

DRUG ADDICTION DURING PREGNANCY: A CALL FOR INCREASED SOCIAL RESPONSIBILITY

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I. INTRODUCTION

It is a story that is told more and more often across the nation in newspaper headlines, classrooms and courtrooms. The place is Brooklyn, New York. The year is 1993. A woman named "Molly" is in labor and checks into a local hospital. Molly gives birth to a baby boy hours later. So far, the story seems to be a happy one. However, there is a sad twist. This innocent newborn baby has a positive toxicology for cocaine and methadone.¹ Put more bluntly, this baby is a drug addict by no choice of his own.

The Child Welfare Administration ("CWA") prevents both Molly and the newborn baby from leaving the hospital on schedule. After minimal counseling at the hospital, Molly is permitted to return home with the baby on the condition that she attend weekly counseling at

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1. The facts of this narrative are true. They are provided by Elizabeth B. Rittenhouse. Ms. Rittenhouse is a family counselor affiliated with Heart Share Human Services of New York, a division of the Child Welfare Administration of New York City. She is the counselor who was assigned to the case of the drug-addicted woman discussed in this opening narrative. While Ms. Rittenhouse was able to fully share the facts of this client's case with me, confidentiality requirements prevented her from divulging her client's name. Thus, the name "Molly" is not the true name of this woman and is used for convenience purposes only.

Heart Share Human Services of New York. During counseling, Molly admits to the family counselor that she did indeed use drugs during this pregnancy. In fact, Molly explains that her methadone use during pregnancy was part of her normal routine. In contrast, Molly says that she only used cocaine once during the pregnancy. Molly is fairly disinterested in the counseling offered to her through Heart Share. In fact, after only a few visits she stops attending the counseling sessions altogether. The family counselor assigned to the case contacts CWA to determine what steps should be taken to ensure the continuation of Molly's counseling. CWA advises the family counselor to close the case, and the system forgets Molly, as well as, the newborn baby. In the words of the family counselor, "they just fell through the cracks of the system."

Unfortunately, Molly's story is not unique. Hundreds of thousands of babies are born addicted to drugs each year. Molly's story reflects a growing social problem which has led to charged and emotional debates in state legislatures across the nation. Legislators are struggling to fashion comprehensive solutions to the dilemma posed by drug-addicted pregnant women. The goal of this paper is to suggest a solution to this social problem which would decrease the number of children born addicted to drugs in this country, while, at the same time, furthering the interests of the women who mother these children. The theory is that by serving the interests of pregnant, drug-addicted women, society will also be serving the interests of their fetuses. This is true because a healthy mother-child relationship is the primary interest of both mother and fetus.

To comprehend the extent of the social problem presented by substance abuse during pregnancy, Part II of this paper examines the statistics reflecting the number of children born addicted to drugs in this country each year, as well as, the effects which the addiction has upon these innocent children. Part III draws upon the tenets of cultural feminist theory to advocate solutions which not only recognize that the interests of mother and fetus are compatible, rather than conflicting, but also recognize a societal duty to aid substance-addicted pregnant women. Part IV criticizes the post-birth solutions of criminal prosecutions and the use of parental abuse and neglect statutes because they do not adequately fulfill society's affirmative obligation to provide rehabilitative aid to substance addicted pregnant women. Part V examines involuntary civil commitment of pregnant, drug-addicted women, in order to determine if such commitment serves the interests of both mother and fetus. This inquiry reveals that, while involuntary civil commit-

ment may be benevolent in theory, its present day application is subject to the same criticism levied upon the post-birth solutions. That is, the present structure of commitment programs and the lack of social funding currently available to needy pregnant women combine to make the use of involuntary civil commitment undesirable, as it would ultimately create conflict between mothers and their fetuses. Finally, Part VI examines more holistic approaches which would give greater social support to drug-addicted pregnant women, and argues that such approaches are the only mechanisms which will enable mother and fetus to pursue their shared interest in a healthy birth.

II. THE GRAVITY OF THE PROBLEM

The numbers are staggering. It is estimated that between 350,000 and 739,200 infants are born each year exposed to drugs *in utero*.² Furthermore, approximately eleven percent of all pregnant women have used illegal drugs while pregnant, and of those eleven percent, seventy-five have used cocaine during a pregnancy.³ In urban areas, the rate of newborn addiction has quadrupled since 1985.⁴ Hospitals in such areas estimate that more than twenty percent of the babies born in their facilities are exposed to drugs *in utero*.⁵

To truly comprehend the tragedy that lies behind these statistics, one must examine the detrimental effect which substance use during pregnancy has on the developing fetus and, ultimately, the child. The adverse effects of cocaine use on the health of the fetus are numerous.⁶ Scientists have shown that pre-natal exposure to cocaine causes

2. Julia Elizabeth Jones, Comment, *State Intervention in Pregnancy*, 52 LA. L. REV. 1159, 1160-61 n.9 (1992); see Ira J. Chasnoff, *Drugs, Alcohol, Pregnancy, and the Neonate; Pay Now or Pay Later*, 266 JAMA 1567 (1991) (discussing the discrepancy between the Institute of Medicine figures and the Gamby and Shiono figures).

3. Jones, *supra* note 2, at 1160; see Board of Trustees, American Medical Association, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2666 (Helen M. Cole ed., 1990) (explaining that infants who have been exposed to cocaine *in utero* have severe problems, such as rapid heart rates, below average weight and decreased immune systems).

4. See generally James M. Wilton, *Compelled Hospitalization and Treatment During Pregnancy: Mental Health Statutes as Models for Legislation to Protect Children from Prenatal Drug and Alcohol Exposure*, 25 FAM. L.Q. 149, 149 (1991) (analyzing the decision of some states to allow forced treatment for pregnant addicts, which may include incarceration for the period of pregnancy, forced injections, and even forced caesarian sections); see also Dolores Kong, *Massachusetts Reports 600 Infants Born Addicted Each Year*, BOSTON GLOBE, Oct. 11, 1989, at 1, col. 2 (relating annual figures on the number of addicted newborns in Boston over the past decade).

5. Jones, *supra* note 2, at 1160.

6. See Jones, *supra* note 2, at 1161 (examining the physical effects of addiction on newborns, such as stunted growth in the limbs, underdeveloped organs, missing organs and abnormal brain chemistry. These newborns often cost the hospital as much as twice the cost of infants who are born prematurely for other reasons, because of extensive testing and

an increased chance of fetal stroke and spontaneous abortions. Prenatal exposure to drugs is also linked to infant mortality.⁷ Compared to the average newborn, cocaine-addicted babies have shorter body lengths and lower birth weights.⁸ In addition, these babies often have smaller head circumferences, which are associated with lower IQ scores.⁹ Symptoms of drug withdrawal displayed by cocaine-addicted babies are body tremors and irritability.¹⁰ Perhaps most significantly, cocaine-exposed babies are often resistant to interaction with their primary caretakers.¹¹ As explained by a foster mother of a cocaine addicted infant, "[t]he more you bounce them and coo at them, the more they arch their backs to get away."¹² Thus, cocaine use during pregnancy is likely to impair the natural bond between mother and child.¹³ Many of the adverse effects on fetal development associated with cocaine use during pregnancy also apply to use of heroin and other narcotics by pregnant women.¹⁴ In addition, narcotic-exposed infants suffer very severe withdrawal symptoms which continue for approximately four to six months after birth.¹⁵

While the primary focus of this paper is upon drug use during pregnancy, excessive drinking of alcohol during pregnancy raises many of the same concerns and, therefore, is also a problem deserving of legislative attention.¹⁶ Excessive drinking by pregnant women has adverse effects upon the fetuses they carry.¹⁷ Alcohol related birth defects are referred to as Fetal Alcohol Syndrome ("FAS").¹⁸ Recent studies have shown that FAS is the leading known

monitoring procedures.).

7. See Jones, *supra* note 2, at 1160.

8. *Id.*

9. Jones, *supra* note 2, at 1161.

10. Wilton, *supra* note 4, at 153.

11. See Anastasia Toufexis, *Innocent Victims*, TIME, May 13, 1991, at 56, 60 (describing how addicted newborns tend to reject human contact, crying loudly and straining to get away).

12. *Id.*

13. See *id.* (stating that doctors at Harlem Hospital, in a study of seventy crack babies under age two, found that almost half suffered from slow social and basic motor skill development, and many had difficulty distinguishing between their mothers and strangers).

14. See generally Board of Trustees, *supra* note 3, at 2666 (discussing the legal rights and obligations of mothers and physicians).

15. See Wilton, *supra* note 4, at 153 (contending that effects of maternal drug abuse stay with infants for life); see also Ira Chasnoff, William Burns, Sidney Schnell & Karen Burns, *Cocaine Use in Pregnancy*, 313 NEW ENG. J. MED. 666, 668 (1985) (detailing results of comparative experiment between women who used cocaine while pregnant, women who had used narcotics and were maintained on methadone throughout pregnancy and women who were drug-free).

16. See Wilton, *supra* note 4, at 149 (reporting statistics on Fetal Alcohol Syndrome).

17. Fetal Alcohol Syndrome occurs when an infant is born addicted to alcohol. This occurs in approximately fifty percent of births to mothers who are themselves addicted to alcohol. Infants with Fetal Alcohol Syndrome are generally underweight and have underdeveloped brains. Wilton, *supra* note 4, at 149.

18. Wilton, *supra* note 4, at 149.

cause of mental retardation, having a worldwide incidence rate of 1.9 cases per 1,000 live births.¹⁹ In fact, given the severity of FAS, excessive drinking during pregnancy has the potential to cause even greater and more permanent damage to fetuses than that caused by cocaine or heroin use.²⁰

The social costs associated with the effects of substance abuse during pregnancy are astounding. The national cost of medical care for substance addicted infants in 1990 was estimated to be \$504 million.²¹ On average, the neonatal cost of care and treatment of a cocaine-exposed infant is \$5,200 more than the cost of neonatal care for an unexposed infant.²² Finally, children exposed to substance *in utero* often require special education because of the learning disabilities caused by the substance use during pregnancy.²³ Special education for one drug-exposed child in Boston, Massachusetts for one year can cost \$13,000, while the cost of one year of regular schooling for a student not exposed to drugs is only \$5,000.²⁴ This analysis of the detrimental effects of substance abuse during pregnancy, as well as the social costs associated with those effects, demonstrates that any excessive drug or alcohol use that is not monitored during pregnancy is contrary to the societal and maternal goals of promoting healthy babies.

III. RECOGNIZING SHARED INTERESTS

Most discussions on the issue of substance abuse during pregnancy are flawed because they presume the mother and fetus are antagonistic entities with conflicting interests.²⁵ This notion of maternal-fetal

19. Wilton, *supra* note 4, at 149; see also Warren & Bast, *Alcohol Related Birth Defects: An Update*, 103 PUB. HEALTH REP. 638, 638 (1988) (discussing long-term effects of Fetal Alcohol Syndrome, such as short attention spans, learning impediments like dyslexia and short term memory loss).

20. See generally Cynthia Gorney, *Whose Body Is It Anyway? The Legal Maelstrom That Rages When the Rights of Mother and Fetus Collide*, WASH. POST (Inset: *Maternal-Fetal Conflict: Five Questions*), Dec. 13, 1988 at D2 (questioning whether pregnant women who abuse alcohol, refuse to take diabetic medication, or refuse medical treatment for religious reasons should undergo coerced cesarean section operations).

21. See Jones, *supra* note 2, at 1163 (comparing the treatment costs between infants born addicted to cocaine and infants born drug-free); see also Ciaran S. Phibbs, David A. Bateman, Rachel M. Schwartz, *The Neonatal Costs of Maternal Cocaine Use*, 266 JAMA 1521, 1525 (1991) (examining the causes of increased neonatal costs due to fetal cocaine exposure, such as longer periods in a respiratory unit or the need for expensive drugs to combat the cocaine addiction).

22. Jones, *supra* note 2, at 1162.

23. Jones, *supra* note 2, at 1162; see Toufexis, *supra* note 11, at 57 (discussing how cocaine-addicted newborns have problems in school as a result of short attention spans, speech impediments and poor hand and eye coordination).

24. See also Toufexis, *supra* note 11, at 59.

25. Board of Trustees, *supra* note 3, at 2666.

conflict stems from the movement for greater recognition of fetal interests warranting legal protection.²⁶ Advocates of fetal protection have been successful in guaranteeing greater protection of the fetus in many areas of the law.²⁷ Specifically, both criminal and tort law have moved in the direction of recognizing fetal interests.²⁸ In some jurisdictions, criminal law has awarded the fetus protection through statutes which punish fetal assault and feticide.²⁹ For example, in 1970, California amended its homicide statute by defining murder as "the unlawful killing of a human being, or a fetus," except in the case of therapeutic abortions.³⁰ As the California statute manifests, live birth is not always a prerequisite to a conviction for fetal assault or feticide.³¹

Tort law has recognized fetal interests through wrongful death statutes which are designed to compensate survivors for the death of a family member.³² Some jurisdictions have found a viable fetus to be a "person" for the purposes of wrongful death statutes.³³ In these jurisdictions, parents can bring a wrongful death action against the tortfeasor where his or her actions cause a spontaneous abortion or a stillborn baby, as opposed to limiting wrongful death actions to situations where there is a live birth, but the baby subsequently dies due to the harm inflicted by the tortfeasor.³⁴ Thus, as with criminal law, many jurisdictions do not require live birth as a condition for recovery in tort under wrongful death statutes.³⁵

While concepts of criminal and tort law have explicitly recognized fetal interests, these concepts do not place the mother and fetus in

26. Board of Trustees, *supra* note 3, at 2666.

27. Board of Trustees, *supra* note 3, at 2666.

28. See Kandel v. White, 1995 WL 500318, at 2 (Md., Aug. 24, 1995) (citing precedent for allowing a tort cause of action for the death of a fetus); but see Johnson v. State, 602 So. 2d 1288, 1295 (Fla. 1992) (overturning an appellate decision to criminally prosecute a mother for transferring drugs to her fetus through her umbilical cord after birth but before the cutting of the cord).

29. See Cheryl E. Amana, *Maternal-Fetal Conflict: A Call for Humanism and Consciousness in a Time of Crisis*, 3 COLUM. J. GENDER & L. 351, 357 (1992) (discussing fetal rights in the substantive areas of probate, criminal and tort law).

30. CAL. PENAL CODE § 187 (West 1988).

31. *Id.*

32. See generally Justus v. Atchison, 19 Cal. 3d 564, 565 (Cal. 1977) (holding that the distinction drawn between unborn and born children in a wrongful death statute is not arbitrary, but is rationally related to legislative goals); W.E. Shipley, Annotation, *Modern Status of Rule Denying a Common Law Recovery for Wrongful Death*, 61 A.L.R.3d 906, 914-15 (1975) (stating that, with the exception of Hawaii, courts have consistently held that wrongful death is a statutory creation which did not exist at common law).

33. See Amana, *supra* note 29, at 358; DiDonato v. Wortman, 358 S.E.2d 489 (N.C. 1987); see also W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 127, at 945-60 (5th ed. 1984).

34. Amana, *supra* note 29, at 358.

35. Amana, *supra* note 29, at 358.

conflicting positions. Instead, these developments in criminal and tort law recognize that the interests of parents and children in these circumstances are shared.³⁶ The parents and their unborn children share the goal of having a healthy pregnancy free of any harmful interference from third parties.³⁷ By enabling the state, in the criminal context, and the parents, in the civil context, to impose liability on third parties who hinder the shared parental-fetal goal of a healthy pregnancy, these doctrines of criminal and tort law recognize the compatibility of interests between parents and their unborn children.³⁸

The movement for greater protection of fetal interests is however, problematic where the alleged "bad actor" is the mother.³⁹ State intervention during pregnancy is troubling because the cornerstone of the American legal system is the promotion of individual rights.⁴⁰ The law strongly recognizes that pregnant women have individual rights deserving of constitutional protection. Such rights include the right to reproductive and familial privacy,⁴¹ the right to bodily integrity⁴² and the right to equal protection under the law.⁴³

It is true that the law has not recognized any constitutional right to life or good health on the part of the fetus.⁴⁴ In fact, the Supreme

36. See *Amana*, *supra* note 29, at 359 (citing *Johnson v. Ruark Obstetric and Gynecology Associates*, 365 S.E.2d 909 (N.C. Ct. App. 1988), *aff'd*, 395 S.E.2d 85 (N.C. 1990) (holding that the parents' emotional distress was not too remote to prohibit recovery for physician's negligence in causing a child to be stillborn)).

37. *Amana*, *supra* note 29, at 359.

38. *Amana*, *supra* note 29, at 359.

39. See generally *Amana*, *supra* note 29 and accompanying text.

40. MARY A. GLENDON, RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE, 40 (1991) (discussing the American tendency to define rights in absolute terms and how the right of privacy model has steadily replaced the property rights model as the basis of law).

41. See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 112 S. Ct. 2791 (1992) (holding that the state may not "unduly burden" a woman's right to choose to abort a fetus before viability); *Moore v. East Cleveland*, 431 U.S. 494 (1977) (striking zoning ordinances that impaired the ability of families to live together).

42. See *Casey*, 112 S. Ct. at 2791 (holding that compelling a woman to carry a pregnancy to term infringes upon her right to bodily integrity by imposing physical demands, invasions and health risks); see, e.g., *Winston v. Lee*, 470 U.S. 753 (1985) (invalidating the surgical removal of a bullet from a murder suspect under the theory of bodily integrity); *Stanley v. Georgia*, 394 U.S. 557, 565 (1969); *Rochin v. California*, 342 U.S. 165 (1952) (holding mandatory stomach-pumping unconstitutional).

43. See *Wengler v. Druggists Mutual Ins. Co.*, 446 U.S. 142 (1980) (striking down a state statute that paid worker's compensation to widows of deceased workers but not widowers of deceased workers).

44. *Roe v. Wade*, 410 U.S. 113, 158 (1973) (denying fetal rights); see also, Julie N. Qureshi, Note, *People v. Davis: California's Murder Statute and the Requirement of Viability for Fetal Murder* 25 GOLDEN GATE U. L. REV. 579, 588 (1995) (stating that the use of separate feticide statutes instead of general murder statutes takes the explosive issue of viability out of the argument over whether the state has a perpetual interest in the potential life because the fetus is being abused by the mother's negligence. The state draws a distinction as to when they can intervene, between harming a fetus a mother intends to birth and terminating a pregnancy as a legal,

Court held in *Roe v. Wade* that the fetus is not a "person" under the Fourteenth Amendment and is not entitled to the constitutional protection of this Amendment.⁴⁵ However, *Roe* did recognize a state interest in protecting potential life.⁴⁶ Furthermore, since *Roe*, the Supreme Court has magnified the state interest in protecting the fetus and has given the state more authority to intervene during pregnancy.⁴⁷ State intervention during pregnancy is constitutional where the state interest in protecting the fetus is deemed to outweigh the constitutional rights of the pregnant woman.⁴⁸ Even where the constitutional balance favors state intervention during pregnancy, such interference is problematic because it infringes upon the individual rights of the pregnant woman. The constitutional analysis which balances the rights of the pregnant woman against the state's interest in protecting the fetus places the rights of the mother in direct conflict with the interests of the fetus.⁴⁹

This balancing test has had an impact upon the unfolding debate as to how the government should approach the problem of maternal substance abuse. Because this issue has been framed in terms of inherently conflicting constitutional rights, the most common proposals addressing drug addiction during pregnancy vindicate either the rights of the mother or the state interest in protecting the fetus without attempting to fashion solutions which would meet the needs and interests of both mother and fetus. This all-or-nothing approach is typical where the problem presented is framed in terms of rights.⁵⁰ Rights analysis does not leave room for compromise.

conscious choice.).

45. *Roe*, 410 U.S. at 158; but see Christina L. Misner, *What if Mary Sue Wanted an Abortion Instead? The Effect of Davis v. Davis on Abortion Rights* 3 AM. U. J. GENDER & L. 265, 287 (1995) (stressing that the fetus is in an unusual position because it is not given the rights of a living human, but is more than a non-sentient grouping of cells).

46. *Roe*, 410 U.S. at 154.

47. See *Casey*, 112 S. Ct. at 2818-19 (holding that states may intervene "[e]ven in the earliest stages of pregnancy" as long as such intervention does not impose an "undue burden" on a woman's ability to decide whether to terminate the pregnancy); cf. Bicka A. Barlow, Comment, *Severe Penalties for the Destruction of "Potential Life" - Cruel and Unusual Punishment?* 29 U.S.F.L. REV. 463, 469 (1995) (arguing that if the privacy rights of the mother are not implicated, then the state's interest in the well-being of the fetus can prevail. This has important implications for maternal substance abusers, who are breaking the law and therefore may not be protected by privacy arguments).

48. See *Roe*, 410 U.S. at 163-64 (creating trimester system).

49. See Gorney, *supra* note 20, at D2 (criticizing the emphasis of fetal rights over maternal rights in criminal law because it pits the mother against the fetus as adversaries, and fails to solve the problems related to fetal cocaine exposure).

50. Cf. GLENDON, *supra* note 40, at 40-46 (discussing the distinctly American belief in the illusion of absolute rights. Glendon argues that the idea of rights without responsibilities brings one individual, who may feel she has an inherent right to drive without wearing a seatbelt, into direct conflict with another, who bears the burden of the inevitable loss of a loved one and financial responsibility of paying the medical bills or funeral expenses.).

Where the rights of two individuals or groups of individuals are slightly in tension with one another, the law solves the conflict by vindicating the rights of one or the other, but never both.⁵¹ Because rights, by definition, are all-or-nothing, solving social problems through rights analysis requires that one individual or group win and the other lose.⁵²

Feminist legal theory has widely criticized rights analysis.⁵³ Specifically, cultural feminist theory argues that the law is a reflection of the masculine voice and therefore reflects only the value of autonomy.⁵⁴ The focus of the American legal system on rights analysis is an example of the lack of a female voice in the law.⁵⁵ Cultural feminism defines women as typically more oriented toward relationships and therefore, more caring than men.⁵⁶ Cultural feminists assert that men usually view problems in terms of "abstract rights," while women approach dilemmas in terms of "real and complex relationships between people."⁵⁷ Women attempt to resolve conflicts through "strategies that maintain connection and relationship."⁵⁸ Thus, the theory underlying cultural feminism is that by embracing the female voice, the law would come to recognize and respect the specifically feminine values of connection and caring over the male value of autonomy.⁵⁹ More importantly, the recognition of the female voice in the law would lead to solutions of social problems which vindicate the interests of all parties involved rather than merely vindicating the rights of one party over another.⁶⁰

51. GLENDON, *supra* note 40, at 46.

52. GLENDON, *supra* note 40, at 40-46.

53. See Patricia A. Cain, *Feminist Jurisprudence: Grounding the Theories*, 4 BERKELEY WOMEN'S L.J. 191, 200 (1990) (arguing that one must first understand the different levels on which feminism is viewed in society to conduct a discourse on rights analysis).

54. *Id.*

55. *Id.*

56. See Naomi R. Cahn & Marie Ashe, *Child Abuse: A Problem for Feminist Theory*, 2 TEX. J. WOMEN & LAW 75 (1993) [hereinafter *Child Abuse*] (contending that the ideology of modern femininity is centered around self-sacrifice and domesticity); see also CAROL GILLIGAN, IN A DIFFERENT VOICE 100 (1982) (arguing that women are more self-critical than men, and therefore have a harder time achieving success than men).

57. See *Child Abuse*, *supra* note 56, at 95 (observing that the moral structures of women make their approaches to obstacles in life different from the approach of men); see generally RAND JACK & DANA C. JACK, MORAL VISION AND PROFESSIONAL DECISIONS: THE CHANGING VALUES OF WOMEN AND MEN LAWYERS 188 (1989) (showing through statistics the difference between the way male and female attorneys approach problems).

58. See *Child Abuse*, *supra* note 56 (citing NEL NODDINGS, CARING: A FEMININE APPROACH TO ETHICS AND MORAL EDUCATION 51-58 (1984)) (offering a definition of liberal feminism, cultural feminism, radical feminism and postmodern feminism).

59. Cain, *supra* note 53, at 200.

60. Cf. GLENDON, *supra* note 40, at 40-46 (advocating a more feminine approach to maternal substance abuse regulations).

Because of cultural feminism's emphasis on maintaining relationship and connection, it is a very useful perspective from which to analyze the social problem of substance-abusing pregnant women.⁶¹ Cultural feminist theory, as applied to this problem, has two implications. First, cultural feminism stands for the proposition that society has an affirmative obligation to act in order to aid pregnant women addicted to controlled substances.⁶² Second, in fulfilling this obligation, society should act in a facilitative, rather than in an adversarial manner.⁶³

The first assertion that society has a duty to aid pregnant women stems from the fact that the experience of "mothering" is central to cultural feminist theory.⁶⁴ Cultural feminists assert that women are more connected to others because their mothering experiences make them more cognizant and appreciative of their own interdependence with their children.⁶⁵ This celebration of the female role as mother serves as the basis for the cultural feminist assertion that society must guarantee special protection for women in order to accommodate their particularized role as nurturers.⁶⁶ Thus, cultural feminist theory supports the notion that society has a duty to recognize and accommodate the special needs of pregnant women.⁶⁷ This societal duty

61. See GILLIGAN, *supra* note 56, at 100 (introducing the concept that feminism should be discussed with the current cultural limitations of women in mind).

62. See Cain, *supra* note 53, at 200 (developing the concept of cultural feminism as a facilitative approach to solving the problem of fetal cocaine addiction).

63. Cain, *supra* note 53, at 200.

64. See *Child Abuse*, *supra* note 56, at 95 (taking a Freudian approach to the role and history of motherhood); see also Sara Ruddick, *Maternal Thinking*, 6 FEMINIST STUD. 342, 343 (1980) (describing the experience of mothering in conjunction with concepts of power and powerlessness); Robin West, *Jurisprudence and Gender* 55 U. CHI. L. REV. 1, 27-29 (1988) (stating that "women have a 'sense' of an existential 'connection' to other human life which men do not."); see generally NANCY CHODOROW, *THE REPRODUCTION OF MOTHERING: PSYCHOANALYSIS AND THE SOCIOLOGY OF GENDER* (1978).

65. *Child Abuse*, *supra* note 56, at 95; see West, *supra* note 64, at 27-29 (asserting that cultural feminism views women as feeling a natural sense of hierarchy because the most important "other" in her life is the infant who depends upon her).

66. See *Child Abuse*, *supra* note 56, at 95 (explaining the pitfalls of not addressing women's particular experiences in sexual equality cases, such as economic conditions, physical needs and social obstacles based on gender); see also Christine A. Littleton, *Does It Still Make Sense to Talk About Women?*, 1 UCLA WOMEN'S L.J. 15, 19 (1991) (alleging that the inclusion of men in the Family and Medical Leave Act of 1990 resulted in the ultimate defeat of the Act); Christine A. Littleton, *Reconstructing Sexual Equality*, 75 CAL. L. REV. 1279 (1987) (proposing a theory of sexual equality called "equality as acceptance" and arguing that "women's biological and cultural differences from men . . . are real and significant [and] [w]omen's inequality results when society devalues women because they differ from the male norm.").

67. See *Child Abuse*, *supra* note 56, at 96 (supporting cultural feminism's unique approach to maternal substance abuse which advocates cooperation with the mother instead of placing antagonistic restrictions on her); see also Littleton, *supra* note 66, at 26-27 (discussing dangers of using pregnancy leave as a "special" need which dilutes feminist claims of equality with men); cf. Linda J. Krieger & Patricia M. Cooney, *The Miller-Wohl Controversy: Equal Treatment, Positive Action and the Meaning of Women's Equality*, 13 GOLDEN GATE U. L. REV. 513, 560 (1983).

includes the obligation to address the very particularized needs of pregnant substance-addicted women.⁶⁸ The second assertion of cultural feminism is that society must not adopt adversarial approaches which view the mother and fetus as distinct legal entities with adverse interests and assume that the state must protect the fetus from the mother.⁶⁹ Adversarial approaches create maternal-fetal conflicts which ultimately inhibit the governmental objective of promoting healthy births.⁷⁰ Cultural feminism embraces facilitative approaches which realize that pregnant women share the state's interest in protecting their fetuses and promoting healthy babies.⁷¹

Facilitative approaches recognize that obstacles which exist in the lives of many pregnant women, not bad intentions, hinder the achievement of this common goal.⁷² Such obstacles include addiction, poor information and poverty.⁷³ Facilitative approaches attempt to remove these obstacles. Such approaches consist of positive, effective and cost efficient governmental policies which expand the choices of pregnant women by providing them with greater financial, physical and emotional support.⁷⁴

In order to accept the need for positive governmental policies in addressing this social problem, it is necessary to understand the plight of women who abuse their fetuses by using substances during pregnancy. In other words, it is necessary to fully examine the everyday circumstances under which these women live.⁷⁵ Greater awareness of the impediments that exist in the lives of women who use controlled substances during pregnancy will make society less apt to condemn, and more willing to aid, these women.⁷⁶

(presenting view that women are subjected to a disability that men do not confront when companies impose a no-sick-leave policy disallowing them to take off work during their pregnancy); *But see* Lucinda Finley, *Transcending Equality Theory: A Way Out of the Maternity and Workplace Debate*, 86 COLUM. L. REV. 1118, 1181-82 (1986) (concluding that maternity leave benefits both men and women).

68. *Child Abuse*, *supra* note 56, at 96.

69. *See* Dawn Johnson, *Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty*, 43 HASTING'S L.J. 569, 570 (1992) (reciting restrictive measures that the government has already imposed on pregnant women who are substance abusers, such as incarceration for the period of the pregnancy).

70. *Id.* at 572.

71. *Id.*

72. *Id.* at 571.

73. *Id.* at 574.

74. *See* Johnson, *supra* note 69, at 571 (asserting that the government should help mothers, but not control their life-decisions, such as having children).

75. *See* CHODOROW, *supra* note 64 (discussing society's pressing need to condemn maternal substance abusers).

76. *But see* *Child Abuse*, *supra* note 56, at 76 (describing the stereotypical image of the "bad mother," as being a mother who abandons her children, either by leaving them at home while she works, or abusing them in some way, including substance addiction. This concept puts the

Even cultural feminist theory, however, has not attempted to tell the story of abusive mothers, and has not included these mothers within its definition of motherhood.⁷⁷ This is surprising given cultural feminism's focus on the importance of "understand[ing] the pain in women's lives as different from that in men's lives."⁷⁸ Feminist scholars have a duty to give a voice to these women by telling their narratives and applying feminist theory to their circumstances.⁷⁹ Thus, before accepting or rejecting a solution to the problem of drug use during pregnancy, society must be willing to open its eyes to the complete narratives of women who abuse drugs while pregnant.⁸⁰

Only part of Molly's narrative is revealed in the opening paragraphs of this paper. It is important to note, that given the lack of female voice in law and in society in general, the facts included in the opening paragraphs are all that would be recited if Molly's story were recounted in the headlines, or even in the courtroom. More importantly, these facts alone make Molly seem extremely culpable and deserving of punishment. After all, she did use drugs during pregnancy and, as a result, her child was born an addict. On these facts alone, society would undoubtedly be willing to condemn her. However, by taking the time and effort to uncover and listen to the complete narrative of Molly, one comes to realize that she is not as culpable as she first appears.⁸¹

blame for fetal cocaine addiction solely on the mother, and not on the other individuals involved or the society in which she lives).

77. *Child Abuse*, *supra* note 56, at 95 (claiming that cultural feminists do not have the concept of a "bad mother" in their ideology).

78. *Child Abuse*, *supra* note 56, at 95; see also Robin West, *The Difference in Women's Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory*, 3 WIS. WOMEN'S L.J. 81 (1987) (arguing that the joy and pain men and women experience is different and that women's pain is often ignored by the law and provided no remedy).

79. See *Child Abuse*, *supra* note 56, at 95 (averring the need for cultural feminists to widen their outlook with regard to the needs of maternal substance abusers and the infants who suffer most).

80. *Child Abuse*, *supra* note 56, at 95.

81. *Child Abuse*, *supra* note 56, at 95; see also Ira J. Chasnoff, *Drug Use in Pregnancy: Parameters of Risk*, 35 PEDIATRIC CLINICS OF N. AM. 1403, 1406 (1988) (discussing the pros and cons of the "Methadone Maintenance Program," a program which takes a limited number of substance addicted candidates and breaks their addiction by giving them regular injections of methadone. The individuals must come to the clinic to get their injections and participate in seminars designed to help them get a job and make them better equipped to deal with finances and raising a family. Participants become addicted to the methadone, but it is much easier to break the addiction to methadone than to break an addiction to cocaine or heroin. Although most clinics will not take pregnant substance abusers, a few will, on an in-patient basis. The pregnant women complain that these programs restrict their freedom and sometimes force them to undergo medical procedures that they do not want, such as caesarian sections. Women also fear prosecution for their drug use, which could cause them to lose custody of their child. As a result, the methadone maintenance program has not had a high success rate for maternal substance abusers.).

Molly is an unemployed, single Hispanic woman who lives in public housing and survives from day to day on public assistance.⁸² Molly is the mother of five children. Molly's explanation for her fifth baby's positive toxicology for methadone is quite revealing. She is a recovering heroin addict and has been for years. As part of her recovery she participates in the "Methadone Maintenance Program."⁸³ This is a government funded program which was instituted as a solution to the growing problem of heroin use. Individuals addicted to heroin are advised to come to the clinic on a regular basis to receive a dosage of methadone. Methadone acts as a substitute for heroin and is equally addictive. The initial philosophy of the program was to slowly decrease the dosage individuals received at the clinic in order to wean people off the substances altogether. However, the program has been true to its name and individuals are maintained on methadone indefinitely. Thus, during her pregnancy, Molly continued participating in the methadone maintenance program because she was never advised to discontinue her use.⁸⁴ As a result, her baby was born addicted to methadone.

Molly describes the baby's positive toxicology for cocaine as a "cultural thing."⁸⁵ She says that she only used cocaine once during the pregnancy at the very end.⁸⁶ She explains that when she went into labor, she was told by some of her female neighbors that by taking a "hit" of cocaine she would be able to deliver the baby faster and more easily. Since cocaine speeds up the body's processes, Molly's neighbors were correct. What neither Molly nor her neighbors knew was that this single "hit" of cocaine would negatively effect Molly's newborn.⁸⁷

Molly's full narrative demonstrates that she did not have a malicious desire to harm her fetus. Rather, obstacles, such as poverty, addiction and lack of information, prevented her from delivering a healthy baby. Thus, before condemning Molly, society must be willing to take responsibility for failing to fulfill its duty to support her in her mothering role through financial, physical and emotional support.

82. These additional facts of the "Molly" narrative were also provided by Ms. Rittenhouse, *supra* note 1.

83. Chasnoff, *supra* note 81, at 1406.

84. Interview with Elizabeth B. Rittenhouse, *supra* note 1.

85. Interview with Elizabeth B. Rittenhouse, *supra* note 1.

86. Cf. Jones, *supra* note 2, at 1161 (stating that cocaine is not physically addictive, but habit forming. This means that a single hit of cocaine for a pregnant woman is not likely to cause the fetus to be born addicted to cocaine. It is, however, likely to cause severe birth defects.).

87. Interview with Elizabeth B. Rittenhouse, *supra* note 1.

IV. A CRITIQUE OF SOLUTIONS WHICH FAIL TO REHABILITATE

In an attempt to address the dilemma posed by substance-addicted pregnant women, state policy makers have invoked both criminal statutes and abuse and neglect laws.⁸⁸ When viewed from the perspective of cultural feminism, both these forms of state intervention are faulty because they do not adequately fulfill society's affirmative obligation to render rehabilitative aid to substance abusing women.

In 1977, prosecutors in California sought to convict a woman under its felony child endangerment statute for using heroin during pregnancy.⁸⁹ The prosecution was unsuccessful, as the California Appellate Court held that pregnant women could not be prosecuted under the felony endangerment statute because a fetus is not a "child" within the meaning of the statute.⁹⁰ To overcome the problem that a fetus is not considered a child under criminal abuse or endangerment statutes, prosecutors in Michigan, Florida, Georgia, South Carolina and Massachusetts have attempted to convict substance-abusing pregnant women under statutes prohibiting delivering drugs to minors.⁹¹

The argument follows that in the one-to-two minute time period after birth, but before cutting the umbilical cord, drugs are delivered by the mother to the newborn baby.⁹² The intent of these statutes, however, was obviously not to punish pregnant women who use drugs, but rather to convict drug dealers.⁹³ Recognizing this, appellate

88. See Board of Trustees, *supra* note 3, at 2666 (listing the various regulations in force regarding maternal substance abuse, such as criminal penalties, wrongful death actions and forced incarcerations for pregnant substance abusers).

89. Marcy Tench Stovall, Note, *Looking for a Solution: In re Valerie D. and State Intervention in Prenatal Drug Abuse*, 25 CONN. L. REV. 1265, 1267 (1993); see also Tamar Lewin, *Court in Florida Upholds Conviction for Drug Delivery by Umbilical Cord*, N.Y. TIMES, Apr. 20, 1991, at 6 (upholding the first conviction of a woman charged with delivering cocaine to her infant through umbilical cord); but see *Reyes v. Superior Court of San Bernadino*, 141 CAL. REPT. 912, 912-13 (1977) (holding that the penal statute prohibiting the sale or delivery of drugs to a child does not include a fetus or unborn child).

90. Stovall, *supra* note 89, at 1267.

91. Stovall, *supra* note 89, at 1269; see also Jan Hoffman, *Pregnant, Addicted—and Guilty?*, N.Y. TIMES, Aug. 19, 1990 (Magazine), at 32, 34 (detailing current legislation on pregnant women who deliver drugs to an infant *in utero*. The article criticizes forced incarceration and forced medical treatment for pregnant substance abusers who seek help because they are concerned for the health of their fetus.); cf. *People v. Marabito*, 580 N.Y.S.2d 843, 844-45 (Geneva City Ct. 1992) (holding that giving rights to the fetus would deny the mother due process).

92. Stovall, *supra* note 89, at 1269.

93. See Stovall, *supra* note 89, at 1280 (suggesting that cooperative treatment between the mother and health care officials should be favored by courts over statutes which punish mothers for their behavior); see also *Johnson v. State*, 602 So. 2d 1288, 1295 (Fla. 1992) (stating that the legislature expressly chose to treat drug-dependent mothers and newborns as a health problem

courts, relying purely on statutory interpretation, have overturned convictions of mothers under drug delivery statutes.⁹⁴ In fact, no appellate court has upheld a criminal conviction for transmission of a controlled substance *in utero* or for transmission during birth.⁹⁵ Courts, however, have not foreclosed the possibility that legislatures may amend their criminal statutes to prohibit drug use during pregnancy.⁹⁶

State child protective agencies have instituted abuse and neglect proceedings in cases where women gave birth to drug-addicted babies.⁹⁷ In particular, Connecticut recently attempted to use child-protection laws to terminate the parental rights of a woman who gave birth to a cocaine-addicted baby named Valerie D.⁹⁸ In August of 1991, the appellate court upheld the termination of parental rights in the case of Valerie D., finding that "a petition for termination of parental rights can be supported solely by evidence of a mother's prenatal conduct."⁹⁹ The Connecticut Supreme Court reversed the termination of parental rights, reasoning that the legislature did not intend for the termination statute to apply to prenatal parental conduct that harmed a child.¹⁰⁰

As an alternative to termination of parental rights, child protective agencies have attempted to petition for custody of babies born addicted to drugs, arguing that they are neglected, uncared for and abused.¹⁰¹ Courts have defeated such civil prosecutions on statutory grounds, finding that legislatures did not intend to protect fetuses under these laws.¹⁰² As with criminal statutes, courts have left state

rather than impose criminal penalties on women who were addicted while pregnant).

94. Stovall, *supra* note 89, at 1269; see Johnson, 602 So. 2d at 1288 (holding that the transfer of drugs through the umbilical cord did not constitute delivery of drugs to a minor according to the criminal statute).

95. See Janna C. Merrick, *Maternal Substance Abuse During Pregnancy: Policy Implications in the United States*, 14 J. LEGAL MED. 57, 62 (1993) (theorizing on the effects of criminalizing maternal substance abuse).

96. But see *In re Valerie D.*, 613 A.2d 748, 755 (Conn. 1992) (refusing to terminate the parent-child relationship on the theory of prenatal delivery of drugs to an unborn minor when the mother's drug use transferred cocaine to the fetus via the umbilical cord).

97. *Id.* at 755.

98. See *id.* at 755 (alleging that the act of commission or omission of proper and necessary care authorized the termination of the mother's parental rights).

99. See *In re Valerie D.* 595 A.2d 922, 925 (Conn. App. Ct. 1991), *rev'd* 613 A.2d 748 (Conn. 1992) (deciding that the use of drugs during pregnancy could be used as evidence of neglect on the part of the mother).

100. Stovall, *supra* note 89, at 1266; see *In re Valerie D.*, 613 A.2d at 758-62 (requiring more than substance abuse to terminate parental rights for neglect).

101. See Stovall, *supra* note 89, at 1266; see also *In re Valerie D.*, 613 A.2d at 755 (proclaiming that maternal substance abuse constitutes "intentional and severe parental neglect").

102. See Robert Horowitz, *Prenatal Substance Abuse: A Coordinated Public Health and Child Welfare Response*, CHILDREN TODAY, July-Aug. 1990, at 8 (outlining the constitutional issue of a woman's right to privacy).

legislatures free to amend their child protection laws to include protection of fetuses.¹⁰³

State legislatures should not adopt statutes sanctioning intervention during pregnancy through criminal or civil prosecutions. Neither making drug use during pregnancy criminal, nor the use of child protection statutes satisfies the dual cultural feminist goal of promoting healthy births while maintaining the mother-child relationship. Criminal prosecution in this context is faulty for two reasons. First, it constitutes an adversarial rather than facilitative approach and does not focus on maintaining the mother-child relationship.¹⁰⁴ Second, criminal prosecution for drug use during pregnancy typically occurs only after pregnancy and, consequently, does not further the goal of promoting healthy births.¹⁰⁵

In theory, the use of abuse and neglect statutes does further the goal of maintaining the mother-child relationship with the primary goal of state intervention under these statutes being reunification of the family.¹⁰⁶ However, the use of child protection laws in this context is similar to that of criminal statutes because state involvement typically occurs only after birth. Post-birth legal responses do not prevent harm to the child caused by prenatal substance abuse.¹⁰⁷

By bringing a criminal prosecution against the mother the state adopts an adversarial rather than facilitative approach. Such prosecutions place the mother and the newborn in conflicting positions and ignore their interdependence and shared interest in a healthy mother-child relationship.¹⁰⁸ If the state is successful, the mother will be incarcerated and thus separated from her child.¹⁰⁹ By invoking criminal sanctions in this context, society directly punishes these women for their behavior during pregnancy. The threat of punishment posed by criminal prosecution is likely to discourage pregnant women from seeking prenatal care for fear of being incarcerated.¹¹⁰ Failure to receive prenatal care is extremely harmful to both mother and fetus.¹¹¹ The underlying assumption of criminal

103. In re Valerie D., 613 A.2d at 757.

104. See Horowitz, *supra* note 102, at 8 (rejecting a strictly criminal approach to maternal substance abuse and favoring a more cooperative approach instead).

105. Horowitz, *supra* note 102, at 8.

106. Horowitz, *supra* note 102, at 8.

107. Horowitz, *supra* note 102, at 8.

108. Amana, *supra* note 29, at 359-61.

109. Amana, *supra* note 29, at 359-61.

110. See Stovall, *supra* note 89, at 1266 (inferring a connection between maternal substance abuse statutes and most maternal substance abusers' refusal to get prenatal care).

111. See Stovall, *supra* note 89, at 1267 (proposing that a facilitative approach will bring more maternal substance abusers in for treatment without fear of prosecution).

prosecution in this context must be that it is beneficial for society to protect these children from their abusive mothers.¹¹² This assumption, however, is faulty.¹¹³ As the perspective of cultural feminism makes clear, the most socially beneficial solution to drug abuse during pregnancy is a solution which rehabilitates the mother and, in doing so, promotes the relationship between mother and child.¹¹⁴ Therefore, any form of state intervention, such as criminal prosecution, which obstructs or severs the mother-child relationship, serves only to punish, and thereby defeats the socially beneficial goal of maintaining any relationship.

Perhaps more importantly, both criminal prosecution and the use of child protection laws are deficient because state involvement occurs only after birth and cannot achieve the goal of ensuring healthy babies.¹¹⁵ Rehabilitation must come during or prior to pregnancy in order to benefit the children of drug-addicted women.¹¹⁶ Society must attempt to rehabilitate women addicted to substances through financial, physical and emotional support.¹¹⁷ Thus, the state has an obligation to become involved prior to birth in order that the shared maternal-fetal interest in a healthy newborn as well as a healthy mother-child relationship may be achieved.

V. INVOLUNTARY CIVIL COMMITMENT: A BAND-AID SOLUTION

Involuntary civil commitment is a mechanism used by the state to force individuals to receive treatment or care when he or she poses a threat of "harm to self or others" due to a mental or physical impairment or disability.¹¹⁸ Involuntary hospitalization has been a part of mental health law in this country for a century and a half.¹¹⁹ Involuntary civil commitment serves the dual function of safeguarding society from the mentally ill and affording treatment and rehabilitation for the individual patient.¹²⁰ Commitment laws, in general, are justified by both the police power of the state, which permits state

112. Stovall, *supra* note 89, at 1277.

113. Stovall, *supra* note 89, at 1277.

114. See *Child Abuse*, *supra* note 56.

115. Stovall, *supra* note 89, at 1298-99.

116. Stovall, *supra* note 89, at 1266.

117. See Stovall, *supra* note 89, at 1266.

118. See Sandra Anderson Garcia & Ingo Keilitz, *Involuntary Civil Commitment of Drug-Dependent Persons With Special Reference to Pregnant Women*, 15 MENTAL & PHYS. DISAB. L. REP. 418, 418 (1991) [hereinafter *Involuntary Civil Commitment*] (describing the process whereby legal and social service systems work together to forcibly impose treatment on mentally or physically impaired people).

119. See Wilton, *supra* note 4, at 163 (citing BRAKEL, PARRY & WEINER, *THE MENTALLY DISABLED AND THE LAW* 22 (3d ed. (1985))).

120. Wilton, *supra* note 4, at 163.

action to protect society from dangerous individuals,¹²¹ and the *parens patriae* power, which permits state action to protect individuals who are unable to protect or care for themselves.¹²² Some states have considered alcoholism and drug dependence to be impairments subject to commitment laws.¹²³ Thus, while treatment programs for drug-dependent persons are mostly voluntary in this country, civil commitment laws have been used to forcibly admit and treat alcoholics and drug addicts.¹²⁴

The Supreme Court, in dicta, affirmed the constitutionality of the practice of involuntarily committing substance-dependent individuals for alcohol or drug treatment in *Robinson v. California*.¹²⁵ The *Robinson* Court invalidated a criminal statute, which made the "status" of narcotic addiction a criminal offense on the grounds that the statute inflicted "cruel and unusual punishment" in violation of the Eighth and Fourteenth Amendments.¹²⁶ The Court opined that states could constitutionally address the social problem presented by drug-dependent individuals through "compulsory treatment, involving . . . confinement" of individuals addicted to narcotics.¹²⁷

Currently, twenty-three states and the District of Columbia have specific provisions providing for the forced civil commitment of drug-dependent persons, while eleven states have limited provisions sanctioning such commitment.¹²⁸ An additional eleven states permit the involuntary commitment of drug-dependent persons under the

121. Wilton, *supra* note 4, at 163.

122. Wilton, *supra* note 4, at 163-64.

123. Wilton, *supra* note 4, at 165 (discussing the traditional practice of some states to broadly interpret general statutory language as allowing civil commitment of drug and alcohol addicts).

124. See *Involuntary Civil Commitment*, *supra* note 118, at 418 (noting that the District of Columbia, along with 75% of the states, have involuntary commitment laws which deal with drug dependent persons).

125. See David F. Chavkin, "For Their Own Good": *Civil Commitment of Alcohol and Drug-Dependent Pregnant Women*, 37 S.D. L. REV. 224, 246 (citing *Robinson v. California*, 370 U.S. 660, 665 n.7 (1962) (holding the criminalization of alcohol or drug dependency unconstitutional, yet noting that civil commitment and mandatory treatment for alcohol and drug dependency is a constitutional alternative)).

126. See *Robinson*, 370 U.S. at 666 (explaining that laws that make it a crime to be mentally or physically ill would be considered cruel and unusual punishment by most of society even though society often deals with the mentally and physically ill in the same manner, through compulsory treatment).

127. *Id.*

128. See *Involuntary Civil Commitment*, *supra* note 118, at 418 (noting that a state may provide for the commitment of drug addicts by adopting an involuntary commitment statute. In addition, states without involuntary commitment provisions for drug dependency may classify drug dependency as a mental illness and apply the provisions for the involuntary commitment of the mentally ill). The states with detailed provisions specifically authorizing civil commitment are: Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Iowa, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, New Mexico, North Carolina, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Washington, West Virginia and Wisconsin.

traditional "mentally ill commitment laws."¹²⁹ However, four states expressly exclude substance dependence or addiction from the coverage of their commitment laws.¹³⁰

The statutes having specific provisions authorizing forced civil commitment of drug-dependent persons share some common features. First, because these commitment laws are modeled after mental health commitment laws, they limit involuntary civil commitment to "drug-dependent persons who are in need of treatment and care, are likely to be dangerous to themselves or others, or who are unable to meet their basic needs for sustenance, shelter or self-protection."¹³¹ Second, under most drug-dependency commitment laws, commitment proceedings may be initiated by any adult, as well as by law enforcement officers and authorized care and treatment providers.¹³² Third, in order to meet the constitutional requirements of procedural due process, all involuntary civil commitment laws require procedural protections including notice, a commitment hearing, the right to counsel at this hearing, judicial review of the commitment order, and a definite initial commitment period.¹³³ The commitment statutes however, typically allow detention of individuals for evaluation or emergency care and treatment pending a formal judicial hearing.¹³⁴

States having civil commitment laws expressly covering drug-dependent persons have generally articulated the legislative intent behind their statutes.¹³⁵ Some of these states explain the public policy behind the commitment of substance addicts as necessary to afford such persons treatment and rehabilitation opportunities in the least restrictive environment possible.¹³⁶ State legislatures have also viewed

129. See *Involuntary Civil Commitment*, *supra* note 118, at 418. Alabama, Indiana, Kentucky, Maine, Michigan, Nebraska, Nevada, Oregon, Tennessee, Vermont and Virginia have limited statutory provisions relating to involuntary civil commitment, but allow civil commitment through their mental illness commitment laws.

130. See *Involuntary Civil Commitment*, *supra* note 118, at 418 (citing ALASKA STAT. § 47.30.915(12) (1984); ARIZ. REV. STAT. ANN. § 36-501(22)(a) (1986 & Supp. 1990); N.H. REV. STAT. ANN. § 135-C:2(X) (1977 & Supp. 1990); N.Y. MENTAL HYG. LAW § 1.03 (20) (McKinney 1988)).

131. *Involuntary Civil Commitment*, *supra* note 118, at 419.

132. *Involuntary Civil Commitment*, *supra* note 118, at 419.

133. See *Involuntary Civil Commitment*, *supra* note 118, at 422 (discussing state statutory provisions intended to preserve due process protections in civil commitment matters because of the deprivation of liberty involved).

134. See *Involuntary Civil Commitment*, *supra* note 118, at 421 (allowing periods of detention ranging from 72 hours to two weeks for the states with specific civil commitment laws. Generally to be committed on an emergency basis a person must be dangerous to herself or others.).

135. *Involuntary Civil Commitment*, *supra* note 118, at 420.

136. See *Involuntary Civil Commitment*, *supra* note 118, at 420 (noting that Hawaii, Louisiana, North Carolina, Oklahoma and Wisconsin have articulated a desire to provide treatment in an environment that is minimally restrictive).

these commitment laws as a way to return drug addicts to society.¹³⁷ In addition, some states assert that their commitment laws serve to protect the rights and personal liberties of individuals addicted to drugs, because forced civil commitment is viewed as an alternative to criminal punishment.¹³⁸ Finally, the legislative intent behind some of these commitment laws is the more conservative desire to protect the health and safety of the general public and to prevent or reduce substance abuse.¹³⁹

Minnesota is one of the twenty-four states having specific provisions providing for involuntary civil commitment of drug-dependent persons.¹⁴⁰ Minnesota, however, goes further than the other twenty-three states in that only Minnesota has explicitly provided for the involuntary civil commitment of pregnant drug-dependent women.¹⁴¹ In addition, Minnesota is one of the few states which *requires* a physician to test a pregnant woman for drug use where the physician has reason to suspect drug abuse by the pregnant woman.¹⁴² Furthermore, Minnesota law imposes a duty on physicians to report a positive toxicology test of a pregnant woman to the local welfare agency.¹⁴³

These mandatory testing and reporting laws, which apply only to pregnant women, reinforce the Minnesota involuntary civil commitment provision. When a welfare agency receives a report of drug use by a pregnant woman, the agency must offer services, such as referrals for chemical dependency assessment, treatment and prenatal care.¹⁴⁴

137. See *Involuntary Civil Commitment*, *supra* note 118, at 420 (citing the statutes from Florida, Louisiana and North Dakota as examples of states that seek to use commitment as a means of returning drug addicts to the community).

138. See *Involuntary Civil Commitment*, *supra* note 118, at 420 (observing that Louisiana, North Carolina, North Dakota, Oklahoma and Wisconsin denote civil commitment as an alternative to criminal punishment).

139. See *Involuntary Civil Commitment*, *supra* note 118, at 420 (reporting that only California, the District of Columbia and Oklahoma specifically express an interest in protecting individuals from drug addiction, referring to the problem as a social "menace").

140. MINN. STAT. ANN. § 253B.02 subd. 2 (West 1982 & Supp. 1991) (providing that pregnant women who partake in "habitual and excessive use" of cocaine, heroin, phencyclidine, methamphetamine or amphetamines may be committed for up to six months, after which another petition for commitment may be filed).

141. MINN. STAT. ANN. § 253B.02 subd. 2 (West 1982 & Supp. 1991) (defining a "chemically dependent person" to include "a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following controlled substances or their derivatives: cocaine, heroin, phencyclidine, methamphetamine, or amphetamine").

142. MINN. STAT. ANN. § 626.5562 (West 1982 & Supp. 1991).

143. MINN. STAT. ANN. § 626.5561-5562 (West 1982 & Supp. 1991); See also Horowitz, *supra* note 102, at 8.

144. MINN. STAT. ANN. § 626.5561 (West 1982 & Supp. 1991).

The agency is authorized to commence civil commitment proceedings if the pregnant woman refuses to cooperate in treatment.¹⁴⁵

State legislatures view involuntary civil commitment of pregnant drug users as a mechanism to address the social problem of substance addiction during pregnancy.¹⁴⁶ Civil commitment is distinguishable from criminal and civil prosecutions, in that it is a form of pre-birth intervention, which has the potential both to protect the developing fetus and to rehabilitate, rather than punish, the expecting mother. Arguably, this form of state intervention is a paternalistic approach, which would force a pregnant woman to act against her will in the short term in order to help herself and her baby, so that she can achieve her long term goal of a healthy baby and the potential for a healthy mother-child relationship.

The Minnesota scheme, which expressly provides for civil commitment of pregnant drug-dependent women, as well as the civil commitment statutes of other states, which permit forced commitment of pregnant substance abusing women, have been greatly criticized and challenged on constitutional grounds.¹⁴⁷ A common constitutional attack on this form of state intervention is based upon the privacy rights guaranteed by the Fourteenth Amendment.¹⁴⁸ Opponents argue that forced civil commitment of drug-dependent pregnant women infringes upon reproductive and familial privacy rights, the right to bodily integrity and the right to equal protection.¹⁴⁹

The right to reproductive and familial privacy has been established through Supreme Court precedent, which affirms privacy rights in activities related to marriage,¹⁵⁰ contraception,¹⁵¹ abortion,¹⁵² family

145. MINN. STAT. ANN. § 626.5561 (West 1982 & Supp. 1991).

146. See *Involuntary Civil Commitment*, *supra* note 118, at 420 (explaining that as commitment was used to solve the "social problem" of the mentally ill, so too has it been used for the problems of drug dependency. However, in applying commitment statutes meant for the mentally ill to the pregnant, drug-dependant, there has been a gradual shift in the exact definition of the "social problem" commitment is meant to solve. Increasingly, courts have sought to include the fetus as a person under the commitment criteria of "dangerous to others" and to include child abuse as one of the "social problems" associated with pregnant drug addicts.).

147. See Kary L. Moss, *Forced Drug or Alcohol Treatment for Pregnant and Postpartum Women: Part of the Solution or Part of the Problem?*, 17 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 1, 3-4 (1991) [hereinafter *Forced Drug Treatment*] (arguing that forcing women into treatment, whether it is for their own good or the good of the fetus, subjects pregnant women to a different set of laws than the rest of society).

148. U.S. CONST. amend. XIV § 1. See Wilton, *supra* note 4, at 154 (discussing the right of privacy as found by the Court under the Fourteenth Amendment concept of personal liberty).

149. See Wilton, *supra* note 4, at 154 (citing *Roe v. Wade*, 410 U.S. 113 (1973)).

150. See generally *Loving v. Virginia*, 388 U.S. 1 (1967) (referring to marriage as a basic civil right).

relationships,¹⁵³ child rearing¹⁵⁴ and education.¹⁵⁵ Opponents of civil commitment argue that this form of state intervention infringes upon the right to reproductive and familial privacy, in that it is a form of governmental regulation, which greatly influences female decision-making regarding reproduction.¹⁵⁶ More specifically, the threat of civil commitment is likely to significantly impact upon a drug-addicted woman's decision-making regarding her pregnancy.¹⁵⁷ For example, the fear of being committed for drug use during pregnancy may cause an addicted woman to decide to terminate her pregnancy or, in the alternative, to avoid seeking prenatal care for fear of detection. Thus, civil commitment constitutes an "undue burden" on a woman's privacy rights and therefore, is unconstitutional.¹⁵⁸

Those who propose using civil commitment statutes to force drug-dependent pregnant women to receive treatment adamantly reject the assertion that state intervention would constitute an unjustified infringement on the constitutional rights of pregnant women.¹⁵⁹ Ironically, those who favor committing pregnant drug users rely on *Roe v. Wade*, a case usually associated with protecting female autonomy, to refute the assertion that civil commitment violates the right to reproductive and familial privacy.¹⁶⁰

151. *Griswold v. Connecticut*, 381 U.S. 479 (1965) (holding that the regulation of contraception is an unconstitutional infringement on marital privacy).

152. *Roe v. Wade*, 410 U.S. 113 (1973) (holding that there is a right to privacy in the concept of personal liberty under the Fourteenth Amendment which encompasses a woman's right to choose an abortion).

153. See e.g., *Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (recognizing the right of related persons to live together in one household); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (creating a right of marital privacy which includes the right to use contraception); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (holding that people have the constitutional right to have offspring).

154. See *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925) (prohibiting the state from dictating the upbringing of children who are under the control of a parent or guardian).

155. See *id.* (prohibiting the state from requiring that all children be publicly educated).

156. See Wilton, *supra* note 4, at 160 (suggesting that legislation needs to be drafted narrowly so as to safeguard pregnant women's right to bodily integrity and only allow medical intervention when necessary).

157. Wilton, *supra* note 4, at 156.

158. See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 112 S. Ct. 2791, 2819 (1992) (holding that the Due Process Clause is violated when a state regulation imposes an undue burden on a woman by limiting her right to determine whether or not to terminate her pregnancy).

159. Wilton, *supra* note 4, at 157.

160. See Louise Marlane Chan, Note, *S.O.S. From the Womb: A Call for New York Legislation Criminalizing Drug Use During Pregnancy*, 21 FORDHAM URB. L.J. 199, 221 (1993) (using *Roe*, advocates of state intervention in the pregnancy of drug-addicted women have argued that a woman's privacy rights do not always outweigh state interests. In *Roe*, the Court enunciated that in the third trimester, the state's compelling interest in protecting potential life outweighs the woman's privacy rights to have an abortion if the means are narrowly tailored.); Wilton, *supra* note 4, at 155 (noting that the framework of *Roe* allows for an increasing state interest as the woman progresses in her pregnancy).

In *Roe*, the Court expressly recognized the health of the mother and the potential for human life as two legitimate state interests in the abortion context.¹⁶¹ Through the trimester approach, the *Roe* Court recognized that the state's interest increases as the pregnancy progresses.¹⁶² Furthermore, in later abortion cases, the Court indicated that the state's interest in protecting potential life exists throughout the pregnancy.¹⁶³ Thus, the abortion cases arguably support civil commitment during pregnancy given the justified state interest, both in protecting the health of the mother and in protecting the potential life of the fetus.

Furthermore, proponents of civil commitment argue that the state interest in ensuring that infants will be born healthy, is much stronger than the state interest in the abortion context of simply ensuring that fetuses be born.¹⁶⁴ Thus, greater intrusion into the private decisions of pregnant women is constitutionally permitted in the context of drug addiction during pregnancy than is permitted in the abortion context. In other words, a woman's constitutional right to reproductive privacy is not as compelling where the woman engages in harmful behavior once she has decided to carry her child to term, as in the abortion context.¹⁶⁵ Once a woman chooses not to exercise her constitutional right to an abortion, she has an obligation to protect her fetus and the state has a right to intervene to ensure such protection.¹⁶⁶

The right to bodily integrity was recognized at common law as "the right of every individual to the possession and control of his [or her] own person."¹⁶⁷ This right is protected under the Constitution by the Fourth Amendment's prohibition on unreasonable searches and

161. See *Roe*, 410 U.S. at 154 (finding a state's interest in preserving the potential life of the fetus in prior challenges to abortion laws).

162. See *id.* at 163 (finding that in the first trimester, a woman's privacy right generally outweighs the state's interest in preserving the fetus, but that by the third trimester, the state's interest becomes compelling due to the viability of the fetus, and outweighs the woman's interest).

163. See *Casey*, 112 S. Ct. at 2818 (recognizing an abandonment of the trimester system to ensure the protection of fetal life and the interests of the mother throughout the pregnancy).

164. See Wilton, *supra* note 4, at 156 (distinguishing the degree of compelling interest a woman has in deciding whether or not to carry a child to term from her right to determine her behavior while pregnant).

165. Nat Hentoff, *No 'Right' to Abuse a Fetus*, WASH. POST, Jan. 19, 1991, at A15. The view discussed in this article is that of Natasha Lisman, who is on the Massachusetts Board of the American Civil Liberties Union (ACLU). The article makes clear that Lisman's position on this issue is not supported by her colleagues in the ACLU, who advocate complete autonomy for pregnant women.

166. *Id.*

167. See Wilton, *supra* note 4, at 157 (citing *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) (which held that the lower court could not order plaintiff in a tort suit to submit to a surgical examination to determine the extent of injury)).

seizures,¹⁶⁸ as well as the Fifth and Fourteenth Amendments' guarantees of due process of law.¹⁶⁹ Opponents of involuntary civil commitment assert that this form of state intervention directly infringes upon the woman's right to bodily integrity as it allows forced drug or alcohol testing,¹⁷⁰ as well as compulsory treatment for substance addiction.¹⁷¹

Proponents of civil commitment during pregnancy concede that this intervention does infringe upon the right to bodily integrity, however, they contend that this infringement is constitutional where certain substantive and procedural safeguards are guaranteed.¹⁷² Infringements on the right to bodily integrity are substantively justified where the state interests in intrusion outweigh the individual's right to be free from intrusion.¹⁷³ The following are relevant factors in balancing state interests against the individual interests of pregnant substance users: the absence of less restrictive alternatives that protect the state interest while accommodating individual rights; whether the individual receives some benefit from the intervention; and whether the intervention is necessary to protect third persons.¹⁷⁴ Proponents argue that, in the context of drug use during pregnancy, this balancing test favors civil commitment because the

168. U.S. CONST. amend. IV. See also *Winston v. Lee*, 470 U.S. 753 (1985) (finding that unreasonable bodily intrusion is prohibited by the Fourth Amendment); *Youngberg v. Romeo*, 457 U.S. 307 (1982) (holding that the right to be free from bodily restraint is included in the Due Process Clause).

169. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990) (holding that competent patients have a constitutionally protected liberty interest in refusing unwanted medical treatment); *Youngberg*, 457 U.S. at 316 (holding that the Due Process Clause creates a liberty interest in involuntarily committed mental patients to be free from bodily restraint).

170. See *Wilton*, *supra* note 4, at 159 (noting that the possibility of drug testing as part of any fetal health legislation would infringe on a woman's right to bodily integrity and thus require constitutional evaluation). See also Kary L. Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278, 291 (arguing that once testing is allowed, reporting would also be required and would thus violate a woman's privacy interest); *Whalen v. Roe*, 429 U.S. 589 (1977) (stating that patients have a privacy right regarding their mental history).

171. See *Wilton*, *supra* note 4, at 160 (discussing the right to bodily integrity as it is encompassed under the Fourteenth Amendment's protection against unreasonable searches and seizures and the Fifth and Fourteenth Amendments due process protections).

172. See *Wilton*, *supra* note 4, at 159-60 (noting that relying only on medical necessity, providing options for voluntary treatment, and using drugs that benefit the mothers as well as the fetus, are procedural safeguards that could preserve the constitutionality of civil commitment legislation).

173. See e.g., *Cruzan*, 110 S. Ct. at 2853 (finding that the state's interest in protecting life must be balanced against an individual's right to refuse treatment); *Jacobson v. Massachusetts*, 197 U.S. 11, 38 (1905) (holding that the state's interest in public health must be weighed against an individual's right to refuse a smallpox vaccination).

174. See *Washington v. Harper*, 110 S. Ct. 1028 (1990) (holding that prison inmates have a liberty interest in refusing administration of anti-psychotic drugs under the Due Process Clause).

state interest in protecting both the mother and the fetus outweighs the mother's right to bodily integrity.¹⁷⁵

In support of this conclusion, proponents argue that any bodily integrity violation in the context of civil commitment is minimal at best. In this context, the only bodily invasions are forced drug or alcohol testing, and possibly, any invasions necessary in treating the individual for the addiction. Such bodily invasions do not warrant the same level of constitutional scrutiny as forced stomach pumping to obtain evidence or compelled continuation of life support systems.¹⁷⁶ Thus, according to proponents, as long as civil commitment statutes are narrowly drafted to permit only necessary and effective pregnancy intervention, and adequate procedural safeguards are guaranteed, the application of civil commitment laws to pregnant drug-addicts does not violate the constitutional right to bodily integrity.¹⁷⁷

Another line of constitutional attack against a state policy of civil commitment of drug-dependent pregnant women focuses on equal protection concerns. The testing, reporting and subsequent treatment provisions of Minnesota's law expressly apply only to pregnant women.¹⁷⁸ Therefore, on their face, these statutory provisions classify according to pregnancy.¹⁷⁹ Other state statutes, while not facially discriminatory, are arguably applied disproportionately against pregnant women, and therefore also classify on the basis of pregnancy.¹⁸⁰

According to opponents of civil commitment, the classifications created by these statutes cannot withstand equal protection scrutiny. More specifically, any classification which singles out pregnant women for special treatment reinforces stereotypical attitudes that have historically impeded women's efforts to join the workforce on an equal footing with men, and therefore, unconstitutionally discriminates against pregnant women.¹⁸¹ Opponents further argue that

175. See Wilton, *supra* note 4, at 160 (demonstrating the ability of protective statutes to pass constitutional muster if they are narrowly tailored to accomplish the state's interests).

176. See *Rochin v. California*, 342 U.S. 165 (1952) (holding that the use of morphine capsules extracted from defendant's stomach against his will, through stomach pumping, to convict defendant for illegal possession of morphine violated the Due Process Clause); see also *Cruzan*, 497 S. Ct. at 261 (holding that competent persons have a constitutionally protected liberty interest in refusing unwanted medical treatment).

177. Wilton, *supra* note 4, at 160.

178. MINN. STAT. ANN. §§ 626.5561-5562 (West 1982 & Supp. 1991).

179. MINN. STAT. ANN. §§ 626.5561-5562 (West 1982 & Supp. 1991).

180. See Moss, *supra* note 170, at 293-94 (arguing that state statutes are often based on the false assumption that it is only the drug taking of the mother that effects the fetus).

181. See *California Federal Savings & Loan Ass'n v. Guerra*, 479 U.S. 272, 300 (1987) (White, J., dissenting) (asserting that "preferential treatment represents a resurgence of the 19th-century

these statutes "relegate [women] to second-class status, subjecting them to different laws than the rest of the populace."¹⁸² Finally, there is an injustice in a system which forces treatment upon a woman, not because she has committed a crime, but rather because she has become pregnant.¹⁸³

In response to the equal protection challenge, proponents of civil commitment statutes argue that although these statutes classify on the basis of pregnancy, it does not subject them to heightened scrutiny.¹⁸⁴ In *Geduldig v. Aiello*,¹⁸⁵ the Supreme Court found that pregnancy-based discrimination is not gender discrimination because it does not treat men and women differently; rather, classifications based on pregnancy treat men and non-pregnant women differently than pregnant women.¹⁸⁶ Therefore, pregnancy-based classifications are only subject to rational-basis constitutional scrutiny.¹⁸⁷ According to the proponents of civil commitment, this pregnancy-based classification survives rational-basis scrutiny because civil commitment of pregnant drug-addicts is rationally related to the legitimate state interests in protecting fetuses and rehabilitating pregnant drug addicts.¹⁸⁸

Even if civil commitment of pregnant drug addicts is deemed to create gender-based classifications and is therefore subject to heightened equal protection scrutiny, advocates of civil commitment argue that it survives such scrutiny.¹⁸⁹ In order to survive constitutional scrutiny, any classifications based on gender must serve "important governmental objectives" and must be "substantially related" to achieving those objectives.¹⁹⁰ Civil commitment of drug-

protective legislation which perpetuated sex-role stereotypes and which impeded women in their efforts to take their rightful place in the workplace").

182. *Forced Drug Treatment*, *supra* note 147, at 4 (criticizing the special treatment of pregnant women by the law as paternalistic and harmful, despite the laws protective intention).

183. *Forced Drug Treatment*, *supra* note 147 at 4.

184. See Jones, *supra* note 2, at 1168; *Loving v. Virginia*, 388 U.S. 1 (1967) (deciding that strict scrutiny analysis would require a determination of whether restricting the mother's rights was a necessary means to achieve the state's compelling interest in the protection of potential life).

185. *Geduldig v. Aiello*, 417 U.S. 484 (1974).

186. See *id.* at 496-97 (applying a rational-basis scrutiny to uphold a California state insurance program which excluded pregnancy-related disabilities from coverage).

187. *Id.*

188. See Jones, *supra* note 2, at 1168 (discussing the important governmental interests in protecting human life).

189. See Jones, *supra* note 2, at 1168 (proposing a way to pass constitutional muster by applying a gender neutral statute that punishes men as well as women who supply the fetus with illegal substances).

190. See *Craig v. Boren*, 429 U.S. 190, 197 (1976) (holding that an Oklahoma statute which prohibits the sale of beer to males under the age of twenty-one and females under the age of eighteen is an unconstitutional denial of equal protection for eighteen to twenty year old men);

dependent pregnant woman serves the important governmental objective of protecting fetuses from the harmful effects of substance abuse during pregnancy. Furthermore, civil commitment of pregnant substance abusers is substantially related to the achievement of this objective. By committing these women, the state ensures that they receive treatment for their addiction and do not continue to use drugs while pregnant.¹⁹¹ Civil commitment of pregnant drug-addicts arguably survives the two prong heightened equal protection analysis.

The debate between those who support and those who reject forced civil commitment of pregnant women illustrates how discourse on the use of involuntary civil commitment statutes degenerates into a battle over conflicting rights.¹⁹² Opponents criticize these statutes by arguing that they infringe upon the constitutional rights of women, while proponents support these statutes because they vindicate fetal rights. A more useful analysis would focus upon whether or not such commitment programs achieve the socially desirable goal of promoting healthy births and preserving the mother-child relationship. The opponents of civil commitment implicitly recognize that in light of the male-centered structure of existing commitment programs, and the lack of resources currently available to pregnant women in our society, involuntary civil commitment, while benevolent in theory, is not alone capable of achieving its goal.¹⁹³

A system of involuntary civil commitment does not protect the health of pregnant substance-addicted women who have not voluntarily sought treatment for their fetuses.¹⁹⁴ Currently, there are not sufficient resources for pregnant substance-addicted women who voluntarily seek treatment.¹⁹⁵ There are few drug-treatment pro-

see also Mississippi Univ. for Women v. Hogan, 458 U.S. 718, 730 (1982) (holding that a state nursing school policy of only admitting women violates the Equal Protection Clause because the state failed to show a substantial relationship between gender classification and alleged remedial objective).

191. See Chavkin, *supra* note 125, at 247-48 (discussing the 1990 findings of the Office of National Drug Control that involuntary treatment can be effective in producing healthy newborns).

192. See Chavkin, *supra* note 125, at 225 (challenging the assertion that civil commitment is substantially related to achieving the governmental objective of protecting the fetus, given that the threat of civil commitment is likely to deter pregnant drug-addicts from obtaining prenatal care).

193. Chavkin, *supra* note 125, at 241-43.

194. See Christopher D. Webster, *Compulsory Treatment of Narcotic Addiction*, 8 INT'L J.L. & PSYCHIATRY 133, 136 (1986) (analyzing findings in New York, California and Kentucky which show that historically, involuntary treatment for drug addicts has proven to be largely ineffectual).

195. See Michele Magar, *The Sins of the Mothers*, STUDENT LAW., Sept. 1991 at 30, 34 (noting that a National Association of State Alcohol and Drug Abuse Directors survey documented that in 1989, government-funded treatment centers turned away 250,000 pregnant women).

grams currently in existence which will treat pregnant women.¹⁹⁶ A survey of New York treatment centers found that fifty-four percent of all state-funded programs refuse to accept pregnant women, sixty-seven percent do not accept pregnant women who are Medicaid eligible, and only thirteen percent treat pregnant Medicaid eligible women who are crack-dependent.¹⁹⁷ Jennifer Johnson, a woman who was criminally prosecuted under the Florida drug delivery statute for delivering cocaine to her newborn through the umbilical cord, sought treatment during her pregnancy but was unable to find a substance abuse treatment center that would accept her.¹⁹⁸ In striving for a facilitative approach to the problem of substance abuse during pregnancy, society should seek to expand the treatment opportunities for pregnant women.

While, it is possible that a system of involuntary civil commitment might increase the availability of treatment for voluntary, as well as, involuntary patients. Forcing commitment on pregnant women who do not desire treatment may inhibit instead of facilitate their choices, thus creating a maternal-fetal conflict by requiring women to receive treatment they oppose.¹⁹⁹ Added to this is the fact that the few treatment centers that currently do admit pregnant women do not generally provide the comprehensive and unique treatment that pregnant women require.²⁰⁰

Treatment programs almost never provide in-house services for the care of the children of pregnant women in treatment.²⁰¹ To accommodate the needs of pregnant women who have other children, treatment facilities need to offer child care services within the treatment centers. A 1986 study of treatment programs in thirty-four

196. See *Forced Drug Treatment*, *supra* note 147, at 6 (citing insufficient accessibility to drug treatment centers that accept pregnant women as a major obstacle to their treatment).

197. See *Forced Drug Treatment*, *supra* note 147, at 6 (citing David F. Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 AM. J. PUB. HEALTH 483, 485 (1990) (noting that the unavailability of suitable treatment facilities constitutes a major obstacle to courts ordering treatment)).

198. See Jones, *supra* note 2, at 1175 (citing Derrick Z. Jackson, *Inequality and the "Fetal Rights" Concept*, BOSTON GLOBE, Mar. 25, 1990, at A24 (asserting high risk and liability in drug related pregnancies as the reason for treatment centers turning away drug addicted pregnant women)).

199. See Wilton, *supra* note 4 (noting that the balancing of interests in civil commitment cases can create a conflict between an unwilling mother and her fetus).

200. See Chavkin, *supra* note 125, at 242 (discussing the findings of treatment professionals that pregnant women have unique emotional needs, as well as physical needs such as transportation and child care); see also Richard Whitmire, *Drug-Using, Pregnant Women: Medical or Criminal Problem?*, GANNETT NEWS SERV., Mar. 30, 1994 (quoting Dr. Richard Schwarz, former President of the American College of Obstetricians and Gynecologists, on their 1991 survey finding a national shortage of drug treatment programs designed for women, "our drug abuse treatment system is male oriented").

201. See Chavkin, *supra* note 125, at 242.

cities nationwide found that lack of child care was the main reason why drug-addicted women failed to seek available treatment.²⁰² In the absence of child care services, lower-income pregnant drug-addicted women, who do not have family members or friends to care for their children, must choose between potentially losing the children they already have to the foster care system or protecting the fetus they are carrying by receiving treatment.

The lack of prenatal care in most treatment facilities is another way in which these facilities do not respond to the treatment needs of pregnant women.²⁰³ The lack of child care and prenatal care services is a manifestation of the dominant approach in most treatment facilities which is to cater to male, rather than female, experiences and circumstances.²⁰⁴ Pregnant women are forced to endure treatment which fails to fully serve their needs, such as child care for other children, so that the interests of their fetuses may be served. Therefore, a policy of forced commitment of pregnant women to facilities which are not equipped to address their unique needs creates a maternal-fetal conflict.

Pregnant women who are not ready to seek voluntary aid or who are aware that the treatment programs will not serve their unique needs are likely to perceive involuntary civil commitment as a threat.²⁰⁵ That is, a woman who has not sought voluntary treatment has not yet decided to address her addiction and therefore, may be threatened by compelled treatment. Likewise, civil commitment may threaten a pregnant, addicted woman with two children who knows that if she is forced to receive treatment she will lose custody of her two children while in treatment because the treatment facilities do not offer in-house child care. The fear of detection is likely to deter pregnant, addicted women from seeking prenatal care.²⁰⁶

202. See Jones, *supra* note 2, at 1177 (citing Michele L. Noris, *Cries in Dark Often Go Unanswered*, WASH. POST, July 2, 1991, at A1, A8 col. 6).

203. Jones, *supra* note 2, at 1177.

204. See Leslie Laurence, *Drug, Alcohol Programs Designed Mostly for Men*, CINN. POST, Aug. 12, 1994, at 4B (citing findings by a General Accounting Office report that in 1990 less than eleven percent of the estimated 280,000 pregnant women who needed drug treatment received care); *id.* at GAO/HRD-90-138 Report, at 36.

205. See Joan McKinney, *Abuse Programs Said Missing Addicted Pregnant Women*, BATON ROUGE ADVOC., Dec. 2, 1993, at 14A (citing the 1993 study by the Southern Governors' Association which found that drug-dependant pregnant women avoided treatment because they feared that their children would be taken away because of their drug problem, or because they could not find alternative care for their children while they underwent treatment).

206. See Chavkin, *supra* note 125, at 245-46 (noting that women may lie about their drug history in a prenatal evaluation or avoid going until their drug usage subsides to a less obvious level, thus undermining the purpose of prenatal care).

Pregnancies of women addicted to substances are high risk pregnancies given the harmful effects of substance abuse on the fetus.²⁰⁷ Therefore, while prenatal care is essential for all pregnant women, it is vitally important for pregnant women using substances. Studies demonstrate that the negative effects of substance abuse during pregnancy are greatly reduced by providing prenatal care and helping substance addicted women to abstain during pregnancy.²⁰⁸ Furthermore, data developed by the Institute of Medicine shows that for each dollar spent on providing prenatal care to low-income, poorly-educated women, society saves three dollars and thirty-eight cents in medical care for the infants of these women in the first year of life.²⁰⁹ Thus, involuntary civil commitment is problematic to the extent that it may deter some pregnant, addicted women from seeking prenatal care.

Involuntary civil commitment of pregnant drug-dependent women, in light of the structure of treatment facilities and the funding available to pregnant women in our society, does not achieve the goal of promoting healthy relationships between mothers and their children. Rather, legislatures which adopt such statutes, without restructuring treatment programs to serve the unique needs of pregnant women, and without increasing the resources available to pregnant women, would create conflict between mother and fetus. Civil commitment statutes alone cannot rectify society's failure to provide pregnant women with the financial, physical, and emotional aid necessary for healthy pregnancies.

VI. SOCIALLY RESPONSIBLE SOLUTIONS

Society must take action to address the fact that hundreds of thousands of babies are born each year addicted to drugs. Society should not seek to address this problem through involuntary intervention either during or after pregnancy. It does not matter whether this intervention is criminal prosecution, civil prosecution or civil commitment. Each of these mechanisms focuses on intervention

207. See Chavkin, *supra* note 125, at 245 n.136 (discussing the high risk factors of babies born to drug abusers including low birth weight and abnormal development).

208. See Chavkin, *supra* note 125, at 245 n.136 (citing, Ira J. Chasnoff, *Drugs, Alcohol, Pregnancy, and the Neonate: Pay Now or Pay Later*, 266 JAMA 1568 (1991) noting the reduced rate of prematurity, low birth weight, head size and other complicating factors which effect newborns, with the improved use of services for drug addicted mothers who receive prenatal care).

209. See Chavkin, *supra* note 125, at 245 n.136 (citing, Ira J. Chasnoff, *Drugs, Alcohol, Pregnancy, and the Neonate: Pay Now or Pay Later*, 266 JAMA 1568 (1991) utilizing a cost benefit analysis this author supports the funding of prenatal programs for drug-addicted mothers and demonstrates the proven costs to society of caring for their babies).

rather than assistance, and therefore fail to fulfill society's affirmative obligation to provide the aid which pregnant women need to fulfill their unique role as nurturers. The key distinction between intervention and assistance is the voluntariness of the participation. When the state intervenes to address substance abuse during pregnancy, the pregnant woman is forced to follow the dictates of the state. In contrast, when the state offers assistance to a pregnant woman, it is facilitating and expanding her choices so that, through her own free will, she may make decisions beneficial to both herself and her unborn child. Society has an obligation to offer assistance rather than intervention.

Cultural feminism supports the notion that because of the unique and celebrated role of women as mothers, society has a duty to recognize and accommodate the special needs of pregnant women.²¹⁰ This societal duty includes the obligation to address the particularized needs of pregnant substance addicted women. The notion underlying the argument for greater public responsibility is that by eradicating public neglect, and educating parents, society encourages and enables private responsibility.²¹¹ Thus, legislatures should be more concerned with providing a "social fabric" which will assist parents and their children to form trusting relationships.²¹²

Applying this philosophy to drug use during pregnancy, society should adopt measures which demonstrate concern for women and their children by developing a comprehensive health care system that includes prenatal care as well as gender-sensitive drug treatment programs.²¹³ Furthermore, society must offer this assistance prior to pregnancy by developing programs to discourage alcohol and drug use and taking account of the factors which lead to substance abuse such as poverty and inadequate nutrition.²¹⁴

By giving all-encompassing assistance prior to pregnancy or birth, society would best facilitate private responsibility. For example, society must recognize and address the fact that poverty prevents many pregnant women in our society from receiving adequate

210. *Child Abuse*, *supra* note 56, at 95.

211. See Martha Minow, *Rights for the Next Generation: A Feminist Approach to Children's Rights*, 9 HARV. WOMEN'S L. J. 1, 24 (1986) (discussing the interconnected spheres of public and private responsibility in child rearing).

212. See *id.* at 24 (using the family court as a base from which children and adults can create trusting relationships based on public and private responsibility).

213. See *Forced Drug Treatment*, *supra* note 147, at 16 (maintaining that gender-sensitive programs will better fit the life of drug addicted women and will focus on factors like poverty and health).

214. *Forced Drug Treatment*, *supra* note 147, at 16.

prenatal care.²¹⁵ The lack of funding allocated to providing prenatal care to lower-income pregnant women is a separate and distinct social problem which aggravates the social problem of substance-abuse during pregnancy. That is, the lack of prenatal care gives rise to a lack of information which, in turn, leads to substance abuse during pregnancy. Women who do not receive prenatal care are often unaware that substance abuse during pregnancy has harmful effects on fetuses, and therefore engage in such abuse. Society has an obligation to educate pregnant women as to the harmful effects of prenatal substance abuse on their fetuses so that they may act responsibly to protect their fetuses. Thus, by guaranteeing prenatal care to all pregnant women, society would provide the preconditions necessary for private responsibility.

Some state legislatures have recognized the social duty to care for and aid pregnant women by adopting holistic approaches to the social problem of substance addiction during pregnancy.²¹⁶ For example, Washington State passed the "Maternity Access Bill" in 1989 which provides substantial funding for drug and alcohol treatment programs.²¹⁷ This program caters to the needs of pregnant women and gives them priority status for receipt of treatment services.²¹⁸

Wisconsin, in 1989, appropriated funds for the dissemination of information regarding the effects of substance addiction during pregnancy and available treatment.²¹⁹ In addition, the Wisconsin legislature provided funding for comprehensive alcohol and drug treatment, including prenatal care, for pregnant women addicted to alcohol or drugs.²²⁰ In 1989, the Oregon state legislature also provided funding to serve the unique needs of pregnant women. The funding provided for the biological needs of pregnant women, such as detoxification, dietary, and obstetrical services, along with the physical and psychological needs, such as child care, transportation, housing assistance, and education.²²¹

215. See Stovall, *supra* note 89, at 1277 n.67 (citing Elizabeth Rosenthal, *Despite More Funds, Women Face Barriers to Prenatal Care*, N.Y. TIMES, Jan. 6, 1993, at C12) (discussing obstacles to women's access to prenatal care including lack of organization in public health facilities, long waits to see medical personnel and other socio-economic factors such as education, or single parent status).

216. WASH. REV. CODE ANN. § 74.09.760 (West 1989 & Supp. 1995).

217. *Id.*

218. See Horowitz, *supra* note 102, at 8 (discussing the various programs recently enacted in states like Washington which sought to expand its drug treatment program for pregnant women).

219. Horowitz, *supra* note 102, at 8.

220. Horowitz, *supra* note 102, at 8.

221. Horowitz, *supra* note 102, at 8.

State health officials in Maryland recognized the need for holistic treatment of substance addiction during pregnancy when they provided \$1,050,000 as initial funding for The Center for Addiction and Pregnancy at Francis Scott Key Medical Center.²²² This Center is one of the few treatment programs in the nation which adopts a multi-disciplinary approach to the treatment of substance-addicted pregnant women. The main goal of the Center is to "give the children of drug addicts a more promising start," while at the same time, "improv[ing] their mother's lives."²²³ The philosophy of the Center is that, in order to achieve this goal, it must provide patients with more than just treatment for substance-addiction. Thus, in conjunction with addiction treatment, the Center provides both prenatal care and child care services.²²⁴ In addition, the Center informs its patients of proper nutrition during pregnancy and the use of reliable birth control. Perhaps most importantly, the Center teaches vital parenting skills and emphasizes the importance of nurturing the mother-child bond.²²⁵

The Center for Addiction and Pregnancy is an entirely voluntary program. Women seeking treatment are usually accepted into the program within forty-eight to seventy-two hours of their initial request for admission.²²⁶ While the Center is a sixteen bed-unit, the structure of the program enables the Center to treat more than sixteen patients at one time. Patients are treated on an in-patient basis only for the first seven days of their treatment.²²⁷ After this initial period, patients are given "intensive out-patient care." That is, they come to the Center each day to receive multi-disciplinary treatment and return to their homes each evening. The Center provides transportation for its patients to ensure that they are able to receive their daily treatment.²²⁸ The highest percentage of "drop-out"

222. See Amy Goldstein, *A Fresh Start and a New Life: State-Funded Center Molds Drug Treatment and Prenatal Care to Help Recovering Addicts and Their Babies*, WASH. POST, June 11, 1992, at M1. In May of 1994, the name of the program discussed in this article was changed to the Center for Addiction and Pregnancy at Johns Hopkins Bayview Medical Center.

223. See *id.* (asserting that seventy percent of all babies born drug addicted suffer from some form of learning or health disability and the Center works towards producing healthier mothers and babies).

224. *Id.*

225. Telephone interview with Lisa Weinstein, Intake Coordinator for the Center for Addiction and Pregnancy (May 1994) [hereinafter *Telephone interview with Ms. Weinstein*]. The author was informed prior to the publication of this paper that Ms. Weinstein was no longer employed by the Center.

226. *Telephone interview with Ms. Weinstein, supra* note 225.

227. *Telephone interview with Ms. Weinstein, supra* note 225.

228. *Telephone interview with Ms. Weinstein, supra* note 225.

occurs during the transition from in-patient care to out-patient care.²²⁹ In order to combat this, the Center has developed incentive programs to encourage women to continue their treatment beyond the initial seven days. For example, women who return for out-patient treatment are eligible to win weekly drawings and receive prizes. Such incentive programs have been helpful in decreasing the drop-out rate during this transition period.²³⁰

As of 1994, the success of the Center is proven by the fact that, on average, the babies born there are heavier and closer to term.²³¹ The reason for the success of the Center is undoubtedly its multi-disciplinary approach to treatment.²³² In order to effectively treat pregnant substance-addicted women who have limited resources, treatment programs must provide prenatal care, child care, transportation and educational opportunities.²³³

Skeptics may argue that such holistic approaches to the problem of substance abuse during pregnancy may be sound in theory, but are not practical because they are too expensive. However, this argument fails in light of the extraordinary cost of providing the necessary medical attention and special education for children born addicted to substances. The increase of social funding to eradicate drug-addiction during pregnancy by aiding drug-addicted women cannot be rejected as too expensive given the costs which society already incurs as a result of the problem of substance-addiction during pregnancy.

States who have used involuntary civil commitment to address the problems of substance abuse during pregnancy should not be faulted entirely. At least, through commitment laws, states are recognizing the need to allocate funding towards the treatment of addicted women in order to help them in their unique role as child bearers. However, forced civil commitment of pregnant women is, at best, a band-aid solution to the problem of drug addiction during pregnancy. Furthermore, it is an unjust solution in light of the lack of resources presently available to many pregnant women, as well as the current male-centered structure of most treatment facilities. Rather than allocating funding for forced civil commitment, state legislatures must devote funds toward facilitating the choices of pregnant women by providing them with financial, physical, emotional, and educational

229. Telephone interview with Ms. Weinstein, *supra* note 225.

230. Telephone interview with Ms. Weinstein, *supra* note 225.

231. Telephone interview with Ms. Weinstein, *supra* note 225.

232. Telephone interview with Ms. Weinstein, *supra* note 225.

233. Telephone interview with Ms. Weinstein, *supra* note 225.

support. There is an undeniable need to increase social programs in this area. Parenting is the most important job in our society. Society has an affirmative obligation to offer the necessary assistance and care so that all woman and their partners may have the opportunity to have healthy babies.

