National Advocates for Pregnant Women

N A P W

ANALYSIS OF
KENTUCKY HB 136 (2010)
A Law to Punish Women Who Give Birth to Certain Kinds of Children

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Introduction

Kentucky House Bill 136 ("HB 136") "Alcohol or Substance Endangerment of a Child Prior to Birth," creates a new crime applicable only to women.

Section 4 (2) of the bill states: "A woman is guilty of substance endangerment of a child prior to birth when, knowing she is pregnant, *she causes her child to be born . . .* "

The bill goes on to say "with" controlled substances or alcohol in the child's bodily fluids.

If passed and enacted, Kentucky would be an outlier in the nation. While many states have considered bills to make it a crime for a woman to go to term in spite of a drug problem, not a single state legislature in the country has in fact passed such a criminal law. This is in large measure because leading medical, public health, and child welfare organizations agree that such laws are bad for babies and undermine maternal, fetal, and child health.

HB 136 proposes a law that is unconstitutionally vague, sex discriminatory, that permits searches in violation of the Fourth Amendment and that is irrational. Rather than leading to healthier birth outcomes, this bill sends the message that if certain women continue their pregnancies to term and cause their children "to be born" they will be committing a criminal offense. This law, focusing particularly on drug and alcohol using women, also rests on outdated and alarmist medical misinformation that experts in the field now reject.

Moreover, while the bill acknowledges that treatment would be "the most desirable course for preventing negative outcomes[,]" it appropriates no additional funds for treatment desperately needed by both mothers and fathers across the state.

In sum, this bill would cause real and devastating health consequences by deterring women from seeking prenatal care and drug and alcohol treatment altogether, by discouraging pregnant women who do seek medical treatment from disclosing critical information about their drug use to their health care providers, and by creating an incentive for women who cannot overcome their addictions in the short term of pregnancy to have abortions rather than face criminal charges upon the birth of a child.

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Summary of Bill

HB 136 would create a new crime entitled "Substance Endangerment of a Child Prior to Birth." If enacted, this law would punish a woman who gives birth to a newborn that:

1) tests positive for "a dangerous level of alcohol," prescription drugs "if lawfully prescribed to the mother by a practitioner [but] was knowingly taken in an amount in excess of the lawfully prescribed amount," or tests positive for controlled substances – (illegal drugs) in any amount;
2) exhibits "clear symptoms of withdrawal" from alcohol or drugs; or
3) has "a health problem "directly resulting" from the pregnant mother's use before birth" of alcohol, legal drugs if taken in excess of the prescribed amount, or illegal drugs.

According to this bill, a "court may order a toxicology test, drug test, or alcohol test for the mother, child or both, if there is probable cause as indicated by a qualified health professional, upon motion of the prosecution, the mother, or on its own motion." Results of a confirmed test may be used as evidence in criminal proceedings against the woman.

A first offense is a class B misdemeanor, punishable by 90 days in jail. A second offense is a class A misdemeanor, punishable by one year of imprisonment.

A woman would be directed to treatment instead of prison only if she first pleads guilty or is found guilty by the court. Failure to complete whatever treatment or education program the court selects for her or failure to pay the amount specified by the program would constitute contempt of court and would result in the imposition of a jail term.

HB 136 Would Make Kentucky An Outlier Among Virtually All of Its Sister States.

Although many state legislatures over many years have considered legislation that would create new criminal laws permitting punishment of pregnant women who use drugs and continue their pregnancies to term, not one legislature in the country has adopted such a law. This is in part because every leading medical, public health, and child welfare group to address the issue has concluded that such an approach is bad for babies.

The only state to permit the prosecution of pregnant women who go to term in spite of a drug problem is South Carolina. This is the result of judicial interpretation, effectively overruling the State legislature that had rejected (on eleven separate occasions) bills that would have created special penalties for pregnant women who used drugs or "endangered" their fetuses. Although still the law in South Carolina, a recent unanimous decision by the State Supreme Court suggests that this ruling is in some doubt.

In the McKnight case, the South Carolina Supreme Court ruled that Ms. McKnight, who had been convicted of homicide by child abuse based on the medically unsubstantiated

claim that the stillbirth she had suffered was caused by her drug use, had not received a fair trial. Specifically, the court noted that Ms. McKnight's trial counsel had failed to challenge the "outdated" research the State relied on to show Ms. McKnight's drug use caused the stillbirth. The court specifically noted that trial counsel failed to call experts who would have testified about "*recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor.*"[i]

HB 136 Would Undermine the Dramatic Health Improvements Achieved by Kentucky's Public Health Approach to the Issue of Drug Use and Pregnancy.

In 1992, after careful consideration, the Kentucky legislature enacted the Maternal Health Act (MHA), finding it "necessary to treat the problem of alcohol and drug use during pregnancy solely as a public health problem" and that "punitive actions taken against pregnant alcohol or substance abusers would create additional problems, including discouraging these individuals from seeking the essential prenatal care and substance abuse treatment necessary to deliver a healthy newborn."[ii]

In passing the Maternal Health Act, the Kentucky Legislature sought to improve maternal and fetal health by making sure pregnant women who seek prenatal care could do so without fear of prosecution. Since the passage of the MHA, the Commonwealth has seen a steady and dramatic increase in the number of women receiving prenatal care. In 1990, Kentucky was ranked 26th out of 50 states for prenatal care, with 69.7 percent of women receiving prenatal care. In 2000, Kentucky improved its rank to 11th, with 80.2 percent of women receiving prenatal care.[iii] In addition, infant mortality rates fell 25 percent during that decade.[iv] In 2001, Kentucky reported the lowest infant mortality rate since statistics were first recorded.[v] In contrast, South Carolina, the only state that has upheld the prosecution of pregnant women,[vi] remains near the bottom of the list on infant mortality and other health indicators.[vii] Accordingly, HB 136 threatens to undermine the achievements of decades of health-centered policies that have benefited thousands of women and children in Kentucky.

HB 136 Will Not Increase Funding for or Access to Appropriate Treatment for Pregnant and Parenting Women. Rather it Will Permit the Arrest, Prosecution and Incarceration of Pregnant Women at Considerable Expense to Commonwealth Taxpayers.

Despite Kentucky's progress and national leadership in efforts to increase access to prenatal care and drug treatment, both remain in short supply, especially in rural Kentucky. As Kentucky's Office of Women's Physical & Mental Health observed, "[o]nce women decide to seek treatment for substance abuse they find that in Kentucky, there is a large gap between the need for treatment and the availability of services, particularly gender-specific and sensitive treatment services."[viii] The issues women bring to substance abuse treatment are numerous and complex. Compared to the general population, women in treatment show significantly higher rates of childhood sexual abuse, domestic violence, medical problems and mental health problems.[ix] In addition,

women often have "[p]rimary caretaking responsibilities for children and other family members" and have high levels of "shame and guilt related to their substance abuse."[x] "Successful treatment for women substance abusers must address these sensitive issues with an emotionally and physically safe context."[xi]

According to the University of Kentucky Institute on Women and Substance Abuse, Kentucky has approximately 72,000 women in need of treatment for drug misuse.[xii] Kentucky has roughly 270 residential beds that women can access for treatment, satisfying only about four percent of the treatment needs. Residential programs typically have waiting lists, often two months long or longer, particularly programs exclusively serving women.[xiii] The barriers to substance abuse treatment are much greater in rural Kentucky.[xiv]

Prosecuting women who love their children but are unable to overcome a drug dependency problem during the short term of a pregnancy, disregards the fact that many women, especially low income, rural women cannot access appropriate treatment through no fault of their own.

While no additional funding will be provided for treatment for pregnant or parenting women, this bill will require the state to pay for the far greater costs associated with arrest, prosecution, imprisonment, and foster care for the children the imprisoned mother leaves at home.[xv]

The Assumption Underlying HB 136 – that Pregnant Women Who Use Any Amount of Alcohol or an Illegal Drug Cause Unique and Substantial Harm to Their Newborns – Is Not Supported by Scientific Research.

This proposed legislation is based on the assumption that pregnant women who use any amount of alcohol, an illegal drug, or an "excess" of a prescription drug have created unique and substantial harm or risk of harm to their newborns.

Certainly, some newborns exposed prenatally to some substances and conditions do suffer adverse short or long-term consequences. These infants include those whose mothers lacked access to quality prenatal care and adequate nutrition, smoked cigarettes while pregnant, worked in certain occupations,[xvi] used Accutane,[xvii] or used fertility-enhancing medications that cause multiple births associated with prematurity and other life-threatening hazards.[xviii]

Sensational, inaccurate, and misleading news reports -- especially about cocaine -- however have convinced many people of the necessity for significant and intrusive state responses to the problem of children exposed to illegal drugs. The belief that prenatal exposure to any amount of an illegal drug causes unique harm lacks basis in scientific research.[xix]

Indeed, dozens of carefully constructed studies establish that the impact of cocaine on newborns has been greatly exaggerated and that other factors are responsible for many of

the ills preciously associated with cocaine use – with poverty chief among them.[xx] Based on a systematic review of all leading English-language studies of the effects of in utero cocaine exposure, leading researchers in the prestigious Journal of the American Medical Association (JAMA) concluded that:

> [T]here is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity difference in severity, scope, or kind from the sequelae of many other risk factors. [xxi]

Specifically, these researchers found that when studies are controlled for prenatal exposure to tobacco and alcohol, prenatal cocaine exposure is not associated with physical growth retardation; there is little or no impact of prenatal cocaine exposure on children's scores on assessments of cognitive development; "[p]roblem-solving abilities [do] not differ between cocaine-exposed and unexposed preschoolers," nor does cocaine exposure impact standardized language measures. In fact, the oldest group of children studied to date registered *no* effect from in utero cocaine exposure on any IQ scales or on academic achievement.[xxii]

Furthermore there is scant scientific evidence linking prenatal cocaine exposure with such things as sudden infant death syndrome or infant mortality in general. This is in sharp contrast to the research on prenatal exposure to cigarettes. Low birth weight, sudden infant death syndrome, spontaneous abortion, premature rupture of the membranes, and abnormal placentation and stillbirth are all well established consequences associated with prenatal tobacco exposure.[xxiii] By contrast, cocaine – while not benign – does not cause "the frank damage found with nicotine or smoking."[xxiv]

Today courts and leading federal government agencies confirm that "the phenomena of 'crack babies' . . . is essentially a myth."[xxv] As the National Institute for Drug Abuse has reported, "Many recall that 'crack babies,' or babies born to mothers who used crack cocaine while pregnant, were at one time written off by many as a lost generation. . . . It was later found that this was a gross exaggeration."[xxvi] The U.S. Sentencing Commission has similarly concluded, "research indicates that the negative effects from prenatal exposure to cocaine, in fact, are significantly less severe than previously believed" and "research on the impact of prenatal exposure to other substances, both legal and illegal, generally has reported similar negative effects."[xxvii]

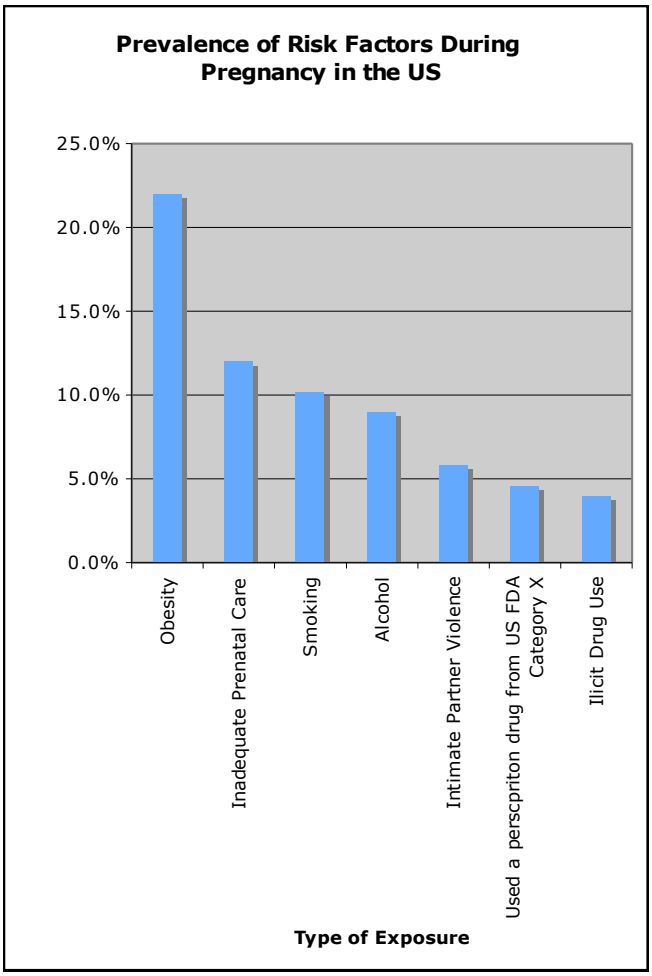
Of all illegal drugs, marijuana is the one most often used by pregnant women, parents, and people living in the United States. The leading researcher in the field of prenatal exposure to marijuana has stated unequivocally:

> Based on my 30 plus years of experience examining the newborn, infants, toddlers, children, adolescents and young adults born to women who used marihuana during pregnancy it is important to emphasize that to characterize an infant born to a woman who used marihuana during pregnancy as being 'physically abused' and/or 'neglected' is contrary to all scientific evidence (both mine and subsequent work by other researchers. The use of marijuana during

> pregnancy (in the absence of other factors that may put a child at risk for physical abuse and/or neglect) has not been shown by any objective research to result in abuse or neglect.
>
> There have been a few reports of mild negative effects in high-risk populations on the birth weight or birth length of newborns but, in those studies, these effects were no longer present after a few months. This is in contrast to many other substances that are commonly used during pregnancy, including alcohol and cigarettes, where the effects on growth are much more pronounced.[xxviii]

Despite the prevailing popular belief that even minimal exposure to alcohol in pregnancy places a child at immediate risk of fetal alcohol syndrome or other birth defects, the best epidemiological evidence strongly indicates otherwise. Most babies born even to the very few women who are unable to control their drinking during pregnancy are unaffected by fetal alcohol syndrome, and prospective studies find that less than five percent of such babies have fetal alcohol syndrome.[xxix]

Finally, research shows that a positive drug test is indicative only of exposure to the drug and does not mean that there is harm caused to the child or that the pregnant woman or mother is abusing drugs or alcohol.[xxx] Moreover, singling out drug and alcohol use for criminal punishment ignores many significantly greater threats to fetal and child health.



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Prosecuting Pregnant Women for Continuing to Term In Spite of a Drug or Alcohol Problem Will Undermine Maternal, Fetal and Child Health.

The medical profession has long recognized that drug dependence is an illness that cannot often be overcome without treatment.[xxxii] One of the hallmarks of drug dependency is the inability to reduce or control substance abuse *despite* adverse consequences.[xxxiii] Because of the compulsive nature of drug dependency, criminal sanctions are unlikely to achieve the goal of deterring drug use among pregnant women; rather, such sanctions are likely to drive addicted women further into the shadows and away from critical health care opportunities.

Indeed, it has specifically been recognized that pregnant women who are threatened with criminal sanctions are likely to be deterred from seeking care that is critical to the health of both pregnant woman and fetus.[xxxiv] Studies of drug-dependent pregnant women have found that "fear and worry about loss of infant custody, arrest, prosecution, and incarceration for use of drugs during pregnancy" is "the[ir] primary emotional state."[xxxv]

Even for those women who are not completely deterred from seeking care, fear of

prosecution is likely to discourage them from being truthful about drug use, corroding the formation of trust that is fundamental to any health care provider-patient relationship. As the U.S. Supreme Court recognized, a "confidential relationship" is a necessary precondition for "successful [professional] treatment."[xxxvi]

Open communication between drug-dependent pregnant women and their health care providers is especially critical.[xxxvii] Feelings of shame, fear and low self-esteem are significant barriers to establishing the trust prerequisite to patients' full disclosure of this medically vital information.[xxxviii]

HB 136 will also encourage women who cannot overcome a drug problem in the short term of pregnancy to have abortions in order to avoid arrest for giving birth. Leading medical organizations and courts have recognized this possibility. [xxxix] In a North Dakota case, Martina Greywind, who was approximately twelve weeks pregnant was arrested. She was charged with reckless endangerment based on the claim that by inhaling paint fumes, she was creating a substantial risk of serious bodily injury or death to a "person" -- her "unborn child." Ms. Greywind then obtained an abortion. As a result, the prosecutor dropped the charges citing the fact that she had "terminated her pregnancy."[xl]

Thus, enacting HB 136 would send a perilous message to pregnant women with substance abuse problems, *not* to seek prenatal care or drug treatment, *not* to confide their addiction to health care professionals, *not* to give birth in hospitals, or *not* to carry the fetus to term – all in order to avoid criminal punishment. This result would be to undermine, not advance, the Commonwealth's objective of promoting maternal and fetal well-being.

HB 136 Will Stigmatize and Harm Children by Making their Birth a Crime

HB 136 makes it a crime to give birth to certain kinds of children – ones exposed prenatally to certain substances. Children of mothers charged under this statute will be deemed substance-endangered whether or not they have in fact experienced any harm. Being identified as a substance-endangered child creates stigma, reducing, for example, expectations for a child's success in school and in life.[xli] Knowing that the occasion of their birth was the reason for their mothers being arrested could also be a source of life long pain and embarrassment.

HB 136 Could Make Women Who Obtain Federally Recommended Methadone Treatment Criminals.

HB 136 makes it a crime to give birth to a child with "clear symptoms of withdrawal from a controlled substance." As a result of this, pregnant women who follow the advice of the U.S. government to obtain methadone treatment could be arrested.[xlii]

Methadone maintenance has been firmly established as the best practice for treating women with opiate addictions, as opposed to quitting "cold turkey," which places a fetus in extreme danger.[xliii] Some newborns born to women receiving methadone treatment

may experience "mild to modest opiate withdrawal signs and symptoms in the early postnatal period. . . ."[xliv] When such withdrawal occurs, it is readily managed by appropriate medical steps, and there is no evidence indicating any long-term adverse consequences to the child.[xlv] Thus, a woman in a federally recommended methadone treatment program could be charged with "Substance Endangerment of a Child Prior to Birth" if her baby exhibits signs of withdrawal despite following a physician's orders.

HB 136 Will Transform Health Care Providers Into Police Agents and Violate the Fourth Amendment Rights of Pregnant Patients and New Mothers.

HB 136 amends a statute that authorizes health care providers to perform drug screens on pregnant women but also guarantees that "No prenatal screening for alcohol or other substance abuse or positive toxicology finding shall be used as prosecutorial evidence." Although these provisions are not repealed by HB 136, two provisions of 136 transform authorized testing into searches that will facilitate criminal justice investigations.

Section 1 (4) is amended to clarify that reports of positive drug tests to the Cabinet for Health and Family Services may be provided to criminal justice authorities, the "county attorney." Section (3)(a) of HB 136 would also permit a court to "order a toxicology test, drug test, or alcohol test for the mother, child, or both, if there is probable cause as indicated by *a qualified health professional*, upon motion of the prosecution, the mother, or on its own motion."

These provisions directly contradict the guarantee of confidentiality from criminal justice authorities provided in Section 1 (5) and necessarily transforms the testing that health care providers are authorized do for medical purposes into searches for potential criminal justice purposes. This makes it likely that the bill violates the Fourth Amendment and that as written, will leave some health care providers vulnerable to lawsuits for damages for patient civil rights violations.[xlvi]

HB 136 Contemplates Selective Drug Testing That Will Lead to Discriminatory Race and Class Based Testing and Reporting

The bill does not address how women or newborns would be selected for toxicology testing that may be reported to criminal justice authorities. It is clear, however, that this bill authorizes selective rather than universal testing.

As a result, discriminatory application of the laws is all but guaranteed. Evidence-based, peer-reviewed research indicates that selective testing and reporting of pregnant women to child welfare and police authorities results in race and class-biased testing and reporting. For example, a study published in the New England Journal of Medicine found that while rates of illegal drug use were similar for white women and African American women, African American women were ten times more likely to be reported to state authorities.[xlvii] Similar results were found in Illinois.[xlviii] A recent investigative report in California also found that testing policies were implemented in ways that resulted in significant racial disparities.[xlix]

This is why some groups recommend universal testing. Calling for universal testing or no testing at all, the New York Legal Aid Society Juvenile Rights Division noted:

> Currently, this determination [of who will be tested] is left to the physician or hospital staff based on their subjective judgment whether there is a risk the child has been prenatally exposed to drugs or alcohol. While independent medical judgment is usually an adequate basis for such decision-making, the reliability of doctors' testing choices has been shown to be seriously undermined by racial and class biases as well as economic and peer pressures.[l]

And while universal testing would be necessary to ensure some measure of fairness, it would be extremely expensive. A 1994 cost estimate in New York concluded that it would cost New York State 26.1 million dollars per year to perform urine drug screens alone and an estimated 95.9 million to include alcohol and confirmatory drug tests.[li] This money could much more wisely be spent on training health workers to evaluate effectively true markers of neglect and to establish the comprehensive treatment programs that women and families need and want.

<u>As a Result of HB 156, Pregnant Women, New Mothers, and Babies Would Have Less Protection from Erroneous Drug Test Results than Hospital Employees and Job Applicants.</u>

While HB 136 states that a court-ordered, *confirmed*, toxicology test may be used as evidence to establish a crime, it does not define what kind of testing or even what cut-off levels would constitute a "confirmed" test.

In 1993, the U.S. Department of Health and Human Services Substance Abuse Mental Health Services Administration (SAMHSA) convened an expert consensus panel to improve drug treatment for pregnant women. The SAMHSA expert panel clearly stated that if pregnant women are subjected to alcohol and drug testing, that testing should be done with the woman's informed consent and in accordance with the standards used for urine drug testing in the workplace as proscribed by the federal workplace drug testing guidelines.[lii]

Notably, the federal workplace drug testing guidelines establish certain cut-off levels to establish a true positive result, require a confirmatory test, and require that the person tested have the opportunity to challenge results and have a re-test.[liii] HB 136 does not afford pregnant women, new mothers, and newborns the same safeguards.

Without such safeguards there is a high incidence of false (simply wrong) or innocent (positive for a prescribed drug or over the counter medication) positives.[liv] Thus HB 136 could easily result in the arrest and prosecution of women who have positive drug tests as a result of eating poppy seed bagels, using certain over the counter pain medications, or receiving prescription medication during labor and delivery that is not easily distinguishable from illegal drugs. Moreover, because HB 136 does not define what a confirmed test means, it will be up to the discretion of, arresting officers, and prosecutors to decide which women have committed a crime by giving birth.

HB 136 Would Empower Judges to Sentence Women To Attend Non-Existent or Inappropriate Treatment .

HB 136 expresses the view that treatment is "most desirable." It also states that "the cabinet *may* establish pilot projects to treat pregnant and post-partum women for alcohol and drug abuse." The bill however appropriates no additional funding for needed programs. Moreover the bill authorizes judges to sentence women to "treatment" without defining that term. As a result, judges would be permitted to require women to attend anything the judge defined as "treatment" without any requirement that it be medically appropriate, evidence-based, or even actually accessible to the woman.

HB 136 is Unconstitutionally Vague.

Both the U.S. Supreme Court and the Kentucky Supreme Court have ruled that a criminal statute can be "void for vagueness" unless "it contains sufficient definiteness such that ordinary people can understand what conduct is prohibited."[lv] The "void for vagueness" doctrine also requires that "a criminal statute be worded so as to not encourage arbitrary or discriminatory enforcement."[lvi]

As written, HB 136 is unconstitutionally vague, leaving local police officers and prosecutors with extraordinary discretion to determine who will be investigated, arrested, and prosecuted.

For example, the bill permits prosecution of a woman if her newborn is born with a "dangerous level" of alcohol in its bodily fluids. The bill, however, provides no definition of what that means, and there is no medical consensus or official standard defining what that level is.

The bill also permits prosecution if the newborn shows "clear symptoms" of withdrawal from a controlled substance or alcohol. Again, there is no definition of this term. Moreover, many "symptoms" that were in the past attributed to drug use turned out to be symptoms that are the result of other substances or conditions. For example, "withdrawal" symptoms may be a result of nicotine or caffeine ingestion during pregnancy, not a mother's drug or alcohol use.[lvii]

HB 136 also permits prosecution of a woman who gives birth to a newborn with a health problem "directly resulting" from the pregnant mother's use before birth of alcohol, legal drugs if taken in excess of the prescribed amount, or illegal drugs. The bill offers no criteria for determining what proof would be necessary to establish causation – even just for purposes of initiating criminal charges. As courts have recognized, however, even where identifiable birth defects exists, it is often impossible to "tell what caused the birth defects in any given case."[lviii] HB 136 thus grants to arresting officers and prosecutors and the practitioners they rely on, the discretion to make determinations about medical causation that neither they nor most front-line health care providers are qualified to make.

HB 136 is Sex Discriminatory.

HB 136 singles out women for unique penalties that do not apply to men. Scientific research regarding the relative risks of prenatal exposure to drugs, the lack of universally available drug treatment, and that threats of criminal penalty undermine rather than further state interests in maternal, fetal, and child health, make HB 136 irrational. As a result, it is likely that, if enacted, HB 136 would not survive judicial scrutiny under a sex discrimination or any other constitutional due process or equal protection claim.

Conclusion

HB 136 is likely to undermine efforts to address those situations where a pregnant woman's drug or alcohol use is in fact problematic. As the Center for the Future of Children recommends, "[w]omen who use illegal drugs during pregnancy should not be subject to special criminal prosecutions or special civil commitment provisions." Instead research should be done to "determine the effectiveness of drug treatment and intervention programs" and drug treatment "should be available for all drug [using] pregnant women, parents and infants."[lix]

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[i] *McKnight v. State*, 661 S.E.2d 354, 358 n.2 (S.C. 2008) (emphasis added).
[ii] 1992 Ky. Acts 442, Preamble.
[iii] UNITED HEALTH FOUND., STATE HEALTH RANKING (2002 ed.).
[iv] *See* Office of Women's Physical and Mental Health, Kentucky Women's Health 2002: Data, Developments and Decisions 28 (2002).
[v] *Id*. at 11.
[vi] *See Whitner v. State*, 492 S.E.2d 777 (S.C. 1997). *But see McKnight v. State*, 661 S.E.2d 354 (S.C. 2008) (overturning a homicide by child abuse conviction because of ineffective assistance of counsel who failed to call experts to testify about "recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor").
[vii] South Carolina continues to have one of the highest infant mortality rates in the nation. *See* U.S. Census Bureau, STATE RANKINGS INFANT MORTALITY 2005, STATISTICAL ABSTRACT OF THE UNITED STATES (2008), *available at* http://www.census.gov/compendia/statab/ranks/rank17.html (showing South Carolina had third highest infant mortality rate in the U.S., while Kentucky ranked 27th). South Carolina recorded its most significant increase in infant mortality in a decade in 1997. ANNIE E. CASEY FOUNDATION, 2001 KIDS COUNT DATA BOOK 112 –113 (2001). This increase coincided with the *Whitner* decision and the publicity surrounding it. During roughly the same period of time, the number of abandoned babies in South Carolina increased twenty percent. *See Discarded Children Increasing; Abandoned Children: More Children Were Abandoned in South Carolina Last Year Than in the Previous Year*, POST & COURIER (Charleston, S.C.), Apr. 19, 1999, at B1.
[viii] *See* Office of Women's Physical and Mental Health, Kentucky Women's Health 2002: Data, Developments and Decisions 88 (2002).
[ix] *Id.*
[x] *Id.*
[xi] *Id.*
[xii] Div. Substance Abuse, Ky. Dept. Mental Health & Mental Retardation, *Women and Substance Abuse Fact Sheet*, June 2003, *available at* http://chfs.ky.gov/NR/rdonlyres/86D46357-3288-4F92-8BF1 EE055286B402/0/WomenandSubstanceAbuse.doc (last visited Mar. 13, 2008).

[xiii] Interview with Carol Stange, retired Women's Program Administrator, Div. Substance Abuse, Ky. Dept. Mental Health & Mental Retardation (2002). **Check if these numbers are current**

[xiv] *See* Office of Women's Physical and Mental Health, Kentucky Women's Health 2002: Data, Developments and Decisions 87, Fig. 2 (2002) (identifying barriers to treatment).

[xv] *See* Charles Marwick, *Physician Leadership on National Drug Policy Finds Addiction Treatment Works*, 279 JAMA 1149 (1998) (drug "treatment costs ranged from $1,800 per patient for outpatient treatment to $6,800 for long-term residential care," which is far less expensive than the $25,900 per year it costs to keep one person in prison); *see also* Center for the Future of Children, *Recommendations*, *in* THE FUTURE OF CHILDREN 8, 14 (Richard F. Behrman ed., 1991) (noting that "it is extraordinarily costly for government to rear children through foster care, with costs typically around $3,000 per year per child, but reaching as high as $35,000 or even double that when the children have special medical complications").

[xvi] *See UAW v. Johnson Controls*, 499 U.S. 187, 205 (1991) ("[e]mployment late in pregnancy often imposes risks on the unborn child"); *see also Johnson Controls*, 886 F.2d 871, 914 & n.7 (7th Cir. 1989) (Easterbrook, J., dissenting) (an estimated 15 to 20 million jobs entail exposure to chemicals that pose fetal risk).

[xvii] In April 2003, the *Boston Globe Magazine* published an article about Accutane, a powerful anti-acne drug that is described as "the most widely prescribed birth-defect causing medicine in the United States." The story confirmed reports of 160 drug-affected births: "Some of these children died before they reached their first birthdays because of major organ system failures. The most seriously affected babies have been institutionalized. The rest live with a variety of severe defects, ranging from heart and central nervous system abnormalities to missing or malformed ears, asymmetrical facial features, and mental retardation." Ellen Rafshoon, *What Price Beauty?*, BOSTON GLOBE MAG., Apr. 27, 2003, at 15). In addition, numerous prescription drugs create risks to the health of the future child, including anticonvulsants, Lithium and other mood-stabilizers, benzodiazepines (the class of medications which includes Valium, Librium and Xanax), as well as some antibacterials (especially Tetracyclines), anticoagulants, thyroid medications, and antihypertensive drugs.

[xviii] Women who take fertility drugs and choose to carry three or more embryos to term often experience pregnancy loss and risk severe life long harm to the children who survive, Steinbock, *The McCaughey Septuplets: Medical Miracle or Gambling with Fertility Drugs?*, ETHICAL ISSUES IN MODERN MEDICINE (5th ed., J.Arras & B. Steinbock eds 1999) 375, 376 ("Even if they are born alive, 'super-twins' (triplets, quadruplets and quintuplets) are 12 times more likely than other babies to die within a year … Many will suffer from respiratory and digestive problems. They are also prone to a range of neurological disorders, including blindness, cerebral palsy and mental retardation."). In Arizona, deliveries of multiple births from fertility drugs have more than doubled in the last ten years. *See* Ariz. Dep't of Health Servs., reprinted at www.hs.state.az.us/news/2002-diro/multiple_births.htm. *See also* Howard Fischer, *Arizona sees dramatic rise in multiple births*, ARIZ. DAILY STAR, Jan. 23, 2002, at A6.

[xix] *See, e.g.*, Susan Okie, *The Epidemic that Wasn't*, N.Y. TIMES, Jan. 26, 2009, *available at* http://www.nytimes.com/2009/01/27/health/27coca.html. As the National Institute for Drug Abuse has reported, "Many recall that 'crack babies,' or babies born to mothers who used crack cocaine while pregnant, were at one time written off by many as a lost generation. . . . It was later found that this was a gross exaggeration." NIDA Research Report, *Cocaine: Abuse and Addiction*, 6 (2004), *available at* http://www.drugabuse.gov/ResearchReports/Cocaine/cocaine4.html.

[xx] Research has found that crack-exposed children are not doomed to suffer permanent mental or physical impairment, and that whatever effects may result from the use of this drug are greatly overshadowed by poverty and its many concomitants – poorer nutrition, inadequate housing, health care and stimulation once the child is born. *See* Deborah A. Frank et al.,

Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review, 285 JAMA 1613 (Mar. 28, 2001); Wendy Chavkin, MD, MPH, *Cocaine and Pregnancy – Time to Look at the Evidence*, 285 JAMA 1626 (Mar. 28, 2001); Hallam Hurt, M.D. et al., *Problem-Solving Ability of Inner-City Children With and Without In Utero Cocaine Exposure*, 20 DEV. & BEH. PEDIATRICS 418 (Dec. 1999); Alan Mozes, *Poverty Has Greater Impact Than Cocaine on Young Brain*, REUTERS HEALTH, Dec. 6, 1999. *See also* Linda C. Mayes *et al., The Problem of Prenatal Cocaine Exposure: A Rush to Judgment*, 267 JAMA 406 (1992). As yet other researchers explain:

> The "crack baby" on which drug policy is increasingly based does not exist. Crack babies are like Max Headroom and reincarnations of Elvis – a media creation. Cocaine does not produce physical dependence, and babies exposed to it prenatally do not exhibit symptoms of drug withdrawal. Other symptoms of drug dependence – such as "craving" and "compulsion"—cannot be detected in babies. In fact, without knowing that cocaine was used by their mothers, clinicians could not distinguish so-called crack-addicted babies from babies born to comparable mothers who had never used cocaine or crack.

John P. Morgan & Lynn Zimmer *The Social Pharmacology of Smokeable Cocaine Not All It's Cracked Up to Be, in* CRACK IN AMERICAN: DEMON DRUGS AND SOCIAL JUSTICE 131, 152 (Craig Reinarman & Harry G. Levine eds., 1997).

[xxi] Deborah Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613, 1621 (2001). *See also* T.A. Campbell & K.A. Collins, *Pediatric Toxicologic Deaths: A 10 Year Retrospective Study*, 22 AM. J. FORENSIC MED. & PATHOLOGY 184 (2001); M.A. Sims & K.A. Collins, *Fetal Death: A 10-Year Retrospective Study*, 22 AM. J. FORENSIC MED. & PATHOLOGY 261 (2001) (Independent studies finding that they were unable to link cocaine use during pregnancy to an increased risk of stillbirth (intrauterine fetal death).

[xxii] Frank et al, *supra* note 20 (citing G. Richardson et al., *Prenatal cocaine exposure: effect on the development of school age children* 18 NEUROTOXICOL TERATOLOGY 627 (1996)). *See also* G.A. Wasserman et al., *Prenatal Cocaine Exposure and School Age Intelligence*, 50 DRUG & ALCOHOL DEPENDENCE 203, 209 (1998) ("prenatal cocaine exposure does not seem to confer an additional risk for adverse developmental outcome"); H. Hurt et al., *Children with In Utero Cocaine Exposure Do Not Differ from Control Subjects On Intelligence Testing*, 151 ARCHIVES PEDIATRIC & ADOLESCENT MED. 1237 (1997).

[xxiii] *See* K. Wisborg et al., *Exposure to Tobacco Smoke in Utero and the Risk of Stillbirth and Death in the First Year of Life*, 154 AM. J. EPIDEMIOLOGY 322, 323 (2001) (finding that, in a controlled study of 25,102 women, smokers had about twice the risk of stillbirth and infant death as compared to nonsmokers and that approximately 25 percent of all stillbirths and 20 percent of all infant deaths could be avoided if all pregnant smokers stopped smoking by the sixteenth week in a population with 30 percent pregnant smokers); T.A. Slotkin, *Fetal Nicotine or Cocaine Exposure: Which One is Worse?*, 285 J. PHARMACOLOGY & EXPERIMENTAL THERAPEUTICS 931, 937 (1998) [hereinafter *Fetal Nicotine or Cocaine Exposure]* ("The conclusion is inescapable that smoking itself . . . is responsible for tens of thousands of perinatal deaths and for like numbers of infants whose debilities may range from outright brain damage to subtle cognitive defects."); J. DiFranza & R. Lew, *Effect of Maternal Cigarette Smoking on Pregnancy Complications and Sudden Infant Death Syndrome*, 40 J. FAM. PRAC. 385 (1995) ("A national medical analysis on cigarette effects indicates that "Each year the use of tobacco products by women results in the deaths of 19,000 – 141,000 fetuses . . ."); L.C. Castro et al., *Maternal Tobacco Use and Substance Abuse: Reported Prevalence Rates and Associations with the Delivery of Small for Gestational Age Neonates*, 81 OBSTETRICS & GYNECOLOGY 396 (1993); Office on Smoking and

Health, The Health Consequences of Smoking: Nicotine Addiction 602 (1988). According to the Campaign for Tobacco Free Kids:

> A more recent comprehensive study found that parental smoking causes 2,800 deaths at birth and 2,000 deaths from SIDS. Fetal mortality rates are 35 percent higher among pregnant women who smoke than among nonsmokers.
>
> Smoking during pregnancy creates a more serious risk of spontaneous abortion and a greater threat to the survival and health of newborns and children than using cocaine during pregnancy. It is also a much more pervasive problem.

Campaign for Tobacco-Free Kids, *Harm Caused by Pregnant Women Smoking or Being Exposed to Secondhand Smoke*, http://tobaccofreekids.org/research/factsheets/pdf/0007.pdf.

[xxiv] *Fetal Nicotine or Cocaine Exposure*, *supra* note 13, at 939.

[xxv] *United States v. Smith*, 359 F. Supp. 2d 771, 780 n.6 (E.D. Wis. 2005).

[xxvi] NAT'L INSTITUTE ON DRUG ABUSE, RESEARCH REPORT, COCAINE: ABUSE AND ADDICTION 6 (May 2009) (emphasis added), *available at* http://www.drugabuse.gov/PDF/RRCocaine.pdf.

[xxvii] U.S. Sentencing Commission, Report to Congress: Cocaine and Federal Sentencing Policy 68, 70 (May 2007), *available at* http://www.ussc.gov/r_congress/cocaine2007.pdf.

[xxviii] Affidavit of Peter Fried, Ph.D. at ¶ 4, Defendant's Answer to Complaint for S.C. Code § 63-7-1650, S.C. 13th Judicial Family Court (2009).

[xxix] Elizabeth Armstrong, Department of Sociology, Woodrow Wilson School of Public and International Affairs, Letter to the Hon. Janet Napolitano, 2003 (on file with NAPW).

[xxx] *See* A. J. McBay, *Drug-Analysis Technology - Pitfalls and Problems of Drug Testing*, CLINICAL CHEMISTRY 33.11(B) (1987) ("Even if a drug or metabolite in urine is positively identified and precisely quantified, there is as yet no scientific basis for forming opinions 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]."); Mark P. Stevens and James R. Addison, *Science and Law in Drug Testing*, CHAMPION 23 (1999) ("A drug test may only tend to show that a person had been exposed to a particular substance (or a chemically similar substance) within a period of days or weeks prior to the test.").

[xxxi] Obesity: Kim SY, Dietz PM, England L, Morrow B, Callaghan WM. Trends in pre-pregnancy obesity in nine states, 1993-2003. *Obesity* (Silver Spring) 2007;15:986-93; CDC, National Center for Chronic Disease Prevention and Health Promotion. Pregnant Women Who are Obese Linked with Greater Health Care Services Use Also have longer hospital stays. Retrieved on 2/23/2010 from http://www.cdc.gov/media/pressrel/2008/r080402.htm; Prenatal Care:Joyce A. Martin; Brady E. Hamilton; Fay Menacker; Paul D. Sutton; and T.J. Mathews. Preliminary Births for 2004: Infant and Maternal Health. CDC's National Center for Health Statistics. Retrieved on 3/6/09 from http://www.cdc.gov/nchs/products/pubs/pubd/hestats/prelimbirths04/prelimbirths04health.htmAmerica's health rankings. Adequacy of Prenatal Care. Retrieved on March 9, 2009 from http://www.americashealthrankings.org/2008/prenatal.htmlMarch of Dimes. Adequacy of prenatal care by maternal race/ethnicity United States, 2000. http://www.marchofdimes.com/aboutus/1546.asp; Smoking: Salihu HM, Aliyu MH, Pierre-Louis BJ, Alexander GR. Levels of excess infant deaths attributable to maternal smoking during pregnancy in the United States. Matern Child Health J 2003;7:219--27.Joyce A. Martin; Brady E. Hamilton; Fay Menacker; Paul D. Sutton; and T.J. Mathews. Preliminary Births for 2004: Infant and Maternal Health. CDC's National Center for Health Statistics. Retrieved on 3/6/09 from http://www.cdc.gov/nchs/products/pubs/pubd/hestats/prelimbirths04/prelimbirths04health.htm; Alcohol: Day NL, Cottreau CM, Richardson GA. The epidemiology of alcohol, marijuana, and

cocaine use among women of childbearing age and pregnant women. *Clinical Obstetrics and Gynecology* 1993;36(2):232–245; Williams L, Morrow B, Shulman H, Stephens R, D'Angelo D, Fowler CI. *PRAMS 2002 Surveillance Report*. Atlanta, GA: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 2006.. 2002 PRAMS Surveillance, Report: Multistate Exhibits Alcohol Use. Retrieved on March 11, 2009 from http://www.cdc.gov/PRAMS/2002PRAMSSurvReport/MultiStateExhibits/Multistates12.htm#ch12fn10, Intimate Partner Violence: Silverman, J.G., Decker, M.R., Reed, E., & Raj, A. (2006). Intimate partner violence victimization prior to and during pregnancy among women residing in 26 U.S. states: Associations with maternal and neonatal health. *American Journal of Obstetrics and Gynecology*, 195(1), 140-148; Prescription Drug from Category X:Andrade SE, Gurwitz JH, Davis RL, et al. Prescription drug use in pregnancy. American Journal of Obstetrics Gynecology 2004; 191: 398–407; Illicit Drug Use: Substance Abuse and Mental Health Administration. Results from the 2005 National Survey on Drug Use and Health: National Findings. Office of Applied Studies, NSDUH Series H-30, DHHS, Publication No. SMA 06-4194, Rockville, MD, 2006. http://www.oas.samhsa.gov/2k5/pregnancy/pregnancy.htm; Marijuana use accounted for over 75% of the reported drug use among pregnant women in this nationally representative sample. urce: Substance Abuse and Mental Health Services Administration. (2000) *Summary of findings from the 1999 National Household Survey on Drug Abuse* (DHHS Publication No. SMA 00-3466, NHSDA Series H-12). Rockville, MD.

[xxxii] For example "Psychoactive Substance Dependence" is listed as a mental illness with specific diagnostic criteria in the Am. Psychiatric Ass'n, THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994) (used by mental health professionals to diagnose mental illness).

[xxxiii] Am. Med. Ass'n, *Legal Intervention During Pregnancy*, 264 JAMA 2667 (1990).

[xxxiv] *See, e.g.*, Southern Reg'l Project on Infant Mortality, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING WOMEN 6 (1993). *See also* A. Srinivasan & G. Blomquist, *Infant Mortality and Neonatal rates: The Importance of Demographic Factors in Economic Analysis*, *available at,* http://gatton.uky.edu/GradStudents/srinivasan/InfantHealth.pdf (2002) (examining infant mortality in Kentucky); A. Racine et al., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 JAMA 1581, 1585-86 (1993) (finding that pregnant women who use cocaine but who have at least four prenatal care visits significantly reduce their chances of delivering low birth weight babies).

[xxxv] *See* Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. DRUG ISSUES 285 (2003); M.L. Poland et al., Punishing Pregnant Drug Users: Enhancing the Flight from Care, 31 DRUG ALCOHOL DEPENDENCE 199 (1993).

[xxxvi] *Jaffee v. Redmond*, 518 U.S. 1, 12 (1997).

[xxxvii] *See* Kelly et al., *The Detection & Treatment of Psychiatric Disorders and Substance Use Among Pregnant Women Cared For in Obstetrics*, 158 AM. J. PSYCH. 213-19 (2001).

[xxxviii] *See* S. KANDALL, SUBSTANCE & SHADOW: WOMEN & ADDICTION IN THE UNITED STATES 278-79 (1996).

[xxxix] *See e.g., Johnson v. State*, 602 So. 2d 1288, 1296 (Fla. 1992) ("Prosecution of pregnant women for engaging in activities harmful to their fetuses or newborns may also unwittingly increase the incidence of abortion.").

[xl] *See* Motion to Dismiss With Prejudice, *State v. Greywind*, No. CR-92-447 (N.D. Cass County Ct. Apr. 10, 1992) (in seeking dismissal of reckless endangerment charge based upon inhaling paint fumes during pregnancy, the prosecutor stated that "[d]efendant has made it known to the State that she has terminated her pregnancy. Consequently, the controversial legal issues presented are no longer ripe for litigation").

[xli] See, e.g. Thurman, S.K., Brobeil, R.A., Duccette, J.P., & Hurt, H., "Prenatally Exposed to Cocaine: Does the Label Matter?" 18 Journal of Early Intervention 119 (1994). (Presented with children randomly labeled "prenatally cocaine-exposed" and "normal," childcare professionals ranked the performance of the "prenatally cocaine-exposed" children below that of "normal," despite actual performance.); Antwaun Garcia, *They Called Me a 'Crack Baby'*. Antwaun Garcia. Represent Magazine 2004

[xlii] *See* US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Methadone Treatment for Pregnant Women, *available at* http://csat.samhsa.gov/publications/PDFs/PregnantWomen.pdf

[xliii] Opiate detoxification is always associated with a significant risk of relapse to illicit drug use, but is particularly dangerous during pregnancy because withdrawal can cause uterine contractions, miscarriage or early labor. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Methadone Treatment for Pregnant Women*, Pub. No. SMA 06-4124 (2006), *available at* http://csat.samhsa.gov/publications/PDFs/PregnantWomen.pdf.

[xliv] Institute of Medicine, *Federal Regulation of Methadone Treatment* 203-4, National Academy Press (1995), *available at* http://www.nap.edu/openbook.php?isbn=0309052408 (last visited Feb. 11, 2010).

[xlv] *Id.*

[xlvi] *See Ferguson v. City of Charleston*, 532 U.S. 67 (2001); *Ferguson v. City of Charleston*, 308 F.3d 380 (4th Cir. 2002).

[xlvii] *See* Ira Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENGLAND J. MED. 1202 (1990) (comparing results of universal testing with the number of cases reported to child welfare authorities Dr. Chasnoff concluded that pursuant discretionary testing "a significantly higher proportion of black women than white women were reported, even though we found that the rates of substance use during pregnancy were similar").

[xlviii] *See* Brenda Warner Rotzoll, *Black Newborns Likelier to be Drug-Tested: Study*, CHI. SUN-TIMES, Mar. 16, 2001, at 18 (noting that "Black babies are more likely than white babies to be tested for cocaine and to be taken away from their mothers if the drug is present, according to the March issue of the Chicago Reporter").

[xlix] *See, e.g.*, Troy Anderson, *Race Tilt in Foster Care Hit; Hospital Staff More Likely to Screen Minority Mothers*, L.A. DAILY NEWS, June 30, 2008.

[l] New York Legal Aid Society, *Governmental Action in Cases of In Utero Drug or Alcohol Exposure: The Role and Responsibilities of Child Protective Authorities and the Family Court*, Position Paper, Dec. 1997.

[li] Memorandum from Dr. Wendy Chavkin to Jane Spinak and Danny Greenberg; "Position Paper on Government Action of In Utero Drug or Alcohol Exposure" (May 24, 1996) (on file with NAPW).

[lii] *Id.*; *see also* Substance Abuse & Mental Health Serv. Admin., Dept't Health & Human Serv., Mandatory Guidelines for Federal Workplace Drug Testing Programs, Apr. 13, 2004, *available at* http://www.workplace.samhsa.gov/fedpgms/Pages/HHS_Mand_Guid_Effective_Nov_04.aspx

[liii] Substance Abuse & Mental Health Serv. Admin., Dept't Health & Human Serv., Mandatory Guidelines for Federal Workplace Drug Testing Programs, Apr. 13, 2004, *available at* http://www.workplace.samhsa.gov/fedpgms/Pages/HHS_Mand_Guid_Effective_Nov_04.aspx

[liv] *See e.g.*, Troy Anderson, *False Positives Are Common in Drug Tests on New Moms*, L.A. DAILY NEWS, June 28, 2008.

[lv] *See, e.g., Kolender v. Lawson*, 461 U.S. 352, 357 (1983); *Commonwealth v. McBride*, 281 S.W.3d 799, 806 (Ky. 2009).

[lvi] *See, e.g.*, *Kolender*, 461 U.S. at 357; *McBride*, 281 S.W.3d at 806.
[lvii] *See* Ashraf H. Hamdan, *Neonatal Abstinence Syndrome* (updated June 19, 2009), *available at* http://emedicine.medscape.com/article/978763-overview (last visited Feb. 10, 2010).
[lviii] *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 43 F.3d 1311, 1313 (9th Cir. 1995).
[lix] CENTER FOR THE FUTURE OF CHILDREN, 16 THE FUTURE OF CHILDREN (1991).