

In searching for governmental solutions to maternal drug use, the use of criminal prosecution stands on the vanguard. Criminal programs operate on several different levels. The first level is seen in Charleston, South Carolina, where prosecution has been used to "add some teeth to our counseling efforts."36 There, women testing positive during screening are given an ultimatum: attend and complete treatment or be arrested. On a second level, proponents of punitive policies contend that prosecutions also have a deterrent effect.37 On the final level, incarceration may be used to "force an incarcerated or detained wo-

34. Id. at 667.
37. Most medical associations have concluded that deterrence is ineffective at curbing chemical dependency. AMCH, supra note 31 (observing that "addiction is an illness and has been shown to persist despite adverse consequences. . . . There is no evidence that criminal prosecutions will deter alcohol or drug use during pregnancy."); MARCH OF DIMES, supra note 31 (stating that "[a]ddiction is an illness and there is no evidence currently available to demonstrate that the threat of criminalization will deter addictive behavior.").
man to adopt behavior that would promote the health of her fetus." In practice, criminalization policies typically rely on all three rationales.

Regardless of the obstensibility of these rationales, criminalization policies share a common orientation. They create a "climate in which the fetus and the pregnant woman are legal adversaries from the moment of conception until birth." Such policies foster a confrontational approach between the mother and the fetus that has been aptly referred to as "a boxing match between a woman and her child."

A variety of statutes have been used to define the bounds of this boxing match. Although ideally, a separate legislative pronouncement should be addressed specifically to such maternal conduct, the vast majority of policies simply employ existing statutes. Simple possession is the unsurprising foundation for many local criminalization policies. Given that simple possession clearly applies regardless of whether a woman is pregnant, application is unencumbered. Distribution to a minor is another common approach in which the essence of the actus reus involves passage of cocaine metabolites through the umbilical cord, although states may differ as to the actual timing of the offense. Still more colorful charges include "child abuse or endangerment" and neglect of a dependent.

38. Cole, supra note 3, at 2667.
39. 3 STATE COUNCIL ON MATERNAL, INFANT AND CHILD HEALTH CARE, OFFICE OF THE GOVERNOR OF SOUTH CAROLINA, 1991 SOUTH CAROLINA STUDY OF DRUG USE AMONG WOMEN GIVING BIRTH (1992) [hereinafter MICH 3 Study].
40. Interviews with Ms. Lynn M. Paltrow, Director of Special Litigation for the Center for Reproductive Law and Policy, New York, New York (May-June 1993).
41. MICH 3 Study, supra note 39, at 26; see infra note 91 and accompanying text.
42. Paltrow, supra note 24, at 88. States and policies differ with regard to the timing of the offense. Some policies charge the offense as occurring prior to birth (citing Declaration of Barry Zuckerman, M.D., Ferguson v. Charleston, No. 2-93-2624-2 (D.S.C. filed Oct. 5, 1993). Others make the timing of the offense identical to the time of birth. See Paltrow, supra note 24, at 88 (citing Florida v. Johnson, No. E89-890-CFA (Fla. Cir. Ct. July 13, 1989), aff'd, 602 So.2d 1288 (Fla. 1992)). By defining the actus reus as occurring in the moment after birth, yet before the umbilical cord is severed, the state is able to avoid the controversy of whether the unborn child is a minor.
B. Sample Policy Illustrative of Current Trend

Criminalization policies targeting pregnant women may orbit a successful patient screening procedure. The Charleston, South Carolina policy, used as a model for this Note, illustrates the central role that the health care provider can play in such policies. As a routine background matter, prenatal medical interviews already inquire into the drug use habits of the mother. Those women responding affirmatively to these queries are reported to the authorities. By exploiting the confidences revealed to the health care provider, interested prosecutors assure themselves of a steady stream of subjects.

Women who do not admit drug use to their physician may still run afoul of the policy. Blood tests and Urine Drug Screens (UDS) are often performed without express notice to the patient. Authority for performing these tests may be premised on implied consent. The standard blanket consent for treatment also provides the authorities for the doctor to "test

44. The Charleston "Interagency Policy" is used as a model for the purposes of this Note. See MICH 3 Study, supra note 39, at 25-26. The MICH 3 Study provides a vignette of the Charleston "Interagency Policy" typical of punitive approaches. Id.

The Charleston Solicitor's Office has described the policy as a mechanism for coordination between law enforcement, the Department of Social Services, the Medical University of South Carolina, the Charleston County Substance Abuse Commission, and the Solicitor's Office. Women at risk for drug abuse are identified by a drug screen at the Medical University Obstetrical Clinic. Consent for this urine screen is included in the consent for medical treatment that must be signed by all patients seeking treatment at the clinic. Drug screens are performed on patients who exhibit one of six "clinical indicators" of drug use. If a woman tests positive for cocaine use, she is shown a film on the danger of drug use during pregnancy and offered immunity from prosecution if she accepts a referral to the Substance Abuse Commission, successfully completes a rehabilitation program, maintains negative urine tests, and continues prenatal care. Failure at any of these conditions results in arrest.

Id.

45. In many cases, the decision about which patients to screen is based on protocol factors. Such screenings may identify and test factors such as signs of abruptio placentae, or late or non-existent prenatal care. Unfortunately, the discretion granted to health care providers as to which patients to test often leads to racially biased policy applications. In fact, the APHA found national surveys of prosecutions "indicate that women of color and low-income women are disproportionately affected by punitive measures." APHA, supra note 2, at 240; see Edgar O. Horger III et al., Cocaine in Pregnancy: Confronting the Problem, 86 J. S.C. MED. Ass'n 528 (1990) (noting the protocol adopted for use as an indicator of possible drug use).

46. MICH 3 Study, supra note 39, at 35 (suggesting that consent can be inferred from a patient's physical cooperation).
for drugs if deemed advisable.\textsuperscript{47} Upon the completion of testing, positive results are then disclosed to authorities.

After notification is received by the prosecutor's office, the police department, or both, patients are then confronted with the options available under the program. Owing to the lower cost of outpatient care and the reduced legal burdens, patients are often afforded the chance to seek treatment voluntarily. In Charleston, women were provided with a photocopied statement from the prosecutor informing them that they could enter the program voluntarily and submit to future drug screenings.\textsuperscript{48} The statement further detailed, however, that failure to enter treatment voluntarily would result in their immediate arrest and prosecution.\textsuperscript{49}

For those women electing to enter the program voluntarily, subsequent positive drug screens create serious legal problems. The original offense that is waived by the prosecutor upon entering the program is reinstated and coupled with the current, second offense. Arrested patients face jail time before and/or after delivery, depending on the timing of their second positive result. "Some women have been arrested and jailed while still pregnant, brought to the hospital in shackles to deliver, and then returned immediately to jail. Other women have been taken from their hospital beds days or even hours after delivery."\textsuperscript{50}

The timing of the subsequent positive tests also affects the statutory violations charged. The most common policy framework involves a sliding scale of offenses. As the delivery date

\textsuperscript{47} See the Medical University of South Carolina Authorization for Release of Medical Information and Consent for Medical Treatment Form [hereinafter Blanket Consent] which states in pertinent part:

"CONSENT FOR MEDICAL TREATEMENT - I acknowledge that I am suffering from a condition requiring Medical/Hospital care and thereby voluntarily consent to such Medical/Hospital care encompassing diagnostic procedures and medical treatment by my physician . . . as may be necessary in his or her judgment. I further consent to the testing of drugs \textit{if deemed advisable by my physician.}" (emphasis added).

\textsuperscript{48} MICH 3 Study, supra note 39, at 26.

\textsuperscript{49} Id.

nears, the number of charges increases. For instance, drug use during the early days of pregnancy may result in charges of simple possession. During the middle trimester of the term, a second positive test results in charges of simple possession as well as distribution of drugs to a minor. Should testing indicate drug use in the weeks immediately before birth, child neglect or endangerment are often included with the other charges.  

Regardless of the timing, criminalization policies almost universally refer the case to child welfare representatives. The newborn seldom returns home when the woman is labeled as an addicted mother. Separated at birth from the mother, the child is placed in foster care. Besides the prospect of criminal charges, the woman must then attempt to utilize the family court system to regain custody of her child.

III. MEDICAL EFFICACY

Due to the paucity of statistical data, little concrete evidence exists to show that intrauterine cocaine exposure equals "harm" to the fetus. In one study, less than half of the neonates exposed to cocaine demonstrated immediate effects of that exposure at birth. However, current studies display statistical shortcomings. Since cocaine users quite frequently also use other illicit drugs as well as alcohol and tobacco, isolating the effects of cocaine is nearly impossible. Similarly, other environmental factors, such as poor maternal nutrition and lack of prenatal care in test subjects, exacerbate the statistical shortcomings. Thus, without further studies, a solid scientific basis for assessing the scope of the medical risks to the fetus remains lacking.

52. MICH 3 Study, supra note 39, at 26 (referring to programs in Greenville and Charleston, South Carolina).
53. Even assuming a conclusive demonstration of harm, it is unclear that cocaine exposure poses any greater risk to the fetus than exposure to alcohol, a drug not typically criminalized under such policies. See Declaration of Barry Zuckerman, supra note 42, at 7-8.
54. Chasnoff, supra note 4, at 1567.
55. MICH 3 Study, supra note 39, at 13-14 (citing multiple drug use and other confounding factors).
56. Chasnoff, supra note 4, at 1568. "Lack of prenatal care among the drug using women was a major and significant factor in neonatal costs in the Phibbs et al. study." See Ciaron S. Phibbs et al., The Neonatal Costs of Maternal Cocaine Use, 266 JAMA 1521 (1991).
Criminalization policies have raised both consternation and concern among members of the medical community. By relying on physicians to disclose the confidential statements and test results of their patients, the state effectively "deputiz[es] doctors to be police informers." This extension of the doctor's role has been criticized on several grounds. Most significantly, commentators note that total candor must be encouraged, for physicians cannot effectively operate on incomplete knowledge. The court in Hammonds v. Aetna Casualty and Surety Co. embraced this rationale stating that "[m]odern public policy, not the archaic whims of the common law, demands that doctors obey their implied promise of secrecy." This sound public policy also finds a second level of support in the Hippocratic Oath's restriction of the physician's ability to disclose information. Finally, on a more sinister level, NAPARE reported studies suggesting prejudicial selectivity in disclosure and revealing that despite the fact that black and white women had similar rates of substance abuse, black women were reported at approximately ten times the rate of white women.

These concerns have prompted a cacophony of dismay from medical societies and commentators at any suggestion of compromise. The American College of Obstetricians and Gynecologists flatly stated that considering concerns for the pregnant woman's autonomy and preservation of the physician-patient relationship, "resort to the courts is almost never justified" in order to compel treatment. Similarly, both ASAM and NAPARE recommended against such a role for

57. Paltrow, supra note 24, at 87.
59. Id. at 795.
60. Id. The court quoted the Hippocratic Oath in part: "Whatever in connection with my professional practice or not in connection with it I see or hear in the life of men which ought not to be spoken abroad I will not divulge as recommending that all such should be kept secret." Id. at 797.
61. NAPARE, supra note 31 (recommending against an investigatory rule for physicians).
62. COMM. ON ETHICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, OPINION NO. 55, PATIENT CHOICE: MATERNAL-FETAL CONFLICT (Oct. 1987). The Committee went on to add that, "Furthermore, inappropriate reliance on judicial authority to implement treatment regimens in order to protect the fetus may lead to undesirable societal consequences, such as the criminalization of non-compliance with medical recommendations." Id.
investigatorial physicians. NAPARE ominously forewarned that placing health care providers in a conflicting position in which they must choose between legal and ethical duties of confidentiality would create a climate that many would find professionally "intolerable.""

Perhaps still more disturbing is the probable adverse effect of such policies on both maternal and fetal health. The prospect of punitive measures often succeeds only in driving pregnant women out of the health care system entirely. The most obvious deterrent is the fear of prosecution. Additionally, the Southern Regional Project on Infant Mortality reported that among women desirous of treatment, one of the "major barriers reported by women [was] fear [that] their children would be taken away." Even voluntary admission to treatment often necessitates relinquishing child custody since programs rarely accommodate dependent children.

On a more subtle level, punitive measures also operate to undermine the resolve of women considering treatment. Wendy Chavkin, in the *Journal of the American Medical Association* stated that punitive measures serve to emphasize the guilt and shame already experienced by addicted pregnant women. One study even reported that "42% [of women surveyed] said that guilt and shame over their drug use was their principal reason for avoiding prenatal care."

The results of punitive policies coupled with compelled treatment programs appear, at best, lackluster. No scientific evidence suggests that prosecution policies have improved fetal health. In fact, in the *JAMA* "Law and Medicine/Board of Trustees Report," Helen Cole observed that "incarcerating

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64. NAPARE, *supra* note 31, at 1.
65. MARCH OF DIMES, *supra* note 31 (advancing the position that "[f]ear of punishment may cause women most in need of prenatal services to avoid health care professionals."). See also Maternal Rights, *supra* note 43, at 1011 (advocating an educational approach over criminalizing maternal conduct).
67. Paltrow, *supra* note 24, at 86 (stating "other programs effectively preclude women because they fail to provide child care").
69. Id.
70. PEDIATRICS, *supra* note 2, at 641 (finding that punitive measures such as incarceration have no proven benefits for infant health). See also Chavkin, *supra* note 68, at 1560.
pregnant women in order to preserve fetal health may prove counterproductive."\textsuperscript{71} This adverse effect can be attributed to several causes. Incarcerated women face poor prison nutrition, poor sanitary conditions, and medical facilities that leave much room for improvement.\textsuperscript{72}

Even for those women not incarcerated, the mere threat of incarceration can be a deterrent to seeking prenatal care. The ASAM Policy Statement on punitive measures concluded that "[c]riminal prosecution of chemically dependent women will have the overall result of deterring such women from seeking both prenatal care and chemical dependency treatment, thereby increasing, rather than preventing, harm to children and society as a whole."\textsuperscript{73} This conclusion was buttressed by GAO surveys indicating that such policies increase the likelihood of women delivering at home and thus avoiding prenatal care altogether.\textsuperscript{74} Given that evidence suggests that prenatal care may be more important than maternal drug use in determining fetal health, punitive approaches appear to do more harm than good.

Punitive policies combined with compulsory drug treatment also have an adverse effect on success with drug abuse counseling. As previously noted, guilt and shame are a primary reason why women fail to seek treatment.\textsuperscript{75} As blame and stigma are increased, the woman’s resolve to seek treatment is further undermined.\textsuperscript{76} Yet, personal resolve and a degree of self-esteem are essential to successful recovery. At least one study has demonstrated that female addicts compelled into treatment were less likely to remain in treatment than voluntary entrants.\textsuperscript{77} Thus, there appears to be some credibility to the truism that, "One can compel attendance, but not meaningful participation."\textsuperscript{78}

Unquestionably, these results from a medical perspective are less than stellar. The punitive approach, flawed as a device

\textsuperscript{71} Cole, supra note 3, at 2667.
\textsuperscript{72} Id.
\textsuperscript{73} ASAM, supra note 31, at 47-49.
\textsuperscript{74} See GAO Study, supra note 18.
\textsuperscript{75} Chavkin, supra note 68, at 1559.
\textsuperscript{77} Chavkin, supra note 68, at 1557.
\textsuperscript{78} Id.
to improve maternal and fetal health, may have the ironic consequence of encouraging abortion. Under a number of policies, there is no prosecution unless there is a child involved. Given the scarcity of adequate treatment options, women may be effectively encouraged to seek abortions.

IV. LEGAL ANALYSIS

A. General Problems

Regardless of the medical efficacy of the current punitive trend, serious legal obstacles confront such policies. On the most basic level, the characterization of addiction as a "disease" in Robinson v. California raises the specter of punishing involuntary physical conditions and immutable traits. Although the Court accepted that "use" may be criminal, it found punishment for the illness of addiction to impugn the Eighth and Fourteenth Amendments. Analogizing to other involuntary physical ailments, the Court lamented that "[e]ven one day in prison would be a cruel and unusual punishment for the crime of having a common cold."

A second fundamental problem with a punitive approach regards the slippery slope encountered in defining the actus reus. Is the culpable conduct under such policies drug use, being pregnant, or delivering the child? While the answer might appear obvious, the State of Florida calls it into question. In the closing arguments of Florida v Johnson, "the prosecutor made clear that Johnson's real crime was not the delivery of

79. See infra note 81 and accompanying text.
80. Id.
82. 370 U.S. 660, 667 (1961). The Court stated that "narcotic addiction is an illness. Indeed, it is an apparently an illness which may be contracted innocently or involuntarily." Id. (citing the brief written by the state). This type of questioning of the "voluntariness" has not been isolated. "Thus, [h]owever the initial use of a drug might be characterized, its continued use by addicts is rarely, if ever, truly voluntary." Wendy K. Mariner et al., Pregnancy, Drugs and the Perils of Prosecution, 9 CRIM. JUST. ETHICS 30, 36 (1990); See also Linder v. United States, 268 U.S. 5, 18 (1924) (stating addicts are "diseased and proper subjects for such treatment.")
83. Robinson, 370 U.S. at 666 (analogizing the criminalization of addiction to the criminalization of mental illness, leprosy, or venereal disease).
84. Id. at 667.
drugs, but the delivery of her child: 'When she delivered that baby, she broke the law in the State.'

The selective application of punitive policies to pregnant women virtually condemns the state to wrestle on this slippery slope. Without question, drug use, possession, and distribution statutes apply to the public at large and not merely to pregnant women. But enforcement and testing policies single out pregnant women seeking prenatal care as the recipients of increased testing and enforcement. Thus, regardless of the definition of the actus reus, punishment remains inextricably linked to pregnancy. The fundamental nature of reproductive autonomy rights suggests that such a link is unconstitutional.

Even excluding the act or element of pregnancy, considerable difficulty remains in defining the criminal act. A variety of acts have been shown to have a detrimental effect on fetal health. Smoking, alcohol consumption, excessive exercise, and vigorous sexual intercourse all have been shown to endanger fetal health to some extent. With the only available evidence suggesting that 50% of cocaine-exposed infants show effects at birth, cocaine may not be scientifically demonstrated to present a more compelling level of "harm." Without a distinguishing feature, the criminalization (on grounds of fetal protection) of cocaine use alone may be sufficiently underinclusive as to raise equal protection problems as well.

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86. See generally Cleveland Bd. of Education v. LaFluer, 414 U.S. 632 (1974) (recognizing that overly restrictive maternity leave regulations can constitute a heavy burden on the exercise of protected freedoms); Roe v. Wade, 410 U.S. 113 (1973) (concluding that the right to privacy protects personal decisions regarding abortion); Griswold v. Connecticut, 381 U.S. 479 (1965) (finding that a statutory prohibition on contraception intrudes upon right of marital privacy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (finding that a statutory prohibition on contraceptive use by unmarried persons conflicts with certain fundamental rights).

87. See Paltrow, supra note 24, at 88. Other less obvious activities also exposing the fetus to risk include "expos[ing] the fetus to health risks by flying to Europe or cleaning [a] cat's litter box." Id. See Chasnoff, supra note 4 (noting that alcohol and tobacco exposure also pose fetal health risks); See MICH 3 Study, supra note 39, at 20-21.

88. Chasnoff, supra note 4, at 1567-68.

89. This is not to suggest that there may not be grounds for punishment for the woman's cocaine use. The argument is that the policy is severely underinclusive. Even if the drug statutes apply equally to all citizens, under punitive policies, only pregnant women...
The most perplexing of the fundamental problems associated with punitive policies involves the hierarchy of punishments for offenses. Oftentimes, the level of punishment increases as the date of delivery nears. This scheme has been questioned under at least two rationales. The first rationale is

are tested for cocaine use upon hospital admission. See Yick Wo v. Hopkins, 118 U.S. 356 (1886) (holding that the city ordinance regarding fire safety denied equal protection when applied disproportionately against Chinese immigrants). Further, the emphasis on cocaine abuse is severely underinclusive since cocaine has not been demonstrated to have a more severe fetal impact than other drugs such as alcohol, nicotine, or heroin. While underinclusive statutes might normally survive Constitutional review, policies with a discriminatory intent face greater challenge. See New York Transit Authority v. Beazer, 440 U.S. 568 (1979) (upholding the New York Transit Authority policy against hiring users of methadone despite the fact that it was overinclusive since not all methadone users were dangerous). In this case, the policies only apply to pregnant women. The punitive policies focusing on cocaine use by women also disproportionately snare African-Americans. Studies have shown that blacks are appreciably more likely to use cocaine than whites, even given that overall drug use is relatively equal across race. MICH I study, supra note 10, at 25. In this light, the concerns aired in Skinner v. Oklahoma, 316 U.S. 535 (1942), again become poignant. In Skinner, the Court found a state law requiring sterilization of habitual criminals to be unconstitutional due to its violation of the Equal Protection Clause. Id. at 538.

The Supreme Court in Wayte v. U.S., 470 U.S. 598, 608 (1985), made clear that discriminatory effect alone is not enough to support selective enforcement arguments. See Washington v. Davis, 426 U.S. 229, 239 (1976) (requiring discriminatory intent in addition to disparate impact). However, as demonstrated in Yick Wo, when the disparate impact is so gross as to not be rationally explainable on neutral grounds, intent can be inferred. Yick Wo, 118 U.S. at 373-74.

In Wayte both the majority and the dissenting opinions view the three factors enunciated in Catsteneda v. Partida, 430 U.S. 482, 494 (1977), as sufficient to establish both discriminatory intent and effect. To prevail, the individual must show "[f]irst that he is a member of a distinct and recognizable class. Second, he must show that a disproportionate number of this class were selected for . . . possible prosecution. Third, he must show that his selection procedure was subject to abuse or otherwise not neutral." Id. at 626 (J. Marshall, dissenting).

Pregnant women and African-Americans are clearly members of a distinct class. Statistics on relative drug use by race shows that the underinclusive scheme, even at its best, would single out African-Americans. In fact, the complaint filed in Charleston, South Carolina alleged that the women pursued under the policy were "virtually all African-American." Drug Testing Leads to Complaint, CHARLESTON NEWS & COURIER, Jan. 21, 1994, at B1, B4. Finally, the selection standards for testing only applied to pregnant women. The testing for cocaine instead of "all drugs" virtually assured a racially skewed result given the statistical data of the MICH study. MICH I Study, supra note 10, at 7 (stating that African-American women are six times more likely than Caucasian women to use cocaine).

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"3. CHARGES TO BE FILED The following criminal charges will be filed against arrestees: (a) if the pregnancy is 27 weeks or less - Possession . . . . (b) if the pregnancy is 28 weeks or more - Possession AND Distribution to persons under eighteen. (c) if the patient delivers while testing positive . . . Unlawful neglect of a child."

(Exhibit on file with author).
found in the concurring opinion of Judge Reilly in *People v. Hardy* that focused on the unexpected nature of child delivery in general. He feared that criminalization based on use just before delivery would be based on the “occurrence of a contingency [labor] which is not within her control and is not reasonably anticipated at the time the drugs are used.” Judge Reilly concluded that to make the grade of the offense contingent on such fortuitous events was unjust.\(^9\)

The other problematic element of graduated punishment schemes is their lack of correlation to the harm involved. There is little question that the fetus is most vulnerable to deformation during the earliest stages of development.\(^9\) But graduated punishment schemes provide the lowest level of punishment for conduct during this high-risk period.\(^9\) This incongruous outcome may result from a prosecutorial fixation on the *Roe v. Wade*\(^9\) trimester framework. However, this attempt to avoid the limitations on the state’s interests (and the fetus’ rights) expounded by *Roe* may prove counterproductive. For although the state’s interests in potential life may increase during gestation, the deterrent diminishes as the danger increases.\(^9\)


\(^{92}\) Id.

\(^{93}\) Telephone Interview with Dr. William C. MacLean, Jr., Vice President of Pediatric Nutritional Research and Development of Ross (Abbott) Laboratories (Mar. 30, 1994). The fetus faces the greatest risk of deformity during the early stages of pregnancy. During the first stages, the fetus starts as a single cell which possesses all the genes for the entire body. These cells must divide and then specialize. Thus, errors occurring in the earliest stages may be replicated. As the fetus develops, genes in certain cells are “turned on and off” to differentiate into major organs, bones, and muscle. The further along the fetus is in this process of differentiation, the less danger toxins pose to development. This suggests that the risk of deformity stemming from exposure in the late stages of pregnancy is lower than from exposure occurring in the first weeks.

However, there is a second type of risk. While fetuses exposed to drugs during the late stages of pregnancy face lower risk of deformity, they may face an increased risk of carryover effects like withdrawal symptoms. Dr. McLean opined that while hard statistical evidence documenting such a secondary risk may be elusive, experts in the field probably would be willing to support the hypothesis on at least theoretical grounds.

\(^{94}\) See *Maternal Rights*, supra note 43, at 998.


\(^{96}\) Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. 2791, 2803 (1992), appears to have dispensed with the *Roe* trimester framework by recognizing the state’s interest throughout the full term of pregnancy. Freed from the rigidity of *Roe*, the inverse relation between punishment and risk to the fetus only becomes more perplexing.
B. Statutory Interpretation in Light of the Concept of "Fair Warning"

A common conception of due process is that statutes must detail, with some specificity, exactly what conduct is forbidden. The court in State v. Graham stated that a prohibition requiring that "men of common intelligence must necessarily guess at its meaning and differ as to its application violates the due process of law." Thus, constitutional concerns "prohibit prosecutors from inventing new crimes and from interpreting existing crimes in new, unforeseeable, and unintended ways."

Even in instances where statutes fail to rise to the level of due process or are constitutionally vague, courts have consistently striven to preserve the concept of fair warning. When engaged in statutory interpretation, courts often balk at expanding the meaning of statutes and words beyond their plain meaning. This concern is particularly evident when the statute or word in question has a long-established application or meaning. Such unannounced alterations in a statute's application would deprive even a well-informed reasonable person of notice.

As illustrated in Keeler v. Superior Ct. of Amador County, attempts to expand existing criminal statutes to include fetuses have encountered notice problems. The court was asked to extend a homicide statute to include feticide. As
previously applied, homicide required the death of a person. After lengthy debate, the court concluded that a fetus was outside the common conception of the term person and that extending the meaning of homicide would deprive the defendant of fair warning. The court thus refused to allow the conviction.103

The application of child neglect and drug delivery charges in reference to an unborn fetus is plagued by the same concerns. Plain reading of most of these statutes limits applicability to "persons." Although statutes must be examined individually, typical wording describes conduct perpetrated against a "child" or a "person."104 Yet it is relatively evident that a "fetus" does not meet the definition of a person.105 Referring to child endangerment and drug distribution charges stemming from maternal drug use, the MICH Council stated that "[a]ll courts considering the issue have held that statutes of this type do not apply to drug use during pregnancy."106

Thus, even if evidence can be marshaled against offending women, fair warning concerns may restrain courts from applying existing penal statutes. The lack of applicability of most existing laws, well-chronicled by the cases above, underscores the need for specific legislative deliberation and drafting.107 In cases of such profound public policy, the legislature, not the prosecutor's office, is best designed to define the bounds of the public good.

103. Id. at 630.


105. In the abortion context, the fetus must have be viewed by the Court as being distinct from a person, for otherwise the fetus' demise would be homicide. See Roe v. Wade, 410 U.S. 113, 156-69; Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. 2791, 2803 (1992).


107. MICH 3 Study, supra note 39, at 3 (stating that "[i]f pre-birth intervention by the Dept. of Social Services or another agency is regarded as desirable, new legislation would be necessary to authorize and fund interventions specifically oriented toward preventing prenatal harm.")
V. THE CONSTITUTIONAL RIGHTS INVOLVED

A. Penumbral Privacy

Punitive policies necessarily encounter constitutional difficulty surrounding rights of personal privacy. As Justice Douglas enunciated in *Griswold v. Connecticut*, a "protected zone" emanating from the First, Fourth, Fifth, and Ninth Amendments exists in which the individual's privacy is protected from intrusion. Justice Goldberg's concurrence, relying on Justice Brandeis' dissent in *Olmstead v. United States*, aptly referred to the "right to be let alone — the most comprehensive of rights and the right most valued by civilized men." It is within this "right to be let alone" that the rights surrounding reproductive autonomy and bodily integrity are reposed — potentially catastrophic hurdles for any punitive drug treatment policy aimed at pregnant women.

1. The Right to Reproductive Autonomy

The federal judiciary has long endorsed a primarily laissez-faire approach towards regulation of "family planning" issues. The origin of this approach can be seen as early as *Skinner v. Oklahoma* in which the Court invalidated the Oklahoma Habitual Criminal Sterilization Act. In the initial sentence, Justice Douglas characterized procreation as "a sensitive and important area of human rights." Invalidating the statute under the Equal Protection Clause, the Court emphasized that "[m]arriage and procreation are fundamental to the very existence and survival of the race." Although the *Skinner* rationale rested on Equal Protection grounds, subsequent cases including *Griswold v. Connecticut* demonstrated the Court's due process privacy commitment to attaining the same "hands off" result.

The decision in *Roe v. Wade* grappled with the due process quagmire of maternal versus fetal rights. In *Roe*, the
Court concluded that the existence of the fetus did not alter the nature of the woman's fundamental right. Rather, the Court determined that any interest of the state in fetal rights must properly be addressed through the strict scrutiny interest balancing framework.\textsuperscript{115} Recognizing that "[l]iberty finds no refuge in the jurisprudence of doubt," Justice O'Connor's opinion in \textit{Planned Parenthood of Southeastern Pa. v. Casey} affirmed Roe's protection of procreation, contraception, marriage, and family.\textsuperscript{116} Significantly, she cautioned that "[b]eliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."\textsuperscript{117} The concept of personal freedom regarding reproductive autonomy remained triumphant, even if the court did concede that state interests could predominate in certain limited circumstances.\textsuperscript{118}

Within this laisséz-faire framework of reproductive privacy, the Court quickly signaled that government intrusion need not be complete to offend. In \textit{Cleveland Board of Education v. LaFleur},\textsuperscript{119} the Court struck down a restrictive maternity leave requirement. The Court concluded that disparate treatment based only on the fact of pregnancy effectively served to punish women for exercising their right to bear children.\textsuperscript{120}

Punitive policies plunge headlong into this morass of individual rights by directly influencing decisions regarding pregnancy, abortion, and family planning. That such policies punish pregnancy is hardly a novel conclusion. Dorothy Roberts, states "[i]t is important to recognize . . . that the prosecutions are based in part on a woman's pregnancy and not on her illegal drug use alone."\textsuperscript{121} Roberts' opinion was well supported by the

\begin{flushleft}
\textsuperscript{115.} \textit{Id.} \\
\textsuperscript{116.} 112 S. Ct. at 2803. \\
\textsuperscript{117.} \textit{Id.} at 2807 (emphasis added). \\
\textsuperscript{118.} \textit{Id.} \\
\textsuperscript{119.} 414 U.S. 632, 651 (1974). \\
\textsuperscript{120.} \textit{Id.} at 640. \\
\textsuperscript{121.} Dorothy E. Roberts, \textit{Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy}, 104 \textit{Harv. L. Rev.} 1419, 1445 (1991) (stating that "[i]t is the choice of carrying a pregnancy to term that is being penalized"). This notion is underscored by the fact that in most instances, charges will be dropped if the pregnancy is aborted. Also, as previously discussed, selective enforcement creates the burden on reproductive rights. While drug use is criminal in general, only pregnant women are subjected to the increased screening and enforcement under these policies. See \textit{Yick Wo v. Hopkins}, 118 U.S. 356, 373-74 (1886). By singling out women on the basis of pregnancy, the pregnancy in effect becomes a required element under these policies.
\end{flushleft}
cavalier statements in the *Florida v. Johnson* transcript proclaiming that “[w]hen she delivered that baby, she broke the law in the State.”\(^{122}\)

In evaluating the propriety of punitive drug approaches, pregnant women are clearly isolated and given different treatment — treatment that discourages pregnancy. Unable to envision an acceptable punitive plan, the MICH Council ultimately concluded that the *LaFleur* analysis “would apply to requirements that medical confidentiality be breached, that ... criminal penalties be imposed, that drug testing be required . . . for pregnant women, if these same requirements would not apply to a person who was similarly situated except for the fact of pregnancy.”\(^{123}\)

When applied to punitive policies, the *LaFleur* analysis of indirect punishment of pregnancy is far surpassed. Upon delivery, punitive policies subject women to prosecution for charges including simple possession, distribution to a minor, child endangerment, and neglect of a dependent.\(^{124}\) Criminal law does not offer a clearer deterrent for conduct. Given the involuntary nature of drug use in the context of addiction, what is truly punished is pregnancy.

The alternatives facing women under such policies are bleak. “Indeed, for a woman accused of prenatal child abuse, the only option to avoid punitive measures may be an unwanted abortion.”\(^{125}\) Such government coercion was disparaged as early as *Skinner* where the court feared that “[i]n evil or reckless hands, [control of reproduction] can cause races or types which are inimical to the dominant group to wither and disappear.”\(^{126}\)

In the current context, this fear may be well-founded. Punitive policies are commonly applied in indigent care facili-
Cocaine use tends to be higher among blacks than whites, although both races display roughly equal usage of drugs overall. At least one study has shown that physicians are more likely to report women of color to the authorities. Protocol testing factors that leave the question of whom to test largely to the discretion of nursing staffs likewise lead to racially-biased results. The gestalt of these factors is a policy in which the impact is borne almost exclusively by lower income women of color.

2. The Right to Bodily Integrity

Penumbral privacy also contains a right of bodily integrity. This right to be free from bodily invasion originated in the common law. The court in *Norwood Hospital v. Munoz* declared that "individuals have a common law right to determine for themselves whether to allow a physical invasion of their bodies." Thus, Judge Cardozo's maxim that "every human being of adult years and sound mind has a right to determine what shall be done with his own body" still echoes in court decisions.

Courts, not content to rest on common law foundations, have investigated the existence of aconstitutional basis for the right to refuse medical treatment. With reference to *Roe, Griswold*, and others, the court in *In re Quinlan* concluded that the same constitutional right encompassing abortion also was broad enough to "encompass a patient's decision to refuse medical treatment." Later cases such as *Norwood* confidently asserted that "[i]ndividuals also have a penumbral constitutional right of privacy to reject medical treatment."

127. See Ferguson v. Charleston, No. 2-93-2624-2 (D.S.C. filed Oct. 5, 1993) (stating that the Medical University of South Carolina was the only indigent care facility in the area and was the only hospital in the area involved in the policy).
128. MICH 1 Study, supra note 10, at 6-8.
129. NAPARE, supra note 30, at 1.
Only recently, however, has the United States Supreme Court entered the fray. In *Cruzan v. Director, Missouri Department of Health*, the Court carefully recounted the development of both the common law and constitutional foundations for the right to bodily integrity.\(^{134}\) In its schizophrenic journey, the Court refused to definitively comment on the existence of a constitutional basis.\(^{135}\) Stating "we think the logic of the cases discussed above would embrace such a [constitutional] liberty interest,"\(^{136}\) the decision then proceeded based on a hypothetical assumption that such a right might exist. The Court did, however, resolve that the "Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment."\(^{137}\) It also emphatically acknowledged the common law doctrine of informed consent.\(^{138}\) Having discussed the right to refuse treatment as the logical corollary of informed consent, it appears the Court may have given both concepts constitutional stature.

The doctrine of informed consent typically requires the physician to disclose to the patient all relevant risks of the procedure unless they are statistically remote or of only minor severity.\(^{139}\) These risks include "(1) the diagnosis, (2) the general

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135. Id. at 279. Unfortunately, the Court was not specific in resolving the basis for the right. Justice Rehnquist recognized the popularizing influence of *Quinlan* for the constitutional theory. Id. However, cases such as *In re Storar*, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981), in which the New York court refused to base its decision on grounds of constitutional privacy, were also discussed approvingly. One possible explanation is that while a majority supports the existence of such a constitutional right in this context, it fears that recognition would open the door to arguments in the abortion context. Thus, the Court's discussion of *Quinlan* and its progeny may display the court approaching acceptance of this new theory.

However, with the arrival of *Casey*, the Court's previously equivocal embrace of a constitutional right to bodily integrity was solidified. See *Casey*, 112 S. Ct. at 2810. Justice O'Connor's opinion, ending debate on whether *Roe* and *Griswold* included a right of "bodily integrity," cited *Cruzan* as resolving the question. Id. Office Interview with Prof. Melvin Durchslag, Professor of Law at Case Western Reserve University School of Law, Cleveland, Ohio (Mar. 9, 1994). See also Daniel Avila, *Medical Treatment Rights of Older Persons and Persons With Disabilities: 1991-92 Developments*, 8 ISS. OF LAW & MED. 429, 436 (1993) (interpreting *Casey*'s reference to *Cruzan* as an indication of the Court shifting the grounds of its abortion decisions from the *Griswold* privacy right toward a fundamental right of bodily integrity).

137. Id. at 280.
138. Id. at 270.
139. See Hook v. Rothstein, 316 S.E.2d 690, 703 (S.C. App. 1984) (stating that "[t]he physician's chief concern when treating a patient should be the patient's best interest.") Id. at 697.
nature of the contemplated procedure, (3) the material risks involved in the procedure, (4) the probability of success associated with the procedure, (5) the prognosis if the procedure is not carried out, and (6) the existence of any alternatives to the procedure.”

Covert drug testing and the related risk of prosecution employed by punitive policies faces serious legal obstacles unless accompanied by consent. The risk of prosecution appears to be within the Canterbury v. Spence conception of a “material risk” that might “potentially affect the patient’s decision.” Empirical evidence supports that women view the risk of prosecution as material. Fear of prosecution has been cited as a major reason for women avoiding prenatal care. This same fear prompted the GAO’s prediction that punitive policies would result in more women delivering at home to avoid detection.

Drug testing under punitive policies notably lacks any form of consent. Implied consent, based on the patient’s cooperation, cannot be relied upon when the patient is unaware that the procedure is being performed. There must be some appreciation of the risks and the procedures for which the implied consent is given. Thus, “it could not be implied that a pregnant woman had consented to a drug screen which would be reported to authorities . . . merely by consenting to an otherwise ‘routine’ blood test.”

Defending of punitive policies, proponents often futilely proffer the “blanket consent” signed by the patient upon admission. Courts considering express consent, however, have consistently disregarded such “blanket” statements. As stated in Feliciano v. City of Cleveland, consent must be “unequivo-
Under the Feliciano formulation, every aspect of valid consent is lacking. "Intelligent" consent is unlikely when the patient is neither informed that the test will be performed nor told of the material risks. The "blanket consent," by its very nature, precludes any argument of "specificity." Finally, the "medical judgment" provisions in the blanket consent make it equivocal at best when employed for law enforcement rather than medicine.

Likewise consent gained upon confrontation by the authorities is also invalid. The court in United States v. Lopez emphasized that consent is not voluntary if it is the "product of duress or coercion, actual or implicit." When presented with a choice between prosecution or entry into a "treatment" requiring random drug testing, patients can hardly be viewed as unpressured actors. Any consent given to future drug testing can only be viewed as tainted.

B. The Fourth Amendment Search and Seizure

The Fourth Amendment secures for every citizen the right to be free of "unreasonable searches and seizures" of their "persons, houses, papers, and effects." Non-consensual drug testing and subsequent disclosure of results, relied on by punitive policies, violates the Fourth Amendment. The Court in Mapp v. Ohio decried the use of evidence obtained in illegal searches and declared that "invasion of [a subject's] indefeasible right of personal security [or] any forcible and compulsory extortion of a man's own testimony" is within the condemnation of the Bill of Rights. Recognizing that what constituted a reasonable search could not be gauged by reference to a rigid
formula, the Court suggested that it must be established on an ad hoc basis.\footnote{151}

The privacy of the home examined in \textit{Mapp}, however, pales in importance when compared to the privacy of the person. Just five years after the \textit{Mapp} decision, the Supreme Court addressed the issue directly in \textit{Schmerber v. California}.\footnote{152} Considering the blood and alcohol testing of a drunk driving arrestee, the Court was convinced that the test was clearly a Fourth Amendment search.\footnote{153} The Court then opined that “the Fourth Amendment’s proper function is to constrain not all intrusions as such, but against intrusions which are not justified in the circumstances.”\footnote{154} While the test was found to be reasonable on the facts of the case, the Court emphasized that it condoned only “minor intrusions into an individual’s body under stringently limited conditions” and emphasized that courts would not tolerate further expansion.\footnote{155}

The analysis of Fourth Amendment cases is relatively straightforward. The Supreme Court first considers whether the test was administered by the agents of the government.\footnote{156} Addressed next is the issue of whether the test “constitutes a search or seizure by infringing a legitimate expectation of privacy.”\footnote{157} Only with both questions answered in the affirmative will the court then turn to the reasonableness of the challenged conduct.\footnote{158}

The numerous factors relevant to the reasonableness determination essentially require an ad hoc review of the record. \textit{Feliciano} concentrated on the existence of probable cause to justify the search as well as the nature of the search.\footnote{159} The Court strongly rejected arguments that drug testing might fall within

\footnotesize{\begin{tabular}{l}
151. \textit{Id.} at 653. \\
152. 384 U.S. 757 (1966). \\
153. \textit{Id.} at 767. \\
154. \textit{Id.} at 768. \\
155. \textit{Id.} at 772. Later cases have affirmed that drug testing constitutes a Fourth Amendment search. \textit{See, e.g., Feliciano}, 661 F. Supp. at 584 (finding that “[b]ased upon the weight of the precedent holding that urinalysis is a [F]ourth [A]mendment search or seizure, numerous courts have simply adopted a holding without independent analysis.”) \\
\end{tabular}
the scope of de minimus intrusions such as fingerprinting.\textsuperscript{160} Interpreting \textit{Schmerber}\textsuperscript{161} through the lens of both \textit{Mara}\textsuperscript{162} and \textit{Davis},\textsuperscript{163} the \textit{Feliciano} court found a distinction between “intrusions involv[ing] physical characteristics that are ‘constantly exposed to the public’” and those “probing into an individual’s private life and thoughts.”\textsuperscript{164} In the absence of consent or a warrant, the Court noted that such intrusions of the person must be accompanied by probable cause.\textsuperscript{165}

Given that UDS tests performed under punitive policies constitute a search under the Fourth Amendment, the inquiry then turns to the issue of government involvement. Admittedly, testing under such policies is conducted by health care professionals rather than by the police. In context, however, the clinicians effectively assume the role of deputized police informers.\textsuperscript{166}

The Charleston policy provides an ideal illustration. The UDS testing was performed at the request of the Solicitor’s Office.\textsuperscript{167} Results were then disclosed to the police and the Solicitor. The Medical University of South Carolina (MUSC) was an official member of the “interagency” policy group. Appearances of agency were further enhanced by the active counseling role played by physicians. First, physicians would confront the patient and present her with a notice letter signed by the Solicitor. Next, they would show her a film on the dangers of drug

\textsuperscript{160. \textit{Id.}}
\textsuperscript{161. \textit{Schmerber v. California}, 384 U.S. 757 (1966) (stating “[i]n the absence of a clear indication that in fact such evidence will be found, these fundamental human interests [of privacy] require law officers to suffer the risk that such evidence will disappear” and thus constrains them from conducting a search).}
\textsuperscript{162. \textit{United States v. Mara}, 410 U.S. 19, 21 (1973) (finding that a handwriting sample taken is not a search since handwriting is continuously exhibited in public).}
\textsuperscript{163. \textit{Davis v. Mississippi}, 394 U.S. 721, 727 (1969) (holding that fingerprinting arrestees does not amount to “search”).}
\textsuperscript{164. \textit{Feliciano}, 661 F. Supp. at 585.}
\textsuperscript{165. \textit{Schmerber}, 384 U.S. at 770.}
\textsuperscript{166. Courts have displayed hesitance in accepting evidence obtained in a search by a private party. \textit{See Gundlach v. Janing}, 401 F. Supp. 1089, 1092-94 (D. Neb. 1975) (explaining that the policy against receiving such evidence was grounded in discouraging officials from participating in or encouraging searches conducted by private parties on behalf of the government). \textit{See also Water v. United States}, 447 U.S. 649, 656 (1980) (limiting the scope of the government’s ability to further investigate articles obtained through a private party search).}
\textsuperscript{167. Letter from Charles Condon, Solicitor, South Carolina Office of the Solicitor General (Oct. 18, 1989) (stating that positive test results were being forwarded to the solicitor’s office pursuant to an interagency policy) (on file with the author).}
use, also provided by the Solicitor. Finally, they would secure the patient's signature on a contract to get treatment to avoid prosecution. All of these steps were performed for the benefit and under the control of the sovereign.\footnote{168}

The drug screenings employed by punitive policies, once defined as a search conducted by the government, must then be justified. There are three possible avenues: (1) obtaining a warrant;\footnote{169} (2) finding probable cause for arrest and a need for urgent search;\footnote{170} and (3) securing consent.\footnote{171} Without question, warrants are absent for the drug tests performed under punitive policies. Such policies are largely self-executing since the physicians perform the tests without direct supervision by the prosecutor or police. Health care providers lack access to warrants without the assistance of the prosecutor or the police.

Punitive policies also lack any trace of justification for a warrantless search. Both Schmerber and Lopez suggest that for searches made incident to an arrest, there may be an exception to the warrant requirement.\footnote{172} However, to qualify for this limited exception, the probable cause supporting the arrest must typically be augmented by extenuating circumstances.\footnote{173} First, there must be insufficient time to visit the magistrate.\footnote{174} Second, there must be some serious risk of the evidence being destroyed or a significant danger of concealed weapons.\footnote{175}

\textit{Schmerber}, as well as the continued routine administration of breathalyzer tests in the field, demonstrate that courts have

\footnotesize{168. Statement by Dr. David Orenlichter, the AMA's Ethics and Health Policy Counsel (stating "[i]f you try to make physicians agents of the state then you are going to discourage people from using the health care system."). See Bruce Smith, \textit{MUSC Program Under Fire, Charleston News & Courier}, Jan. 23, 1994, at B1.}

\footnotesize{169. \textit{See} \textit{Mich 3 Study, supra} note 39, at 4 (stating "[d]isclosure of Drug Test results for criminal prosecutions would normally require a warrant.").}

\footnotesize{170. \textit{See} Schmerber, 384 U.S. 757 (1966).}


\footnotesize{173. \textit{See} Winston v. Lee, 470 U.S. 753 (1985) (applying the \textit{Schmerber} balancing test to a search incident to arrest and refusing to force a suspect to undergo surgery to have a bullet removed for evidence); U.S. v. Robinson, 414 U.S. 218 (1973) (endorsing a warrantless search of a person incident to arrest, but not dealing with invasive procedures).}


\footnotesize{175. \textit{Id.; Lopez}, 327 F.Supp. at 1093 (suggesting "hot pursuit," "danger of weapons," and "destruction of evidence" as possible justifications for warrantless searches accompanying arrest).}
found the limited life of drug metabolites in the blood pose a
danger of evidence that may be destroyed. In drunk driving
cases, the arrestee’s inebriated conduct provides the officer with
probable cause for arrest. This probable cause for suspicion
of drug or alcohol abuse, when combined with the limited
timeframe for gathering medical evidence, arguably supports
warrantless testing.

Punitive policies are more problematic. Testing, based on
protocol factors rather than observed erratic behavior, lacks the
probable cause inherent in the drunk driving scenario. The pro-
tocol factors identified above seem sufficiently equivocal to
undermine any strong inference that a crime requiring immedi-
ate investigation has been committed. Without legitimate
reason to suspect the woman of a crime, there is no logical rea-
son to fear for the destruction of evidence.

Consent is also conspicuously absent. As previously dis-
cussed in reference to the right to bodily integrity, neither im-
plied nor express consent is present to authorize either the drug
testing or the disclosure of results to prosecutors. Failing to
even rise to the level of specificity required to satisfy the re-
quirements of informed medical consent, little justification can
be found for UDS tests performed primarily for the purpose of
prosecuting the patient.

176. South Carolina’s drunk driving test is of interest. The arrestee has the option of
refusing the breathalyzer test. This refusal is tied to an automatic temporary suspension of
driving privileges. Regardless, it is significant that even arrestees in cases in which probable
cause is clearly present are at least given a choice regarding the test. See PATRICIA S.
WATSON & WILLIAM S. McANNICH, GUIDE TO SOUTH CAROLINA CRIMINAL LAW AND

177. Schmerber, 384 U.S. at 768.

178. Horger et al., supra note 45, at 528 (listing as protocol factors (1) no prenatal
care; (2) abruptio placentae; (3) intrauterine fetal death; (4) pre-term labor; (5) intrauter-
ine growth retardation; and (6) previously known drug or alcohol abuse).

179. Even while upholding protocol searches in the realm of airport hijackings, the
based upon statistical research designed to predict who might commit crimes and giving
them the special attention of law enforcement agencies is particularly disturbing.” Id.
(emphasis added). The Court appeared fearful at the prospect of abuse under such
systems.

The abuse forecasted by the Lopez court has come to fruition with punitive policies.
Studies have indicated that the protocol factors are most effective at targeting poor women
of color. See supra note 45 and accompanying text.

180. See supra part IV.A.2.

181. MICH 3 Study, supra note 39, at 4.
Assertions of consent based on "blanket admission" consent forms are unconvincing and ultimately irrelevant. The consent gained by health care providers upon admission is a "medical consent" rather than a consent waiving the patient's constitutional rights. The plain reading of most admission forms suggests that tests and procedures would be administered based on "medical judgment." By performing the UDS based on protocol rather than medical necessity, punitive policies necessarily exceed the bounds of any consent granted.

VI. STRICT SCRUTINY REVIEW REQUIRED

By forcing women to waive constitutional rights in order to receive state-provided indigent medical care, punitive policies unconstitutionally employ indirect compulsion to further law enforcement policy.

Traditionally, the Court has taken great care in protecting the Bill of Rights from both direct and indirect threats. As articulated in Thomas v. Review Board of the Indiana Employment Security Division, even indirect compulsion is suspect because "[w]hile the compulsion remains indirect, the infringement upon free exercise is nonetheless substantial." The Court has vociferously objected to such bargaining of rights, claiming that by attaching differing prices to the exercise or waiver of rights, economic realities too often strip away individuals' freedoms and choices.

With its focus on protecting the right to choose, the doctrine of unconstitutional conditions broadly extends to most rights of personal autonomy. The decision in St. Agnes Hos-

182. See Blanket Consent, supra note 47. The 1993 MUSC Patient Information Handbook (Welcome to MUSC Medical Center) further bolsters the inference that test results will remain confidential by stating that patients can expect privacy in their medical care and medical records.
184. Id. at 718.
185. See, e.g., Weiman v. Updegraff, 344 U.S. 183 (1952). In Weiman, the Court deliberated on the propriety of forcing government employees to take a test oath renouncing affiliation with prior political parties as a condition of retaining employment. Id. Justice Black, in his concurrence, ridiculed such practices as a "tools of tyranny" and noted that the policy effectively made employees buy continued employment through waiver of rights to political choice, affiliation, and free speech. Id. at 193-94.
186. See Kathleen M. Sullivan, Unconstitutional Conditions, 102 HARV. L. REV. 1413, 1426 (1989) (stating that "[p]ersons on the wrong side of an unalterable-characteristic line are not hurt by any pressure to opt into the benefited class"). Such disparate treat-
Health care policies often place the poor in an unconstitutional dilemma of having to choose between a governmental benefit of health care and the exercise of their constitutional rights. Although the policies stop short of creating active governmental impediments, they exact a heavy toll for the receipt of medical care. Only by ceding rights to free speech, freedom of religion, freedom from illegal search and seizure, and freedom from self-incrimination are the women affected by punitive policies able to receive health care. By putting a cost (forbearance of medical care) on the exercise of constitutional rights, such policies unacceptably engage in the indirect compulsion condemned in *Thomas v. Review Board of the Indiana Employment Security Division.*

Government policies serving as a vehicle for the restriction of protected rights must be justified under a strict scrutiny level of review. In order to survive strict scrutiny, the state action...
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(1) must be justified by a compelling state interest, (2) must display a narrowly tailored means-ends relationship, and (3) there must be no less discriminatory alternative.193

Proponents of punitive policies view them as valiant attempts to further the legitimate state interests of curbing drug use and improving child welfare. Unfortunately, as previously discussed, significant problems are encountered by the means employed. To paraphrase Chief Justice Marshall's opinion in *McCulloch v. Maryland*, let the ends be legitimate, and all means not repugnant to the Constitution are acceptable.194 However, even when the state interests reach constitutional proportions, the court in *Goodall by Goodall v. Stafford County School Board* acknowledged that the state may not violate one constitutional tenet to further another.195 In *Goodall*, parents sought a state-provided sign language interpreter for their son's use in a private religious school.196 The court noted that the existence of Equal Protection problems (the interpreter was provided in secular environments) did not justify the state's providing assistance that would violate the Establishment Clause.197

The state interests implicated by punitive policy programs are arguably compelling. The laudatory goals of improved child welfare and reduced drug use appear to fall within the state's

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193. *Elrod*, 427 U.S. at 363 (requiring "precision of regulation as the touchstone," and stating "[i]f the State has open to it a less drastic way of satisfying its legitimate interests, it may not choose a legislative scheme that broadly stifles the exercise of personal liberties").


196. *Id.* at 364.

197. *Id.*
traditional bastions of public health, safety, and welfare. However, to survive strict scrutiny, *Elrod v. Burns* cautioned that "precision of regulation must be the touchstone in an area so closely touching our most precious freedoms."\(^{198}\) Not only must there be a positive, demonstrable means-ends relationship, the means also must be "narrowly tailored" to accomplish the objective.\(^{199}\)

Simply put, punitive policies fail strict scrutiny review because they fail to further the state interests proffered by the government. Rather than curbing drug use and improving child welfare, such programs have been shown to have an adverse affect on fetal and maternal health.\(^{200}\) Studies also have shown treatment on a voluntary basis to be more successful.\(^{201}\) Again, "[o]ne can compel attendance, but not meaningful participation."\(^{202}\) By further retarding the delivery of prenatal care to those women most in need, it is probable that child welfare is diminished rather than enhanced. Since punitive policies appear inimical to the goal of improving child welfare and ineffective at curbing maternal drug use, such programs lack the narrowly tailored means-ends relationship required to overcome a constitutional challenge.

More effective methods requiring less restriction of constitutional rights exist for attaining the ends sought by the state. The *Elrod* court required that "[i]f the state has open to it a less drastic way of satisfying its legitimate interests, it may not choose a legislative scheme that broadly stifles the exercise of personal liberties."\(^{203}\) The remainder of this Note will address

\(^{198}\) *Elrod*, 427 U.S. at 363.

\(^{199}\) See, e.g., *Weiman v. Updengraff*, 344 U.S. 183, 191 (1952). In *Weiman*, the state advanced the compelling interests in cooperative government and uniform policy in support of loyalty oaths. *Id.* The Court concluded that there was no evidentiary or logical basis to support the policy. *Id.* Without a clear demonstration of a positive relationship between efficient government and the renunciation of political beliefs, the Court found that the policy lacked the narrowly tailored means-ends required to survive strict scrutiny. *Id.*

\(^{200}\) *Cole*, *supra* note 3, at 2667 (stating such policies drive many mothers away from care).

\(^{201}\) See *Chavkin*, *supra* note 68, at 1556-57.

\(^{202}\) *Id.* at 1559.

\(^{203}\) *Elrod*, 427 U.S. at 363. In *Elrod*, the state claimed that, among other things, political patronage helped preserve the democratic process. The court readily accepted preservation of democracy as a compelling state interest. However, it noted that patronage was not shown to be effective in this manner and that the goal could likely be furthered by less intrusive means. *Id.* at 372-73.
more effective, yet less intrusive, means of addressing the problems of maternal-fetal drug use.

VII. PROPOSED POLICY EFFORTS

The preferred solution to the problem of substance abuse by pregnant women encompasses three broad areas. Education must be the first priority. Second, treatment must be voluntary. Finally, treatment must be both accessible to women and tailored to their needs.

"The public must be assured of non-punitive access to comprehensive care which will meet the needs of the substance-abusing pregnant woman and her infant." 204 This call to arms is in accord with the views of many medical and health associations. The APHA, ASAM, AMCH, March of Dimes, as well as others, all conclude that drug problems should be addressed as a public health issue. 205 As expressed by the ASAM, the law should avoid the "prenatal child abuse" trend since punitive policies are inappropriate and counter-productive. 206

Instead, the focus must be on education. The APHA and ASAM both herald the need for increased educational efforts. 207 These calls appear prudent in light of opinions identifying "education" as the "most cost-effective" method of dealing with the problem. 208 In fleshing out its proposal, the ASAM identified four specific educational objectives:

(1) age-appropriate school-based education; (2) public media forms of education including health warning labels, posters, and various forms of public service announcements; (3) pre-

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204. PEDIATRICS, supra note 2, at 642.
205. APHA, supra note 2 (confirming that the organization views this as a public health problem and recommends against punitive measures); AMCH, supra note 31; MARCH OF DICHES, supra note 31.
206. ASAM, supra note 31 at 47, 49. This is not to suggest that it is unconstitutional to punish drug use. The proposition is more limited. In general, to punish drug use by incarceration or even mandatory treatment, the state might reasonably be viewed as a medically positive response, even if it is not the most effective. However, from a health perspective, punitive policies applied to pregnant women are counter productive.
Rather than producing a net positive result (even if less than ideal), women are driven away from the health care system entirely. The adverse effects on fetal health outweigh the questionable benefits of compelled treatment. Thus, the resulting negative impact on overall maternal-fetal health under punitive policies differentiates them from the typical drug use case.
207. See APHA, supra note 2; ASAM, supra note 31, at 47; Cole, supra note 3, at 2668.
208. Chasnoff, supra note 4, at 1568.
natal education about alcohol and other drugs for all pregnant women and significant others as part of adequate prenatal care; (4) professional education for all health care professionals . . . in the care of chemically dependent women and their offspring.209

By employing voluntary, non-confrontational methods, government efforts at curbing drug use will realize two benefits. Most notably, voluntary programs would avoid the marriage of medicine to the state criminal system which has driven women out of the health care system and possibly hurt more fetuses than it has helped.210 By avoiding the adversarial relationship between a woman and the fetus, as well as the patient and the physician, trust and disclosure will improve diagnostic and treatment results. Additionally, there are some indications that women entering treatment on a voluntary basis are more likely to be successful in rehabilitation.211

Second, voluntary programs largely avoid the constitutional pitfalls encountered with punitive policies. This benefit of voluntary treatment and public education programs prompted the MICH Council to recommend that “[e]fforts to address . . . drug use during pregnancy should focus on prevention, education, and treatment programs which do not affect the constitutional rights of the pregnant woman.”212 Without compulsion, education and voluntary treatment allow women to retain freedom and dignity — ideals firmly within the aegis of the Constitution.

Finally, treatment services must be tailored to the needs of women and must be available on a vastly increased scale. The Coalition on ADDWIC's finding that women desiring to enter treatment must face a six to eighteen month waiting list demonstrates that demand far exceeds supply.213 Treatment delays can be catastrophic. Once a woman has resolved to seek treatment, immediate admission must be available, for even minimal delays can lead to a change of heart.

In addition to the need for treatment space, women also have specific needs in treatment. At present, “[m]ost programs

209. ASAM, supra note 31, at 47.
211. Chavkin, supra note 68, at 1556-57.
212. MICH 3 Study, supra note 39, at 3.
213. ADDWTC, supra note 28, at 1.
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[are] designed for males and are not responsive to the psychological, social, and economic conditions in women's lives.\textsuperscript{214} The most basic need that must be addressed is that of child care. Programs designed to effectively treat women must provide some form of child care. With current facilities, women often must choose between receiving treatment and abandoning their children.\textsuperscript{215} With child care provided, women would be freer to pursue the long-term residential care viewed as most effective in dependency treatment.

Another significant hurdle is the financial barrier. The money currently spent prosecuting and mandating treatment for unreceptive mothers might be better spent on increasing the availability of treatment. The acceptance of Medicaid at drug treatment facilities also has been suggested as a method of expanding access.\textsuperscript{216}

Transportation barriers faced by women desiring treatment also must be eliminated.\textsuperscript{217} A significant number of substance abusing women lack the financial resources to commute to outpatient treatment. While perhaps not as vital in urban environments featuring mass transit systems, in more rural areas the problem is real.

The Southern Legislative Summit on Healthy Infants and Babies tackled this problem with concrete suggestions.\textsuperscript{218} The summit recounted several possible solutions. In particular, "Mom Vans," donated vehicles which could make weekly rounds to provide shuttle service to the needy, were lauded.\textsuperscript{219} As an example, the successful Washington, D.C. program in which donated vans were operated on stipends received from the city was cited. Another workable solution was the provision of bus or subway tokens.\textsuperscript{220} Perhaps the most innovative proposal was that of a "mobile treatment unit."\textsuperscript{221} Regardless of the

\textsuperscript{214} Paltrow, supra note 24, at 86.
\textsuperscript{215} Paltrow, supra note 24, at 86; ASAM, supra note 31, at 48; Chasnoff, supra note 4.
\textsuperscript{216} See Maternal Rights, supra note 43, at 1012; ADDWTC, supra note 28, at 1; Southern Legislative Summit on Healthy Infants and Families 4, Southern Regional Project on Infant Mortality 1, 4 (1990) [hereinafter Southern Summit].
\textsuperscript{217} Chasnoff, supra note 4, at 1568.
\textsuperscript{218} Southern Summit, supra note 215, at 6.
\textsuperscript{219} Id.
\textsuperscript{220} Id.
\textsuperscript{221} Id.
solution selected, the logic is inescapable. By making treatment more accessible to those in need, more women will be willing to undertake the commitment.

VIII. CONCLUSION

Proposals resting on education, voluntary treatment, and increased access are hardly a panacea. What they do represent is a more medically effective way to deal with the problem of substance abuse by pregnant women. They also avoid employing means repugnant to the Constitution. While fears regarding cost and funding abound, these issues may be specious. Considering the cost of the current system (both in dollars and in rights) compared with the surprising lack of success, searching for new solutions to the problem appears the only socially responsible avenue.