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National Advocates for Pregnant Women

www.advocatesforpregnantwomen.org

Women & Harm Reduction International Network

Family Law & Cannabis Alliance

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Sexual Rights Initiative

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SisterReach

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Native Youth Sexual Health Network

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1. This document is a joint submission from the International Network of People Who Use Drugs (INPUD), International Network of Women who Use Drugs (INWUD),[i] the Women and Harm Reduction International Network (WHRIN),[ii] National Advocates for Pregnant Women (U.S.A.) (NAPW),[iii] SisterReach,[iv] the Sexual Rights Initiative,[v] Family Law & Cannabis Alliance (U.S.A.) (FLCA),[vi] and Native Youth Sexual Health Network.[vii]

Executive Summary

2. This report focuses on the United States of America's failure to address and curtail the growing body of counterproductive and regressive state laws, policies, and practices that are increasingly being used to substantially undermine women's dignity and status as persons under the law.

3. Based on a devastating combination of ideological prejudice and misinformation, prosecutors, courts, and legislators across the United States are overtly discriminating against many of society's most traumatized and marginalized pregnant women. This is manifested in the reinterpretation of existing laws and the creation of new laws to punish pregnant women for the circumstances or outcomes of their pregnancies.

4. The arrest and incarceration of pregnant women and new mothers, coupled with interventions by child welfare authorities not only deprive women of their fundamental rights, but also threaten maternal, fetal and child health across the United States. The effect of these policies is most devastating to women who are marginalized on the basis of race, socioeconomic status, and their use of prescribed or illicit drugs.

Overview: The Punishment and Surveillance of Pregnant Women

5. In 2008, a woman named Amanda Kimbrough was rushed to Helen Keller Hospital in Alabama. She was 25 weeks pregnant and experiencing an umbilical cord prolapse, an unpredictable condition that can lead to fetal demise in a matter of minutes. Kimbrough had a history of preterm labors, but even so, an emergency labor was unexpected. Her newborn son, Timmy, was delivered by cesarean section, still and unresponsive. He survived for only 19 minutes. But while Ms. Kimbrough grieved the loss of her baby, the State of Alabama gathered samples of her bodily fluids and those of her baby to be used to mount a case against her. Confronted with a positive drug test,

she admitted to having used methamphetamine once during her pregnancy. Her two young daughters were immediately removed from her custody for 90 days. Just six months after her loss, Ms. Kimbrough was arrested and charged with a child endangerment crime. She is currently serving a sentence of ten years in the Julia Tutwiler women's prison, which has been named one of America's ten worst prisons.[viii]

6. This policing and punishment of pregnant women who use drugs has most affected women who give birth, but there have been many cases brought against women who were still pregnant and were drug free. Women have been punished because they suffered from sexually transmitted diseases or mental illness while pregnant, or because they wanted to deliver at home, because they refused cesarean surgery or failed to access prenatal care. In several cases referenced in NAPW's 2010 report[ix] and documented in NAPW's 2013 peer-reviewed study,[x] women were charged with one or more felonies after suffering a miscarriage; others were charged after giving birth to healthy babies who tested positive for criminalized drugs; some were even charged after attempting suicide.

7. These cases are not isolated incidents. Amanda Kimbrough is just one of over 750 women in the United States who have been subjected to some form of punishment or surveillance by the state because of the circumstances or outcome of their pregnancies from 1973 to the present day.[xi] The penalties vary, ranging from separation from their children, to unwanted medical interventions, to lengthy prison sentences; the crime with which Ms. Kimbrough was charged carries a potential life sentence.

8. What unifies these cases is a profound disregard for the health, rights and dignity of pregnant women, infants and families. All are attempts by the state to treat fertilized eggs, embryos and fetuses as though they were separate juridical persons.

9. This legal fiction is not only contrary to United States Supreme Court jurisprudence,[xii] but is being used to deprive women of fundamental human rights such as physical liberty, bodily autonomy, family integrity, due process of law, and even life itself.[xiii]

10. Attempts to create new and separate rights for fertilized eggs have not only led to the punishment of pregnant women, but have also created gender-based barriers to health and health care when women fear that they can be punished for drug use and pregnancy outcomes in ways that men cannot. The threat of punitive responses to pregnancy creates a climate of mistrust, drives pregnant women away from prenatal care, drug treatment, and even harm-reduction services for fear of reporting, arrest, or loss of child custody. It also foments uncertainty among medical professionals as to their duty to protect patient confidentiality. The presence of police and prosecutors disrupts important medical care that is already often difficult to access.

11. While all women become vulnerable when the state treats fertilized eggs as legally separate persons, research shows that these policies overwhelmingly impact low-income women with the least access to health care or legal defense and disproportionately affect women of color.[xiv]

Discrimination against Pregnant Women in Health and Law

12. The phenomenon of criminalizing mothers and pregnant women for drug dependence and pregnancy outcomes, precipitated by the war on drugs, harsh sentencing and efforts to recriminalize abortion, is wreaking havoc on the lives of marginalized women.[xv] The trend is being driven by continuous misinformation in the media and in the courts, particularly in relation to babies born to drug-dependent mothers.[xvi] The expectation that pregnant women are ultimately and solely responsible for pregnancy outcome effectively blinds the public to the state's obligation to prevent and address pervasive racial disparities in maternal care and infant outcomes, shifting attention away from the chronic lack of adequate drug treatment and support available for pregnant women.

13. Upon learning they are pregnant, women who may be drug-dependent (on prescribed or illicit opiates) need prioritization in health care and should be offered humane, evidence-based prenatal care and support, including the option of receiving opiate substitution therapies such as methadone or buprenorphine.[xvii] Abrupt discontinuation of opioids in a dependent pregnant woman (either self-determined or due to incarceration or coercion) carries much greater risks to the fetus, and medical authorities agree that withdrawal must be avoided.[xviii]

14. National and international authorities have access to decades of research demonstrating that controlled and stable dosing of methadone, either withdrawn incrementally or kept stable right up to delivery is safe for the baby and mother. Recent studies show that babies exposed prenatally to buprenophine require even less post-delivery medical assistance than those exposed to methadone, significantly reducing the babies' length of stay in the hospital.[xix] "Neonatal Abstinence Syndrome" (NAS) is recognized by medical authorities the world over as simple to both diagnose and treat in newborns. No long-term harm to the newborn is directly attributable to prenatal opiate exposure, whether the mother's use is prescribed or illicit.[xx]

15. Discriminatory, invasive surveillance of pregnant women in prenatal or hospital settings fosters fear and anxiety and is a breach of a woman's right to "non-discrimination in health care services."[xxi] Furthermore, women who are drug tested in a hospital will normally not receive the benefit of important procedural safeguards, which require any initial positive result be confirmed using a secondary method. Drug tests performed on newborns are known to be particularly unreliable; however, such unconfirmed, unreliable test results, along with consistent misinformation about NAS are often used to mount child abuse and criminal cases against mothers and pregnant women.[xxii]

16. Racial discrimination in the criminal justice system is systemic, and thrives in situations where authority figures have to make snap decisions.[xxiii] This disparity continues in the context of criminalization of pregnancy, particularly in the South. This is demonstrated by the finding that three-quarters of cases brought against pregnant African-American women originated in the South, while only half of cases brought against pregnant white women came from the southern states.[xxiv] The report raised important questions as to whether pregnant women subject to arrests, detentions, and

forced interventions were deprived of the right to procedural due process, including the right to effective assistance of counsel, at critical stages in proceedings against them.

I. Threats to Freedom

17. Across the United States, pregnant women's fundamental rights to freedom continue to be threatened by a patchwork of state court decisions and laws that are being used to single them out for special surveillance and punishment. Although many of these laws were passed in the name of protecting pregnant women from violence, promoting public health, and preventing unsafe abortions, they are now routinely used to subject women to criminal punishment for the circumstances or outcomes of their pregnancies. Despite the purported intent of these laws, there is no evidence to suggest that they have been successful in preventing violence against pregnant women and in fact, as this report will discuss, have impacted negatively on public health by driving women away from care.

18. Although the number of arrests across the nation is growing, the majority of U.S. state legislatures and high courts to have considered the issue have rejected creating new laws or expanding existing laws that would specifically target pregnant women. However, since 2010, two states -- Tennessee and Alabama -- have created laws (legislatively and judicially) that criminalize pregnant women who ingest controlled substances in spite of overwhelming criticism by medical and public health experts.

19. The World Health Organization clearly states: "*The imprisonment of pregnant women and women with young children should be reduced to a minimum and only considered when all other alternatives are found to be unavailable or are unsuitable.*"[xxv] Despite this clear guidance, the United States continues to incarcerate pregnant women and mothers at rates that exceed all other nations, threatening not only the health of the women themselves, but that of their children and families.

I (A): Tennessee "Fetal Assault" Arrests

20. Tennessee's new "fetal assault" law went into effect on July 1, 2014. The first woman to be arrested under this law was Mallory Loyola, 26. Charged with assault, she was separated from her newborn after two days and imprisoned on the basis of a single positive drug test. However, the drug this woman is accused of using, methamphetamine, is not a narcotic as defined in the legislation. In addition, exposure to methamphetamine is in no way related to the symptoms of Neonatal Abstinence Syndrome upon which this law was formed. Although there has been no mention that the child exhibited any adverse symptoms at birth, Ms. Loyola entered a guilty plea in an attempt to avoid further jail time, saying she is "hopeful for a future in which she can get visitation rights to be with her daughter."[xxvi]

21. In 2014, Tennessee became the first U.S. state to pass a law criminalizing pregnancy for women who illegally use narcotic substances. The state amended its fetal assault provision, which criminalizes harm to a fertilized egg, embryo, or fetus as a form of assault separate from the assault against a pregnant woman, so that a woman may be

charged with an assaultive offense if she is unable to guarantee a healthy pregnancy outcome. While the acting head of the U.S. Office of National Drug Control Policy noted that the current administration has "really tried to reframe drug policy not as a crime but as a public health-related issue," the federal government would not publicly oppose the proposal.[xxvii]

22. Legal experts warned that the law offends the United States Constitution by openly discriminating on the basis of gender, that it left open the possibility of a sentence of up to 15 years in prison, and presents a putative defense that is impossible to raise in practice.[xxviii] While the law specifically targets women who use narcotics illegally, the language permits women to be charged based on any unlawful act or omission believed to have caused or risked harm to a fertilized egg or fetus.

23. During Tennessee's Senate Judiciary Committee deliberations, legislators used a local news story, "Drug Addicted Babies," as evidence for the law's necessity.[xxix] In a similar outcome to the 1980's "crack baby" hysteria that was used to separate thousands of low-income women of color from their newborns, medically inaccurate media coverage about prenatal opioid exposure or NAS (Neonatal Abstinence Syndrome) became the factually incorrect basis on which the Tennessee law was formed.

24. The new law marked a significant departure not only from the recommendations of medical experts, but from recent progress made by Tennessee itself. In 2013, the state passed the Safe Harbor Act, which incentivized treatment programs by guaranteeing that women would not lose custody of their children if they sought out drug treatment. Without waiting to observe the effects of the Act, lawmakers rushed ahead at the behest of prosecutors to permit criminal charges, passing the pregnancy criminalization bill into law in 2014. The new law's discord with the Safe Harbor Act has caused confusion among pregnant women and medical care providers.

25. The new law is likely to have a harsher impact on black women because they are more likely to face systemic discrimination in criminal justice, social service and child welfare settings, and to be reported more often to authorities for a positive toxicology test than their white counterparts.[xxx] Data on Tennessee arrests are still emerging, but the only comprehensive study of arrests, detentions, and deprivations of liberty of pregnant women found that 59% of the women placed under state control were women of color (black, Latina, Indigenous, or Asian/Pacific-Islander) and 71% were indigent.[xxxi] In the state of Florida, where black people compose 15% of the state population and Caucasians compose 81%, nearly 75% of the women charged were black and 22% were Caucasian.[xxxii]

I(B) Alabama "Chemical Endangerment" Arrests

26. In 2013, the Alabama Supreme Court reinterpreted a criminal child endangerment statute to permit punishment of pregnant women. The statute, which defined the crime of "chemical endangerment" of a child,[xxxiii] was initially intended to punish any person entrusted with the care of a minor who exposes them to environments where illicit

drugs are manufactured, produced, or sold. Nothing in the language of the law had indicated that it was intended to apply to pregnancy.

27. Upon the law's passage in 2006, prosecutors began using it to charge women with a crime for giving birth if they had used a criminalized drug during pregnancy.[xxxiv] The possible sentences ranged from one to 99 years in prison.

28. When women challenged prosecutions under the law on the basis that the prosecution violated a number of rights guaranteed by the U.S. Constitution,[xxxv] the Alabama Supreme Court instead redefined the term "child" in the Alabama Code to include fertilized eggs, embryos, and fetuses.[xxxvi] To the present day, more than 130 women have been charged under this law (and this is a known undercount).

29. The effect of this reinterpretation is that any woman, at any stage of pregnancy from the point of fertilization, may be arrested for ingesting a controlled substance. Because the Legislature did not anticipate this use of the law, it contains no exceptions for prescribed medications, and subjects physicians to liability as accomplices for prescribing pain medication, opioid substitution therapy for dependence, or other controlled substances.

30. While many U.S. states have decriminalized or legalized use of marijuana, women have been arrested for use of this substance. In Alabama, public reports indicate at least 24 women have been charged under the "chemical endangerment of a child" law for testing positive for marijuana upon giving birth, giving rise to further confusion and trepidation amongst pregnant women seeking prenatal care.

31. As predicted by dozens of experts, including the American College of Obstetricians and Gynecologists, the American Medical Association, the American Psychiatric Association, and the National Perinatal Association, who filed amicus curiae briefs urging the Alabama Supreme Court to uphold the rights and health of pregnant women, this policy has had the effect of pushing women away from prenatal care and drug treatment.

32. Recommendations:

a. ***Impose a moratorium on all penal laws punishing harm to the unborn (including, but not limited to feticide and "fetal assault" laws), and undertake comprehensive research into the impact such laws are having on pregnant women and those who support them.***

b. ***Eliminate criminal penalties for personal use and possession of drugs and review the sentences of people incarcerated for nonviolent drug-related offenses.***

c. The U.S. Department of Justice must conduct an investigation into discriminatory and unconstitutional convictions based on wrongful interpretation of criminal laws used to punish pregnant women, and create mechanisms for appeal and financial restitution.

II. Threats to Maternal, Fetal, and Child Health

33. Reform of the health care system has been a priority for the current U.S. administration, and major changes have been introduced through the Affordable Care Act and the expansion of Medicaid. Still, many low-income people continue to struggle to access healthcare, especially in states that have refused the Medicaid expansion. Despite the nation's enormous expenditures on health care, it is still more dangerous to give birth in the United States than in 48 other countries.[xxxvii] Furthermore, black women are at almost four times greater risk of dying during or shortly after pregnancy than Caucasian women.[xxxviii]

34. The criminalization of Indigenous women who are pregnant and use substances does not serve to improve health outcomes, but rather compounds their experiences of violence. Indigenous women who are pregnant and use substances have the right to culturally sensitive sexual and reproductive health and harm reduction services. Indigenous women are already disproportionately targeted for arrest,[xxxix] and this trend towards criminalizing their pregnancies will only seek to push an already marginalized population away from accessing health services in fear of incarceration.

35. These are risks that Indigenous communities cannot afford to be forced to bear. In its 2004 evaluation of the Indian Health Services (the healthcare system put into place for Indigenous communities by the federal government), the U.S. Commission on Civil Rights noted: "The disparities in health status and outcomes experienced by Native Americans are an indictment of the federal government's commitment to fulfilling its moral and legal obligation to provide for the health of Native Americans."[xl]

36. The U.S. Centers for Disease Control and Prevention recognize that "the timing and quality of prenatal care is important to the infant's subsequent health and survival."[xli] Pregnant women face a range of obstacles in obtaining the sexual and reproductive health and other services they need, particularly if they are of low-income or live in rural areas. Obstacles most often include financial, bureaucratic, cultural and language barriers to health care; lack of information about maternal health care and family planning options; lack of shared decision-making in treatment; inadequate staffing and quality protocols; and a lack of accountability and oversight. Access to abortion services is vanishing. All of these obstacles are only compounded for drug-using women by the climate of fear and uncertainty created by the criminalization of pregnancy and miscarriage.

37. Medical experts and human rights advocates agree that prenatal care is a key element in ensuring women's right to safe maternity. Women who do not receive prenatal care are five times more likely to die than women who do.[xlii] It is therefore imperative to ensure that all women, but in particular those who may be struggling with health problems, are able to trust their physicians in order to seek care. The U.S. Department of Health and Human Services stated: "[Q]uality prenatal care is such a critical factor in increasing the likelihood of good birth outcomes, everything possible should be done to ensure that the physician's office is seen as a safe and supportive resource to all pregnant women."[xliii]

38. Nevertheless, recent studies confirm that not only are women fearful of being arrested or imprisoned, or of carrying pregnancies to term, but child welfare reporting laws (and medical providers' policies mis-implementing them) are creating yet another major barrier to prenatal care.[xliv] Among pregnant women of color in the U.S., between 14 and 30% receive delayed or no prenatal care.[xlv]

39. As the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women warned in 2011 and reaffirmed in 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."[xlvi]

40. For many pregnant women, punitive overregulation and unwanted interference in pregnancy extends right up to the moment of giving birth. The number of births delivered by cesarean surgery is more than double the WHO-recommended threshold of 15% in almost every state.[xlvii] Cesarean surgeries have been shown to increase a woman's risk of infection, hysterectomy, and kidney failure, and have been associated with a 52% increase in the risk of developing a life-threatening blood clot (pulmonary embolism).[xlviii] Yet nearly half of U.S. hospitals deny care to women who have had prior cesarean surgery and would like to attempt a subsequent vaginal birth, either as a matter of policy, or because few physicians are willing to attend to women in a vaginal birth after cesarean (VBAC).[xlix] Some hospitals even use threats of court-ordered surgery, calls to child welfare investigators, and unconsented surgery to enforce their refusal policies.[l] This type of coercion violates other rights, including the right to be treated with respect for human dignity, the right to privacy, security of the person, and the right to equal protection under the law and the right to liberty, all enshrined in the International Covenant on Civil and Political Rights (ICCPR).

41. Recommendations:

a. ***Take immediate action to ensure access to a full spectrum of reproductive health services, including contraception, abortion, and evidence-based maternity care for all women, including those incarcerated.***

b. ***Create a comprehensive national plan of action to improve maternal health care and eliminate systemic disparities for pregnant women who use drugs. Relevant stakeholders should be involved in this process including a variety of health care providers (such as physicians, midwives and nurses), experts on public health and social services, and especially members of affected communities. In particular, measures should be taken to ensure women directly affected participate in developing solutions at the federal, state, and local level.***

c. ***Appropriate drug treatment programs and related prevention and support services should be available and offered to all pregnant***

women who need them. Access to such programs and support services should never be the basis for criminal prosecution.

d. ***All pregnant women affected by substance dependency should have access to affordable prevention and treatment services, including opiate substitution therapies. Interventions should be delivered with a special attention to confidentiality and international human rights standards; women should not be excluded or deterred from accessing health care because of their substance dependency or fear of breaches of confidentiality.***

e. ***Sponsor research into the public health consequences of criminalizing pregnancy and pregnancy outcomes.***

f. ***Legislative authorities should confirm that upon becoming pregnant, women retain their civil and human rights through all stages of pregnancy, labor, and delivery.***

III. Threats to the Right to Family Life

42. Article 12 of the Universal Declaration of Human Rights articulates the right to be free from arbitrary interference with the family. Article 17 of the International Covenant on Civil and Political Rights also declares that "no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence." Yet, in many jurisdictions throughout the United States, families are investigated and separated on the basis of a single positive drug test (often unconfirmed by reliable scientific methods[li]) rather than on evidence of actual abuse or neglect.

43. In at least 18 states, a positive toxicology screen at birth creates a presumption of child neglect, which may result in immediate child removal.[lii] That is, a newborn may be separated from their mother, regardless of whether the newborn exhibits any drug-related symptoms, in the absence of reasons to suspect unfitness to parent, and in some cases, without regard for whether the drug was a prescribed or recommended medication. *See* para. 52 below. These zero-tolerance policies have resulted in neglect investigations, and even temporary child removal based on positive drug tests stemming from legal poppy seeds, medical marijuana, and prescription opioids.

44. Under such a regime, women who use any drugs -- both licit and illicit -- and carry a pregnancy to term, can be saddled with the highly stigmatizing label of "child abuser," and are then entered into statewide child abuse and neglect registries. This indelible mark may have consequences on their ability to parent and to seek employment for decades.[liii]

45. Laws that treat parental drug use alone as sufficient grounds for separating mothers and children and subjecting them to state control only serve to increase counterproductive child welfare interventions. The negative impact on women and children's lives (particularly in communities of color) has been well documented for decades.[liv]

46. Moreover, as some U.S. jurisdictions consider drug law reforms removing criminal penalties (particularly for cannabis use[lv]), no corresponding effort has been undertaken to reform child welfare laws, regulations, or policies, creating a form of gender discrimination wherein drug use is legal, decriminalized, or approved for medical use by adults—with the notable exception of parents and pregnant women.

47. In 2003, Congress passed the Keeping Children and Families Safe Act. This legislation reauthorized and amended the Child Abuse Prevention and Treatment Act (CAPTA), the law governing conditions under which state child welfare agencies receive federal funding.[lvi] In doing so, it added a condition that requires states to implement policies and procedures to notify child welfare agencies of all children "affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure."[lvii] This provision of CAPTA does not define the precise meaning of the phrase, nor does it direct states to define a drug-"affected" newborn as abused or neglected under child welfare laws. The legislative history is also riddled with medical misinformation, including phrases such as "neurological damage" in reference to children prenatally exposed to drugs, and declarations that substance use is a "great predictor of child abuse."[lviii]

48. Notwithstanding these ambiguities and often inconclusive research, a majority of states have responded to this legislation by amending civil child welfare laws to specifically address drug use during pregnancy, despite the fact that a positive drug test does nothing more than potentially detect previous exposure.[lix] A positive drug test cannot determine the frequency with which a person uses a drug, or whether she is drug-dependent or suffers any physical or emotional difficulties from her use, or is more or less likely, if she is a parent, to abuse or neglect her children.[lx]

Barriers to Accessing Support

49. Using drugs does not equate to being a bad parent, yet for pregnant women who are drug dependent, seeking help can be anything but straightforward. As of 2014, only 19 states have drug treatment programs specifically tailored to pregnant women, and only eleven give pregnant women priority access to state-funded treatment programs.[lxi] And the few drug treatment facilities in the United States accepting pregnant women often fail to provide childcare, account for the woman's family responsibilities, or provide treatment that is affordable, culturally sensitive or responsive to individual needs. This means that pregnant women who do not receive treatment for drug dependence cannot be assumed to have rejected treatment, but rather, are likely to be facing numerous structural or financial barriers to accessing treatment.

50. Further inequalities are created because child abuse and neglect investigations are civil, not criminal, proceedings and indigent parents charged with child abuse or neglect are not entitled to legal representation.[lxii] The same is true when a child is removed from the home, or when the state seeks to terminate parental rights. And because the proceedings occur in either administrative hearings or in family courts, the criminal burden of proof—beyond a reasonable doubt—does not apply to the state's case. In most civil cases, the burden of proof is "preponderance of the evidence," which requires only a showing that the allegation, more likely than not, is true. Termination of parental rights, which is the most severe civil action that child welfare agencies can

level against a parent, requires the slightly higher standard of "clear and convincing" evidence of parental unfitness.[lxiii] Thus, the state bears a higher burden of proof to convict an individual of a crime than it does to take a child into protective custody or to terminate an individual's parental right.

51. Based on unsupported assumptions about drug use during pregnancy and drug users who parent, punitive responses by the child welfare system undermine maternal, fetal, and child health, and violate numerous human rights principles against arbitrary and unlawful family interference. In addition, this type of state intervention poses a significant risk to women's health and healthy birth outcomes in the United States.

52. For instance, in 2013, an appellate court in New Jersey upheld a lower court ruling that a newborn was abused and neglected because, after birth, he was diagnosed with Neonatal Abstinence Syndrome (NAS).[lxiv] The child's mother, while pregnant, obtained medically recommended and supervised methadone treatment from a methadone treatment program. The ruling, if not overturned by the state supreme court, will effectively ban pregnant women from receiving methadone treatment in the state, thereby seriously jeopardizing maternal, fetal, and child health.

53. Families of color are disproportionately affected by this type of arbitrary and unlawful state interference, as studies reveal that women of color are more likely to be drug tested during pregnancy and to have the result reported to child welfare authorities.[lxv] In one study, black women were 10 times more likely than white women to be reported to child welfare.[lxvi] According to data from the United States Children's Bureau's Adoption and Foster Care Analysis and Reporting System (AFCARS) and U.S. Census Data, black children account for 26% of children in foster care, though the black population is only 13.2%. Hispanic children account for 21% of children in foster care, but are only 17.1% of the population. And white children only account for 42%, even though the white population in the U.S. is 62.6%.[lxvii]

54. Research has shown that racial disparities abound in the criminal justice system, yet so too do people of color suffer similar biases at the hands of the child welfare system.[lxviii] Selective drug testing of pregnant women of color, as well as heightened surveillance of low-income mothers of color in the context of policing child abuse and neglect, exacerbate these racial disparities. In the absence of viable drug treatment options, women's drug use and dependence issues are more likely to be treated as criminal justice issues than as the health problems they truly are; parallel child welfare proceedings often result in further punishment, jeopardizing family ties and child custody.

55. The result is that families and women of color, especially those who use drugs or are low-income, are disproportionately deprived of their fundamental rights to family integrity and parenting.

56. ***Recommendations:***

a. ***Ensure that the right to counsel guaranteed by the Constitution is secured during all civil child welfare proceedings.***

b. ***Require state and local child welfare agencies to maintain standardized, detailed records of child abuse and neglect cases involving parental drug use and prenatal drug exposure, with the purpose of evaluating outcomes for children removed from the homes of caretakers based on allegations of parental drug use.***

c. ***Repeal the provisions of Child Abuse Prevention and Treatment Act (CAPTA) that equate prenatal exposure to certain substances to child abuse and require states, in order to be eligible for federal funds, to have a mechanism for reporting certain mothers and newborns to child welfare authorities, and ensure that children are never removed from parents' custody or subjected to state surveillance based solely on positive toxicology tests.***

d. ***Protect families by ensuring that pregnant women and mothers of young children are prioritized for alternatives to incarceration, such as community supervision.***

e. ***In line with the Government's commitment to ratify CEDAW, adopt an Equal Rights Amendment that clearly acknowledges a right to be free from discrimination on the basis of gender—a right not diminished by pregnancy.***

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[i] The International Network of People Who Use Drugs (INPUD) and its global women's forum INWUD (International Network of Women who Use Drugs) (est. 2008) is a global peer-based, non-profit organization that seeks to promote the health and defend the human rights of people who use drugs.
[ii] The Women and Harm Reduction International Network (WHRIN, est. 2009) advocates for the inclusion of women-specific harm reduction services and other programs and policies to uphold the rights of women who use drugs.
[iii] National Advocates for Pregnant Women (NAPW, est. 2001) is a U.S.-based NGO that works to secure the rights, health, and dignity of pregnant and parenting women.
[iv] SisterReach (est. 2011) offers women and girls in Tennessee surrounding Mid-South area a framework for Reproductive Justice and is committed to education, policy and advocacy for women and girls.
[v] The Sexual Rights Initiative (est. 2006) is a coalition of organizations that has been advocating for the advancement of human rights in relation to gender and sexuality at the UN Human Rights Council.
[vi] Family Law & Cannabis Alliance (FLCA, est. 2013) is a U.S.-based clearinghouse for reliable local, state, and national information related to marijuana policy, Child Protective Services (CPS), and family court, and provides non-legal advice and advocacy to parents and pregnant women.
[vii] The Native Youth Sexual Health Network (NYSHN) is an organization by and for Indigenous youth that works across issues of sexual and reproductive health, rights and justice throughout the United States and Canada.
[viii] James Ridgeway & Jeanne Casella, *America's 10 Worst Prisons: Julia Tutwiler*, Mother Jones (May 9, 2013, 6:00 AM), http://www.motherjones.com/politics/2013/05/americas-10-worst-prisons-julia-tutwiler.
[ix] Ninth Session of the Working Group on the UPR, Human Rights Council, *Report of National Advocates for Pregnant Women, Submission to the United Nations Universal Periodic Review* (April 18, 2010), *available* at http://advocatesforpregnantwomen.org/NAPW_UPRSubmissionUSA.pdf.
[x] Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Pol. Pol'y & L. 299 (2013), *available at* http://jhppl.dukejournals.org/content/38/2/299.full.pdf.
[xi] *Id.*

[xii] Roe v. Wade, 410 U.S. 113, 158 (1973) ("[T]he word 'person,' as used in the Fourteenth Amendment, does not include the unborn.").
[xiii] As the case of *In Re A.C.* (573 A.2d 1235 (D.C. 1990) (en banc)) demonstrates, court-ordered cesarean surgery contributes to the death of pregnant women. *See also* Lynn Paltrow, *Roe v. Wade and the New Jane Crow: Reproductive Rights in the Age of Mass Incarceration*, 103 Am. J. Pub. Health 17, 18 (2013).
[xiv] Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Pol. Pol'y & L. 299 (2013), *available at* http://jhppl.dukejournals.org/content/38/2/299.full.pdf.
[xv] The Rebecca Project for Human Rights, *Mothers Behind Bars: A state-by-state report card and analysis of federal policies on conditions of confinement for pregnant and parenting women and the effect on their children,* National Women's Law Center (Oct. 2010), *available at* http://www.rebeccaprojectjustice.org/images/stories/files/mothersbehindbarsreport-2010.pdf.
[xvi] In an effort to redress the media imbalance, a recent campaign aimed at media and policy makers was supported by over 40 of the most respected and objective health authorities from around the world clearly stating that NAS is both very easily treatable and harbours no long term effects to a newborn. Robert G. Newman et al., *Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women* (Mar. 11, 2013), *available at* http://bit.ly/1eEbXWO.
[xvii] Substance Abuse and Mental Health Services Administration*, Methadone Treatment for Pregnant Women,* U.S. Dep't of Health and Human Servs.*, available at* http://advocatesforpregnantwomen.org/SAMHSA%20Brochure%20%2522Methadone%20Treatment%20for%20Pregnant%20Women%2522.pdf.
[xviii] American College of Obstetrics and Gynecologists, Committee on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (2011) (Committee Opinion), *available at* http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist.
[xix] "On average, neonates exposed to buprenorphine required 89% less morphine than did neonates exposed to methadone … and spent, on average, 43% less time in the hospital (10.0 vs.17.5 days, respectively…)." Hendrée E. Jones, Ph.D. et al., *Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure,* 363 New Eng. J. Med. 2320, 2326 (2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMoa1005359.
[xx] Robert G. Newman et al., *Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women* (Mar. 11, 2013), *available at* http://bit.ly/1eEbXWO.
[xxi] Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, *Addendum Mission to Romania*, U.N. Doc. E/CN.4/2005/51/Add.4 (Feb. 21, 2005) (by Paul Hunt) at para 42. "Ensuring non-discrimination in the provision of health care settings is an essential component to the right to health. Marginalized populations face particular obstacles when seeking access to reproductive health services. The stigma associated with commercial sex work and injecting drug use, for example, affects how people engaged in these services are often treated by health-care workers."
[xxii] *See infra* note 51.
[xxiii] *Report of the Sentencing Project to the United Nations Human Rights Committee: Regarding Racial Disparities in the United States Criminal Justice System,* The Sentencing Project (August 2013), *available at* http://sentencingproject.org/doc/publications/rd_ICCPR%20Race%20and%20Justice%20Shadow%20Report.pdf.
[xxiv] Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Pol. Pol'y & L. 299, 311 (2013), *available at* http://jhppl.dukejournals.org/content/38/2/299.full.pdf.
[xxv] Kyiv Declaration, *Women's Health in Prison: Correcting Gender Inequity in Prison Health*, UNODC and WHO Europe (2009) at para 4 (2).

[xxvi] Aron Wright, *Mom Charged Under Drug-addicted Baby Law Going to Rehab,* WBIR (August 5, 2014, 7:45 PM), http://www.wbir.com/story/news/local/mcminn-monroe/2014/08/05/woman-charged-under-drug-addicted-baby-law-to-appear-in-court/13614755/.
[xxvii] Tony Gonzalez, *Drug Czar Slams Criminalizing Moms as Haslam Mulls Veto*, The Tennesseean (Apr. 28, 2014), http://www.tennessean.com/story/news/politics/2014/04/28/drug-czar-slams-criminalizing -moms-haslam-mulls-veto/8435967/.
[xxviii] The statute permits an affirmative defense (which must be raised at trial, and for which the burden of proof shifts from the prosecutor to the accused), but it is only available to women who were "actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program." Tenn. Code Ann. § 39-13-107-(c)(3). Methadone maintenance treatment, the recommended standard of care for the treatment of opioid addiction among pregnant women, may be lifelong and therefore cannot be "completed" for the purposes of the statute.
[xxix] Allie Spillyards, *Drug Addicted Babies*, YouTube, WVLT-TV (Nov. 28, 2012), https://www.youtube.com/watch?v=wLzcdHj48Tk.
[xxx] *See infra* note 65.
[xxxi] Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Pol. Pol'y & L. 299, 311 (2013), *available at* http://jhppl.dukejournals.org/content/38/2/299.full.pdf.
[xxxii] *Id.*
[xxxiii] Ala. Code § 26-15-3.2 (2012).
[xxxiv] Adam Nossiter, *In Alabama, a Crackdown on Pregnant Drug Users,* N.Y. Times (March 15, 2008), *available at* http://www.nytimes.com/2008/03/15/us/15mothers.html.
[xxxv] *See* U.S. Const. amend. V, VIII, XIV (guaranteeing the rights to due process, equal protection of the law, and freedom from cruel and unusual punishment).
[xxxvi] Petition for Writ of Certiorari, *Ex parte Hope Elizabeth Ankrom*, LEXIS 1110176 at 8 (Ala. Jan. 11, 2013).
[xxxvii] U.S. Central Intelligence Agency, *Country Comparison: Maternal Mortality Rate*, World Factbook, https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html (last visited Sept. 12, 2014).
[xxxviii] Melanie Heron et al., *Deaths: Final Data for 2006*, 57 Nat'l Vital Statistics Reports 2 (April 17, 2009), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf.
[xxxix] Indigenous women are admitted to prison at approximately six times the rate of white women; the corresponding rate for black women is four times that of white women. Nat'l Council on Crime & Delinquency, *Created Equal: Racial and Ethnic Disparities in the US Criminal Justice System* 3 (March 2009), *available at* http://www.nccdglobal.org/sites/default/files/publication_pdf/created-equal.pdf.
[xl] U.S. Comm'n on Civil Rights, Broken Promises: Evaluating the Native American Healthcare System 21 (2004), *available at* http://www.usccr.gov/pubs/nahealth/nabroken.pdf.
[xli] T.J. Mathews & Marian F. MacDorman, *Infant Mortality Statistics From the 2006 Period Linked Birth/Infant Death Data Set*, 17 Nat'l Vital Stat. Rep. 1, 8 (April 10, 2010), available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_17.pdf.
[xlii] Cynthia J. Berg et al., *Pregnancy-Related Mortality in the United States, 1998 to 2005*, 116 Obstetrics & Gynecology 1302, 1305 (2010).
[xliii] Nancy K. Young et al., *Screening & Assessment for Family Engagement, Retention, and Recovery (SAFERR),* U.S. Dep't of Health & Human Servs., Nat'l Ctr. Substance Abuse & Child Welfare, C7-C8 (2007).
[xliv] Sarah C.M. Roberts & Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, 15 Maternal & Child Health J. (2010); Sarah C.M. Roberts & Amani Nuru-Jeter, *Women's Perspectives on Screening for Alcohol and Drug Use in Prenatal Care*, 20 Women's Health Issues 193 (2010).
[xlv] Cara V. James et al., Kaiser Foundation, *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level*, The Henry J. Kaiser Family Foundation 62 (June 2009), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7886.pdf.
[xlvi] American College of Obstetrics and Gynecologists, Committee on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (2011)

(Committee Opinion), *available at* http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist. *See also* American College of Obstetrics and Gynecologists, Committee on Ethics, *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice* (2008) (Committee Opinion), *available at* http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/At_Risk_Drinking_and_Illicit_Drug_Use_Ethical_Issues_in_Obstetric_and_Gynecologic_Practice.

[xlvii] Carol Sakala & Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve* 63 (2008), *available at* http://www.milbank.org/reports/0809MaternityCare/0809MaternityCare.pdf; *see also* Cesarean Rates by State, CesareanRates.com, http://www.cesareanrates.com/csection-rates-by-state/ (last visited Sept. 12, 2014).

[xlviii] *Supra* note 47.

[xlix] *See* Dan Frosch, *Refusals Cut Options After C-Sections,* N.Y. Times, Apr. 14, 2014, *available at* http://www.nytimes.com/2014/04/15/health/refusals-cut-options-after-c-sections.html.

[l] *See* Declaration of Jennifer Goodall, Goodall v. Comprehensive Women's Health Care et al., No. 2:14-cv-399-FtM-38CM (M.D. Fla. July 18, 2014).

[li] Unlike individuals applying for federal employment or those facing employment termination on the basis of a drug test (*see* SAMHSA Mandatory Guidelines for Federal Workplaces Drug Testing Programs, 73 Fed. Reg. 71858 (Nov. 25, 2008)), pregnant women and newborns who are drug tested in a hospital normally do not have the benefit of procedural safeguards requiring that an initial positive result be confirmed using a secondary method. Urine immunoassays (the most common type of drug test) are particularly unreliable when performed on a newborn, and any positive immunoassay result should always be confirmed using gas chromatography/mass spectrometry (GC/MS). One study found that neonatal urine testing has a 47% rate of false positives for THC, the active ingredient in marijuana. Vilte E. Barakauskas et al., *Unresolved Discrepancies between Cannabinoid Test Results for Infant Urine*, 58 Clinical Chemistry 1364 (2012). These concerns are compounded by the tendency of common household products and over-the-counter medications to cause false positives in urine screens more generally. *See* Steven W. Cotten et al., *Unexpected Interference of Baby Wash Products with a Cannabinoid (THC) Immunoassay*, 45 Clinical Biochemistry 605 (2012); E. Chris Vincent et al., *What Common Substances Can Cause False Positives on Urine Screens for Drugs of Abuse?*, 55 Clinical Inquiries 893 (2006).

[lii] Guttmacher Institute, *State Policies in Brief: Substance Abuse During Pregnancy* (Sept. 1, 2014), *available at* http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf.

[liii] Child Welfare Information Gateway, *Disclosure of Confidential Child Abuse and Neglect Records* 4 (2013), *available at* http://www.childwelfare.gov/systemwide/laws_policies/statutes/confide.pdf.

[liv] Joseph J. Doyle, Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 Am. Econ. Rev. 1583 (2007), *available at* http://www.mit.edu/~jjdoyle/doyle_fosterlt_march07_aer.pdf; Dorothy Roberts, *Shattered Bonds: The Color of Child Welfare* (2003).

[lv] Nat'l Org. for the Reform of Marijuana Laws (NORML), http://www.NORML.org/states (last visited Sept. 11, 2014).

[lvi] Keeping Children and Families Safe Act of 2003, Pub. L. 108-36, 117 Stat. 800 (codified as amended at 42 U.S.C. § 5101 *et seq*.).

[lvii] 42 U.S.C. § 5106a(b)(2)(B)(ii) (West 2012).

[lviii] 149 Cong. Rec. H2345-02; 149 Cong. Rec. H5431-01.

[lix] *See, e.g*., A. J. McBay, *Drug-Analysis Technology-Pitfalls and Problems of Drug Testing,* Clinical Chemistry 33.11(B) (1987) ("Even if a drug . . . is positively identified and precisely quantified, there is as yet no scientific basis for forming options as to when, how often, and how much drug was used – or on the past, present, or future effect of the drug on the performance, health or safety of [the person tested].").

[lx] Little research has been attempted to substantiate the oft-repeated conclusion that children of parents who use or misuse drugs are at higher risk of being abused or neglected. Of the research that does exist, no such link has been confirmed. *See, e.g*., Tina M. Smarsh Hogan et al., *Child Abuse Potential Among*

Mothers of Substance-Exposed and Nonexposed Infants and Toddlers, 30 Child Abuse & Neglect 145 (2006); Brenda D. Smith & Mark F. Testa, *The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants*, 26 Child Abuse & Neglect 97 (2002). Children of parents who use drugs in many cases reap the benefit of an intact family. One University of Florida study, which compared outcomes in cocaine-exposed newborns who were placed in foster care to outcomes for those who were able to stay with their drug-dependent mothers, found that separation from their mothers was more toxic to children than the cocaine. Kathleen Wobie et al., *Prenatal Cocaine Exposure: An Examination of Out-of-Home Placement During the First Year of Life,* 34 J. Drug Issues 77 (2004), *available at* http://jod.sagepub.com/content/34/1/77.full.pdf.

[lxi] Guttmacher Institute, *State Policies in Brief: Substance Abuse During Pregnancy* (Sept. 1, 2014), *available at* http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf.

[lxii] Lassiter v. Dep't of Soc. Servs., 452 U.S. 18, 31 (1981).

[lxiii] Santosky v. Kramer, 455 U.S. 745, 753 (1982) ("The fundamental liberty interest of natural parents in the care, custody, and management of their child does not evaporate simply because they have not been model parents or have lost temporary custody of their child to the State.").

[lxiv] *N.J. Div. of Youth & Family Servs. v. Y.N.*, A-5880-11T2, 66 A.3d 237 (App. Div. 2013).

[lxv] "Despite the similar rates of substance abuse among black and white women in our study, black women were reported at approximately 10 times the rate for white women (P<0.0001), and poor women were more likely than others to be reported. We conclude that the use of illicit drugs is common among pregnant women regardless of race and socioeconomic status. If legally mandated reporting is to be free of racial or economic bias, it must be based on objective medical criteria." Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 New Eng. J. Med. 1202 (1990); Bonnie D. Kerker et al., *Patients' Characteristics and Providers' Attitudes: Predictors of Screening Pregnant Women for Illicit Substances*, 28 Child Abuse & Neglect 209 (2004); Sarah C.M. Roberts & Amani Nuru-Jeter, *Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting*, 39 J. Behav. Health Sci. & Res. 3 (2004); Hillary Veda Kunins et al., *The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting*, 16 J. Women's Health 245 (2007).

[lxvi] Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 New Eng. J. Med. 1202 (1990).

[lxvii] U.S. Census Bureau, *State and County QuickFacts* (last updated July 8, 2014), http://quickfacts.census.gov/qfd/states/00000.html; Administration for Children & Families, U.S. Dep't of Health & Human Servs., *Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2012 Data* (Nov. 2013), http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport20.pdf.

[lxviii] In the years immediately following CAPTA's passage in 1974, many children who were removed from their homes on the basis of alleged neglect came from impoverished families, often families of color, and were placed with white families. *See* Leroy Ashby, *Endangered Children: Dependency, Neglect, and Abuse in American History* 14-16 (1997) (providing a detailed account of the history of American child welfare). Black community leaders and Indigenous tribal representatives led the call to constrain the reach of CPS agencies. In 1972, the National Association of Black Social Workers ("NABSW") issued a statement in opposition to transracial adoption and foster care placements, calling this practice a form of genocide and criticizing it as a manifestation of white supremacy. *See Preserving Families of African Ancestry*, Nat'l Assn. of Black Soc. Workers (2003), http://c.ymcdn.com/sites/nabsw.org/resource/collection/0d2d2404-77eb-49b5-962e-7e6fadbf3d0d/Preserving_Families_of_African_Ancestry.pdf. Similarly, calls for reform from Indigenous communities led to the 1978 passage of the Indian Child Welfare Act ("ICWA") (25 U.S.C. §§ 1901 *et seq*. (West 2012)), which included the legislative finding that "an alarmingly high percentage of Indian families are broken up by the removal, often unwarranted, of their children from them by nontribal public and private agencies and that an alarmingly high percentage of such children are placed in non-Indian foster and adoptive homes and institutions…" 25 U.S.C. § 1901(4) (West 2012).