INHERITING YOUR MOTHER'S EYES, HAIR, AND DRUG ADDICTION: PROTECTING THE DRUG-EXPOSED NEWBORN BY CRIMINALIZING PREGNANT DRUG USE

Alexana Gaspari

Despite the absence of statutory criminalization of drug use during pregnancy in the majority of states, states are increasingly recognizing that drug abuse is a massive economic and social problem. Tennessee is the first state to implement a statute that specifically addresses the issue of pregnant drug users by criminalizing those whose use harms their child. Because drug abuse may involve addiction in many cases, the statute provides a defense to those who take reasonable steps to seek help and get clean before the child is born. This Note examines the criminal aspect and impact of drug use during pregnancy and proposes that each state adopt the Tennessee statue, while ensuring pregnant mothers access to drug treatment and assessment through drug courts. Drug use is illegal and drug use during pregnancy should be criminalized as well.

Key Points for the Family Court Community:

- The impact of drug abuse during pregnancy causes unhealthy babies, which creates a financial and social burden on the state.
- Drug use during pregnancy is associated with many risks including mortality, low birth weight, and Neonatal Abstinence Syndrome.
- The goal of incentivizing healthy births can be achieved through a specific statute criminalizing drug use during pregnancy.
- The Tennessee statute provides an affirmative defense for mothers who are actively enrolled in an addiction recovery program before the child is born and successfully complete the program. While still approaching addiction as a disease, this methodology will incentivize pregnant drug users to seek help before birthing an unhealthy child.

Keywords: *Addiction; Criminalization; Drug Abuse; Drug Rehabilitation; Drug Use; Neonatal Abstinence Syndrome; Pregnancy; and Pregnant Drug Use.*

I. INTRODUCTION

On Sunday, July 6, 2014, Mallory Loyola gave birth to a baby girl.[1] Within hours of being born, that baby tested positive for methamphetamine (meth).[2] Meth abuse during pregnancy can lead to increased rates of premature delivery, placental abruption, small size, lethargy, mortality, heart and brain abnormalities, and neurobehavioral problems throughout life.[3] On July 8, 2014, Mallory Loyola was arrested and charged with simple assault under Tennessee's 2014 statute criminalizing pregnant drug use.[4] She pled guilty to a probation violation and was mandated by the drug court to a drug rehabilitation program.[5] The court dismissed her case in February 2015 after she completed a program at Helen Ross McNabb Center and stayed out of trouble for six months.[6]

Tennessee is the first state in the United States to criminalize pregnant drug use.[7] Although Mallory Loyola is the first to face criminal charges for her pregnant drug use, she certainly will not be the last.[8] Based on data averaged across 2012 and 2013 in the United States, 5.4% of pregnant women aged fifteen to forty-four are current illicit drug users.[9] Research from the University of Michigan has revealed that one baby is born every hour addicted to opiate drugs in the United States.[10] Newborns with drug addiction experience longer and more costly hospitalizations than

Correspondence: agaspa8@pride.hofstra.edu

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healthy babies, and the majority of hospital expenditures for this condition are paid for by the state through Medicaid programs.[11] The increasing incidence of drug addicted babies is a serious social problem, and Tennessee is engaged in a useful experiment to analyze whether criminalization is a suitable approach to the problem.[12] In order to reduce antenatal exposure to illegal drugs across the United States, pregnant drug users who do not seek help before her baby is born must be criminalized to create a deterrent and mandated rehabilitation.[13]

This Note proposes that states carefully monitor the implementation of the Tennessee statute and consider its implications in their own states. The Tennessee statute implements criminal assault penalties on a woman for the "illegal use of a narcotic drug while pregnant if her child is born addicted or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant."[14] The statute specifically addresses only those women who birth a child; therefore, pregnant women can still decide to abort the fetus within the limits of Tennessee law.[15] It is the legislative intent that this law will still allow a woman to have the choice to abort the fetus within the limits of Tennessee law.[16] Additionally, the statute provides an affirmative defense for mothers actively enrolled in an addiction recovery program before the child is born and who successfully complete the program.[17] In order to track the impact of the law on mothers and babies in each specific state, the proposal contains a sunset provision in two years to review the statute's overall effect.[18] Every state should adopt the Tennessee statute to ensure a criminal deterrent that also provides access to drug treatment for pregnant women using drugs. The statute should be comprehensively evaluated, as is currently provided, after two years of implementation. This will allow individual states choosing to adopt this legislation to modify and amend it in accordance with their needs.

Part II of this Note provides a background to the growing number of babies being born addicted to drugs and its effects on society, the child's health, the parents, and the state. Part III of this Note discusses the implementation of the Tennessee statute to combat neonatal abstinence syndrome (NAS). Part IV of this Note explores the current state of the law and shows that states are conflicting in their solution to this problem. For example, some states, such as Colorado, consider drug abuse during pregnancy to be a civil wrong, like abuse or neglect.[19] Others, like Alabama, have upheld criminal convictions for pregnant substance abuse.[20] Part V of this Note offers a solution to protect drug addicted babies by proposing that states adopt the Tennessee statute.[21] The national yearly increase in babies that were born drug addicted calls for a novel experiment, such as the Tennessee statute, which should be implemented and carefully coordinated with drug courts to make sure that the promise of drug treatment is assured.[22] Part VI considers potential counterarguments including the costs associated with the proposal, the equal protection clause of the U.S. Constitution, any harmful effects to babies, and a woman's right to individual privacy rights. Part VII of this Note concludes that implementing the Tennessee statute in each state is a potentially advantageous way to provide rehabilitation to mothers and solve the problem of drug use during pregnancy.

II. BACKGROUND INFORMATION ON NEWBORNS WITH NAS

A. NAS

A newborn suffers from NAS when exposure to certain drugs in utero creates drug withdrawal after birth.[23] This occurs when the baby's drug consumption is abruptly stopped when the child is detached from the mother's umbilical cord.[24] Because the baby has developed physical dependence on the drug, the newborn may develop a drug withdrawal syndrome known as NAS.[25] The syndrome most commonly occurs in the context of antepartum opiate use, but other drugs have also been implicated.[26] In addition to giving rise to NAS, illicit drug use during pregnancy is associated with a significantly increased risk of other neonatal issues such as low birth weight and mortality.[27]

Symptoms of NAS have been described in sixty to eighty percent of newborns exposed to heroin or methadone in utero.[28] These newborns experience irritability, hypertonia, tremors, feeding intolerance, emesis, watery stools, seizures, and respiratory distress.[29] Heroin-exposed infants may

demonstrate symptoms within twenty-four hours of birth.[30] A 2012 study in the *Journal of the American Medical Association* (*JAMA*) showed that between 2000 and 2009 the rate of newborns diagnosed with NAS increased from 1.20 to 3.39 per 1,000 hospital births per year.[31] This is consistent with the number of mothers using opiates, which increased from 1.19 in 2000 to 5.63 in 2009 per 1000 hospital births per year.[32]

JAMA published a study showing that, on average, hospital charges for newborns with NAS are about five times more than charges for newborns without NAS.[33] From 2000 to 2009, the cost of health care for newborns diagnosed with NAS rose significantly from $190 million to $720 million.[34] In 2009, the average hospital bill for a baby with NAS was $53,400 compared to the hospital bill of a baby without NAS that is approximately $9,500.[35] According to the University of Michigan, that cost is primarily incurred by the state.[36] By 2009, 77.6 percent of charges for babies with NAS were covered by Medicaid for healthcare costs.[37]

In addition to the financial costs, NAS comes at a very high emotional cost.[38] Symptoms of NAS often begin within one to seven days after birth.[39] Symptoms include excessive crying, high-pitched crying, diarrhea, fever, seizure, rapid breathing, hyperactive reflexes, and vomiting, among others.[40] In order to treat a drug addicted baby, the child must be placed in a monitoring area to be continuously examined for symptom persistence.[41] When nonpharmacological support is not enough, pharmacological management is utilized to relieve moderate to severe signs of NAS and prevent complications.[42] The first-line therapy for opioid withdrawal is treatment with an opiate such as morphine or methadone.[43]

B. RISKS ASSOCIATED WITH SPECIFIC DRUG USE DURING PREGNANCY

Drug use during pregnancy is severe because it affects two people.[44] The range of risks can vary anywhere from miscarriage to maternal death.[45] As drug use causes definite harm, each drug creates its own mark when taken while pregnant.[46]

Marijuana, for example, crosses the placenta to the fetus.[47] The smoke increases the levels of carbon monoxide and carbon dioxide in the blood, which in turn reduces the oxygen supply to the fetus.[48] The toxins from the marijuana prevent the fetus from obtaining the proper supply of oxygen necessary to survive.[49] It has been noted that smoking marijuana during pregnancy can increase the chance of miscarriage, low birth weight, premature births, developmental delays, and behavioral and learning problems.[50]

Frequent use of cocaine is a serious risk for birth defects anywhere from small head development to growth restrictions.[51] Cocaine use in the early stages of pregnancy can dramatically increase the risk of miscarriage.[52] Later in pregnancy, it can cause placental abruption, which causes problems such as severe bleeding, preterm birth, and fetal death.[53] Specifically, pregnant cocaine users have a 25% increased chance of premature labor.[54] Babies born with cocaine exposure may be born with NAS; have learning difficulties; and/or have defects in the genitals, kidneys, and brain.[55]

Heroin and methamphetamine are two other major causes of NAS, leading to newborn drug withdrawal.[56] Pregnant heroin exposure increases the chance of premature birth, low birth weight, breathing difficulties, hypoglycemia, intracranial hemorrhage, and infant death.[57] Use of methamphetamine also increases the likelihood of low birth weight, premature labor, miscarriage, and placental abruption.[58]

III. IMPLEMENTATION OF THE TENNESSEE STATUTE TO COMBAT NAS

In Tennessee, opiate addiction has become a major problem.[59] The Tennessee Department of Health has reported that the ranking of the top three drugs, named as a primary substance of abuse, changed dramatically from 1999 to 2009: opioid abuse in Tennessee is greater than abuse of marijuana or crack/cocaine.[60] In addition to the state's increase in opiate use, the state has seen an increase in NAS patients.[61] In 2013, 921 newborns were born dependent on drugs their mothers used while pregnant.[62] In 2014, that number increased to 973.[63] So far in 2015, as of January 31, there are already 43 cases reported; a number that is already up from the 39 reported by January 25 in 2014.[64]

Since 1989, Tennessee has struggled with amending and editing the state's fetal homicide laws to create a regulation that specifically addresses the drug issues concerning pregnant mothers.[65] On February 14, 2013, Tennessee Pregnancy Criminalization Law, House Bill 1295, was created to amend Tennessee's fetal homicide law to allow a woman to be prosecuted if her child is born addicted to or harmed by her illegal use of a narcotic drug taken while pregnant.[66] This is the companion bill to SB 1391, which Governor Haslam signed into law on April 29, 2014.[67]

The Tennessee statute, issued by Governor Haslam, has only been effective since July 2014 and provides that a woman can be charged with a misdemeanor if her baby is harmed as a result of her illegal use of narcotics during pregnancy.[68] The Tennessee Department of Health explained the intent of the statute is to "give law enforcement and district attorneys a tool to address illicit drug use among pregnant women, through treatment programs including drug courts and particularly in egregious cases such as more than one NAS delivery."[69] The statute allows women to be charged with aggravated assault, which carries a maximum penalty of fifteen years in prison, if their illegal use of drugs results in a pregnancy complication.[70] The state is also committed to tracking the impact of the law on mothers and babies and contains a sunset provision in two years.[71]

A. THE TENNESSEE STATUTE AND ITS RELATIONSHIP WITH DRUG COURTS

Drug courts are specialized courts that operate under a specialized model in which the judiciary, law enforcement, and treatment facilities work together to help nonviolent offenders recover from drug addiction and become productive citizens.[72] In drug court, individuals are forced to complete a drug rehabilitation program under the supervision of the court, as an alternative or addition to jail.[73] If the offender succeeds with treatment, charges against her may be dropped. If she does not comply with program requirements, she is reviewed by the court and sanctioned.[74]

Drug courts work hand in hand with rehabilitation centers.[75] In Tennessee, many of these treatment agencies are paid for by the state and give priority admissions to pregnant intravenous drug users, pregnant substance users, intravenous drug users, and even medically monitored withdrawal management.[76] There are a total of eighty-two state-funded drug rehab centers in Tennessee.[77]

Through the mandating and close monitoring of rehabilitation, drug offenders are able to get the help they need while complying with the law.[78] The legislative intent of the Tennessee statute involves the use of drug courts to rehabilitate nonviolent, remorseful offenders, keeping them out of jail and with their families.[79] Not all drug offenders are eligible for drug court, and worse cases, such as more than one NAS delivery or a blatant disregard for newborn health, will be taken into account.[80]

B. TWO-YEAR SUNSET EVALUATION IN THE TENNESSEE STATUTE

Because the number of newborns with NAS is on a quick and constant rise in the United States, a hurried response is appropriate.[81] One baby is born every hour addicted to opiate drugs in the United States, so a response is necessary within the hour.[82]

Each state should implement the Tennessee statute immediately, with a two-year sunset provision to analyze the results and adjust the law accordingly to fit the needs of that state. For example, the Tennessee Department of Health has reported a statewide increase in drug users and NAS patients.[83] Through careful monitoring and reporting, Tennessee and other states can adjust the statute in regard to the number of illegal drug users and affected babies and program costs, and amend the statute as necessary.

IV. CURRENT STATE OF THE LAW CONCERNING PREGNANT DRUG ABUSE ON A NATIONAL LEVEL

Many states classify prenatal drug exposure as child abuse or neglect, treating the issue as more of a civil matter than criminal.[84] Eighteen states[85] consider substance abuse during pregnancy to be

child abuse under civil child-welfare statutes, and three[86] consider it grounds for civil commitment, such as forced admission to an inpatient treatment program. For example, in Minnesota, the court may order early intervention treatment if the court finds by clear and convincing evidence that a pregnant woman is a chemically dependent person.[87] Four states prohibit publicly funded drug treatment programs from discriminating against pregnant women.[88]

Fifteen states[89] require health care professionals to report suspected prenatal drug abuse, and five states[90] require them to test for prenatal drug exposure if they suspect abuse.[91] For example, Wisconsin requires health care professionals who suspect fetal alcohol syndrome to test the infant and report to the agency responsible for conducting child abuse and neglect investigations.[92] In 2001, the U.S. Supreme Court in *Ferguson v. City of Charleston* held that it is a violation of the Fourth Amendment for a hospital regulation to require pregnant women to be tested for drugs and be reported to the police if the test results are positive.[93] This is a violation of searches without probable cause.[94] However, the case only addressed the issue of evidence collection for criminal prosecution of pregnant women, remaining silent on the more general question of whether such prosecutions are permissible.[95]

Nineteen states have either created or funded drug treatment programs specifically targeted[96] to pregnant women, and eleven provide pregnant women with priority access[97] to state-funded drug treatment programs. Some states, including Tennessee, have utilized federal funds to make drug treatment more readily available to pregnant women.[98]

Tennessee is the only state to specifically criminalize drug use during pregnancy through a statute.[99] However, supreme courts in Alabama and South Carolina have both upheld convictions ruling that a woman's substance abuse in pregnancy constitutes criminal child abuse.[100] Some states have treated the issue as one of civil rather than criminal law by including prenatal drug exposure as grounds for terminating parental rights.[101] These states consider prenatal drug exposure to be abuse or neglect.[102] On the other hand, some states authorize a civil commitment procedure of forced admission to an inpatient treatment program for pregnant women who use drugs.[103] Many states require that health care professionals report or test for prenatal drug exposure.[104] Lastly, some states, including Tennessee, have utilized federal funds to make drug treatment more readily available to pregnant women.[105]

Tennessee is the only state that currently allows criminal assault charges to be filed against a pregnant woman who uses certain illegal substances.[106] Specifically, Tennessee Code Section 39-13-107 classifies victims of the law to include an embryo or a fetus.[107] The law targets women for the "illegal use of a narcotic drug. . .while pregnant, if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant."[108] Under this law, the woman is not criminalized for using drugs while pregnant if the child is not born.[109] Further, the statute states, that "it is an affirmative defense to a prosecution permitted by subdivision (c)(2) that the woman actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program, regardless of whether the child was born addicted to or harmed by the narcotic drug."[110] The law creates a carve-out defense for those who genuinely seek help through a rehabilitation facility.

Both Alabama and South Carolina supreme courts have upheld convictions of pregnant women for drug use during pregnancy.[111] In *Whitner v. State,* the South Carolina supreme court held that cocaine use while pregnant constitutes child abuse.[112] Whitner gave birth to a child that had tested positive for cocaine.[113] She pled guilty to criminal child neglect for using cocaine while pregnant and was sentenced to serve eight years in prison.[114] The court held that child abuse is defined by whether the action is likely to endanger the child, even if the underlying act by itself is legal.[115]

In her defense, Whitner argued that if the word "child" is to include a viable fetus, than every action by a pregnant woman, legal or not, would constitute unlawful neglect.[116] The court disagreed:

> After the birth of a child, a parent can be prosecuted. . .for an action that is likely to endanger the child without regard to whether the action is illegal in itself. For example, a parent who drinks excessively could, under certain circumstances, be guilty of child neglect or endangerment even though the

> underlying act—consuming alcoholic beverages—is itself legal. Obviously, the legislature did not think it "absurd" to allow prosecution of parents for such otherwise legal acts when the acts actually or potentially endanger the "life, health or comfort" of the parents born children. We see no reason such a result should be rendered absurd by the mere fact the child at issue is a viable fetus.[117]

Whether the child has already been born or will be born makes no difference in the court's eyes.[118] A parent has a responsibility not to endanger the life, health, and comfort of her/his child, before or after birth.[119]

In 2011, in Alabama, Hope Ankrom gave birth to a baby boy who tested positive for cocaine.[120] In *Ankrom v. State,* the grand jury indicted Ankrom and she was found guilty of chemical endangerment of a child.[121] The indictment stated that Ankrom "did knowingly, recklessly, or intentionally cause or permit a child. . .to be exposed to, ingest or inhale, or to have contact with a controlled substance, chemical substance, or drug paraphernalia."[122] Alabama did not have a statute specifically criminalizing drug use while pregnant, but the state still found fetal cocaine exposure to be child abuse.[123]

Similar to Whitner in *Whitner v. State,* Ankrom argued that the word "child" does not encompass a fetus.[124] The Alabama court analyzed *Whitner v. State* and appellate court decisions in Alabama and in other states and consulted Webster's dictionary. It concluded that a child does in fact encompass a fetus.[125]

V. PROPOSAL TO PREVENT NEWBORN DRUG AFFECTED HARM

States should implement criminal penalties for women who give birth to a child who is born harmed by drugs.[126] State solutions for women ingesting harmful substances while pregnant currently range radically from prioritizing pregnant women for drug rehabilitation to an approach that allows drug addicted mothers to constantly enter the rehabilitation system without actually having been rehabilitated.[127] Such remedies are inadequate, as they do not provide help to the baby until it is too late and the child is born with drug related problems.

The criminalization of drugs in the United States has usually worked parallel to the goals of reducing drug use, crime, and dependency.[128] The basis for opposing the use of drugs generally includes the fact that drug related activity produces certain social costs in terms of deaths, diminished social productivity, increased healthcare costs, and crime.[129] Criminalization is also a tool of safety and retribution.[130] Under the Tennessee statute's affirmative defense provision, a woman who finds herself pregnant while using drugs is encouraged to seek help for herself and her soon-to-be-born child.[131] Therefore, criminal liability on pregnant substance abusers is only imposed as a last resort.[132] The carve-out defense for women in rehab serves as a deterrent and a last-minute safety net to the unborn child and the mother who wishes not to go to jail.[133]

According to the Model Penal Code, assault is defined as "intentionally putting another person in reasonable apprehension of an imminent harmful or offensive contact. No intent to cause physical injury needs to exist."[134] By intentionally taking drugs while pregnant, the woman has made the conscious choice to expose her child to reasonable apprehension of imminent harm.[135] In order to punish violators of crimes such as assault, the criminal justice system consists of three features: investigating crimes, prosecuting the accused, and guaranteeing a fair trial.[136] The goal of these features is retribution, incapacitation, deterrence, and rehabilitation.[137] This proposal fits the purpose of all four goals of criminalization.

A. THE TENNESSEE STATUTE AS A DETERRENT AND MOTIVATION FOR REHABILITATION

The Tennessee statute exists as a deterrent.[138] Deterrence infers that fear discourages a crime.[139] The law punishes an offender in order to dissuade the public from committing this crime in the

future. The problem with creating this law as a deterrent is when the offender is not just a user, but an addict.[140] Addiction is a disease recognized by the medical community.[141] It is a brain disorder "that causes compulsive drug seeking and use, despite harmful consequences to the addicted individual and to those around him or her."[142] It is important to understand however that not all drug users are addicts.[143] The Tennessee statute can also act as a deterrent to those who are not addicted and have the control to stop. It can also deter the pregnant addict from having her baby without seeking rehabilitation treatment.

B. RETRIBUTION FOR FETAL ASSAULT

Although addiction is a medical disease, the initial decision to take drugs is usually voluntary.[144] Retribution appeases the moral outrage of a society by ensuring that criminal offenders are given their just desserts.[145] Through the retribution theory, criminal punishment is meant to restore justice "through proportional compensation from the offender."[146] Taking drugs while pregnant places the fetus into imminent harm, constituting assault.[147] In order to restore justice, imposing criminal liability on such an act satisfies the retribution theory by ensuring that any woman who assaults her fetus by taking drugs faces the rational consequences.

C. INCAPACITATING FETAL-ASSAULTING CRIMINALS

Incapacitation includes protecting the public by getting criminals out of the community.[148] Taking drugs while pregnant imposes serious health risks on the child once s/he is born.[149] This creates a financial burden on society and creates an unhealthy society.[150] The Tennessee statute promotes the goal of incapacitation by imposing criminal penalties on those who do drugs while pregnant and refuse to seek help.[151] By default, the law removes unfit mothers from the community and prevents repeat offenses.

D. PROMOTES REHABILITION FOR THE PREGNANT DRUG USER AND HER CHILD

The Tennessee statute promotes rehabilitation,[152] especially if there are adequately funded treatment programs that are coordinated with the court system, as in Tennessee.[153] Rehabilitation calls for changing the individual lawbreaker through correctional interventions.[154] For years, scientific research has shown that "treatment is the best way to help patients addicted to drugs stop using, avoid relapse, and successfully recover their lives."[155] Remaining in treatment for an adequate time is critical.[156] That is why the carve-out defense requires the person to successfully complete the rehabilitation program.[157] Unfortunately, however, a study from the National Institute on Drug Abuse shows that forty to sixty percent of drug addicted patients relapse.[158] Therefore, rehabilitation alone is inadequate, as it allows a mother to continue her destructive behavior if she does not successfully complete the program.

VI. COUNTERARGUMENTS AND POTENTIAL PROBLEMS WITH THE TENNESSEE STATUTE

A. EQUAL PROTECTION UNDER THE U.S. CONSTITUTION

The Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution prohibits the states from denying to any person the equal protection of the laws.[159] It can be argued that criminalizing pregnant drug use makes pregnant women a group that will be treated differently from other citizens in the eyes of the law.[160] Unlike crimes such as drug possession or child abuse laws, no man can ever be charged with pregnant drug use.[161] *Reed v. Reed* established that the Fourteenth

Amendment creates the right to be free from gender discrimination and prevents preferential treatment to individuals on the basis of sex.[162]

However, all classifications based on sex are not unconstitutional.[163] The equal protection clause of the Fourteenth Amendment does allow states to treat certain classes of persons in different ways, as long as the state meets a distinct level of scrutiny.[164] The law recognizes that there are differences between men and women, and legitimate accommodations for those differences are permitted.[165] Gender classifications are reviewed under intermediate scrutiny, which means that the state has the burden of proving that the discriminatory law is sufficiently related to an important government interest.[166]

The Tennessee statute is not unconstitutional because it passes the intermediate scrutiny test.[167] There is a state interest in protecting newborn children from being addicted to drugs.[168] With the national rise of newborn babies addicted to drugs, the Tennessee statute combats this public health problem.[169] Because women, not men, can physiologically affect a fetus through drug use, this law is specific to women. There is exceedingly persuasive justification for the law because it is the mother's drug use that directly harms the child.

Only a law that specifically targets the problematic behavior can effectively influence the desired result.[170] Because the problem does not include men or any other class of people aside from pregnant women, this law is constitutional.

B. POTENTIALLY HARMFUL TO BABIES

Opponents of the Tennessee statute are concerned with its efficacy at helping the babies at risk.[171] Specifically, it is argued that women will not get prenatal care because they will fear going to jail.[172] Instead of not doing drugs, it is thought that drug abusing pregnant women will avoid doctors at all costs to keep themselves out of trouble.[173]

The intent of the law is to provide help to women who have been consumed by drugs and desire support, while punishing those who lack any remorse.[174] In many instances, it is not that pregnant drug users do not care about their children, it is that they need the threat of a criminal sanction to enter a rehabilitation program.[175]

According to Governor Bill Haslam of Tennessee, the reason for the law is "to give law enforcement and district attorneys a tool to address illicit drug use among pregnant women through treatment programs."[176] Additionally, the proposal calls for reassessment in two years, allowing officials to collect data concerning the impact on babies and mothers in the state.[177]

If the health of a newborn is not enough to get the mother to seek prenatal care, the proposal's carve-out affirmative defense for those who seek and complete a drug rehabilitation program should be the extra incentive. By providing a second-chance approach to those who truly care about a healthy future for their children, the rehabilitation part of the law does not create a fear of jail, but instead should instill a desire to avoid it.

C. A WOMAN'S INDIVIDUAL PRIVACY RIGHTS: THE RIGHT TO AUTONOMY

It has been argued that Tennessee Code Section 39-13-107 intrudes on a woman's personal autonomy and reproductive rights and that fetal rights should not be advanced at the expense of women's rights.[178] The U.S. Constitution does not specifically grant the right to privacy, but the Supreme Court has recognized that the right of personal privacy does indeed exist.[179] For example, the Fourteenth Amendment states, "no state shall. . . deprive any person of life, liberty, or property, without due process of the law."[180] This concept of personal liberty is the basis of the *Roe v. Wade* decision.[181] The Supreme Court recognized such a fundamental right in relation to women's rights.[182]

Roe v. Wade ultimately clarified that the word "person," as used in the Fourteenth Amendment, "does not include the unborn."[183] Specifically, *Roe* held that the constitutional "right of privacy is

broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The detriment that the State would impose upon the pregnant woman by denying this choice all together is apparent."[184] The protection granted in *Roe* remains as the foundation of freedom for American women.[185]

However, a woman's right to terminate pregnancy is not absolute and is subject to limitations.[186] "At some point the state interests as to protection of health, medical standards, and prenatal life, become dominant."[187] Particularly, the Court in *Roe v. Wade* held that the regulation limiting certain fundamental rights may be justified by a compelling state interest.[188] The Tennessee statute does not deny any woman the right to an abortion by Tennessee law.[189]

The Tennessee statute does not intrude on a woman's personal autonomy and reproductive rights and does not advance fetal rights at the expense of women's rights.[190] *Roe v. Wade* established that the state's determinations to protect health or prenatal life are dominant and constitutionally justifiable.[191] Women's rights are crucial to the benefit of society, as are fetal rights and rights of a newborn.[192] There is a major state interest in protecting babies being born with NAS or other drug related issues.[193] By criminalizing pregnant drug use through the Tennessee statute, a woman still has a choice: the choice to have an abortion or the choice to give birth, the choice to take drugs or the choice not to take drugs, the choice to seek and fully commit to rehabilitation or the choice to face criminal charges.[194]

D. COSTS ASSOCIATED WITH THE PROPOSAL

Criminalizing pregnant drug use will create an increase in taxpayer expenditures for prisons.[195] State expenses for rehabilitation centers and foster care services will also increase.[196] However these costs will, in time, deter future offenders and reduce the number of newborns with NAS, thereby creating a healthier society.

The average cost of incarcerating a prisoner in the United States varies by state.[197] For example, Indiana pays around $14,000 per inmate, while New York pays about $60,000.[198] Unfortunately, running the American prison system is expensive and has been increasingly so.[199] According to a Vera Institute of Justice study, in fiscal year 2010, the number of those incarcerated has cost the tax payer about $39 billion.[200]

Rehabilitation costs are considerable as well. Pregnant women with drug addictions require a specialized addiction treatment plan.[201] Non-opiate detox during pregnancy is safe for both the mother and child; difficulties arise for women who are pregnant and addicted to opiates.[202] States need to help fund facilities that specialize in pregnant drug abuse so that the woman and her child can get the proper help.[203] Methadone maintenance treatment is the standard of care for opioid-dependent pregnant women, but Buprenorphine, which acts as an opioid receptor agonist at low doses and as either an agonist or antagonist at high doses, is also an option for medication-assisted therapy.[204] State health agencies can help optimize service delivery and treatment capacity to ensure women have access to the necessary services in a timely manner.[205] It is important to note that methadone exposure in utero may also result in NAS incidences, but maternal methadone doses have not been consistently found to correlate with the severity of NAS.[206] That is why it is so important to have a pregnant woman treated by the proper facility.[207]

Already in place are federal Substance Abuse Prevention and Treatment Block Grants, which require that states set aside a certain proportion of their block grant funds for services designed for pregnant women and women with dependent children.[208] Many states have either created or funded drug treatment programs specifically targeted to pregnant women, and some even provide pregnant women with priority access to state-funded drug treatment programs.[209] Iowa, Kansas, Missouri, and Oklahoma prohibit publicly funded drug treatment programs from discriminating against pregnant women.[210]

A minor increase in expenses for state foster care services is expected when a mother is imprisoned for her pregnant drug abuse. However, many states already classify prenatal drug exposure as

child abuse or neglect, leaving the child in foster care nonetheless.[211] It is important to note that most children in foster care leave the system by returning to their families or being adopted.[212]

In a 2009 article, *Investment in Early Childhood Development Lays the Foundation for a Prosperous and Sustainable Society,* Jack P. Shonkoff, M.D. suggests:

> Early intervention can prevent the consequences of early adversity. Research shows that later interventions are likely to be less successful—and in some cases are ineffective. For example, when children who experienced extreme neglect were placed in responsive foster care families before the age of two, their IQs increased more substantially and their brain activity and attachment relationships were more likely to become normal than if they were placed after the age of two. While there is no "magic age" for intervention, it is clear that, in most cases, intervening as early as possible is significantly more effective than waiting.[213]

A child's environment from pregnancy to childhood affects cognitive, emotional, and social development.[214] Children require safe, stable, drug-free environments.[215]

The Tennessee statute can test whether deterring and rehabilitating pregnant drug users from harming their soon-to-be newborn can actually reduce the number of babies born with NAS and drug related illnesses. This in turn will decrease state expenditures on treatment for newborns with NAS, which is about five times higher than charges for babies with normal hospital births.[216]

Deterring maternal drug use can help to create a healthier society overall. The benefit of having a healthier society includes a more productive workforce, more productive schools, a less burdened health-care system, disease prevention, and increased overall happiness.[217] Investment in early childhood development lays the foundation for a prosperous sustainable society.[218] The costs associated with the Tennessee statute are minimal in comparison to the costs associated with an unhealthy, drug addicted society.

VII. CONCLUSION

The best way to conquer pregnant drug abuse is for each state to implement the Tennessee statute. After implementing it for two years, each state should then adjust the statute to reflect the needs of that state. The importance of encouraging healthy citizens in society has unlimited benefits and encouraging healthy births is a goal that should be implemented in every state.

NOTES

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19. Colo. Rev. Stat. Ann. § 19-3-102 (West 2015).

20. Whitner v. State, 328 S.C. 1, 492 S.E.2d 777 (1997); *Ex parte* Ankrom, No. CC-09-395 & No. CC-08-381, 2013 WL 135748, at 1–2 (Ala. Jan. 11, 2013).

21. *See* Tenn. Code Ann. § 39-13-107 (2014).

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27. Barry Zuckerman, *Drug-Exposed Infants: Understanding the Medical Risk,* 1 The Future of Child 26, 28 (1991) (citing Inst. of Medicine, Preventing Low Birth Weight Summary (1985)) ("An infant described as 'low birth weight' weighs less than 2500 grams at birth; a 'very low birth weight' infant weighs less than 1500 grams. Low birth weight is a major factor in infant mortality in the U.S. Infants weighing 2500 grams or less are almost 40 times more likely to die during their first 4 weeks of life than the normal birth weight infant. Low birth weight infants are 5 times more likely than normal birth weight infants to die later in the first year and account for 20% of post neonatal deaths. The two major contributors to low birth weight are preterm birth and intrauterine growth retardation (IUGR). Both contribute to inadequate fetal growth. A birth is considered preterm if it has a duration of less than 37 weeks from the last menstrual period. IUGR refers to low weight for a given duration of gestation.").

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50. *Id*.
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57. *Id*.
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59. Rodney L. Bragg, *Prescription drug abuse in Tennessee*, http://tn.gov/mental/policy/persc_drug_docs/Prescription%20Drug%20Use%20in%20TN_2%203%202012_R2.pdf (last visited Nov. 12, 2014).
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99. *See* Tenn. Code Ann. § 39-13-107 (2014).

100. Whitner v. State, 328 S.C. 1, 492 S.E.2d 777 (1997); *Ex parte* Ankrom, No. CC-09-395 & No. CC-08-381, 2013 WL 135748, at 1–2 (Ala. Jan. 11, 2013).

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108. *Id*. § 39-13-107(c)(2).

109. *Id*. (therefore the woman is exempt from punishment if she chooses not to have the baby).

110. *Id*. § 39-13-107(3).

111. Whitner v. State, 328 S.C. 1, 492 S.E.2d 777 (1997); *Ex parte* Ankrom, No. CC-09-395 & No. CC-08-381, 2013 WL 135748, at 1–2 (Ala. Jan. 11, 2013).

112. *Whitner*, 492 S.E.2d 777, at 779–80.

113. *Id*. at 778.

114. *Id*. at 778–89.

115. *Id*. at 781–82 ("For example, a parent who drinks excessively could, under certain circumstances, be guilty of child neglect or endangerment even though the underlying act—consuming alcoholic beverages—is itself legal. Obviously, the legislature did not think it 'absurd' to allow prosecution of parents for such otherwise legal acts when the acts actually or potentially endanger the 'life, health or comfort' of the parents' born children. We see no reason such a result should be rendered absurd by the mere fact the child at issue is a viable fetus").

116. *Id*. at 781.

117. *Id*.

118. *Id*.

119. *Id*.

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121. *Id*.

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124. *Id*.

125. *Id*. ("Not only have the courts of this State interpreted the term "child" to include a viable fetus in other contexts, the dictionary definition of the term "child" explicitly includes an unborn person or a fetus. In everyday usage, there is nothing

extraordinary about using the term "child" to include a viable fetus. For example, it is not uncommon for someone to state that a mother is pregnant with her first "child." Unless the legislature specifically states otherwise, the term "child" is simply a more general term that encompasses the more specific term "viable fetus." If the legislature desires to proscribe conduct against only a "viable fetus," it is necessary to use that specific term. However, if the legislature desires to proscribe conduct against a viable fetus and all other persons under a certain age, the term "child" is sufficient to convey that meaning. In fact, proscribing conduct against a "child" and a "viable fetus" would be redundant.").

126. DHHS, *supra* note 9; *see* Patrick et al., *supra* note 11.

127. *See* Wis. Stat. Ann. § 51.46 (West 2015).

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129. *See generally* NCADD National Counsel on Alcoholism And Drug Dependence, Inc., *Drugs and Crime, available at* https://ncadd.org/learn-about-drugs/drugs-and-crime (last visited Dec. 23, 2015) (stating that without question drug use and criminality are closely linked. Approximately sixty percent of individuals arrested for most types of crimes test positive for illegal drugs at arrest.); *see generally* Ctr. for Disease Control and Prevention, *Prescription Drug Overdose in the United States: Fact Sheet, available at* http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html (last visited Dec. 23, 2015) ("Deaths from drug overdose have been rising steadily over the past two decades and have become the leading cause of injury death in the United States. . .In 2011, drug misuse and abuse caused about 2.5 million emergency department (ED) visits. Of these, more than 1.4 million ED visits were related to pharmaceuticals."); *see generally* State of Alaska Mental Health Board & Advisory Board on Alcoholism and Drug Abuse, *The Economic Costs of Alcohol and Other Drug Abuse in Alaska 2012 Update*, *available at* http://dhss.alaska.gov/abada/Documents/pdf/EconomicCostofAlcoholandDrugAbuse2012.pdf (last visited Dec. 23, 2015) (providing lost production rates due to drug diminished capacity in Alaska).

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131. *Id*.

132. *See* Katie Zezima, *The Obama Administration Does Not Approve of a Law Making it a Crime to Use Drugs While Pregnant*, The Washington Post, http://www.washingtonpost.com/blogs/post-politics/wp/2014/07/01/the-obama-administration-does-not-approve-of-a-law-making-it-a-crime-to-use-drugs-while-pregnant/ (last visited Nov. 12, 2014) (quoting Terri Lynn Weaver, Tennessee state representative, who said it targets women who are "the worst of the worst").

133. *See* Tenn. Code Ann. § 39-13-107 (2014).

134. Model Penal Code § 211.1 (Proposed Official Draft, 1962).

135. *Id*.

136. Frédéric Mégret, *Practices of Stigmatization*, 76 Law & Contemp. Probs. 287 (2013).

137. *Id*.

138. Tenn. Code Ann. § 39-13-107 (2014).

139. Mégret, *supra* note 136.

140. *DrugFacts: Understanding Drug Abuse and Addiction,* Nat'l Inst. on Drug Abuse (Nov. 2012), http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment (last visited Dec. 23, 2015) (stating that "It is often mistakenly assumed that drug abusers lack moral principles or willpower and that they could stop using drugs simply by choosing to change their behavior. In reality, drug addiction is a complex disease, and quitting takes more than good intentions or a strong will. In fact, because drugs change the brain in ways that foster compulsive drug abuse, quitting is difficult, even for those who are ready to do so.").

141. *E.g., id*.

142. *Id*.

143. *Id*.

144. *Id*.

145. Mégret, *supra* note 136 (stating that just deserts include punishment of equal fairness and proportionality for the crime committed). *See also* Monica M. Gerber, *Retributions as Revenge an Retribution as Just Deserts,* 26 Soc. Just. Res.1 (2012), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2136237.

146. Gerber, *supra* note 145.

147. Model Penal Code § 211.1 (Proposed Official Draft, 1962).

148. Zvi D. Gabbay, *Justifying Restorative Justice: A Theoretical Justification for the Use of Restorative Justice Practices,* 2005 J. Disp. Resol. 349, 373 (2005).

149. Doberczak et al., *supra* note 28.

150. *Id*.

151. Tenn. Code Ann. § 39-13-107 (2014).

152. *See id*.

153. Drug and Alcohol Rehab Headquarters, *supra* note 77.

154. Mégret, *supra* note 136; Patrick et al., *supra* note 11.

155. Nat'l Inst. on Drug Abuse, *DrugFacts: Understanding Drug Abuse and Addiction* (Sept. 2009), http://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction.

156. *Id*.

157. *See generally, e.g.,* Patrick et al., *supra* note 11 (explaining the standard rehabilitation program for pregnant opioid dependence: "Methadone is intended to prevent withdrawal and reduce the risk of accidental overdose by providing a stable dosing regiment supervised by health care professionals. By enrolling in methadone programs, pregnant women are given the

added benefit of improved access to the health care system, including drug treatment, obstetric, and medical care. Despite acceptance into the health care system, women enrolled in methadone treatment programs continue to have higher rates of adverse maternal and neonatal outcomes than the general population, likely related to their underlying medical and social circumstances than treatment programs alone. Treatment with methadone requires intensive antepartum management, consisting of obstetric management, substance abuse counseling, as well as the evaluation and treatment of medical comorbidities such as psychiatric disorders, hepatitis C, human immunodeficiency virus/AIDS, and psychosocial risk factors (alcohol and tobacco use). Relapse and continued illicit drug use is common and many coexisting psychosocial risk factors fail to be addressed. During the last several years, buprenorphine has emerged as an alternative to methadone for narcotic replacement therapy. A recent randomized, double-blind trial found that newborns whose mothers were treated with buprenorphine required 89% less morphine and spent 43% less time in the hospital. Possible advantages to buprenorphine include patient-administered dosing, which relieves patients from daily visits to outpatient methadone distribution clinics and has the potential to decrease health care utilization and costs.").

158. NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE (3d ed.).

159. U.S. CONST. amend. XIV.

160. *See generally,* 16B Am. Jur. 2d *Constitutional Law* § 877 (2015).

161. *Id*.

162. Reed v. Reed, 404 U.S. 71 (1971).

163. Michael M. v. Superior Court of Sonoma Cnty., 450 U.S. 464, (1981) ("Legislature may not make overbroad generalizations based on sex which are entirely unrelated to any differences between men and women or which demean ability or social status of affected class, but, because equal protection clause does not demand that a statute necessarily apply equally to all persons or require things which are different in fact to be treated in law as though they were the same, statutes are valid where gender classification is not invidious, but rather realistically reflects the fact that sexes are not similarly situated in certain circumstances").

164. Reed v. Reed, 404 U.S. 71 (1971). *See also* U.S.C.A. Const. Amends. 14.

165. Zvi D. Gabbay, *Justifying Restorative Justice: A Theoretical Justification for the Use of Restorative Justice Practices,* 2005 J. DISP. RESOL. 349, 373 (2005).

166. *See, e.g*., Engineering Contractors Ass'n v. Metropolitan Dade County, 122 F.3d 895, 908 (11th Cir. 1997) (finding that "intermediate scrutiny remains the applicable constitutional standard in gender discrimination cases").

167. *See* Patrick et al., *supra* note 11; *see generally* TENN. CODE ANN. § 39-13-107 (2014).

168. See Patrick et al., *supra* note 11.

169. *Id*.

170. *Id*.

171. Letter from Lynn M. Paltrow, Exec. Editor, National Advocates For Pregnant Women, Letter to Bill Haslam, Governor of Tenn. (Apr. 17, 2014), *available at,* http://advocatesforpregnantwomen.org/NAPW%20Letter%20to%20Haslam.pdf.

172. *Id*.

173. *See generally* http://rhrealitycheck.org/article/2014/10/16/pregnant-texans-charged-crimes-dont-exist/ (last visited Dec. 23, 2015).

174. *Id*.

175. *Id*.

176. *Id*.

177. TENN. CODE ANN. § 39-13-107 (2014).

178. *See* Letter from Lynn M. Paltrow to National Advocates For Pregnant Women, *supra* note 171.

179. Roe v. Wade, 410 U.S. 113, 153 (1973).

180. *Id*.

181. *Id*.

182. *Id*.

183. *Id*. at 158.

184. *Id*.

185. *Id*.

186. *Id*. at 728.

187. *Id*. at 727.

188. *Id*.

189. TENN. CODE ANN. § 39-13-107 (2014).

190. *Id*.

191. *Roe*, 410 U.S. at 156.

192. *Id*.

193. *Id*.

194. *Id*.

195. *See* Christian Henrichson, *The Price of Prisons: What Incarceration Costs Taxpayers*, VERA INSTITUTE OF JUSTICE, http://www.vera.org/pubs/special/price-prisons-what-incarceration-costs-taxpayers (last visited Dec. 23, 2015) (stating that the cost of prisons was $39 billion in fiscal year 2010).

196. *See generally* ASTHO, *Neonatal Abstinence Syndrome: How States Can Help Advance The Knowledge Base For Primary Prevention And Best Practices of Care*, Association of State And Territorial Health Officials, http://www.astho.org/Prevention/NAS-Neonatal-Abstinence-Report/ (last visited Dec. 23, 2015).

197. Henrichson, *supra* note 195.

198. *Compare* http://www.vera.org/files/price-of-prisons-indiana-fact-sheet.pdf (last visited Dec. 23, 2015) ("in fiscal year 2010, the Indiana Department of Correction (IDOC) had $562.2 million in prison expenditures."), *with* http://www.vera.org/files/price-of-prisons-new-york-fact-sheet.pdf (last visited Dec. 23, 2015). ("in fiscal year 2010, the New York Department of Correctional Services (DOCS) had $2.7 billion in prison expenditures.").

199. Henrichson, *supra* note 195.

200. Henrichson, *supra* note 195.

201. *See generally* Robery Brooner, *Center for Addiction and Pregnancy (CAP),* Johns Hopkins Medicine, http://www.hopkinsmedicine.org/psychiatry/bayview/medical_services/substance_abuse/center_addiction_pregnancy.html (last visited Dec. 23, 2015).

202. C. Dorsey, *Addiction During Pregnncy,* New Directions For Women, (Aug. 13, 2012), http://www.newdirectionsforwomen.org/addiction-during-pregnancy/.

203. *See generally* ASTHO, *supra* note 196.

204. *Id*.

205. *Id*.

206. *Id*.

207. *Id*.

208. *Id*.

209. 016 Ark. Code R. § 04.6-4.00 (LexisNexis 2015); Cal. Code Regs. tit. 22 § 50262 (2015); Colo. Rev. Stat. Ann. § 25.5-5-309 (2015); Conn. Gen. Stat. Ann. § 17a-710 (2015); Fla. Stat. Ann. § 381.0045 (West 2001); 20 Ill. Comp. Stat. Ann. 301/35-5 (West 2015); 907 KY. Admin. Regs. 20:050 (2013); Md. Code Ann. Health-Gen. § 8-403.1 (West 2015); Minn. R, 4700.2210 (2015); 482 Neb. Admin. Code Ch. 2-000 § 2-001 (2015); N.Y. Comp. Codes R. & Regs. tit. 18, § 360-3.7 (2015); 10A N.C. Admin. Code 27G.4501 (2015); Ohio Admin. Code 3793:2-3-01 (2015); Or. Rev. Stat. Ann. § 417. 728 (West 2015); 71 Pa. Cons. Stat. Ann. § 553 (2015); R.I. Gen. Laws Ann. § 42-12.3-3 (West 2015); Wash. Admin. Code § 182-533-0720 (2015); Wis. Stat. Ann. § 46.86 (2013). *See also* Guttmacher Inst., *supra* note 84.

210. *E.g.,* Wis. Stat. Ann. § 51.46 (West 2015); Iowa Code Ann. § 125.32A (West 2015); Kan. Stat. Ann. § 65-1, 165 (West 2015); Mo. Ann. Stat. § 191.731 (West 2014); Okla. Stat. Ann. tit. 63, § 1-546.4 (West 2015); *see also* Guttmacher Inst., *supra* note 84.

211. Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care (2014), http://www.astho.org/Prevention/NAS-Neonatal-Abstinence-Report/.

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213. James J. Heckman, *Invest in the Very Young*, Encyclopedia on Early Childhood Development, http://research4children.com/data/documents/EarlyChildhoodDevelopmentFullReportpdf.pdf (last visited Dec. 23, 2015).

214. *Id*.

215. *Id*.

216. DHHS, *supra* note 9.

217. Heckman, *supra* note 213.

218. *Id*.

Alexana Gaspari, J.D., is a 2015 graduate of the Hofstra University School of Law. While in law school she was the 2015 winning competitor of the Hofstra Law Dispute Resolution Negotiation Competition, and she also competed regionally in the Saul Lefkowitz International Trademark Association Moot Court Competition in both her second and third years. She earned the Intellectual Property Honors Concentration and at graduation she won the award for Outstanding Excellence in the field of Intellectual Property as well as the Bronze Award in Public Service. She has assisted publications in the Federation of Defense and Corporate Counsel's 2013 Insurance Institute, and in Gordon & Rees, LLP's Environmental & Toxic Tort Defense Insight. She holds a bachelor of science degree in biology, magna cum laude, from the New York Institute of Technology (NYIT). At NYIT she was a student athlete on the tennis team and the founder of the school's organization "Il Circolo Italiano."

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