CRIMINALIZATION OF PERINATAL SUBSTANCE ABUSE: IMPLICATIONS FOR PRENATAL CARE

by

Olivia Lang

B.A. (Stanford University) 1991

A thesis submitted in partial satisfaction of the

requirements for the degree of

Master of Science

in

Health and Medical Sciences

in the

GRADUATE DIVISION

of the

UNIVERSITY of CALIFORNIA at BERKELEY

Committee in charge:

Professor Marjorie Shultz, Chair
Professor Nancy Milliken
Professor Richard Barth

THE CRIMINALIZATION OF PERINATAL SUBSTANCE ABUSE: IMPLICATIONS FOR PRENATAL CARE

by

Olivia Lang

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

I am forever indebted to all the women who agreed to talk with me about this delicate subject both in interviews and during field study. Without their cooperation, this thesis would not have been possible. Without their incredible stories, this thesis would not have been as personally satisfying. I will cherish and draw from the experience of meeting these women throughout my personal life and my medical career. I would also like to thank the staff at the two facilities I visited for allowing me to talk with the women and for helping in the logistics of the interviews.

Extreme gratefulness and much thanks go to my thesis advisors, Marjorie Shultz, Nancy Milliken, and Richard Barth, who provided guidance and support during the early stages of the project and patiently read and edited countless pages of drafts. I appreciate all their time and hard work in assisting me to write a better thesis. I must also thank Patricia Morgan for teaching me about qualitative research and for directing me in the analysis of the interviews.

I would like to acknowledge my friends and classmates whose words of encouragement helped me through the anxiety of choosing a topic, the emotions from conducting interviews, the late nights of writing, and the joy of completion. My parents and my brother, as always, gave me their unconditional love and support.

Finally, special thanks go to Michael Ward who suffered and celebrated with me throughout the thesis process. I would have never completed this project without his patient listening, his unfaltering advocacy, his expert editing, and his constant love.

INTRODUCTION

> [Mary is] a substance abusing perinatal client...Mary was thirty-four years old, but looked forty-four. For eleven years she used a variety of chemical substances, including alcohol, cocaine, and heroin....In 1990, shortly after using cocaine and heroin, Mary gave birth ten weeks prematurely to a neurological impaired boy, Thomas. Thomas had periods of inconsolable crying and frantic sucking, plus tremors of his limbs that lasted until the age of seven months....When Thomas was fifteen months old...He was undersized, his facial features were asymmetrical, his head circumference was below the fifth percentile, and he had greater coordination with the right side of his body than the left.[1]

Mary and Thomas represent the typical portrait of the substance abusing mother and the prenatally exposed infant that is so commonly depicted in today's media. Beginning in the early eighties, a deluge of newspapers, television programs, and magazines focused attention on the newest tragedy of America's fight against drugs, drug babies--babies born to substance abusing mothers and consequently suffering a vast array of developmental, physical, and emotional problems. Some observers of these children have described them as "the lost generation" and "the children of the damned." Although exact numbers of women who use drugs during their pregnancies are difficult to ascertain, one popular statistic from a hospital-based study conducted by the National Association of Perinatal Addiction, Research, and Education estimated that 11% of the babies born in the United States were exposed to drugs prenatally.[2] Images of shivering and crying drug babies blanketed with medical equipment in an incubator evoke in many a sense of moral outrage. What kind of society

---

[1] Ruhle, Nancy. "Perinatal Substance Abuse: Personal Triumphs and Tragedies". *Hastings Law Journal.* 1992; 43: 549. Excerpt from the author's personal experiences as a public health nurse in the Santa Clara County Health Department.

[2] Chasnoff, Ira J. "Drug use and women: Establishing a standard of care." *Annals of New York Academy of Science.* 1989; 562: 208.

allows innocent babies to be harmed in this way? What kind of mother causes this type of harm to her own child? What can we do to correct this problem?

For the past decade, lawmakers, health professionals, and policy makers have investigated various avenues for the answers to these questions. One proposed method of handling the problem of drug babies is the application of legal statutes to the actions of their addicted mothers. Both civil and criminal statutes have been used to prosecute the mothers on various grounds including child abuse and neglect, drug trafficking to a minor, and failing to follow medical advice. A study by the American Civil Liberties Union documented at least 50 cases throughout the country where laws previously used only for offenses committed against children have been applied to these drug addicted mothers.[3] Criminal liability for prenatal drug use by these women has been the subject of great debate among philosophers, ethicists, lawyers, and health providers. The focus of this paper will not be civil child abuse and neglect claims, but instead the application of criminal statutes to women who use drugs during their pregnancy. Is criminal liability and prosecution the answer to this particular battle in the war on drugs?

In considering an answer to this problem, we must return to Mary and Thomas. The details of Mary's story are not complete. The above account fails to mention that Mary suffered psychological and sexual abuse as a child. In fact, because of childhood trauma, Mary has no memory of her life prior to the age of six. The typical media account would not include the fact that after a period of frequent medical appointments, psychiatric therapy, Alcoholics Anonymous meetings, and drug treatment, Mary has struggled to overcome the problems in

---

[3] American Civil Liberties Union Foundation, Reproductive Freedom Project, New York. State-by-state case summary of criminal prosecutions against pregnant women and appendix of public health and public interest groups opposed to these prosecutions. Memorandum issued October 3, 1990.

her life. With the proper guidance and the availability of education and drug treatment, Mary is now on the road to recovery. These additional facts in Mary's life must also be considered when evaluating criminalization.

The current debate over the use of criminal statutes to prosecute maternal drug use during pregnancy has centered around several key topics. Opponents to the policy have argued against criminalization through discussions of the constitutional rights of the woman, the maternal rights of the mother, and the ethical and moral implications of such a policy. On the other hand, advocates for criminalization have focused on the harms inflicted on the fetus, fetal rights, and rehabilitation of the woman. While both sides of the debate are important in deliberating about this policy, I argue that more attention should be given to the unintended consequences of criminalization of perinatal substance abuse. While the intellectual and legal deliberation of this policy is interesting, on a policy level, these unintended ramifications lend undeniable support to the position against criminalization.

Criminal prosecution will have serious effects on the prenatal care decisions of women. Many studies have already shown that women who use drugs are less likely to obtain adequate prenatal care. Research has demonstrated that prenatal care improves the incidence of low birth weight and premature birth in substance-abusing women. One of the arguments against criminalization of perinatal drug abuse is that these women will be less likely to seek prenatal care because they fear punishment and the loss of custody of their children. For example, after the widely publicized 1985 prosecution of Pamela Rae Stewart, fewer women with a history of drug and/or alcohol abuse sought prenatal care in the local area where the suit was brought.[4] Aside from

---

[4] Paltrow, Lynn M. "Perspective of a Reproductive Rights Lawyer." *The Future of Children*. 1991; 1: 85.

anecdotal evidence, only one study in the literature specifically examines this issue. Researchers in Michigan evaluated the opinions of 142 post-partum low income women on the potential effects of a punitive law on prenatal care decisions. Utilizing questionnaire-based interviews, they found that subjects believed a punitive law would be a deterrent for substance abusing women to seek prenatal care, drug testing, or drug treatment.[5] Although the interviews in this study did include some open-ended questions, the researchers attempted no comprehensive qualitative analysis of the women's attitudes. Moreover, this study was conducted in a narrowly defined population in Detroit, Michigan. Since the prevalence of drug use and the type of drugs used differ geographically, results of this study may not be representative of pregnant women in other states. Furthermore, only 14.8% of the respondents admitted to the use of illicit drugs. A study which considers only women who used illicit drugs during their pregnancies would elicit more evidence of any deterrent effect of punitive laws on prenatal care.

Does imposing stricter criminal penalties on women for drug use during pregnancy unintentionally deter their use of prenatal care? Unlike the above study, my research used qualitative methods to interview a population of substance-abusing women. Through in-depth interviews, I was able to obtain extensive personal histories describing drug use and the circumstances of drug use. Moreover, the qualitative interviews revealed the women's histories of prenatal care as well as their general opinions on prenatal care. Most

---

[5] Using a goodness-of-fit chi -square analysis, this study found that most of the women felt that there would be less use of prenatal care, drug testing and drug treatment ($p < .001$). The demographics of the women in this sample were as follows: 81% single, 85.2% Black, 30% with inadequate amounts of prenatal care, and 14,8% admitted use of illicit drugs during pregnancy.
Poland, Marilyn L., M.P. Dombrowski, J.W. Ager, and R.J. Sokol. "Punishing pregnant drug users: enhancing the flight from care." *Drug and Alcohol Dependence.* 1993; 31: 199, 201.

importantly, the open-ended nature of the interviews allowed me to assess the role of prosecution and the fear of law in their decisions. Other goals of this paper include: 1) a description of the extent of maternal drug abuse; 2) an exploration of the effects of prenatal drug exposure not only on the infant, but also on society as a whole; 3) a discussion of the benefits of prenatal care especially on the drug using woman; and 4) an overview of the legal responses to perinatal substance abuse.

Aside from these intellectual goals, this research also represented the achievement of several personal goals. First, this topic enabled me to explore an intersection of children's health policy, medical ethics and legal issues. Second, I hope that the results will provide additional information both for legal and health policy decisions. Furthermore, the information obtained from the research should enhance our knowledge of substance-abusing women and provide physicians with additional resources to provide prenatal care. This information should also facilitate the doctor-patient relationship in this high-risk and difficult population.

The general layout of the paper will be as follows. The paper will consist of three parts. The three chapters of Part One describe the problem of prenatal substance abuse. Chapter One will examine the prevalence of maternal drug use as well as describe the characteristics of women who use drugs. This chapter will also discuss the current prenatal care of women in this population. Chapter Two describes some of the current effects of prenatal drug exposure including the physiologic, developmental impact on drug babies and drug children. This section will also address the impact of perinatal drug exposure on social services, medical services, and economic costs. Chapter Three will explore the known benefits of receiving prenatal care during pregnancy including the positive impact of prenatal care for the drug abusing woman. Part Two provides a brief

overview of the legal response to prenatal substance abuse including both criminal and civil cases. This part addresses the basic theories behind criminal punishment, and discusses how these theories apply to perinatal drug abuse. Part Three of this paper describes the methods and results of the qualitative research, as well as the conclusions and recommendations that these data suggest.

PART ONE: The Problem of Maternal Drug Abuse

CHAPTER ONE: STATISTICS AND CHARACTERISTICS OF DRUG-ABUSING MOTHERS

The problem of drug use has been present in society throughout its history. Opium was used in Sumeria as early as 4000 B.C., and narcotics first appeared in China in the 7th century.[6] Wars have been fought over drug trade (China's Opium Wars of the 1839-1842). The United States Civil War lead to increased use of morphine and resulted in countless numbers of soldiers suffering from "morphinism." However, even with the long history and persistence of drug use in modern society, media attention and current ideology have depicted drug use as a new societal problem and created such popular colloquialisms as "the war on drugs." Drug abuse is now considered one of the most urgent national crises. Much of this surge in awareness and alarm about drug use is due to the introduction of new forms of drugs to new segments of the population.

Cocaine is an alkaloid derivative from the leaves of the coca plant, which is found indigenously in the Peruvian Andes, Ecuador, and Bolivia. The prevalence of use of this stimulant in the United States has cycled periodically, with heavy intravenous and inhalation use occurring during the 1970's. Although in the 1970's cocaine was mainly a drug of the upper and middle classes, beginning in the mid 1980's, the introduction of cheap freebase smoking of "crack" or "rock cocaine" initiated a new epidemic of cocaine use, especially in low socioeconomic status areas of large cities. Inexpensive and easily obtainable, crack cocaine became especially attractive because it gives users feelings of

---

6 For a complete account of the history of drug use, see: Kandall, Stephen R. & Wendy Chavkin. "Illicit Drugs in America: History, Impact on Women and Infants, and Treatment Strategies for Women." *Hastings Law Journal*. 1992; 43: 615.

power, confidence, and energy.[7] This form of cocaine added to the already high prevalence of alcohol and drug use in this population segment and elevated the problems of substance abuse to crisis proportions. Urban problems related to poverty have exacerbated the negative consequences of this drug.

According to a 1991 report compiled by Alameda County, California, there were an estimated 12,000 heroin and 6000 cocaine and speed IV drug users in the county. Unfortunately, the use of crack is especially high among women of childbearing age. It is estimated that approximately half of the nation's crack addicts are women.[8] In 1989, 1.6 million women of childbearing age were regular users of cocaine (University of Minnesota, 1990). Women who use crack are also more likely to use other drugs. For example, the crack user may concurrently take heroin with the crack to make the "high" better and then use depressants to come off the high. The use of marijuana, PCP, and amphetamines also often accompanies crack use.[9]

The new popularity of crack cocaine among women of childbearing age has contributed to the already existing problem of prenatal drug exposure and has raised the prevalence of prenatal drug exposure to alarming levels. A 1988 nationwide survey of 36 hospitals conducted by the National Association of Perinatal Addiction, Research and Education estimated that 11% of all newborn infants, or 375,000 infants each year nationally, have been exposed perinatally to illegal drugs.[10] A recent review indicated that between 90,000 and 240,000 babies are born each year with specific exposure to crack in utero.[11] However,

---

7 Gay, G. "The deadly delights of cocaine." *Emergency Medicine.* 1983; 2: 67.

8 Alters, J. "Women and Crack: Equal Addiction, Unequal Care." *Boston Globe.* November 1, 1989; 1: 1. Some have theorized that this is because women are attracted to crack because it is smoked, not injected.

9 Toufexis, Anastasia. "Innocent Victims," *Time Magazine.* May 13, 1991; 58.

10 *Supra* note 2, at 208.

11 Phibbs, Ciaran S., D.A. Bateman & R.M. Schwartz. "The Neonatal Costs of Maternal Cocaine Use." *Journal of the American Medical Association.* 1991; 266: 1521.

while many studies suggest that prenatal drug exposure has become an urgent problem, the actual prevalence and incidence of prenatal drug exposure has been difficult to determine. Much of the existing body of research is fraught with methodological problems which include self-selection bias, underreporting, limitations in toxicological screening, and small statistical power. For example, urine tests for metabolites of cocaine can only detect the use of cocaine within 72 hours of the drug's ingestion thus providing only a cross-sectional view of the woman's drug use.[12] Moreover, many of these studies are based on small numbers of hospitals or specific geographic regions making the national application of the findings questionable. Working within these limitations, Gomby and Shiono[13] reviewed the existing literature and concluded that 2-3% of births in the United States were positive for cocaine. Based on NIDA's 1990 Household Survey, the researchers themselves estimated that 4.5% of pregnant women between the ages of 12 and 34 may have used cocaine during their pregnancies.[14]

The prevalence of prenatal drug use is somewhat clearer in the state of California due to a recent population-based epidemiological study aimed at producing such numbers. The study involved urine toxicology screening for a broad spectrum of illicit and non-illicit drugs including alcohol from 29,494 pregnant women admitted for delivery in 202 hospitals throughout the state. It estimated that in 1992, 67,361 or 11.5% of births had evidence of perinatal drug exposure to one or more drugs including alcohol. When only cocaine use was considered, 6635 births were positive for cocaine-use. Alameda county had the

---

12 Zuckerman, B., D.A. Frank, R. Hingson et al. "Effects of maternal marijuana and cocaine use on fetal growth." *New England Journal of Medicine.* 1989; 320: 762-768.

13 Gomby, Deanna S. & Patricia H. Shiono. "Estimating the Number of Substance-Exposed Infants." *The Future of Children.* 1991; 1: 17.

14 *Id.*

highest prevalence rate (16.92%) of some drug and/or alcohol exposure and the highest prevalence rate for cocaine (3.21%).

Identifying and treating women who are substance abusers is difficult. Historically, women were not viewed by society as "drug abusers." One author notes, "women who are identified as abusers have been labeled as morally deficient and subjected to severe public disapproval."[15] Drug use by women through doctor's prescriptions was more common than drug use by men in the last century. In fact, before the Civil War and the advent of "morphinism," there were more women drug users than male addicts in this nation.[16] However, since the end of the 19th century, society held the misconception that drug abuse was a "man's problem." The consequence was much less information available on the characteristics of women who use drugs.

Recently, however, studies have sought to determine the specific and distinctive qualities of this population group. The literature reveals that women who use drugs often have histories of sexual or physical abuse as children, dysfunction in their families of origins, abusive relationships with men, and multigenerational substance abuse. A study conducted by a treatment center for women found that 70% of female substance abusers were sexually abused as children, whereas only 15% of non-users had histories of sexual abuse. The substance-abusing women were also much more likely to be victims of violence (70%). Over 80% of the women had had a chemically dependent parent.[17] The study found that women drug abusers tend also to have higher levels of anxiety, a sense of powerlessness, and a lower level of self-esteem and confidence.

---

15 Tracy, Carol E. & Harriet C. Williams. "Social Consequences of Substance Abuse Among Pregnant and Parenting Women." *Pediatric Annals*. 1991; 20: 549.

16 *Supra* note 6, at 626.

17 "Coordinating Federal and Drug Policy for Women, Infants, and Children." Hearing before the Senate Committee on Governmental Affairs. 101st Cong. 1st Sess. 1989.

Additionally, psychiatric illness, especially depression, seems to be more prevalent in this population. Of 500 opiate-dependent persons, 87% of the subjects who had a psychiatric disorder (70% of the total population) had a major depressive disorder.[18] Other psychiatric problems often encountered in this population include schizophrenia, anxiety and phobic disorders. These women also commonly have diagnosable personality disorders such as borderline, passive, aggressive, and antisocial personality disorders.[19] These findings clearly indicate that social and environmental factors contribute to women's drug use, and as a result, contribute also to the health risk of infants. As one author writes, "The stability which the pregnant woman needs is the very same thing which she lacks the most. In addition to the social and physical dysfunctions suffered by the patient, the pregnant addict must deal with the additional sense of guilt and shame of 'hurting' her growing fetus as a result of drug use."

Generally, the literature suggests that there are no racial or ethnic differences in the amount of maternal drug abuse. Although white women are just as likely to engage in drug use, one author notes that women of color represent a disproportionate number of those against whom prosecutions for perinatal substance abuse have been initiated. A survey of 60 cases of prosecution revealed that 80% of these women were minorities.[20] These figures suggest that women of color are unfairly targeted. Indicators of suspected drug use, such as a poor socioeconomic status, substandard living conditions, and social environment are more common among drug addicted women of color and

---

18 Weissman, M.F., P.B. Slobertz, M. Meritz & P. Howard. "Clinical depression among narcotic addicts maintained on methadone in the community. *American Journal of Pyschiatry*. 1976; 133: 1434.

19 Daghestani, Amin N. "Psychosocial Characteristics of Pregnant Women Addicts in Treatment." In: Chasnoff, Ira J., ed. *Drugs, Alcohol, Pregnancy and Parenting*. Boston: Kluwer Academic Publishers. 1988; 8.

20 Roberts, Dorothy E. "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy." *Harvard Law Review*. 1991; 104: 1419.

therefore bias the defining criteria of a drug user. Thus, these women are more likely to be reported and subsequently prosecuted. On the other hand, a recent study conducted in California that was based on toxicology screens of all women giving birth in 202 California hospitals found that over 14% of Black women tested positive for one or more drugs (excluding alcohol) compared to less than 7% of white women. Importantly, the types of drugs used by each group may also vary among the different ethnicities. Overall, Black women also had the highest level of cocaine use (7.79%), compared to the 0.6% level of women from other racial/ethnic groups.[21,22]

The use of prenatal care by substance abusing women seems to differ from that of the general population. Women who do not receive adequate care are more likely to be drug users. In the above-cited California study, women who did not receive prenatal care had a seven times higher prevalence estimate for use of illicit drugs and tobacco than women who received adequate care. Of women who received no prenatal care during their pregnancy, 11.50% tested positive for cocaine at delivery, whereas only .78% of those women who received some prenatal care tested positive. Women who received first trimester care had lower prevalence rates for most drugs, especially cocaine.[23] Another case-controlled study found that women who did not receive prenatal care or received only a few visits were more likely to be from lower SES and to be drug users. Moreover, there is evidence of lower rates of prenatal care in drug-using women.

---

21 Vega, William A., B. Kolody, J. Hwang & A. Noble. "Prevalence and Magnitude of Perinatal Substance Exposure in California." *New England Journal of Medicine.* 1993; 329: 852.

22 Vega, William A., A. Noble, B. Kolody, P. Porter et al. "Profile of Alcohol and Drug Use During Pregnancy in California, 1992: Perinatal Substance Exposure Study, General Report." State of California, Department of Alcohol and Drug programs. September, 1993; 21-22.

23 *Supra* note 21, at 850.

Phibbs et al.[24] found that drug users were less likely to see prenatal caretakers than non-users.

Unfortunately, the crisis of prenatal drug exposure does not end with crack; there are other new forms of illicit drugs that are gaining in popularity and are threatening to produce another population of "drug babies." According to report issued by the Office of Inspector General of the U.S. Department of Health and Human Services, the next drug crisis is already making its appearance on the west coast. "Ice," a methamphetamine derivative, has been shown to produce serious fetal damage. Moreover, because "ice" creates a long-lasting high, this drug is particularly attractive to drug abusers. The specter of HIV and AIDS also looms over the problem of drug use. Populations at high risk for drug abuse are generally also at high risk for HIV; thus, pediatric HIV infection and AIDS are two other threats to this community.[25]

Practical issues seriously hinder efforts to increase the numbers of women in drug treatment. In 1989, over 67,000 people were on the waiting list for drug treatment programs in the United States.[26] Moreover, services for pregnant women are even more limited given agencies' reluctance to accept the additional responsibilities their care entails. The Institute of Medicine estimates that 105,000 pregnant women need drug treatment in a given year, but only 30,000 of these women receive any treatment.[27] As one reproductive rights attorney states:

> What they [researchers] will undoubtedly find is that there is not enough treatment for men and there is virtually no appropriate treatment available to women, especially pregnant women...a decision based

---

24 *Supra* note 11, at 1521.

25 "Crack Babies: Selected Model Practices." Office of Inspector General. United States Department of Health and Human Services. June 1990; 13.

26 *Supra* note 4.

27 Larson, Carol S. "Overview of State Legislative and Judicial Responses." *The Future of Children*. 1991; 1: 76.

> on stereotypical notions of women addicts being more difficult to treat or on unfounded fears of increased risk of liability.[28]

Some women are also excluded based on their health insurance status. A study of treatment services in New York City found that 54% of the drug treatment programs excluded pregnant women, and 67% refused to treat pregnant women on Medicaid. Additionally, less than one-fifth of treatment programs provided specific detoxification treatment for crack-addicted pregnant women on Medicaid.[29] Because drug-using women are often single mothers, treatment programs exclude more women by not offering child care. As a result, mothers face a choice between obtaining drug treatment and maintaining custody of their children.

Not only are sufficient treatment services lacking for pregnant addicted women, but comprehensive treatment programs are not readily available. For instance, because it provides more comprehensive care and removes a woman from a social environment that fosters drug use, residential care is an effective method of drug detoxification and rehabilitation. However, according to an analysis of available residential services for pregnant women in Alameda County, there were only 51 beds with treatment protocols specifically tailored for women (both pregnant and postpartum). Moreover, each of these programs had waiting lists many times greater than the length of a woman's pregnancy.[30]

---

28 *Supra* note 4.

29 Chavkin, Wendy. "Drug Use in Pregnancy: An Urgent Problem for New York City." for the Reproductive Health Subcommittee of the Committee for Public Health. *New York Academy of Medicine.* March 10, 1989.

30 This analysis was obtained from my field research in December, 1991. I evaluated the seven available residential programs in Alameda County on their programming and abilities to serve the population of pregnant and post-partum women. My results showed a gross deficiency of available beds and lack of research on the effectiveness and cost of residential programs for pregnant women.

A fundamental problem of existing drug treatment services and protocols is that these programs were historically designed for drug-abusing men. Many of the widely used theoretical approaches to drug detoxifications may not be appropriate for the special needs of a drug addicted pregnant women. For example, one author comments:

> Traditionally, substance abuse treatment has been confrontational and punitive...it is clearly inappropriate for women. There is ample evidence that women substance abusers lack a sense of self-worth. Confrontational models reinforce low self-esteem, reducing the likelihood that the client can gain the strength to become free from drugs and face the serious responsibilities of economic survival while raising children.[31]

Women seem to be more responsive to treatment models that are more family-oriented and aid development of self-independence.[32] The existing treatment programs may not be effective in addressing these unique psychological and sociological issues. Moreover, pregnant women also require health care resources that treatment centers find difficult to provide.

Because current treatment and counseling services for drug-using pregnant women are not adequate, energy and money being used to advance a policy of prosecution and criminalization might better be directed at expansion and development of appropriate social services.

> Many alcohol and drug treatment programs are closed to pregnant women and, therefore, also to unborn children--the most crucial patients of all. It is obvious that the much-ballyhooed war on drugs is not being won with guns, but requires the concerted efforts of a

---

31 *Supra* note 15, at 550.

32 Morley, J. "De-escalating the war: rethinking our assumptions about drug treatment. *The Family Therapy Networker*. Nov-Dec 1990; 25-35.

> compassionate society. Alcohol rehabilitation programs should be as easy to get into as liquor stores.[33]

The lack of services for women is especially alarming given a policy of criminalization. A policy of criminalization creates the threat of prosecution without giving these women the means to extricate themselves from a punishable situation.

CHAPTER TWO: THE EFFECTS OF PERINATAL DRUG EXPOSURE --INDIVIDUAL & SOCIETAL

With the alarming rise of maternal drug use and the increased numbers of "drug babies," society has had to deal with the myriad of problems that perinatal substance abuse creates. Not only can the passage of drugs via the placenta to the developing fetus result in devastating physical, physiological, and behavioral defects in the substance-exposed infant, but in utero exposure to drugs has also imposed enormous costs and burdens on social and medical services. The economic costs of this problem are huge. Moreover, there are many hidden costs such as that on the educational system that have yet to be ascertained. Importantly, however, the most dire predictions, which contributed to the overly punitive response to mothers, have not all come true. The results of drug exposure are not as disastrous as previously thought.

Determining the specific impact of various drugs on perinatal mortality and morbidity is difficult. First, because poly drug use is common, determination of the impact of a specific drug on perinatal outcomes is hard to ferret out. Although mothers who use cocaine during pregnancy are more likely to have adverse birth outcomes, many of these women also use other illicit and non-illicit drugs including tobacco and alcohol. Because addiction to cocaine can

---

33 *Supra* note 17, at vii.

depress appetite, poor nutrition also figures into the equation of poor birth outcomes. Studies which could ameliorate this methodological problem require costly multivariate analyses requiring large sample numbers. Second, designation of drug use often relies on self-reporting. If a woman misreports or underreports her drug use, assessment of the impact on perinatal outcome is difficult. Finally, the impact of perinatal drug exposure depends greatly not only on the amount and type of drug, but also on the frequency and timing of exposure. Drugs also exert differential effects on the fetus depending on its developmental stage.

Despite these research limitations and methodological difficulties, existing studies appear to show significant effects of perinatal substance exposure on morbidity and mortality. One case control study found that drug addiction during pregnancy led to an increase in perinatal mortality and morbidity including increased rates of meconium stained amniotic fluid, maternal anemia, premature rupture of membranes and maternal hemorrhage. Moreover, this same study found that cocaine abuse lead to further increases in overall morbidity.[34]

While exposure to drugs in utero can result in both short-term and long-term consequences for the infant, more evidence exists on the more immediate sequelae of prenatal drug exposure. A wide range of physiological and physical effects specific to cocaine exposure have been noted. Thus far, birth defects resulting from maternal cocaine use include myelomeningocele, genito-urinary defects, limb reduction, bowel infarction, and cardiac dysfunctions. A study

---

34 Ostrea, Enrique M. & A.L. Raymundo. "Has Cocaine Abuse Increased Perinatal Morbidity in Maternal Drug Addiction?" *Annals of the New York Academy of Science.* 1989; 562: 376.

conducted by Ira J. Chasnoff,[35] a leading researcher on cocaine use in pregnancy, suggested that cocaine-using women had significantly higher rates of spontaneous abortions and labor with abruptio placentae. Rates of preterm delivery and low birthweight are higher in infants of women who used cocaine through their pregnancies.[36] Albeit rare events, microcephaly and growth retardation have also been observed among infants of cocaine-using mothers.[37,38] Behavioral assessments of infants of drug addicted mothers also indicate impairment of orientation, motor, and state regulatory behaviors.[39,40] Observations of the infants by care providers indicate that these babies are hypersensitive and irritable, have irregular sleep patterns and difficulties with fine motor control. Developmental difficulties in these drug exposed babies have also been noted.[41] One article cited a psychologist who described crack children as "kids wired for 110 volts, living in a 220-volt world".[42]

However, it is important to note that many perinatal effects of cocaine exposure are intertwined with the effects of other social and physical factors, such as poor nutrition, inadequate prenatal care, and poverty. In fact, although the literature and media attention has been focused on the most serious physical,

---

35 Chasnoff, Ira J., W.J. Burns, S.H. Schnoll & K.A Burns. "Cocaine use in pregnancy." *New England Journal of Medicine.* 1985; 313: 666-669.

36 Chasnoff, Ira J., D.R. Griffith, S. MacGregor, K. Dirkes & K.A. Burns. "Temporal patterns of cocaine use in pregnancy." *Journal of the American Medical Association.* 1989; 261: 1741.

37 Fulroth, R., B. Phillips & D.J. Durand. "Perinatal outcome of infants exposed to cocaine and/or heroin in utero." *American Journal of Disease of Children.* 1989; 143: 905-910.

38 *Supra* note 2, at 208.

39 *Supra* note 35.

40 *Supra* note 36.

41 Gittler, Josephine & M. McPherson. "Prenatal Substance Abuse: An overview of the problem." *Children Today.* July-August 1990; 3-7.

42 Rist, Marilee C. "The Shadow Children." *American School Board Journal.* 1990; 177: 18-24.

emotional, and psychological consequences of pre-natal drug exposure, some evidence indicates that the plight of the "drug baby" may not be as awful as once thought. An initial analysis of drug-exposed children born at Mandela House in Oakland shows that all 10 children in the study tested above average in development tests. It is difficult to separate the impact of social problems that commonly accompany drug use (such as smoking, poor prenatal care, homelessness and poverty) on the infant from the effects of the drugs. In a review of existing literature, Diana Kronstadt determined that postnatal environment can greatly ameliorate the impact of prenatal drug exposure. In fact, early childhood intervention significantly reduces developmental problems faced by drug-exposed children.[43]

Nonetheless, some babies are radically affected by prenatal drug exposure, and these congenital problems translate into many burdens for social services and public health. Because of their hypersensitivity and jitteriness, crack-exposed infants are difficult to soothe and interact with. Researchers have suggested that the effects of cocaine exposure on bonding and attachment between infant and caregiver is a serious problem that impacts on the normal psychological development of the infant.[44] Moreover, because substance-using women and their infants are more likely to experience obstetrical and neonatal complications, the increased mother-infant separation at birth has been shown to result in poorer attachment.[45] Care of these infants represents further burdens on the drug addicted mother, who may already be plagued with physical and

---

43 Kronstadt, Diana. "Complex Developmental Issues of Prenatal Drug Exposure." *The Future of Children.* 1991; 1: 36, 44.

44 Rodning, Carol, L. Beckwith & J. Howard. "Prenatal Exposure to Drugs and Its Influence on Attachment." *Annals of the New York Academy of Science.* 1989; 562: 352-354.

45 Mundal, L.D., T. VanDerWeele, C. Berger & J. Fitsimmons. "Maternal-Infant Separation at Birth Among Substance Using Pregnant Women: Implications for Attachment." *Social Work in Health Care.* 1991; 16: 133, 140.

psychological problems of her own. Not surprisingly, cocaine-exposed babies are at high risk for abandonment, neglect and abuse.[46]

Especially in the mid-to-late 1980's, drug-exposed infants created a serious impact on social services including the foster care system and the educational system. Between 1986 and 1989, 80,000 children were added to the foster care population. In California, the foster care population rose from from 47,327 to 66,763 between 1986 and 1989, a 41% increase. In New York, the number of children in foster care increased 98% from 27,504 in 1986 to 52,189 in 1989. Both of these states contain communities in which the crack cocaine epidemic has been especially problematic.[47] One in three foster children is from either California or New York, although less than one in five children live in either of these two states. [48] In the first five months of 1987, 80% of all families in Alameda County whose children were referred for foster care were involved in drug use.[49] Moreover, because of the poor home environments of crack-affected families, drug-exposed children and children from drug-abusing families are also more likely to remain in foster care for longer periods of time than other foster care children. In New York City, 60% of the infants that went to foster care directly from the hospital were still in foster care three years later. The health and developmental problems of these children result in increased emotional, physical, and economic demands on the foster parent. Of those infants

---

46 *Supra* note 41.

47 "Children of Substance Abusing/Alcoholic Parents Referred to the Public Child Welfare System: Summaries of Key Statistical Data Obtained from States," American Public Welfare Association. Final Report submitted to American Enterprise Institute. Washington, D.C. February, 1990; 61.

48 Besharov, Douglas J. "Crack Children in Foster Care: Re-examining the Balance between Children's Rights and Parents' Rights." *Children Today*. July-August 1990; 23-24.

49 Alameda County Perinatal Pilot Project: Project Overview. Alameda County Perinatal Substance Abuse Coordinating Council & Alameda County Board of Supervisors. 1990.

discharged directly from hospitals to foster care, 56% had been in two or more foster homes, and 20% had been in more than three foster homes. There was even one child who in the first three years of his life had been placed in eight different foster homes.[50] Many other problems were anticipated as these children enter the already overburdened educational system. Educators often described cocaine-exposed children as reacting in one of two ways to the natural distractions of the classroom. These children were expected to either become uncontrollable or else withdraw completely.[51] Intense special education and guidance was expected to be necessary to ameliorate the direct effects of drug exposure. These also often lessen the impact of socioeconomically disadvantaged environments. Some educators believed that this wave of hypersensitive children with short attention spans would require a reevaluation of current special education theories and methodology.[52]

In these times of limited health care resources, the problem of drug-exposed infants represents a further drain on limited services. In many high risk regions, such as the nearby Oakland flatlands, there is an increasing trend of "boarder babies," infants who remain at the hospital while awaiting family placement. States such as Florida and Illinois have passed laws to require Child Protective Services reporting of all drug-exposed babies. These laws have increased the numbers of babies "boarding" in hospitals while awaiting CPS attention because of the overload on the system. One hospital in Miami often has 20-30 boarder babies. In 1989, there were 300 children under age two who

---

50 *Supra* note 48, at 24.

51 *Supra* note 42, at 19.

52 Wehling, C. "The Crack Kids are Coming." *Principal.* 1991; 70: 12-13.

boarded in New York City hospitals.[53] These "boarder" infants are using a disproportionate amount of valuable medical resources and services.

The economic costs of neonatal fetal cocaine exposure are large. The monetary impact on social service and health care agencies will undoubtedly impact greatly on a social system already suffering from budget restraints. A recent analysis concluded that neonatal hospital costs were $5200 more for cocaine-exposed infants than for unexposed infants.[54] Phibbs and his research groups also determined that the cost of a drug-exposed but medically well infant who remains in the hospital awaiting foster care and social evaluation was $7700 more than an unexposed infant. Cocaine-exposed babies also require on average 17 more days of hospitalization than unexposed babies. Other researchers have examined the costs of providing early intervention education programs to crack babies. In Los Angeles, while the cost of educating a child in a regular classroom is $3500 annually, the cost for the city's pilot project for drug-exposed children was $15,000 per child annually.[55] The aforementioned costs are only a small sample of the financial expenses for a cocaine exposed child; the real total costs of cocaine babies is undoubtedly much higher.

The effects of prenatal drug exposure on the developing fetus makes the rise in popularity of drugs among women of child-bearing age a serious problem. Not only can prenatal drug exposure result in devastating physiological and developmental consequences in the infant/child, but the resulting behavioral problems may translate into high costs for the social service and educational systems. No one is quite sure how high the total cost of perinatal substance abuse is, but the higher the anticipated cost, the greater the sense of crisis.

---

53 McCullough, Charlotte B. "The Child Welfare Response." The Future of Children. 1991; 1: 65.

54 *Supra* note 11.

55 *Supra* note 41.

CHAPTER THREE: PRENATAL CARE

Because this paper explores the possible deterrent effect of a policy of criminalization on the use of prenatal care, it is important to consider briefly why receiving prenatal care during a pregnancy is important. This chapter considers the impact of adequate prenatal care not only on birth outcomes, but also on the psychology of the mother and child. Although most of the research has focused on the benefits of prenatal care in the normal uncomplicated healthy pregnancy, this section concludes with a description of the positive role that prenatal care can play in improving the birth outcomes in pregnancies of substance-abusing women.

Reintroduced by the nursing profession in the early 20th century, prenatal care has been a staple in the fight to reduce maternal and infant mortality in this century. In 1912, the Children's Bureau was established to address the problems of maternal and infant mortality. This legislation represented the federal government's first acknowledgement of its responsibility to promote the welfare of the nation's children. This program along with the passage of the Sheppard-Towner Act and the establishment of maternal mortality committees produced the steepest decline in the maternal mortality rate between 1920 and 1940.[56] Attention gradually shifted from maternal mortality and morbidity to include discussions on reducing infant morality rates. Between 1960 and 1980, the United States experienced its greatest decline in infant morality rates; rates decreased from 24.7 per 1000 live births to 17.7 per 1000 live births.[57] Many

---

56 Lesser, Arthur J. "The Origin and Development of Maternal and Child Health Programs in the United States." *American Journal of Public Health.* 1985; 75: 590-591.

57 Hobel, Calvin J. "Perinatal Care of High Risk Prevention of Low Birthweight." Presented at the Region IX conference on Infant Mortality, Scottsdale, AZ. September 19, 1985; 6.

factors contributed to this decline including improved economic conditions and living standards, better medical technology, and development of maternal and perinatal services.[58]

Ample evidence suggests that prenatal care is associated with numerous improvements in pregnancy outcome including lower incidence of preterm birth and complications of delivery. Prenatal care is particularly important in the reduction of the incidence of low birthweight births. The United States lags behind other developed countries in terms of infant mortality. The poor infant mortality ranking results primarily from the high incidence of low birthweight births in this country. Low birthweight babies--those who are less than 2500 grams at birth--have higher rates of neonatal morality. The Robert Wood Johnson Foundation Regional Perinatal Care Program in 1975-1980 resulted in fewer neonatal deaths and increased survival of low birthweight infants. In addition, programs providing more comprehensive prenatal care result in greater improvements in birth weights.[59] One prospective randomized study found that comprehensive care was related to higher birth weights for primiparous women.[60] Locally in Alameda County, data indicate that mothers who receive no prenatal care are four times more likely to give birth to low birthweight babies and eight times more likely to give birth to very low birthweight babies than mothers who begin prenatal care in the first trimester.[61] Interestingly, although high socioeconomic status correlates with lower infant mortality rates for both Whites and African-Americans, African-Americans have

---

58 *Id.*

59 Jackson, James E. "Review of Maternal and Perinatal Health." Lecture, August 18, 1991: 5.

60 McLaughlin, Joseph F. et al. "Randomized Trial of Comprehensive Prenatal Care for Low-Income Women: Effect on Infant Birth Weight." *Pediatrics*. 1992; 89: 128.

61 "Healthy Start Proposal: Oakland's Infant Mortality Reduction Initiative 1991-1996." Alameda County Health Care Services Agency. July 15, 1991: 7.

consistently higher rates of low birthweight than whites.[62] One of the major contributors to the poorer birth outcomes in African-American women is that African-Americans are usually further along in their pregnancies before they are able to access prenatal care.[63] However, African-American women and whites wait approximately the same length of time into their pregnancy before they seek care. That African-American women must wait longer for their care points out the key relationship between poor birth outcome and access to care.

Aside from addressing medical complications and problems of pregnancy, prenatal care also aims to provide psychosocial support for pregnant women. First, the physical and hormonal changes of pregnancy greatly impact the psychological processes of the woman and often bring unresolved psychological issues into the limelight. For the drug-abusing pregnant woman, these psychological issues are compounded by her problems of drug use and other negative social process associated with her drug use. For instance, given the dysfunctionality of their own childhood and families, pregnant addicts lack appropriate role models to be good mothers. Moreover, pregnant addicts have issues of guilt and poor self-esteem that impair the belief in becoming good parents. Prenatal care for these women can address these issues. Second, drug-abusing mothers are often so involved in their drugs that they are unable to consider their unborn babies. The attention of prenatal care can help in triggering awareness of the unborn babies. Substance-abusing women are more likely to complain of medical problems than male abusers and often hold grave misconceptions of pregnancy and drug use. Prenatal care educates these women about their pregnancies, their drug use, and good health practices. Finally, the

---

62 Gould, Jeffrey B. & Susan LeRoy. "Socioeconomic Status and Low Birth Weight: A Racial Comparison." *Pediatrics*. 1988; 82: 896.

63 *Supra* note 61.

use of prenatal care by drug-addicted women can also serve as an entree for other public health interventions in this high-risk population. For example, health professionals can introduce these women into drug treatment programs, AIDS education, homeless shelters, and nutrition/food programs. Since women involved in drugs are more likely to be in abusive relationships, referring these women to battered women's shelters and other counseling services is an additional benefit of prenatal care.

There is also a proven economic advantage to providing women with prenatal care. Because medical costs for low birthweight babies are considerably higher than for normal babies, the provision of prenatal care and the resulting decrease in the numbers of low birthweight infants results in considerable savings in health care costs. One study examining Missouri's Medicaid program found that while prenatal care costs were $233 per pregnancy, newborn and post-partum medical costs were $347 lower per pregnancy when prenatal care was provided.[64] The Institute of Medicine found that for each $1 spent on prenatal care for low SES women, $3.38 was saved in first year medical care costs of the infant.[65] Authors of the Phibbs, Bateman and Schwartz study cited above concluded that lack of prenatal care among drug-abusing women was a major contributor to increased neonatal costs.[66]

Despite overwhelming evidence testifying to the positive results of prenatal care, significant barriers to prenatal care exist for many segments of the population. Approximately 25-33% of pregnant women in the United States do

---

64 Schramm, Wayne F. "Weighing Costs and Benefits of Adequate Prenatal Care for 12,023 Births in Missouri's Medicaid Program, 1988." *Public Health Reports*. 1991; 107: 647.

65 Brown S.S., ed. *Prenatal Care: Reaching Mothers, Reaching Infants*. Washington, DC: National Academy Press. 1988.

66 *Supra* note 11, at 1526.

not receive continuous prenatal care beginning early in their pregnancies.[67] 7.2% of all infants born in California in 1989 either had no prenatal care or care only in the third trimester.[68] Not only are fewer physicians offering obstetrical services, but fewer obstetric physicians are accepting MediCal (MediAid) patients. Other barriers to getting prenatal care include lack of transportation, inability to afford care, problems with Medi-Cal, and inadequate child care.[69] Significantly, in this same study, the use of drugs was a serious barrier to care for low-income women; the subjects reported that either they refused care because of their drug use or they avoided care for fear of disclosure.[70] Aside from these socioeconomic barriers to care, motivational and behavioral factors also affect the woman's decision to seek prenatal care. Researchers of the above study found that some women did not seek care because they did not think that it was important or because they were too "depressed."[71]

The benefits of adequate prenatal care seem to be well-supported in the normal pregnancy uncomplicated by drug use. The question is whether prenatal care can benefit birth outcomes in drug-abusing women. Ira J. Chasnoff, one of the nation's leading experts on prenatal cocaine use, conducted a study that examined the birth outcomes of two groups of women who either used cocaine only in their first trimester of pregnancy or used throughout the pregnancy. Those women who received prenatal care with cessation of drug use in their first trimester had improved rates of preterm delivery, low birthweight, and

---

67 "Prenatal Care: Reaching Mothers, Reaching Infants." Institute of Medicine. Washington, D.C.: National Academy Press. 1988.

68 "Advance Tables for 1989 from the Health Data Summaries for California Counties." Health Data and Statistics Branch. Sacramento, California. Department of Health Services. 1991.

69 Aved, Barbara M. et al. "Barriers to Prenatal Care for Low-Income Women." *Western Journal of Medicine.* 1993; 158: 496.

70 Id.

71 Id.

intrauterine growth retardation.[72] Because prenatal care and education may lead to the cessation of drug use, this finding is significant. Another population-based retrospective study based on toxicological screening at delivery found that cocaine-using women with no prenatal care had a 60% chance of delivering a low birthweight infant, while the risk to women with four or more prenatal visits improved to 40%. MacGregor *et al.* conducted a case controlled study that found that substance-abusing women with comprehensive prenatal care had higher mean birth weights, higher mean gestational ages, and lower incidence of preterm deliveries than the group of women who received little or no care. However, even with comprehensive prenatal care, substance-abusing women still had poorer statistics in terms of birth weight, gestation age, and preterm deliveries compared to controls. Thus, although prenatal care can significantly reduce complications of pregnancy and improve birth outcomes, "perinatal morbidity associated with cocaine abuse cannot be eliminated solely by improved prenatal care."[73]

Besides improving perinatal outcomes, adequate prenatal care also provides less measurable psychosocial benefits. For instance, the attention and counseling provided during prenatal care visits may help the drug-addicted mother face certain psychological issues that would otherwise cause her to abuse her child; savings resulting from foster care and other social services further testify to the benefits of prenatal care in this population.

For the past century, the United States has made active attempts to reduce maternal and infant mortality. A large part of this goal has been accomplished through the expansion of prenatal care and perinatal services. Not only has

---

72 *Supra* note 36, at 1741, 1744.

73 MacGregor, Scott N. et al. "Cocaine Abuse During Pregnancy: Correlation Between Prenatal Care and Perinatal Outcome." *Obstetrics & Gynecology*. 1989; 74: 885.

prenatal care generated significant improvements in the birth outcomes of low-income populations, its use seems also to have ameliorated some negative effects of prenatal drug exposure. Given these facts, an important tool to reduce the negative consequences of prenatal substance abuse is the expansion of prenatal care services to pregnant women who are also substance-abusers. Current attempts nationally and locally target this high-risk population for perinatal care services. For example, a large component of Oakland's Healthy Start Initiative to reduce infant mortality in the county aims at promoting social and medical services for women substance abusers.[74] Policies which decrease utilization of services would greatly affect the goal of reducing complications of prenatal drug exposure. Thus, a question of great importance is whether or not criminalization of drug-addicted women will result in decreased utilization of prenatal care. The purpose of the qualitative interviews described below is to explore the psychological and social processes that are involved in a pregnant drug addict's decision to seek prenatal care and to determine how these processes are affected by the fear of detection and prosecution.

---

74 *Supra* note 61.

PART TWO: The Criminalization of Perinatal Substance Abuse

Many communities have responded to the epidemic of maternal drug use with non-legal approaches including education, prenatal counseling, and residential treatment. States including California, Florida, and Washington have funded new drug treatment programs and research specifically dedicated to the needs of drug-abusing pregnant women. Nonetheless, pressured by such societal forces as the administration's "war against drugs," increased public awareness of the issue, and the "fetal rights" controversy stemming from the abortion debate, many communities have increasingly turned to the legal system for the answers to this problem.

Legal and philosophical writers present varied arguments regarding criminalization of perinatal substance abuse. One of the most commonly debated legal issues concerning perinatal substance abuse has been the scope of constitutional rights of both mother and child and the constitutionality of criminalization. Authors have argued that criminalization violates a woman's fundamental rights to bodily integrity and autonomy as protected by Fourteenth Amendment rights to liberty and privacy.[75,76] Others base their constitutional argument on the equal protection clause of the Fourteenth Amendment.[77] Still others argue that the Eighth Amendment prohibits punishment based on status

---

75 Johnsen, Dawn E. "The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection." *Yale Law Journal.* 1986; 95: 600.

76 Note. "Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of 'Fetal Abuse'." *Harvard Law Review.* 1988; 101: 998-1002.

77 Oberman, Michelle. "Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs." *Hastings Law Journal.* 1992; 43: 541.

as "cruel and unusual."[78] While these constitutional issues are critical to the overall debate, they are beyond the scope of this paper.

In the deliberation over criminalization of perinatal substance abuse, two further issues have been on the forefront of moral and legal debate. The first concerns legal abortion and its relationship to the prosecution of drug-addicted mothers. Some authors have suggested that *Roe v. Wade*,[79] which protected a woman's legal right to decide whether or not to bear a child, jeopardized any claim for state intervention to protect the fetus. One author comments, "Whatever social, medical, or legal sanctions that existed for protecting the fetus against potential abuse during pregnancy in the past may have been seriously compromised by the Supreme Court's abortion decision."[80] However, the woman who chooses to abort her pregnancy does not aim to harm her fetus.[81] *Row v. Wade* protected the right to control the outcome of a pregnancy, not the right to harm the fetus. In her review of maternal and fetal harms, Deborah Mathieu identified pregnancy outcome as the "right" women are protecting: "[a woman's interest in an abortion stems from] her desire not to be pregnant, her desire not to bear a child, and her desire not to have a child of hers exist." The woman does not have the right to "harm" her child. Thus, abortion rights are not necessarily jeopardized by criminalizing drug use during pregnancy. Moreover, the argument against criminalization cannot rely on a reference to abortion rights. A drug-addicted woman is most likely to be prosecuted after her child is born. At this point, the woman has conceived the child and made the decision

---

78 Romney, Tiffany M. "State's Interest in Protecting the Rights of a Fetus Versus the Mother's Constitutional Rights to Due Process, Privacy and Equal Protection." *Journal of Contemporary Law*. 1991; 17: 325-344.

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

80 Lappe, Marc. "The Moral Claims of the Wanted Fetus". *Hastings Center Report*. April 1975; 5: 11.

81 This assumption does raise the issue of whether or not nonexistence itself constitutes a harm.

either consciously or unconsciously to forgo an abortion. Claims made on behalf of the fetus now carry more weight as they can be considered as those of a "future child."

The second topic related to the issue of maternal criminal liability for prenatal drug exposure is fetal intervention. Generally defined, the debate over fetal intervention involves the conflict between maternal rights and fetal rights in decisions about medical treatment and/or behavioral limitations that are imposed on the mother to benefit the infant. For example, a prenatal surgery via the mother will correct the developmental pulmonary abnormality of her infant before it is born. Arguments both for and against fetal intervention are similar to those debated over criminalization because in each case the interests of the state in protecting the fetus clash with the privacy and autonomy interests of the woman.

However, there does seem to be a fundamental difference between requiring a women to undergo a surgical treatment and requiring a woman to stop her drug use. Unlike criminalization of drug use during pregnancy, fetal intervention typically does not involve the blameworthiness of the mother because the danger to the fetus is not the result of the mother's illegal act. The state's interest in intervening is solely to protect the fetus, not to punish the mother. Moreover, criminal action, which involves the use of the state's vast criminal resources and possible incarceration is a much more severe action than fetal intervention. In addition, active intervention for fetal therapy can pose risks to the mother while abstaining from drug use during a pregnancy does not create any significant negative risk for the mother (aside from possible physical and emotional withdrawal). On the contrary, the decision not to use drugs has obvious benefits for the mother. Finally, drug use during pregnancy involves an illegal act. This illegality generates questions and problems less relevant to fetal

intervention. Hence, the conclusion must be that arguments for one issue are not entirely appropriate for the other since fundamental differences exist in the mother's situation.

Given these caveats in the discussion of criminalization, these next chapters focus on how well criminalization of perinatal substance abuse follows the basic theories behind criminal law and punishment. Chapter Four briefly addresses the application of civil abuse and neglect statutes to prenatal drug exposure, as well as other state public health measures aimed at this problem. This chapter concentrates on the criminalization of perinatal substance abuse and provides an overview of key judicial cases on the subject. Chapter Five introduces the basic criminal theories behind punishment and examines how each applies to the problem of maternal drug abuse. The arguments supporting a policy of criminalization are examined in this context. Chapter Six considers the mental component or mens rea requirement for criminal liability. In these two chapters, I will show that while strong legal arguments can be made against criminalization, a stronger basis against criminalization lies in the policy arguments. Chapter Seven considers some of these practical arguments against the use of criminal law for maternal substance abuse during pregnancy.

CHAPTER FOUR: OVERVIEW OF CIVIL AND CRIMINAL CASES

State laws reflecting punitive approaches to drug use during pregnancy encompass not only existing criminal statutes, but also civil child abuse or neglect laws. Some states have enacted new laws defining drug use during pregnancy as a criminal act or as abuse or neglect. Others have amended existing civil laws and criminal laws to apply to maternal substance abuse during pregnancy. As of 1990, states which have based their efforts not on criminal statutes, but on existing civil abuse and neglect statutes include Florida, Hawaii,

Illinois, Indiana, Massachusetts, Minnesota, and Oklahoma.[82,83] In these states, evidence of drug exposure during pregnancy constitutes abuse or neglect. Most notably, in 1989 and 1990, Minnesota created specific legislation aimed not at criminal sanctions for drug abuse, but at early identification and provision of services.[84] Although substance exposure during pregnancy can constitute neglect or abuse under Minnesota state laws, the legislation includes a plan of mandatory reporting, care and treatment services including investigation and assessment teams.[85] The Minnesota policy is the most comprehensive plan for state intervention during a drug-addicted woman's pregnancy. A potential model for future state plans, the Minnesota program holds promise as a new method of handling this problem; however, concrete data on the success and efficacy of this method are not yet available.

Some states which require mandatory reporting of all positive tox screens have created additional statutes to encourage the use of prenatal care and drug treatment. For example, in Iowa, tox screen test results cannot be used as the sole basis for prosecution against drug-addicted women. The rationale behind these

---

82 Moore, Kathryn G. ed. "Substance Abuse & Pregnancy: State Lawmakers Respond with Punitive and Public Health Measures." *The American College of Obstetricians and Gynecologists Legis.* 1990; 9: 3.

83 They have amended their abuse and neglect laws to include specifically a newborn who shows physical signs of drug exposure or dependency, thereby requiring reporting of these infants under state mandatory reporting of child abuse laws. See, for example, definitions of abused or neglected children in the following states: Oklahoma ('appears to be a child born in a condition of dependence on a controlled dangerous substance'); Massachusetts ('is determined to be physically dependent upon an addictive drug at birth'); Florida ('physical dependency of a newborn'); and Illinois ('a newborn infant whose blood or urine contains any amount of a controlled substance... or a metabolite,' except as a result of medical treatment.)
Okla. Stat. Ann. tit. 21, section 846 (A) (West Supp. 1991); Mass. Gen. Laws Ann. ch. 119, section 51A (Law. Coop. Supp. 1990); Fla. Stat. Ann. section 415.503(9) (a) (2) (West Supp. 1990); Ill. Ann. Stat. ch. 23, section 2053 (West Supp. 1990).
Supra note 27, at 77.

84 Minn. Stat. Ann. section 626.5562 (1) (West Supp. 1990)

85 Steven, Sonya & A.S. Ahlstrom. "Perspective from a Minnesota County Attorney's Office". *The Future of Children.* 1991: 1: 93.

statutes is to detect women who use drugs during their pregnancy and to promote drug treatment as an option for them without creating fear of prosecution. The hope of Iowa's state legislation passed in 1990 is that "by keeping their [pregnant women's] names off of the permanent child abuse records and offering comprehensive services in return for full cooperation with service providers and abstinence, the state provides an incentive for substance-abusing pregnant women to seek prenatal care and substance abuse treatment."[86] Additionally, in Iowa, women who are pregnant and found to be drug users can choose to undergo drug rehabilitation and be protected from criminal liability for child abuse. California has similar legislation, also adopted in 1990. This law requires that medical professionals or social workers investigate all positive drug screen before reporting and that a positive test alone it not sufficient basis for reporting child abuse or neglect.[87] Thus, a positive toxicological test only involves Child Protective Services when the investigation reveals evidence of abuse or neglect. In addition, many states such as California have created state programs and task forces aimed at providing services, education, and treatment to both drug-exposed children and drug-addicted women.

Perhaps the most heated legal debate about the problem of perinatal substance abuse has been over the use of various criminal statutes, including criminal neglect,[88] drug trafficking,[89] and involuntary manslaughter.[90] The Center for Reproductive Law and Policy found that as of April 1992, 167 women

---

86 *Supra* note 82, at 4.

87 1990 Cal. Stat. ch. 1603 (California Senate Bill 2669)

88 California v. Stewart, No. M508197 (San Diego Mun. Ct., Feb. 23, 1987)

89 Johnson v. Florida, 602 S.2d 1288 (Fla. 1992)

90 McGinnis, Doretta Massardo. "Prosecution of Mothers of Drug-Exposed Babies: Constitutional and Criminal Theory". *University of Pennsylvania Law Review*. 1990: 139: 507.

in 24 states had been arrested on criminal charges related to illegal drug use, alcohol use, or failure to follow a physician's orders during pregnancy.[91] Although many of these cases reached state appeals courts, only two were heard by state supreme courts. As of 1993, no criminal cases of in utero or post-partum transmission of a controlled substance have been upheld by state supreme or intermediate courts.[92]

In the first case involving the criminal prosecution of a drug-addicted mother, Pamela Rae Stewart was arrested under a California child support statute for neglecting to follow medical advice and failing to summon medical help.[93] Against her doctor's instructions, Ms. Stewart consumed some amphetamines, had sexual intercourse with her husband, and neglected to contact medical authorities when she began hemorrhaging. Her son, Thomas, was born with massive brain damage and died six days later.[94] A San Diego municipal court judge ruled that the state did not have the power to apply the statute to this situation because the law was not intended to regulate a pregnant woman's conduct.[95] This decision was in part based on *Reyes v. Superior Court* [96] in which prosecutors attempted to charge a woman for felony-child endangerment for taking heroin during her pregnancy. The court ruled that the statute governing felony-child endangerment did not include an unborn child or fetus in its definition. Nonetheless, the Stewart case made future cases against drug addicted mothers feasible because of the court's suggestion that liability

---

91 "Punishing Women for their Behavior During Pregnancy: A Public Health Disaster." The Center for Reproductive Law and Policy. February 2, 1993.

92 Id.

93 California v. Stewart, No. M508197 (San Diego Mun. Ct., Feb 23, 1987)

94 Chambers, Marcia. "Dead Baby's Mother Faces Criminal Charge on Acts in Pregnancy". *New York Times*. January, 1986.

95 Chambers, Marcia. "Charges Against Mother in Death of Baby are Thrown Out". *New York Times*. February 27, 1987; 25A.

96 Reyes v. Superior Court, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977)

would have been appropriate if the legislature passed a specific bill intended for protection of the fetus.[97] The legislature has so far not passed any such statute, so in San Diego, prosecutions under the current child support statute are not possible.

As the court did in the case of Pamela Rae Stewart, many other courts have ruled that criminal statutes were not intended to cover fetuses because the historical definition of "persons" does not include fetuses. To overcome this obstacle, prosecutors have filed charges based on delivery of drugs during the short time after birth and before severing the umbilical cord. The 1989 Florida case of Jennifer Johnson highlights the prosecutors' sometimes drastic attempts to apply existing statutes to these cases of prenatal drug exposure. In October, 1987, Ms. Johnson delivered a son who tested positive for a metabolite of cocaine after she admitted to using crack before she delivered. Then again in December, 1988, Ms. Johnson took $200 of crack while she was pregnant with her daughter. She was concerned about the effects on her unborn child so she called the paramedics who took her to the hospital for observation. In January, 1989, when she was in labor, Ms. Johnson admitted to her doctor that she had used cocaine earlier that morning. The postpartum investigation by Florida's Department of Health and Rehabilitative Services revealed that she had smoked pot and crack cocaine every other day throughout her second pregnancy and that she been using cocaine consistently for at least three years during which time her son and daughter were born. Jennifer Johnson was prosecuted under a Florida state statute for "delivery of a controlled substance to a minor."[98] The county court

---

97 California v. Stewart, No. M508197 (San Diego Mun. Ct., Feb 23, 1987)

98 Section 893.13(1) (c)1., Florida Statutes (1989) provides for the following:
(c) Except as authorized by this chapter, it is unlawful for any person 18 years of age or older to deliver any controlled substance to a person under the age of 18 years, or to use or hire a person under the age of 18 years as an agent or employee in the sale or delivery of such a substance, or to use such

held that during the short time when the infant is physically separate from the mother, drugs delivered to the infant via the umbilical cord constitute the delivery of drugs to a minor.[99] The first woman to be convicted of prenatal drug abuse, Ms. Johnson was sentenced by the Florida county court to 15 years probation, enrollment in a treatment and rehabilitation program, and court supervision during any future pregnancies.

The District Court of Appeal of Florida affirmed the case in a split decision. The question of whether or not delivery of a controlled substance through the umbilical cord after birth violates state statutes was certified for review by the state supreme court. In a dissent to the court of appeal opinion, Judge W. Sharp stated:

> In my view, the primary question in this case is whether section 893.13(1) (c)1. was intended by the legislature to apply to the birthing process. Before Johnson can be prosecuted under this statute, it must be clear that the legislature intended for it to apply to the delivery of cocaine derivatives to a newborn during a sixty-to-ninety second interval, before severance of the umbilical cord. I can find no case where "delivery" of a drug was based on an involuntary act such as diffusion and blood flow. Criminal statues must be strictly--not loosely-construed.[100]

The Florida Supreme Court decided that such an act did not violate the prohibition against adult delivery of a controlled substance to a minor. Specifically, the court stated:

> [The] legislative history of the statute did not show a manifest intent to use the word 'delivery' in context of

---

person to assist in avoiding detection or apprehension for a violation of this chapter. Any person who violates this provision with respect to:
1. A controlled substance ... is guilty of a felony of the first degree...

99 Florida v. Johnson, No. E89-890-CFA slip op. (Seminole Cty., Fla. Cir. Ct. July 13 1989).

100 Johnson v. Florida, 578 SO.2d 419 (Fla. Ct. App. 1991) (Sharp, J. dissenting).

> criminally prosecuting mothers for delivery of a controlled substance to a minor by way of the umbilical cord. This lack of legislative intent coupled with uncertainty that the term "delivery" applies to the facts of the instant case, compels this court to construe the statute in favor of Johnson.

The highest court of the state of Ohio also found that existing statutes of child endangerment did not apply to use of drugs during pregnancy. Tammy Gray was indicted in 1988 for child endangering because she used cocaine during the last trimester of her pregnancy. The trial court determined that application of the statute was not appropriate and dismissed the case. Both the state appeals court[101] and the state supreme court[102] upheld the decision by reaffirming the trial court's interpretation of the child endangerment statute.

In August of 1989, one month after the Johnson case, prosecutors in Michigan similarly charged Kimberly Hardy for delivering crack to her son through the umbilical cord. Her son tested positive for drugs after Ms. Hardy had smoked crack thirteen hours prior to the birth. Only recently, in April 1991, the Michigan Court of Appeals held that the state statute was not intended to apply to cases of drug delivery via the umbilical cord.[103] Leave to appeal to the state supreme court was denied.

There have been three more recent state appellate court decisions including *State v. Gethers*[104], *Welch v. Commonwealth*[105], and *People v. Morabito.*[106] In *State v. Gethers*, Ms. Gethers was charged with aggravated child abuse after her daughter was born drug dependent. The court decided that the child abuse statutes were not intended for application in this circumstance and

---

101 State v. Gray, WL 125695 (Ohio App. Aug. 31, 1990) (unreported).
102 State v. Gray, 584 N.E.2d 710 (Ohio 1992).
103 *Supra* note 90.
104 585 So. 2d 1140 (Fla. App. 1991).
105 No. 90-CA-1189-MR (Ky. App. Feb. 7, 1992).
106 580 N.Y.S.2d 843 (City Ct. 1992).

dismissed the charges. This decision was upheld by the court of appeals, which cited the same rationale along with the fact that the state's policy was "to preserve family life by enhancing parental capacity to provide adequate child care."[107]

In *Welch v. Commonwealth*, the defendant was charged with second degree criminal abuse of a person, possession of Schedule II narcotics, and possession of drug paraphernalia when her son experienced mild withdrawal symptoms after birth after she had injected herself with Oxycodone during the pregnancy. The jury found the defendant guilty on the basis that although the act occurred prior to birth, the infant suffered the injury of withdrawal after he was born and considered a "child." In 1992, the court of appeals reversed this decision by again concluding that these statutes were not intended to apply to these circumstances of drug exposure.

Finally, in *People v. Morabito*, the court dismissed child welfare endangerment charges against a woman who had allegedly smoked cocaine during her pregnancy on the grounds that the court may not extend the reach of the statute to include fetus within the definition of "child." In this decision, the court also found that important public policy and due process considerations argue against the prosecution of mothers for drug transfer via the umbilical cord.

While the delivery of drugs to a minor has been used in many prosecutions, more serious charges of manslaughter have also been brought against women who abused drugs during their pregnancies. In May 1989 in Illinois, local prosecutors attempted to charge Melanie Green with manslaughter and delivery of drugs to a minor when her baby died shortly after birth.[108] However, the charges were dropped when the grand jury refused to indict. In

---

107 Merrick Janna C. "Maternal Substance Abuse During Pregnancy: Policy Implications in the United States." *Journal of Legal Medicine*. 1993; 14: 64.

108 *Supra* note 90.

Oakland, California, a women pleaded guilty to manslaughter when her crack use led to the death of premature twins.[109]

While states have considered the application of criminal statutes to maternal substance abuse, these cases appear to be isolated instances occurring only in a small group of states. Because most courts considering this issue have ruled against the application of existing statutes to perinatal substance abuse, the primary issue currently is the enactment of new legislation directed specifically at drug-addicted women. Consideration of the legal issues and practical issues involved in this policy is essential before implementation of new statutes. The following chapters in Part Two focus on these legal and practical considerations.

CHAPTER FIVE: BASIC THEORIES OF PUNISHMENT AND THEIR APPLICATION TO CRIMINALIZATION OF PERINATAL SUBSTANCE ABUSE

Four main theories provide the basis for society imposing penalties on individuals who violate laws. Punishment serves 1) to effect retribution for the act; 2) to provide deterrence to others who may consider committing the same act; 3) to reform the criminal; and/or 4) to prevent further harms from this act. In his review of the theories justifying punishment, Kent Greenawalt organizes these four main justifications and other arguments into two broad categories--those that are "retributive" in nature and those that are based on "utilitarian" views.[110] Retributive reasons for punishment are those which have their foundation in issues of "moral wrongs," "revenge," and "deserving punishment." The utilitarian viewpoint, which encompasses the other three theories, emphasizes the praticality and purposefullness of punishment and criminal law. Using Greenawalt's structure, I will address each justification and discuss how

---

109 "Mother Charged in Coke Death of Infant". *Oakland Tribune.* May 19, 1989.

110 Greenawalt, Kent. "Punishment." In: Kadish, Sanford H. *Encyclopedia of Crime and Justice.* New York: Free Press. 1983; 1336-1346.

each applies to criminalization and punishment of perinatal substance abuse. I will consider the leading arguments supporting criminalization.

I. Retributive Justification of Punishment

Simply stated, the arguments based on retribution rely on a "doctrine of legal revenge"[111] in that the infliction of punishment occurs solely because the perpetrator "deserves" the punishment for doing some moral wrong. On one level, retributive theories are based on a symbolic value of punishment; that is, punishment allows society to "condemn" wrong-doing. This justification of punishment emphasizes the distinction between civil torts and criminal law. In criminal law there is an emphasis on the morality of the act, whereas tort law considers only the damage from an act. In Kant's island society, he proposed that even if the community were about to disband, it should execute its last murderer. Kant argued that the failure to do so would reflect negatively upon the entire society and everyone in that society would be considered a "participator" in the murder.[112] As J. Feinberg commented:

> This Kantian idea that in failing to punish wicked acts society endorses them and thus becomes particeps criminis does seem to reflect, however dimly, something embedded in common sense. A similar notion underlies whatever is intelligible in the widespread notion that all citizens share the responsibility for political atrocities...[113]

Under this view, the woman who uses drugs during her pregnancy causes "harm" to her child. The overestimates of fetal harm have resulted in calls for

---

111 Commonwealth v. Ritter. Court of Oyer and Terminer, Philadelphia, 1930, 13 D. & C.285. In: Kadish, Sanford H. & Paulsen, Monrad G. *Criminal Law and its Processes: Cases and Materials*. Boston: Little, Brown and Company. 1975.

112 Kant, Immanual. *The Philosophy of Law: An Exposition of the Fundamental Principles of Jurisprudence as the Science of Right*. Translated by W. Hastie. Edinburgh: T. & T. Clark: 1887. 198.

113 Feinberg, J. *Doing and Deserving: Essays in the Theory of Responsibility*. Princeton, N.J.: Princeton University Press. 1970.

more intense retribution. The woman's punishment is justified because it is "morally wrong" to harm a fetus in that way. If we fail to punish her, then we are accessories to her moral crime.

Three main criticisms of this justification of maternal drug abuse can be made. First, the retributive argument places a large emphasis on the individual's moral guilt for committing a wrong. As Greenawalt points out, "if all our acts are consequences of preceding causes over which we ultimately have had no control, causes that were set in motion before we were born--if, in other words, philosophical determinism is true--then the thief or murder is...more a victim of misfortune than a villain on the cosmic stage."[114] In the case of the drug-addicted woman, the root causes of her drug addiction may be poverty, family dysfunction, sexual abuse, and mental illness. She has no control over these contributors to the moral wrong of exposing her infant drugs. Moreover, retributive theories presuppose "free will" in the decision to violate social norms. As will be addressed more fully below, drug addiction is widely believed by public health and medical professionals to be a "disease." Under this disease model, the drug user has no "free will" since the addictive nature of the drugs compels the user to commit the act. These critics of retribution theory point to the absence of mens rea, the mental component required of any criminal act. The concept of mens rea will be addressed below.

Finally, if the purpose of punishment were to redress moral guilt, then all moral wrongs and guilts should be treated with the same seriousness and severity. This argument can be traced to Aristotle's theory of corrective justice in which he stated:

> For here it does not matter if a decent person has taken from a base person, or a base person from a

---

114 *Supra* note 110, at 1338.

> decent person, or if a decent or a base person has committed adultery. Rather, the law looks only at differences in the harm [inflicted], and treats the peole involved as euqals, when one does injustice while the other suffers it, and one has done the harm while the other has suffered it.[115]

For example, because cigarette smoking during pregnancy has been shown to lead to some adverse effects on the developing fetus,[116] punishment should be similar for smoking mothers and for crack-using mothers. However, in current society, cigarette smoking does not invite the same treatment as crack cocaine or indeed, any punishment at all despite the fact that morally, they can be considered equivalent. Although retribution might still be justified on the basis that penalties for moral transgressions are in the public interest and therefore override the concerns stated above, the retribution theory has lost much of its power.

Supporters of retributive theories also claim a second level of justification. However vindictive the punishment, because the crime is a violation of social norms, the symbolic value of punishment reinforces other goals such as deterrence. In other words, by reaffirming public condemnation, punishment improves deterrence. Clearly, the problem of "drug babies" represents a large burden on society. In this sense, the society has worthy and justifiable interests in upholding social norms through criminal law and the threat of punishment. By doing so, society can make a strong statement of condemnation. Hopefully, society will receive the benefits of improved deterrence of maternal drug abuse.

---

115 Aristotle. *Nicomachean Ethics*. Translated by: Terence Irwin. Indianapolis: Hackett Publishing Company. 1985; V, 1132a2-7.

116 Zuckerman, Barry. "Marijuana and Cigarette Smoking during Pregnancy: Nenonatal Effects." In: Chasnoff, Ira J., ed. *Drugs, Alcohol, Pregnancy and Parenting*. Boston: Kluwer Academic Publishers. 1988: 73-89.

In the introduction of a poignant account of one family's adoption of a child with fetal alcohol syndrome, Louise Erdrich writes,

> The people who advocate forcing pregnant women to abstain from drinking come from within the communities dealing with a problem of nightmarish proportions. Everyone agrees that the best answer is not to lock up pregnant women, but to treat them. Now, this problem is generations in the making.[117]

While Erdrich praises the attempts at compassionate solution to the problem of drug and alcohol misuse, she expresses her frustration with the current policy's slow progress when so many children are born with irreparable harms. Criminalization may not be efficacious as far as the other goals of criminal law, but at least we can "feel better" knowing that these mothers have been punished.

Feinberg offers the following attack on this interpretation of retributive theories:

> Indeed, he [the skeptic] may even add deterrence to the list, for condemnation is likely to make it clear, where it would not other wise be so, that a penalty is not a mere price tag. Granting that point, however, this kind of skeptic would have us consider whether the ends that justify public condemnation of criminal conduct might not be achieved equally well by means of less painful symbolic machinery.[118]

By this argument, perhaps the same public condemnation of maternal substance abuse during pregnancy could still be accomplished through other means not involving the criminal system. For example, given the emotional and psychological trauma associated with the loss of one's child, however brief, the temporary suspension of parental custody until the woman can reestablish her ability to take care of her child may be sufficient condemnation. The placement

---

117 Introductory remarks in: Dorris, Michael. *The Broken Cord*. Harper Collins Publishers. 1989.

118 *Supra* note 113.

of the woman into drug treatment and rehabilitative services may also serve as a public condemnation of her actions.

Although punishment based on retribution is considered the least defensible basis for legal penalties, the concept of morally worthy punishment espoused by retribution does seem to be present in our nation's current attempts to prosecute women for drug use during pregnancy. In fact, the notion of "revenge" or "vindication" is an underpinning of all criminal law and theory. Given the lack of alternatives for combatting this problem, many professionals who must deal with children of drug-addicted moms have turned to a more "retributive" sense of justifying punishment. They see the irreparable harm produced by prenatal exposure to drugs; so while they are not convinced that criminalization can improve the situation, punishment based on the "moral wrong" that the women have committed becomes more attractive. Despite this attraction, retribution alone should not be a sufficient reason for instigating punishment of drug use during pregnancy.

II. Utilitarian Justifications of Punishment

Utilitarian theories justify criminal punishment on the basis that the overall good from such a policy outweighs the negative consequences of punishment. In the classical sense, utilitarianism was more strictly defined as maximizing the "pleasure" of an act so that the happiness derived from the act are greater than the "pains" caused by the act.[119] However, as Greenawalt proposes, a more contemporary application of utilitarianism expands this basic dichotomy of "pleasure" versus "pain" to include all positive and negative consequences of an act. Several of the theories of punishment fall within the category of "utilitarianism."

---

119 Bentham, Jeremy. "Principles of Penal Law." In: Kadish, Sanford H. & Paulsen, Monrad G. *Criminal Law and its Processes: Cases and Materials*. Boston: Little, Brown and Company. 1975; 26, 27.

Considered the most widely accepted rationale for the practice of punishment, the utilitarian theory based on deterrence supposes that after seeing the punishment given other criminals, would-be law breakers will be less likely to commit a crime. Central to the strength of deterrence arguments is the belief that the individual is able to "calculate" the risks and benefits to the supposed "immoral act" and then decide rationally on a course of action. As Bentham states,

> In matters of importance every one calculates. Each individual calculates with more or less correctness, according to the degrees of his information, and the power of the motives which actuate him...This [criminal acts], therefore, will be more successfully combated, the more carefully the law turns the balance of profit against it.[120]

Application of deterrence theories to the individual who commits the crime similarly assumes that because of utilitarian calculations, the one-time offender will be less likely to commit the same act again. Thus, under a utilitarian analysis, one may inflict stronger penalties for a second time offender in hopes that the "balance of profit" will be tipped and result in deterring the third offense.

Moreover, deterrence theories assume that the behavior of the individual can be influenced by external incentives. Despite its centrality to the argument, the idea that external incentives to avoid punishment actually influence individual behavior is not overwhelmingly supported by current research. As the National Research Council noted in its estimation of the effects of criminal sanctions on crime rates:

> [W]e cannot yet assert that the evidence warrants an affirmative conclusion regarding deterrence. We believe scientific caution must be exercised in interpreting the limited validity of the available

---

120 *Id.*

> evidence and the number of competing explanations for the results.[121]

Because of numerous sources of research bias including error in measuring crime, confoundings of deterrence and incapacitation, and the simultaneous relationship between sanctions and crime rates affecting each other, the current analyses showing a negative association between crime rates and sanction risks may not actually imply that criminal sanctions contributed to the lower crime rates and thus, deterred violation of laws. However, the National Research Council concludes by saying:

> Our reluctance to draw...conclusions does not imply support for a position that deterrence does not exist, since the evidence certainly favors a position supporting deterrence more than it favors one asserting that deterrence is absent. The major challenge for future research is to estimate the magnitude of the effects of different sanctions on various crime types...[122]

One of the arguments proposed in support of criminalization relies on deterrence theory of punishment--namely, that "when a pregnant woman chooses to pursue activity which presents a risk to her health she is also deciding to inflict similar risk on the unborn child."[123] Therefore, punishment of these women will serve as a general deterrent to this "choice" of drug activity. While on the surface the argument seems logical enough, upon closer examination there are important caveats to this assumption. First, although the woman does make a choice to use drugs the first time, the cost-benefit analysis made by her may

---

121 "Deterrence and Incapacitation: Estimating the Effects of Criminal Sanctions on Crime Rates." National Research Council. 1978. In: Kadish, Sanford H., Schulhofer, Stephen J. & Paulsen, Monrad G. *Criminal Law and Its Processes: Cases and Materials.* Boston: Little, Brown and Company. 1983.

122 Id.

123 Note, "Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus." *Southern Californian Law Review.* 1987; 60: 1223.

also include the benefits of not being pressured by her partner anymore or the cost of suffering from overwhelming psychosocial burdens. Many women are in abusive relationships with their partner, and often, their drug-addicted partners are the ones who introduce and pressure these women to try drugs. In this case, possible punishment may not be a significant enough deterrent to prevent her from using the drug. The American Medical Association also adds:

> Pregnant women who use illegal substances are obviously not deterred by existing sanctions; the reasons that prompt them to ignore existing penalties might also prompt disregard for any additional penalties. Furthermore, in ordinary instances, concern for fetal health prompts the great majority of women to refrain from potentially harmful behavior. If that concern...is not sufficient to prevent harmful behavior, then it is questionable that criminal sanctions would provide the additional motivation needed to avoid behaviors that may cause fetal harm.[124]

Perhaps more importantly, many of these women are addicted to their drug use. As Doretta McGinnis states in her analysis of the problem, "Punishing involuntary addictive behavior is unlikely to deter that behavior, because the actor is unable to control her behavior."[125]

The concept of addiction as a "disease" has been well-supported not only in medical literature, but also in this nation's legal traditions. The American Medical Association has stated that "it is clear that addiction is not simply the product of a failure of individual will power."[126] In another statement, the AMA states that "punishing a person for substance abuse is generally ineffective

---

124 "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women." *Journal of the American Medical Association*. 1990; 264: 2668.

125 *Supra* note 90, at 523.

126 "Drug Abuse in the United States: a policy report." In: Proceedings of the House of Delegates, 137th annual meeting of the Board of Trustees of the American Medical Association. June 26-30, 1988.

because it ignores the impaired capacity of substance-abusing individuals to make decisions for themselves."[127] Substance abuse disorders are characterized as mental disorders by the American Psychiatric Association. DSM-III R describes the diagnostic criteria of a substance abuse disorder: "continued use despite knowledge of having a persistent or recurrent...problem that is caused or exacerbated by the use of the ...substance."[128] The Supreme Court of the United States endorsed the notion of addiction as a disease and prohibited using the "status" of narcotic addiction as a criminal offense. In *Robinson v. California,*[129] the Court ruled that a California statute making "any person addicted to the use of narcotics" punishable by imprisonment was unconstitutional on the basis that the statute "inflicts a cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments." In the opinion, the court stated:

> The impact that an addict has on a community causes alarm and often leads to punitive measures. Those measures are justified when they related to acts of transgression. But I do not see how under our system being an addict can be punished as a crime. If addicts can be punished for their addiction, then the insane can also be punished for their insanity. Each has a disease and each must be treated as a sick person.[130]

The Court's conclusion emphasized the criminal law distinction between "status" and "acts." Given that drug addiction is a disease, the drug-addicted pregnant woman is not a rational being who "calculates" and makes a "choice" to do drugs. The irrational psychological urges of addiction may negate the existence of an *actus reus,* as required by criminal law. The woman's drug use is not an "action,"

---

127 "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women." *Journal of the American Medical Association.* 1990; 264: 2667.

128 *Diagnostic and Statistical Manual of Mental Disorders.* American Psychiatric Association. Rev. 3d ed. 1987.

129 370 U.S. 660 (1962).

130 Robinson v. California. 370 U.S. 660 (1962) (Douglas, J. concurring).

but an involuntary characteristic of her status as an addict. The role of mental requirements or *mens rea* in the Court's opinion is examined in the next chapter.

A third theory of justification of punishment, rehabilitation, relies on utilitarian goals similar to deterrence. However, the same criticisms stated above apply to this justification. Again, because addiction is a disease state, the woman may not be able to "correct" herself. The rehabilitation of women who use crack cocaine is extremely difficult given the drug's highly addictive powers. In the qualitative analysis of interviews below, I will present some examples of recurrent relapse in drug use despite threats of incarceration and the use of treatment. Moreover, rehabilitation programs, if accessible to the women, may not be appropriate for treating pregnant women. Improved treatment strategies appropriate for women may be a more logical strategy for effecting reform in this population.

Incapacitation of the offender in order to prevent further harms is the fourth theory justifying punishment under utilitarian ideals. Arguably, punishment and subsequent incarceration of the offender can decrease the "pain" of more harms to victims. Moreover, "harms" to the offender him/herself can arguably also be reduced. This theory provides one of the strongest arguments for the use of criminal laws against substance-abusing women. Prosecuting these women and incapacitating them not only reduces the harms in terms of further neglect and abuse to the drug-exposed child, but also prevents the harm of future pregnancies. For example, if a pregnant woman who is using drugs can be prevented from further drug use by legal actions based on criminal law, then the fetus will be spared the additional negative consequences of continued drug exposure. If the assumption is made that the woman who is punished for one offense will be "reformed" and "deterred" from further uses of drugs, especially during pregnancy, then future children will also be protected by this policy of

criminalization. Even if the woman is not fully rehabilitated by punishment, she is at least incapacitated and unable to affect her baby and other children negatively through her continued drug use.

This proposition supports criminalization of perinatal drug abuse; however, there are several caveats that weaken this justification. First, incarceration alone is an inadequate approach to reduce fetal harms. Women need treatment services in addition to incapacitation. One study of 89 pregnant women incarcerated during their third trimester of pregnancy found that numerous risk factors including chemical dependency, poor nutrition, prenatal care, and high levels of anxiety and depression were not adequately addressed by programs in the prison.[131] Although punishing a woman may incapacitate her from further drug use, without adequate services of prenatal care and drug treatment, the possible harms to the fetus are not adequately alleviated. Second, locking these women away may not completely eliminate the presence of drugs in their lives. One author interviewed a physician who recalled two patients who were able to maintain their drug habits until their delivery day while in prison.[132] In Part Three of this paper, I will present some evidence, albeit anecdotal, which suggests that in many local and low-security prison facilities, obtaining drugs while incarcerated is not a difficult task. So while we cannot completely discount prevention of further harm as a justification for criminalization, these concerns do question complete reliance on this justification.

One additional possibility would be the adoption of a policy oriented toward both punishment and treatment. As suggested above, incarcerated women still require care and treatment. The punishment of women does not

---

131 Fogel, Catherine I. "Pregnant Inmates: Risk Factors and Pregnancy Outcomes." *Journal of Obstetrical and Gynecological Nursing*. 1993; 22: 33-39.

132 *Supra* note 90, at 505.

exclude the provision of treatment to these women. Moreover, drug treatment and rehabilitation does not presumably eliminate the need for punishment. However, the unintended consequences of punishment, such as fear, may compromise the efficacy of treatment. For instance, a woman who fearing possible punishment may be less likely to seek drug treatment or prenatal care.

Utilitarian philosophy also supports the component of "vengeance" that exists in punishment.[133] Under this theory, punishment of the offense is justified because the victims and/or society may enjoy a "happiness" based not on any other reduction of harms, but based solely on satisfying their need for "revenge." However, in this interpretation, the individual is not treated as an "end," but instead as "means" to an end. Whereas the punishment may not actually help the offender, justification of punishmen on the basis of its producing more general "good" than "bad" entails use of offenders as a means to this end. Furthermore, punishment would be justified on the basis of achieving a sense of societal satisfaction even if the "offender" were, in fact, innocent.

If vengeance were legitimated by utilitarian ideas, a sense of moral indignation in society would justify punishment of an act which was not necessarily wrong. Take, for instance, a mother who uses aspirin for a headache while she is pregnant. On this occasion, this exposure to aspirin results in congenital defects in the infant. Society may morally condemn the mother's decision to use aspirin during her pregnancy. Society may also feel that its sense of indignation may be relieved by the woman's punishment. However, it seems extreme to prosecute this woman for exposing her fetus to aspirin during her pregnancy, although the punishment would be "justified" if the utilitarian view of vengeance were adopted. It would be better to provide this woman educatio

---

133 *Supra* note 110.

about the ramifications of drug exposure and services to help her with the care of her child.

CHAPTER SIX: DEFINITION OF CRIME: MENS REA

Inherent in many of the above attacks on criminalization is the evaluation of the woman's mental state and the voluntariness of her actions. The principle of mens rea in criminal law addresses these issues. One of the general concepts behind criminal liability, men rea is "the idea that crime requires a guilty mind."[134] This concept has been the subject of great debate among criminal law scholars. This chapter will discuss elements of mental culpability within the context of maternal substance abuse.

The Model Penal Code sought to simplify the definitions of criminal law. It separated mens rea, the element of mental culpability for a crime, into four levels. The Code's four definitions include: 1) purpose--the conscious intent to commit an act of crime, 2) knowledge--the awareness that the act was criminal, 3) recklessness--the conscious disregard of an undesirable consequence, and 4) negligence--a deviation from "normal" standards of action. Under the standards of the Model Penal Code, the degree of mental culpability required by a crime depends on the nature of the crime.

The first two levels of mens rea, purpose and knowledge, reflect the empirical and descriptive component of this requirement. Demonstration of these elements in a perpetrator's state of mind during a criminal act is essential to his/her conviction for certain crimes. Yet, in the case of maternal substance abuse, the empirical and descriptive definitions of a guilty mind cannot always be shown. In most cases, the intent of a pregnant woman who uses drugs is not

---

134 Edgar, Harold. "Mens Rea." In: Kadish, Sanford H. *Encyclopedia of Crime and Justice*. New York: Free Press. 1983: 1028.

to exact harm on the developing fetus. Rather, the woman's purpose is to satisfy her addictive urges. Consider the following analogy. If a pregnant woman goes to an amusement park and rides the rollercoaster after reading the written warnings of possible harm to her fetus, she has harmed her infant knowingly. In some cases of maternal substance abuse, the mother is aware of the consequences of her drug use. In others, however, women of younger age or less education, may not be aware of the deleterious effects of drugs on their babies. Moreover, the behavioral and psychological effects of drug exposure on the baby are not readily observable by the women. A recent article in a nursing magazine stated that "many people still are not aware of the impact of drug abuse on the fetus."[135] According to this article, many women hold erroneous conceptions that the placenta protects the fetus from toxic substances in the maternal circulation. The social environment that fosters drug abuse and addiction may not support adequate education. Thus, pregnant drug abusers may not satisfy the mental requirements of purpose or knowledge.

The other two levels of mental culpability imply not merely a descriptive and empirical definition, but also a normative demand. In a critique of criminalization, James Dennison comments:

> Other levels of intent less than "purposely or knowingly" might apply to the fetal abuse crime--particularly, "reckless disregard for the value of human life"...such an intent element for a fetal abuse statute might consist of knowing that or recklessly disregarding the likelihood that a child would be born defective due the parents' acts.[136]

---

135 Chance, Barbara & Anne M. Watts. "Effects of Cocaine Abuse." *Nurseweek.* January 11, 1993.

136 Dennison, James. "The Efficacy and Constitutionality of Criminal Punishment for Maternal Substance Abuse." *Southern California Law Review.* 1991; 64: 1103.

Where punishment based on recklessness or negligence applies, the woman may be unaware of or not intend her acts, and still be responsible for the results. In other words, if a reasonable woman would suppose that her drug use could negatively affect her fetus, then a woman who uses drugs has committed a crime.

While this argues powerfully that mens rea requirements are met, the voluntary nature of the act remains an important requirement regardless of the required level of mental culpability. We thus return to the arguments of voluntariness and addiction stated above. Albeit originating from a medical model of disease and supported by prominent medical societies, the concept of addiction has also been validated by the Supreme Court.[137] Drawn to the sense of euphoria, elevated power and self esteem that the drug creates, women who abuse drugs do not voluntarily commit these acts. While their initial introduction to drugs may be voluntary, their later drug use is driven by the addictive powers of the drugs.

Although there are strong legal arguments against criminalization of perinatal substance abuse--notably, those involving voluntariness and intent, the strict legal basis for it remains substantial. The courts' current reluctance to support criminalization stems mainly from the application of existing statutes to this situation. The intent of legislatures in drafting these statutes, questions of adequate notice, and ex post facto considerations trigger concerns over fairness in the judges' minds. There would be fewer questions of legality for any newly enacted statutes directed specifically at drug use during pregnancy. Thus, the question becomes whether or not legislature should adopt these new laws. The consideration of the wisdom of and repercussions from such a policy is critical to

---

137 Robinson v. California, 370 U.S. 660 (1962). The Court stated in this case: "In this Court counsel for the State recognized that narcotic addiction is an illness. Indeed, it is apparently an illness which may be contracted innocently or involuntarily..."

this debate. In the next chapter, I examine some of the intended, as well as unintended consequences of criminalization.

CHAPTER SEVEN: THE ARGUMENT AGAINST CRIMINALIZATION: POLICY IN PRACTICE

A central question to criminal law scholars is not only what to punish, but when to punish. In the previous pages, I presented some prevailing theories concerning the justification of punishment and the definition of a crime. Applying these concepts to criminalization of perinatal substance abuse, I have attempted to address whether maternal drug use during pregnancy should be punishable by criminal law. Rationales based on reform and deterrence argue against criminalization. Moreover, in many cases, drug-addicted women do not exhibit the mental culpability component of a crime. While the prevention of further harms through incapacitation of the drug addict argues powerfully for criminalization, other harms that result from criminalization deserve attention. This chapter describes some of the practical issues that represent significant questions of prudence which outweigh arguments for a policy of criminalization.

Given limited societal resources, the economic cost of any public policy is central to whether or not that policy is practically sound. Proponents of criminalization have stated that the enormous costs incurred by society because of maternal drug abuse give rise to a "compelling state interest" in punishing drug-addicted mothers. While the costs associated with "drug babies" are indeed enormous, dealing with the problem through the legal process generates its own impressive economic figures. Without even considering the legal costs of trials and appeals, the price of housing an inmate for one year is estimated at between

30,000 and 50,000 dollars.[138] Multiplying this figure by the estimated number of drug-exposed infants born each year, 375,000 according to the N.A.P.A.R.E. study[139], the potential cost of criminalization to society is enormous. In her examination of policy implications of maternal substance abuse, Janna C. Merrick states:

> In 1989, there were 40,556 women incarcerated nationwide...it is estimated that each year more than 380,000 infants are affected in utero by their mothers' drug and alcohol abuse...if prosecutors were to pursue this route on a more comprehensive basis, growth in the prison industry would be a necessity.[140]

Moreover, to deal effectively with issues of substance abuse, treatment should also be provided to these women while incarcerated. That, too, would be costly.

On the other hand, the monies for this type of approach might be better used to augment drug treatment and rehabilitation services outside of jail and prison. As described above, there is an overall lack of treatment services for women, especially pregnant women. Moreover, the services that do exist have not been designed to meet the special needs of pregnant women. Since waiting lists of treatment centers are long, it is likely that available treatment would not help pregnant women while they are pregnant. Treatment for the mother may come too late to lessen the harms to the child. If criminalization aims to deter women drug-addicts from doing drugs and to prompt them to seek treatment, then the lack of treatment facilities represents a large barrier to this goal. This deficit in treatment is the basis of "status" and "cruel and unusual punishment" arguments against criminalization. Regardless of the persuasiveness of the legal

---

138 Jones, Julia E. "State Intervention in Pregnancy." *Louisiana Law Review*. 1992; 52: 1176.

139 *Supra* note 2.

140 *Supra* note 107, at 70.

argument, the wisdom and efficacy of the policy are subject to deep question. Without access to treatment, these women are not able to change their status as drug users. Punishing these women, but not giving them the means to amend the situation may not be unconstituional, but is certainly not wise.

However, a position against criminalization based on this lack of treatment facilities assumes that drug-using women will seek help for their drug problems. If the powers of addiction can overwhelm the desire for treatment, then these arguments are not valid. Yet, as I describe in Part III, the context and level of drug use can change with time. While drug use in its most extreme form may negate these arguments, women at less severe levels of addiction may still retain their desire to recover from their drug problems. Moreover, as I show later, pregnancy and children are powerful incentives for even the heavily drug-addicted woman to seek help.

Accurate identification of the substance-abusing woman is another practical consideration. Subjecting drug-abusing women to criminal liability requires the ability to correctly identify this population. However, the current methods of identification and testing are inaccurate. A positive drug test at birth is only indicative of drug use in the preceding 24-72 hours; the test gives no information on drug use during the rest of the pregnancy. Consequently, the test does not distinguish between the addict and the one-time user. Moreover, use of licit drugs can result in a false positive toxicology screen. In *In re J. Jeffrey*[141], a child was removed from its mother because of alleged drug use. However, the positive drug test was the result of pain medication prescribed for the woman's car accident injuries. Despite this obvious confusion, one year passed before the mother was able to obtain custody of her child.

---

141 *Supra* note 4, at 89.

The inability to assure accurate identification and detection of all women who use drugs during their pregnancies does not by itself make this policy of criminalization invalid. However, racial bias in testing and reporting is a critical problem with the criminalization of perinatal substance abuse. A policy of criminalization would further exacerbate the social inquities resulting from socioeconomic status or ethnicity/race. Blacks are 9.5 times as likely as Whites to be reported for drug use.[142] This bias in reporting most likely reflects the more frequent testing of African-American women. Indicators of suspected drug use, such as low socioeconomic status, are more commonly seen in women substance abusers of color. Thus, testing and reporting would unfairly target women of color.

Another serious problem for efficacy of screening tests is that drug addicts who are aware of the possibility of urine screening may purposely abstain from drugs in the 72 hours prior to seeing a health professional. This way, the woman is able to continue her drug use and avoid detection. Obviously, the goal of criminalizing maternal drug abuse and deterring women from the use of illegal substances would then not be realized. Moreover, the benefits of early identification and intervention in these high-risk pregnancies would be lost.

A policy of criminalization may also cause harm by undermining the adequacy and effectiveness of the delivery of health care in this country. Health professionals normally depend on the trust developed between the professional and the patient. While mandatory reporting of positive tox screens would be a possible method of effective detection of women who use drugs, requiring such reporting by health professionals, even to social services, erodes the trust between patient and physician. Once a woman finds out that physicians are screening for drugs, she may be fearful of disclosing the full facts of her health

142 *Supra* note 20.

and lifestyle to her physician for fear of criminal prosecution. Moreover, since poor women and women of color are already at risk for receiving little or no prenatal care, such a policy of tox screening and reporting would further jeopardize the already tenuous relationship between this population and health care providers. At some level, this problem is already present in some communities (please see the analysis in Part Three, *infra*); however, a policy of criminalization may exacerbate this problem.

Perhaps the most serious practical objection arises from the possibility that criminalization of drug-addicted pregnant women fosters avoidance of prenatal care. The benefits of prenatal care have been outlined in preceding sections. Women who use drugs are already at high risk for not receiving adequate prenatal care. The fragile link between women drug abusers and proper prenatal care might be severed because fear of prosecution would deter women from participating in treatment or seeking prenatal care. As mentioned previously, after charges were brought against Pamela Rae Stewart in San Diego, the number of women with drug or alcohol histories seeking prenatal care declined.[143] According to a General Accounting Office study, many of these women are fearful of incarceration and of losing their babies to foster care.[144] Hospital officials also report that some women are avoiding hospitals and giving birth at home.[145] While the goal of prosecution of the mother may be to help a drug-exposed infant, such a practice may actually result not only in the incarceration of mothers, but also in a widespread lack of critical prenatal health care. The policy thus would deliver a second strike against the normal health of the infant--

---

143 *Supra* note 4, at 85.

144 Bowsher, C.A. "Drug-exposed infants: A generation at risk." Statement before the Committee on Finance, United States Senate. Washington, DC: U.S. General Accounting Office (GAO/HRD-90-46) June 28, 1990.

145 Matthiessen, Constance. "A Fighting Chance." *Image Magazine: San Francisco Examiner*. May 3, 1992.

the first being the exposure to drugs and the second being the loss of prenatal care.

Avoidance of prenatal care because of the fear of prosecution is a strong argument against criminalization. Despite the plausibility of this line of argument, no detailed examination supplements the anecdotal evidence of this phenomenon. Many public health, medical, and public advocacy groups have based their arguments against criminalization on this assumption.[146] Clearer research evidence regarding this claim is urgently needed. The research presented in the following part of this paper provides additional information about this issue.

---

146 "The March of Dimes is concern that legal action, which makes a pregnant woman criminally liable solely based on the use of drugs during pregnancy is potentially harmful to the mother and to her unborn children..." Statement on Maternal Substance Abuse. The March of Dimes.
" Criminalization of prenatal drug use "will deter women who use drugs during pregnancy from seeking the prenatal care which is important for the delivery of a healthy baby..." Policy Statement No. 1, "Criminalization of Prenatal Drug Use: Punitive Measure Will be Counter-Productive." National Association for Perinatal Addiction Research and Education. 1990.
"[A] punitive approach is fundamentally unfair to women suffering from addictive disease ands serves to drive them away from seeking both prenatal care and treatment for their alcoholism and other drug addictions. It thus works against the best interests of infants and children..." Policy Statement, "Women, Alcohol, Other Drugs and Pregnancy." National Council on Alcoholism and Drug Dependence. 1990.

PART THREE: Qualitative Interviews: Methodology, Results & Analysis

The main purpose of the research was to ascertain the role, if any, that the threat of prosecution or other criminal action plays in the decision-making of substance abusing mothers regarding prenatal counseling and medical care. Additionally, the study explored the general attitudes and beliefs of substance abusing women toward prenatal care, including: 1) the perceived availability of and access to medical care; 2) the reasons for using or not using prenatal care; and 3) the personal experiences of either the lack of prenatal care or legal/criminal involvement. The qualitative interviews also obtained these women's personal histories of drug involvement, physical and emotional abuse, and treatment experiences. Although the small sample size of 10 is by no means a guarantee of representativeness, these women's stories provide a glimpse into the lives of women who abuse drugs.

The methods and procedures in recruiting subjects, conducting interviews, and analyzing data are discussed in Chapter Eight. The thirteen sections of Chapter Nine present the findings from the qualitative interviews. These sections also discuss theories and explanations derived from the interview transcripts. Notably, the ninth section examines the women's experiences with pregnancy and prenatal care. This section specifically addresses the effect that a policy of criminalization had on the prenatal care decisions of these ten women. This chapter concludes with a summary of the findings and conclusions.

CHAPTER EIGHT: METHODS

I. Subjects/Recruitment/Procedures

The study consisted of open-ended interviews with ten women who fulfilled the following characteristics:

1) currently uses illegal substances or has a history of illegal substance abuse;
2) currently is or has been pregnant
3) used illegal substances at some point during the pregnancy.

The women were contacted and recruited through field-based methods. I did several hours of field study prior to any recruitment of subjects at the two sites, a women's day shelter in West Berkeley and a transitional housing program in Oakland. The directors and staff of these two facilities were contacted first, and they granted approval to recruit subjects for the study from their establishments. Each meeting with directors and staff members emphasized the confidentiality procedures. I spent several afternoons over approximately two weeks at these two sites to acquaint myself with the social, as well as physical environment. Because of the different nature of these two sites, the recruitment process was slightly modified to fit the necessary protocol. At the women's shelter, the initial recruitment was done through a posted flyer as well as by announcements at the organization's weekly house meetings. Fortunately, one of the first interviews at this site was with a key member of the community who in turn provided many referrals. At the second site, because of the private nature of the residential housing program, staff members recruited the women. The staff talked to these women about the study, and then asked if they would be willing to participate.

Once the women expressed their willingness to volunteer to participate in the study, they either contacted me directly by phone, in person or through the director and staff of the program. In this initial contact, the women were screened with the three criteria stated above. Once a subject was determined to be appropriate for the study, a "Statement to the Subject" describing the interview schedule was read to her. If she agreed to the stipulations of the study protocol, I arranged an interview time to fit the woman's needs, as well as the facility's schedule.

The interviews were conducted at various sites including: the women's day shelter, the park next to the shelter, the housing program, and the subject's apartment. At the beginning of each interview, I again presented the "Statement to the Subject" sheet to the subject and explained to her the schedule of the interview. To maintain the anonymity of the subject, oral consent was obtained and documented on audio tapes. Each subject was partially compensated for her time and energy with twenty dollars. Four of the ten women were from the transitional housing program. Because the financial situations of the women were in part controlled by the program, the directors did not wish that the money be given directly to the women. Instead, with the consent of the women, the compensation funds were given directly to the program's funds for programming and services. Single 1-2 hour semi-structured interviews were conducted with each of the women. These interviews were audiotaped for later transcription.

The actual interview consisted of various open-ended questions loosely organized around an interview guide. The guide included the following topics:

- the subject's family and social history
- the subject's history of substance abuse
- the subject's experiences with substance abuse during pregnancy
- the subject's use of prenatal care
- the subject's reasons for seeking/or not seeking prenatal care
- the subject's experience with the legal system regarding substance abuse, especially as related to their pregnancies

I used a life-story format to guide the discussion of these topics. Since the main goal of this research was to explore the women's opinions and actions concerning prenatal care and criminalization, more structured questioning was used for this latter part of the interview. Nonetheless, in all the interviews, I emphasized my desire to hear a "story" and invited free discussion and conversations at the end

of the inteview. The women could refuse to answer any question or stop the audiotaping at any point in the interview.

II. Confidentiality

Due to the sensitive nature of topics discussed in the interview, a rigid protocol was followed to maintain confidentiality and anonymity of the subject. All materials associated with each subject were labelled by code. A master list of the subject's first name and her code was kept separate in a locked cabinet. All audio tapes and written materials were kept locked during the study. I have also made minor changes in the identifying characteristics of the women in the data presentation and analysis sections.

III. Analysis

Analysis and interpretation of the interview transcripts were based on methods of qualitative research. Analysis of the data began with open coding of the interviews in which various themes and concepts were grouped under codes. Each code represented some recurring theme in the interviews. A code list was generated from the first 2-3 interviews. The remaining interviews were labelled with this list of codes although some additions to the list of codes were made during this analysis phase. These codes were eventually grouped under larger categories for comparison between codes and between subjects. Explanations of any differences and interpretations of any phenomenon were sought for each category. Eventually, dominant theoretical themes emerged from the data. Records of this analysis were kept in the form of theoretical memos and lists of codes with interpretations under each category. New information from each interview was added to these lists and memos. In the following section, I describe some of these dominant themes and interpret their underlying meanings based on the collective responses of all the women.

In addition to this coding analysis, basic demographic and descriptive data were collected for each of the ten women. The descriptive data from this portion of the analysis will be presented in the first part of the following section (sample characteristics).

Because of the small number of interviews and the limited scope of population sampled in this study, in the conclusion section, I have attempted to incorporate some qualitative data from ethnographic studies[147] and some quantitative data from the Perinatal Needs Assessment Study conducted in Alameda and Fresno Counties.[148] Much of the qualitative support for my findings is from a recent qualitative study on mothering in relation to maternal crack cocaine use done by Kearney et al. [MCC study] based on 68 open-ended interviews of drug-using mothers. The subjects in this study did not necessarily use crack cocaine during their pregnancies, and the study did not consider issues related to pregnancy. However, because this population of women was obtained from the San Francisco Bay area, and because some of the basic demographic characteristics of the sample in this study approximate the characteristics in my study group,[149] the results and conclusions of this qualitative study are

---

147 The two qualitative interview-based studies that I have used include:
Murphy, Sheigla & Marsha Rosenbaum. "Women Who Use Cocaine Too Much: Smoking Crack vs. Snorting Cocaine." *Journal of Psychoactive Drugs*. 1992; 24: 381-388.
Kearney, M.H., S. Murphy & M. Rosenbaum. "Mothering on Crack Cocaine: A Grounded Theory Analysis." *Social Science and Medicine*. 1994; 38: 351-361.
In addition, the researchers of these two studies are currently conducting a qualitative study on pregnant drug users. Although data from this research endeavor are not yet published, the concluding section incorporates some information from this study obtained through phone interviews with its research staff.

148 Klein, D., E. Zahnd, S. Holtby & R. Barth. "Perinatal Needs Assessment Study: Preliminary Report." Submitted to the State of California Department of Alcohol and Drug Programs. Western Consortium for Public Health. December 1993. Draft.

149 Specifically, as stated below, the age, socioeconomic status, educational levels, number of children, amount of drug used between the two groups were similar.

applicable to the population in this study. Quantitative data from the not yet published Perinatal Needs Assessment Study conducted by researchers at the Western Consortium of Public Health and the University of California at Berkeley lend further support to the findings presented here. This needs assessment evaluated the questionnaire-interview responses of 401 pregnant women with histories of drug or alcohol use recruited from social service agencies, health care facilities, and prisons. Although this study was designed to ascertain this population's perceived inadequacies of health care, treatment, and social services, the data does at least describe various trends seen in this drug using population. The qualitative and quantitative data not only provided further corroboration of and justification for the results of this study, but the data also supply a better understanding of the issue. Thus, a clearer picture of the actual problem of maternal drug abuse results from combining the data from the qualitative interviews and the quantitative data.

CHAPTER NINE: FINDINGS & ANALYSIS

I. Sample Characteristics

Age:.

The ages of the women interviewed ranged from 23 to 42 years old with the average age being 32.9 years.

Race/Ethnicity.

All of the ten women in the study were African-American. This result is due to the homogeniety at the two sites where participants were solicited. Only 3-4 non-African-American women of the 20-30 women were present daily at the women's day shelter in West Berkeley. Although I made efforts to recruit these women, many of the women did not fulfill the screening criteria. When I

However, no statistical analysis was actually done to compare the characteristics of the two groups.

introduced the topic of my study to the remaining non-African-American women, they emphatically denied the use of any drug during their pregnancies. At the time of my interviews at the transitional housing program in Oakland, no non-African-American women were available for interviews.

Given that many authors have considered the important impact that race and ethnicity have on drug use,[150,151] the lack of ethnic representation limits the results of this study. The case histories of these ten African-American women provide us only with information on this one segment of the drug-using population. Because there are racial and ethnic differences in the type, frequency, and amount of drug use, conclusions from this data set are not applicable to other groups. However, this study's consistency in ethnicity provides specific information of the impact of criminalization on this particular group's prenatal care. Additionally, the homogeneity of the group allows comparison with quantitative data on this same ethnic group from the Perinatal Needs Assessment Study.

Socioeconomic Status.

Although detailed financial data were not available, all of the mothers were of low-income status. Seven of the 10 mothers were receiving AFDC. Two women were receiving SSI benefits because of mental disabilities. One woman was not currently receiving any public assistance.

Current Living Situation.

Due to the two sites of recruitment, the women were divided into two groups according to their current living situations. Four of the women interviewed were living at the transitional housing program. The length of stay at the program ranged from two weeks to two years. The mothers had between

---

150 *Supra* note 20.

151 *Supra* note 21.

one and four children living with them in the provided apartments. Two of these four women had been homeless prior to entering the housing program. A range of living situations existed among the women recruited from the day shelter. One woman was living in her own apartment although she did report being worried about how long she could keep the subsidized housing. One twenty-eight-year-old woman was living with her mother along with three middle-aged siblings in West Berkeley. Three women were temporarily staying with friends or relatives. One of the ten women was homeless and staying primarily at a homeless shelter in Oakland.

Number of Children.

The women in this study had an average of three living children. However, they reported an average of approximately five pregnancies. One woman had three abortions and four miscarriages before giving birth to her one-year-old son. Another mother had given birth to ten children; however, three of the ten had perished in a house fire. One mother had seven miscarriages and tubal pregnancies interspersed among the births of her three living daughters. At the lower end of the range, two mothers had been pregnant only twice in their lives and had one and two children each. I will address below the issue of miscarriages and loss of children especially in the context of their drug use.

Custody of Children.

All of the women interviewed had lost or given up custody of their children at some point in their lives. Two of the women had given up a child at birth for adoption. Four of the women currently have custody of all of their children. This phenomenon of relinquishing custody or having custody taken from the women is examined more fully below in the context of parenting and mothering characteristics of the group.

Marital Status.

None of the ten women was currently residing with her significant other. Seven women were single mothers and had never been married. Of these seven women, one reported being a lesbian for the last ten years. The three other women interviewed were either divorced or separated.

Drug Use.

All but one women had used primarily crack cocaine during a pregnancy. The one mother who did not use crack was older and had used LSD and acid during her pregnancy nineteen years ago. All of the women reported heavy crack cocaine use at some time in their lives. The four women residing in the transitional housing program were all clean and sober at the time of interview (range of time spent clean and sober: 1-2 years). Two of the women recruited from the day shelter in Berkeley reported being clean and sober for 2 months and for 1 month. The four remaining women reported current regular use of crack cocaine.

II. Growing Up: Family Issues

Several recurrent themes emerged in the analysis of these women's childhood and adolescent lives. Clearly, most of the women interviewed had serious problems growing up. These problems included lack of stable home environment, lack of parental role models, strict upbringing, violence, abuse, and running away from home. The PNA study found similar results in its sample; about half of the women reported problems growing up during their childhood and adolescence.[152] The women in my study alluded that disruptions in their family background precipitated or augmented their use of drugs. Various forms of abuse played an enormous role in many of these women's childhoods. The next section discusses this violence and abuse separately.

---

152 *Supra* note 148, at 133.

Characteristics of Upbringing.

Many of the women spoke about their strict upbringings. The strict environment was both a result and a cause of the disarray in these women's lives. Most of them saw the reasons for the strictness in their unstructured and difficult lives. Yet they reported feeling rebellious against the household rules.

The interviews suggested that religion was an important aspect in their caregivers' attempt to provide structure and rules for these women as children. For three of the women, religion greatly influenced their childhood environment.

> We call her [auntie] mean but she said she was firm. She was a Seventh Day Adventist. So, when we would go to school, we would go directly home from school. There was no playing outside--it was okay in the backyard, that's about it. Couldn't have friends over. Couldn't have no phone calls. We stayed in the apartment year round.

> I was brought up strict. There was a lot I couldn't do. Being Seventh Day Adventists, couldn't go outside after the sun goes down on Friday. Couldn't do nothing from sundown Friday to sundown Saturday. Couldn't go outside. Couldn't watch T.V. Only had to listen to gospels....and go to church Saturday morning...I just wanted to see...I just wanted to see what was happening out there.

Although, perhaps, strict upbringing was an attempt to provide order in these women's lives, the above accounts suggest a pervading sense of deprivation that eventually led to rebellion against this environment. Experimentation with drugs during adolescence was a common characteristic in these women's stories. In one of the above excerpts, the strict religious background deprived the woman of experiencing daily life activities. Her urge to "see the world" led to years of teenage rebellion and experimentation with marijuana and acid. Because of their strict upbringing, these women were even more inclined during adolescence to experience those things which had been denied them.

Many of the women described environments of strict upbringing incongruent to their other experiences. For example, Alyssa was raised by her great grandparents in a strict household, yet her own sixteen-year-old mother had herself been on heroin when she gave birth. The great grandparents may have tried to provide containment and structure in her childhood through strict rules. However, her experiences at school and on the streets with her friends were in direct conflict with the environment fostered at home. Clearly, the strict demands made by her great grandparents did not obscure the problems that Alyssa's mother created. In fact, when her mother made attempts to create a stricter parenting environment, Alyssa showed great resentment.

> So when you ditch me for this man which I already have a feeling you are not going to be with eternally, and then you want to run back in my face and play a mother role after you did this to me. Just little things like that, those types of things went on and so eventually I left home at the age of 15.

Thus, while strictness provided the structure lost in her mother's drug use and abandonment, the attempt to compensate for these family circumstances created resentment of and rebellion against this structure.

The loss of a parent early in life combined with a previous strict upbringing also seemed to hasten the woman's initiation to drugs.

> [My childhood was] kinda like really confined, strict for me because my father was a policeman...but then when I lost my father, by him being so strict, I kinda like went bezerko, you know...so...that's when drugs really began for me because....I guess I was trying to escape reality. You know, Daddy was gone...I wish I could depart from him because he was so strict, but when he left, it just kinda like tore me to pieces.

With the death of her father, the structure provided by her strict environment was lost. Moreover, this woman had to cope with the guilt from "wishing something bad" on her father and the sense of abandonment from losing her father. Using drugs became her coping mechanism.

Lack of A Parent.

The lack of a stable home environment seemed to be a clear deficit in most of these women's lives. Notably, many women spoke of their lack of respect for a parent.

> She said go stay with your father in East Oakland. Now my father--never did like him 'cause he never did come over to see how I was doing or anything. He never did that.

The women hinted at their discomfort and uneasiness about not having a mother or father.

> The main thing that led to try doing them [drugs] [sic]...the main thing was not having a father--that really bothered me. I never had a father...growing up in school, where everybody on family days...everybody father was there. Goddamn. I had my mom, but I never had...I mean, I wanted my father. I wanted to know my father. And he died. At the time, I didn't understand "dead", but I didn't want to understand it. And I figured he would come back. But he never came back.

These last two quotes allude to a recurring issue in the lives of these women--the lack of a parent either due to physical loss or emotional loss had direct impact on these women's psychology.

Some women spoke directly about the lack of emotional expression of love in their childhood. One woman who was also severely physically abused by her mother said this:

> She would tell me verbally that she didn't love me and she didn't show me love. She never hugged me or kissed. She would say she'd worry about me.

The issue of love--the lack of love from parents--emerged in many of the conversations with these women. The lack of parents or role models and the imposed strictness within family life excluded or severely limited expressions of love. In her description of her relationship with her nineteen-year-old daughter, forty-year-old Marsha said:

> When I'm with her, I do not use drugs. I don't have no urge 'cause when I'm with her, I feel all the love. That's basically what anybody wants--love. And especially drug addicts. I mean, people don't use drugs 'cause it's just there. There's something missing in their life. And until they find what's there missing, they'll use drugs for the rest of their lives.

Although the lack of a parental role model or parental love cannot be solely responsible for the woman's drug use, incompleteness in emotional expression seemed to be at least one void in these women's lives filled by drugs.

Loss of Own Childhood.

Several women spoke about their childhoods being inadequate because they were never allowed to be children. Respondents in the MCC study also commented on how they "never really had a chance to be a child when they became teenage mothers"[153] In this present study, however, teenage pregnancy was not the sole cause of this lack of childhood; the missing parents in their own lives and subjects' surrogate parenting of their siblings also constituted reasons for a missed childhood. For instance, Mary, whose parents both worked long hours, said that, being the oldest, she was responsible for the care of her six brothers and sisters. She described herself in this mothering role as "being a hundred years old." In a second example, the woman was responsible for raising her four siblings after her mother died from lung cancer. Yet even prior to her mother's death, she states:

> She [mother] put so much pressure on me. Like when I take my brothers and sisters to the movies, you are the oldest, you take care of them. Ok. But I'm a kid too.

---

153 Kearney, *supra* note 147, at 351.

III. Violence and Abuse

Perhaps among the most vivid accounts in my interviews with these ten women were the graphic and extremely disturbing descriptions of emotional, physical, and sexual abuse in their lives. This abuse not only occurred in their family life growing up, but also persisted into and pervaded their adult lives. As I described in Part I, the incidence of sexual and physical abuse is reportedly quite high among women substance abusers. In fact, the PNA study stated that "one of the most important findings of the PNA is the centrality of violence and abuse in the lives of low-income, substance-involved pregnant women." Specifically, the study found that abuse and victimization played a heavy role in the lives of almost half of the women interviewed.[154] This next section discusses the evidence of physical, emotional, and sexual abuse in these women's lives.

Violence & Abuse during Childhood.

Physical abuse during childhood was graphically portrayed by one women, Natalie. Natalie was a thirty-eight-year-old woman currently living on the streets and in various shelters. She tended to portray herself as a "victim"; the miseries in her life were inevitably caused by external events. This tendency toward victimization made many of answers to other parts of the interview difficult to interpret. However, Natalie's childhood history sheds light on why she views herself as a victim. Natalie gave a vivid and disturbing account of the physical abuse inflicted on her by her mother.

> ...[O]ne night I was the one that did the kitchen...there was nothing to scrub it [a pot] with so everything was immaculate n the kitchen but that one pot that was sitting in the sink...So she [mother] comes home...it was about midnight and it's a school night. She gets me up...and starts whipping me with my brothers' drug sticks...I go and try to scrub the pot with my nails and so it wasn't fast enough for her. So she stripped me down nude...ties my hands, gags my

154 *Supra* note 148, at 129.

> mouth and tie my legs and beat me...it was two extension cords doubled...

Throughout her childhood and adolesence, Natalie was a "victim" of her mother's mental and physical cruelty. Thus, she approached all the events in her life with this sense of victimization.

Despite this abuse, Natalie still reported feeling a bond with her mother. She states that she felt a great responsibility to take care of her mother when she got sick with cancer. It seems almost self-destructive for her to feel this obligation until we realize that she was an eleven-year-old child desperately in need of her mother's approval and attention. Having felt unloved and unwanted because of her mother's abuse, Natalie may have finally felt "needed" by her mother. On the other hand, her mother's invalid state may have allowed Natalie to finally feel some control over both her mother and her own situation. Taking care of her mother was Natalie's chance to regain some self-eteem and self-worth.

Natalie goes on to say later in the interview:

> I was devastated by all of these things that my mother physically and mentally did to me. And it still bothers me...even now I go to mental health because I still have this...nightmares....she's dead but...I can't rid myself of her...Why did my mother do this to me?...So drugs were my way out.

In a previous discussion, I described how the lack of affection in their childhood contributed to these women's problems later in life. A history of physical abuse by a parent is the most extreme form of this deficit of love. Natalie never did feel loved or appreciated during her childhood. This, combined with gender, racial, and class factors, contributed to Natalie's unfortunate life. Later in Natalie's life, drugs were her way of filling this void as well as tempering the rejection by her mother. The rest of Natalie's life was punctuated with unstable relationships, physical and sexual abuse by her partners, and the general feeling of inadequacy.

A problem that arose during analysis of these interviews was that while several women spoke of extreme corporal punishment in their lives, many of them felt that these actions did not constitute "abuse." However, these women stated that the recent attitude toward child abuse would have defined these actions as "abuse and neglect."

> Iron from the corn and beatings and stuff...You know how the laws have changed. Now you can go for child abuse even if you touch them with a milk [sic]. I just remember whuppings, but ah...I said it was just normal to me...I mean she didn't whup us for nothing...I can't really say that I felt like I was abused.

One explanation for these women's attitudes is that they are in denial about the abuse and dysfunction in their lives. Alternatively, the use of corporal punishment in their childhoods may have been culturally or socially appropriate. While these are interesting theories, no clear conclusions can be drawn about this issue from the present data.

Four women discussed the sexual abuse in their childhoods. This abuse came from various members of family and friends. One 23-year-old woman with two crack-exposed children said that she was sexually abused in her family house by her mother's numerous boyfriends. Another mother was abused from age seven to fourteen by her father. When such abuse came during early adolescent years, it often led to drug use. For example, Letitia said that she first began using marijuana at age 16 and then later started using crack cocaine. There seemed to be no clear impetus, aside from peer pressure, for her initiation of use until I questioned her about sexual abuse. She reluctantly reported the following:

> Well, um...when I was--when I was at home [voice got really soft],...um...my grandfather would come down the stairs and he would give me head. Or I'll jerk him of. By this time, I knew that it was wrong...he came in the back door. I think he just said Letitia,

> come in...'cause he pulled--he pulled his thing out..And he said, here , do this...And he did what he did...

When Letitia started using marijuana soon after this abuse by her grandfather, she also began hanging out with the drug dealers in Oakland, and subsequently became involved in prostitution. She later admits that the sexual abuse in her teenage years may have led to prostitution. She states:

> And why I started doing what I did--working the streets--because of that. From him being the older figure in my life and that happening. That's probably why I did what I did. 'Cause I still don't know why...

One woman, Bernie's story was almost unbelievable in the degree to which sexual abuse was central to the dynamics of her entire family. Bernie's mother was physically and sexually abused by her father. Her nine-year-old brother began molesting Bernie when she was five because of what he saw going on in the house. Bernie was also early in her physical development which she cites as a reason for her father's sexual abuse.

> I looked like a baby with a woman's body. And I didn't like my breast being so gigantic...when I get home, my dad and my brother would mess with me...when my brother stopped doing it, my father began...I used to get out of the shower, and my dad used to say, "boys gonna want to touch this." And he's touch my vagina...it felt so horrible. I remember crying...

At age eighteen, Bernie gave birth to her oldest daughter--fathered by her own father. Bernie's horrifying story of sexual abuse persisted into her married life when her father would still come periodically to her house, beat her up, and rape her. Bernie admits:

> And people were really trying to help me but I still had nightmares--I would have nightmares of my Dad coming up to my bed. He kept his house pitch black...and cold...he would come up to my bed. And he would crawl on top of me. And sometimes in my dreams, I would feel it. And I'd wake up with cold sweats.

Bernie's drug use began when she was six years old. She began drinking alcohol to, in her own words, "kill the pain." Later in her life, when she suffered physical and sexual abuse at the hands of her partners, she reported using crack cocaine to escape reality. Below, I will more specifically address the use of drugs to escape reality.

In the accounts where physical and especially, sexual abuse, were a large part of the woman's childhood experience, two dominant themes emerged. First, the abuse represented another way in which their childhoods had been usurped from them. In Bernie's case, because of her early physical development, she was not allowed to be a child, but instead was forced into a sexual lifestyle with her brother and father. In this sense, her early experience with sexuality robbed her of the ability to be a child and teenager.

> I was nothing. I was nothing. I didn't exist. I was not a woman. I was not a little girl. I had no childhood 'cause I'd been having sex since I was a little girl. I didn't know nothing...so I was just stuck in the situation.

A second motif in these women's stories is the subsequent lack of self-esteem and self-worth that resulted from these histories of abuse. In Bernie's case, this lack of self-worth led to many later sexual and violent encounters with drug dealers. She reports:

> This drug dealer seen me, and he said, you're gonna be my woman...I was used to men abusing me. So when he came in, raped me and started beating on me...and it went from there...tied me, blindfold me and have sex with me...he peed on me. He did all kinds of things to me...and he'd let his friends come in and have sex with me...what I would do. I'd get the [drugs] and I'd take it, and I'd get real, real bombed out, and I'd let all these males--I don't know how many there was--just screw me, do what they want.

Having only experienced physical abuse and emotional devaluation, Bernie did not feel she deserved any other type of treatment. Thus, the abuse in her childhood created a pattern for her future social interactions.

Violence & Abuse in Other Relationships.

As exemplified in Bernie's story, the experience of physical and sexual abuse did not end in childhood for many of these women, but rather established a vicious pattern of abuse and violence in their other relationships. Two key concepts arose from the analysis: 1) persistent intergenerational violence and abuse in the families, and 2) abusive relationships with boyfriends and husbands.

Again, I return to the story of Bernie as an example of what I term "intergenerational abuse." Sexual abuse was the dominant pattern in her family's interpersonal relationships. Her father physically abused Bernie's mother. He sexually abused Bernie and her sisters. He physically tortured and sexually molested her brother. In turn, Bernie's older siblings molested her and the younger ones. Although Bernie has been fortunate in being able to escape from her dysfunctional family, she reports that her sisters are still caught in this family trap of abuse.

> My sisters are still in the sexual situation. My little sister has become my dad's woman. She's be thirty years old this year, and she's still doing it to my dad.

As victims of sexual abuse themselves, Bernie's brothers and sisters continued the cycle of abuse by molesting her children. She explains:

> My sister molested Jennifer [oldest daughter]. And my dad would stick his tongue in my daughter Tracy's ear and go in her panties. And they were messing with my kids like they did me. It was, like a generational thing. Okay, we did your mamma. Now it's your turn.

The presence of physical and sexual abuse in these women's relationships with partners is striking.

> He used to beat me up a lot. He had shot me up with Raid and Chlorox in my arm when I was pregnant with my son. ..every time we'd get to fighting, he wanted to beat me up. 'Cause--I couldn't say what was on my mind. And if I just shutup and don't say nothing--I couldn't do that neither. He wanted me to say

> something--or he'd hit me. But I think, I think we both had played a part with that. 'Cause I could've left, he could've left, but neither one of use choosed to leave.

In addition to the drug use often present in the relationship (to be discussed below), the women also reported having no confidence or low self-esteem and being told this by their partners. One woman, Sandy, who had been going to the local junior college at the start of her relationship with her children's father, stated that she stopped going because "he told me, I was too stupid to continue." This same woman said:

> He wanted to rule me. He wanted to shape me into what he wanted me to be. He didn't want me to have my own opinions. I couldn't--I couldn't voice my opinions on nothing...That was that. He guess he thought he had been through a lot, and he can shape me the way he wanted...instead of my having my own opinion about anything.

This continued reinforcement of inadequacy and lack of worth seemed to contribute to the woman's use of drugs throughout the relationship. She never felt "good" enough to deserve a better life. In many of the interviews, the use of drugs was entangled in this complex web of abuse and lack of self-worth.

Mary spoke of the physical abuse inflicted by her boyfriend when she was pregnant with their son.

> I don't see how I made it [through the pregnancy] because you see, I used to get stomped. I mean, literally just...my head knockin' off and stuff, like, you know, serious. He was really a big old' guy too. Two eighty.

However, embroiled in a situation of drug use and sexual/physical abuse, the women repeatedly told of how they felt unable to leave these relationships. Mary remarked that although she had been repeatedly abused by her boyfriend, she kept returning to him.

> I was doing anything they [outpatient treatment counselors] said, but I was going back to their daddy...I would stop smoking and do

> everybody, but I was going back to their daddy. They could not stop me from doing that...(*Why did you feel this way?*) I don't know. That's just the way I felt. I was going back no matter what.

This behavior reflects the "co-dependent" nature of abusive relationships. Like other women in abusive relationships, this woman is caught in this disastrous relationship, yet she feels powerless to leave her partner. The drug-using woman may also be dependent on her partner for drugs. The power of addiction keeps her from leaving the relationship. Moreover, the lack of education or job skills also contribute to her insecurity. With the constant devaluation, she may not feel capable of living her own life.

The cruel nature of these women's family background seemed to have created feelings of worthlessness, inadequacy, and stupidity. When these women were involved with men, these feelings were only reinforced. Because of the deep roots of this self-identity, perhaps these women even sought men who would strengthen these feelings of worthlessness. However, not to be forgotten is the large role that drug use may have played in this relationship. The dependency of the women, in many cases, on their male relationships for the support of their habits also contributed to the co-dependent nature of these dysfunctional relationships. In addition, for many of these women, abusive, deprecating relationships with family members were the only standards they had in developing other relationships. Thus, the cycle of abuse and constant devaluation was perpetuated. This theory is reflected in other studies. The MCC study also found that if a male partner was "abusive or opposed a woman's search for help or personal advancement outside the relationship, it was difficult for her to pull away from drugs and from him."[155]

---

155 Kearney, *supra* note 147, at 358.

IV. Initiation and Perpetuation of Drug Use:

Although it was not the main focus of the interviews, the women also spoke at length about the factors which affected their drug use. While some of the impetus for drug use in these women (i.e. sexual abuse, abusive relationships) have been mentioned already, this next section will consider drug initiation and introduction more closely.

How They Got Into Drugs.

The women gave a wide range of accounts of their introduction to drugs. However, three primary forces seem to dominate the women's initial experimentation of drugs. First, many women spoke of the role that male relationships had in introducing them to drugs--especially crack cocaine. Yet, although the women's partners were involved with drugs, early in the relationship the women were either oblivious to the drugs or able to resist the drug use. However, with time, each of these women reported succumbing to her partners' pressure to try drugs. Sally remarked:

> He would say...because I didn't want to, and he started me up anyway...Cause I said I didn't want none, and he hollered and screamed and talked about me so bad. So I tried it anyway. And once I tried it, it was no stopping. And he told me that I couldn't get hooked. And I did. He told me it wasn't a physical thing, it was a mind thing--that I could stop once I got good and ready to stop, but I couldn't do that. So he played a good part in [my drug use].

When asked what compelled her to try crack cocaine, Gloria, a thin and young appearing twenty-eight-year-old, answered:

> He was a few year older--I was eighteen...He kept, like nigging [sic] at me. "Here, try, try." I said I never will use it no matter what. And...and, and I did it because of him--to make him--I was in love with him...you know? I wanted to be in with him...I just wanted to make him happy. So to get him off my back and nigging' me, I tried it...I hate I did. I hate it. I hate I did it...Don't fuck with it. Don't even try it.

Gloria's older and more sophisticated boyfriend had the status and the material possessions that an eighteen-year-old craved. She wanted to be "in" with him. Trying crack cocaine was her way of gaining the approval and the love of her boyfriend.

Other studies of this population have found that the characteristics of the woman's partner influenced her substance abuse. In a description of female substance abusers, one author writes that "partners (of female drug abusers) tend to be substance abusers themselves more than partners of male addicts."[156] In a comparison of two case histories of two different women, one who used crack cocaine, and the other who snorted cocaine, Sheigla Murphy and Marsha Rosenbaum write:

> In the crack scene, men play an important role in the initiation and continuation processes among women...In crack-using circles, as in other drug scenes, men often manipulate women, and women, in turn, attempt to manipulate men for drugs and money.[157]

For the women in this study, the men in their lives manipulated them to start using drugs or to augment their drug use practices. Later we shall see how these women also, in turn, tried to manipulate the men in their lives through sex.

Despite the many urgings from boyfriends and husbands to try drugs, curiously, these partners would later object to their drug use. In fact, the disapproval by partners occurred even though in all of the cases, the men themselves were involved with drug use. One woman spoke of her boyfriend who currently was in jail for selling drugs. She remarks:

> He did, to tell the truth--selling drugs. And then it's like--he don't--he don't allow me to do it. Period. Okay? Drugs is out. He'd go crazy on me if he ever thought that I...he'd go off on me...when he's

---

156 *Supra* note 19, at 11.

157 Murphy, *supra* note 147, at 385.

> here, it's like I would have to sneak. And I don't like to sneak just to get high.

Adrianne's boyfriend, who had forced her to try crack cocaine in the first place, did not like a woman on drugs. She remarks:

> I really don't know...'Cause he always said he didn't want no woman who was on drugs. I guess one--he was enough. But he always said he didn't want one. And then for him to start me off--I really don't know why.

For some of these women, their partners' violent opposition to their drug use even led to physical abuse. As another woman states:

> He kicked me down two flights of stairs. 'Cause he thought I was next door at this lady's house smoking...which in actual fact...I was sitting there talking to two other ladies at her house...But he thought I was at there smoking, but I wasn't...the only thing too is...he was smoking too.

Here we have an obvious "double standard" of how the men allowed themselves to act and how their women were supposed to act. The question is why these men felt this way about their wives and girlfriends using drugs and why their impressions changed from the time when they initially introduced the women to drugs. There are several possible answers to this question. Many other studies have documented the exchange of drugs for sex in the drug world.[158,159] "Experimentation" of drugs is "okay" with the male partners. However, once the woman becomes more deeply entrenched in drug use and suceptible to the sexual aspects of the drug world, the male partner feel threatened by her drug use and its associated world. These men simply do not want their women to be sexual victims of drug abuse. Furthermore, because these men themselves can be instigators of sexual abuse to other female drug users, they may be even more acutely aware of the sexual and abusive

---

158 *Id.*

159 Ratner, Mitchell S., ed. *Crack Pipe as Pimp: An Ethnographic Investigation of Sex-for-Crack Exchanges*. New York: Lexington Books. 1993.

ramifications of drug use. Alternatively, as the woman has more children and continues to use drugs, the male partner may become aware of her role as a mother. It was acceptable for the woman to use drugs when she was alone. But once she becomes a mother, her drug use no longer is appropriate to her role. Here, the man's perspective and interpretation of what a "mother" should and should not do creates the ambivalent attitude toward the woman's continuing drug use.

Peer pressure and peer experimentation also influenced these women's drug use. Starting their use of drugs in this way was especially characteristic of the women who began their drug use early in their adolescent years. However, peer pressure to use drugs during the school years seemed to be primarily directed at marijuana and alcohol use. The use of crack cocaine often began later in the woman's life and usually resulted from use by family members or friends.

The third initiator of a woman's drug use was the familial use of drugs. The most extreme example of this situation is Bernie's story of how she started using drugs. Her father actually made her sit in the kitchen and smoke a joint because he felt that if Bernie was going to do drugs, then she "would do it in his house." This warped sense of family "training" was present in a milder degree in several of the other women I talked with. One woman talked about how even now she occasionally will smoke crack cocaine with her parents. She reports:

> My father is still indulging. Me and my father indulged approximately four months ago...It would have kept going on with me doing it with my mother if I would have let it kept going on...We would have been still doing it together...

In other cases, peripheral members of the family "turned" these women "out" to drugs.

> I went over to...auntie's house in Berkeley and they was in there basing. I didn't know what they's doing. They was in there smoking...I was sitting in the living room...they was sitting at the

> kitchen table just smoking. I kept seeing this white smoke just going up...I kept looking....I want to try it out...So I hit it. I got sick. I tried it again. I was on after that. And I was twenty-two at the time I started smoking crack. And within a matter of weeks, I had learned how to cook it up into rock.

The role of family use of drugs extended beyond the mere introduction of the woman to drugs but also helped maintain her drug use. One woman, who had been at a treatment program during her pregnancy, returned home from delivering her child. This is what happened:

> When I came home...I immediately started using drugs...(*What made you start using?*) It was here...It was here in my house. Like I said, my whole family uses--the whole family uses drugs, it's hard to stop using drugs, okay? And I came home and it was right there in my face...Everybody was using. "Take a hit. You just had a baby"...I mean, it's like, it's coming to me left and right. The devil--. right here. Right here at the door. Right here.

For this woman, not only did her family encourage her to continue her drug use, but also prevented her from stopping her drug use. This phenomenon was also present in several other stories. A sister, a brother, or an uncle or aunt would encourage the woman to start using drugs again. Another woman I interviewed commented on how her godmother helped in the care of her one-year-old son. She remarked that she "couldn't run on the streets" if her godmother did not take care of her son for her for a few days each week. This woman's description implied that the family environment actually provided her with support for her continued use of drugs.

Family interactions and activities often centered around drug use. For instance, one woman described how her brother, her sister-in-law, and she spent their evenings together.

> They had--they were doing free-basing through the mask. You know, the oxygen mask. And we used to get so high that it felt like we were going through the ceiling. I remember doing drugs like

> that--every night...we smoked. All we do was smoke, smoke, smoke, smoke, smoke.

Much like the nuclear family who sits in the den playing scrabble all night, in this family, smoking crack cocaine had replaced all other forms of family interactions and group activity.

Influence of Environment on the Woman's Drug Use.

Many interviews brought out another feature of the women's drug use--the continual impact that their surroundings had on their drug use. As one woman states above, the drugs are everywhere and even in her own house. How is she to escape from it if she cannot even avoid it in her daily life? Several women described how their environment influenced their own drug use.

> It was very hard [to stop] because I was still on the street and still had the people in the vicinity doing it around me...I had to make myself strong and stop.

> I had moved back with his [son's] father...he smoked like a damn choo-choo train...And I was right back in the same old mix. anytime, I go to West Oakland, I go back. Twelfth Street is a down fall for me. [When] I'm not there, I'm not around the people smoking...

> Oakland is kinda like drug-infested. That's my terminology, short and sweet. It is. Because it's like...every corner, in certain areas, you know. East Oakland, West Oakland. It's just there. Infested.

> The drugs are at people's park and I mean everybody that I know that smokes crack and so when I go around them I want to get that same in the group. But now I am coming down here, there's no drugs...But when I go up the park they greet you. The D boys are here and there they are the big fat rocks.

The above accounts describe how the woman's environment influenced the woman's inability to discontinue her drug use. Returning to an old environment of former drug use was often the trigger for relapse. Feelings of powerlessness, desperation, and anxiety resulting from the inability to stop themselves from using drugs are interwoven in many of the women's stories. These women have

limited amounts of the inner strength required to stop using drugs. Their willpower is quickly overwhelmed when the persuasive power of old drug-using environments comes into the picture.

In fact, all of the women were aware of the influence their surroundings had on their drug use. For example, Marcella, a forty-two-year old woman who has been battling her addiction to crack cocaine for ten years, talked at length about the decrease in her drug use when she was away from Oakland. However, because she was homeless and without a permanent address, Marcella had to return to the area every month to pick up her welfare check. With her money in hand at the first of the month, she was often unable to resist the pull of her old surroundings. In my interview with her, she spoke with great anxiety about the upcoming month because she would again have to return to Oakland. Many spoke of their need to escape their drug use by leaving their environments. Juliet, a twenty-eight-year-old mother of a year old son, discussed her plans to leave her drug-using family and go to Sacramento where there was less incentive to smoke crack.

The women's awareness of their drug environment may have been due to the sample population. All of them had had experiences with some type of drug treatment and rehabilitation. Some of the women sought treatment for their drug addition voluntarily; for some of the women, the courts or Child Protective Services required treatment. Often seeking residential in-patient treatment, these women were aware that removing themselves from their surroundings helped to decrease the urge to use. For women whose treatment was mandatory, the education of the drug program was likely to have instilled this sense of awareness. It is possible that drug abusers with no history of treatment and deeper into drugs would be less likely to recognize this influence.

The PNA study clearly demonstrates the belief among drug-using women that their environment exacerbates their own drug use. Seventy-five percent of the women screened in for the study indicated that drug use or drug dealing was a problem in their neighborhood. Only 39.8% of those women who were screened out of the study indicated neighborhood problems with drugs. When the sample was separated by county, more women from Alameda County agreed that drug use and dealing was a problem than women from Fresno. Moreover, more African-Americans than any other racial/ethnic groups viewed drug use in their neighborhood as a significant problem.[160] Given that the women from my study were all African-American and from Alameda County, these results lend considerable support to the above findings.

V. Consequences of their Drug Use:

Interwoven into the stories of these ten women are the consequences of their drug use for their family, their children, and themselves. I will attempt to provide a summary of these accounts as an example of how deeply the women's drug use was embedded into their world.

Impact on Family Relations.

The PNA Study found an association between heavy substance use and increased family and relationship problems; however, the researchers were unable to comment on a causal relationship. They stated:

> While isolation and lack of family or social involvement can make life hard for people and lead to problems, it is also the case that for many AOD [alcohol or drug]-involved people, both the use and the problems occur because of social ties...it is not always possible, however, particularly in a retrospective and close-ended one-time study such as

160 *Supra* note 148.

> this; to determine whether the heavy substance use is a response to family and relationship problems, or creates them; perhaps most likely, both are true.[161]

In some of the sections above, I have already shown how family and relationship problems resulted in increased use of drugs for the women I interviewed. The PNA study's presumption that the two problems were interdependent was clearly supported through the open-ended format of the interviews and the qualitative analysis. Those women who described a lot of drug use by family members also commented on how, in many instances, drugs had destroyed the fabric of unity in these homes, and consequently, resulted in family and relationship problems.

> They [siblings] use drugs. That's why it's a clash...We get along when there's no drugs. When there's no drugs along, we all get along. But when drugs come in and you can't get some of it, they get--tripping, cussing, acting funny...the love is gone. You know, when the boot isn't around, love it there...it's like competition.

For this woman, drug use among all her brothers and sisters had created this alternative form of "sibling rivalry." Drugs were the limited commodity for which they all had to compete.

Even for those women whose families were not necessarily heavily into drug use, the woman's substance abuse created problems for family relationships. The destruction of trust was a pervasive theme in many of the women's accounts of family life.

> To an extent, it kinda destroyed our relationship because my mother is totally--she thinks drugs is the end of the world...I think she kinda, like, lost trust...Trust. You know, it evaporated. She tried to hold on but she...I didn't really do a lot of scandalous things, you know, to my mom, but she could see...that is was coming.

---

161 *Id.*, at 124, 125.

For this woman, the lack of trust between her mother and herself resulted in her mother's withdrawal from her life. Because her mother could no longer trust her, she no longer supported her. This support was precisely what this drug-using woman needed most. Therefore, from this example, we can see how drug use invades the bonds of trust between family members and consequently destroys the possibility of family support for the substance abuser from the family.

Impact on Themselves.

Other studies have documented the impact of drugs on the women themselves. In the MCC study, criminality and prostitution or other sex-for-drugs exchanges were prevalent among the women interviewees. As the MCC study and another study conducted by Sheigla Murphy and Marsha Rosenbaum[162] document, for women substance abusers from lower socioeconomic classes and limited resources, the economic drain from supporting drug use often led to criminality, and in the most desperate cases, prostitution. As Kearney et al. states: "Women with adequate financial means had access to a better quality of drugs..they were less vulnerable to victimization and degradation by male street dealers and had less need to trade sex for drugs--every woman's last resort."[163] This section will describe these same consequences of heavy drug use observed in the ten interviews.

Criminality.

Some studies have found that female drug abusers tend to commit the crimes of shoplifting, drug sale and prostitution, while male drug abusers are more likely to commit robbery, burglary, and assault.[164] Nonetheless, in the ten interviews of this study, "female-type" crimes (shoplifting, drug sale,

---

162 Murphy, *supra* note 147.

163 Kearney, *supra* note 147, at 358-359.

164 *Supra* note 19, at 11.

prostitution) as well as "male-type" crimes (especially robbery and burglary) were observed in the women substance abusers. For example, the women were all asked the worst thing that they had done because of drug use. Below are a couple of the replies:

> My cousin's boyfriend sells drugs. And she was selling drugs. So I went ahead and got in the business of selling drugs.
>
> I stole stuff...I never hurt anyone for drugs...physically, you know. And, I--kinda like--money-wise, I kinda did.

Most of the women who sold drugs reported serving jail sentences for drug trafficking. In addition, here is another example of how men influenced these women's lives. The female drug dealers spoke about how male partners and friends introduced them to selling drugs. This recruitment process is most likely because women elicit less suspicion for drug trafficking.[165]

In the PNA study, one in four women reported having an arrest 'because of drugs.[166] Among the ten women in the present study, six mothers spoke of their experiences with being in jail. For the most part, their jail sentences were due to prostitution and drug trafficking.

Sex-for-Drugs: Prostitution & Toss-Up.

Aside from drug selling, the other main criminal act reported by the ten women was the exchange of sexual acts for drugs or money. Surprisingly, all of the women indicated that they had done sexual acts for drugs/money in both formal and casual situations. One woman reported being a sex worker prior to the start of her heavy crack cocaine use. She states:

> Everyday I was giving [making a hand motion]--just doing head, going crazy...and then he asked me would your rather be getting paid, than doing it for free?...So we goes down and buys a wig. A

---

165 *Id.*

166 *Supra* note 148.

> short outfit. Some heels. So they take me down here around the corner...and that's where I got turned out at.

For others, sex-for-drugs exchanges occurred in "toss-up" situations. A "toss-up" is "a woman who is known to have sex in exchange for crack." Additionally, this woman will do anything for the slightest amount of crack. Murphy and Rosenbaum further state, "in the crack scene, tossups are more stigmatized than professional prostitutes owing primarily to their reputation for putting up with degrading and demeaning demands from customers, getting little payment, and trading sex for drugs instead of money."[167] The following are some accounts of "tossing-up" in this present study:

> 'Cause when you live in a crack house, excuse me, you're a child. You're open prey. Anybody can screw you--women, men, boys...you're just through...And everybody bring you a drug--you know? They bring you a drug. Oh, I'll give you a hit, if you let me suck your titties.

> I never considered myself a prostitute. I mean, I did things for the drug, but never on a corner--nothing like that. No.

> During the four years that I was homeless. That's how I kept housing...I stayed with some sugar daddies--them old men. Nasty dogs...they would take care of [my son]...but I had to screw them old dogs. And they let me get high.

Although Murphy and Rosenbaum found that being a tossup was an even lesser status than a normal prostitute, many of the women in my study seemed to make a clear distinction between their sexual activity for drugs versus standing on the street corner. For example, in the second quote above, this woman stated emphatically that while she did have sex in exchange for drugs, she <u>never</u> was a "prostitute." This impression suggests that, at least for her, the label of prostitute was worse. I believe that the level of "tossing-up" may account for this discrepant of report. It may be that Murphy and Rosenbaum's subjects were

---

167 Murphy, *supra* note 147, at 388.

more entrenched in the crack houses and being "rock house tossups" while the women in my study exchanged sex for drugs at a less depraved level.

VI. Women & Drugs: Psychological Issues:

After spending numerous afternoons talking with these women, I found that important psychological issues were present at some level for all of the women. The women reported their reasons why they thought they used drugs. They talked at length about their loss of control as they plunged deeper and deeper into the drug world. Importantly, these control issues (especially the lack of it) were critical in the underlying framework of their actions during their drug use. Additionally, psychological processes of rationalization and loss of control compromised their ability to think and act rationally. The psychological issues presented in this next section must be considered when exploring the woman's actions during her pregnancies and are important components in the discussion of criminalization.

Self-Reported Reasons for Drug Use.

Many of the women's perceived reasons for using drugs have already been presented in the above discussion of the women's histories of drug use and the characteristics of their background and environment. Most of the self-reported contributors to drug use dealt with external elements in the lives of these women. Violence and abuse during childhood, loss of a parent or loved one, and loss of children due to drug use were the most commonly reported factors of continued drug use. Asked why she used drugs, Marsha summarized:

> Because I was the black sheep of the family. I was not wanted. And my dad sexually abused me. I always heard all my life, you know, "you're not my child." I've been slapped around. I've been raped twice...my lover was killed..These drugs will make you feel good...Ain't gonna have to worry about that problem.

Juliet reported that the devastation of losing three of her children to a house fire and the subsequent financial crisis were important accessories to her use of crack cocaine.

> Everything started down, sliding down hill after I moved--after I had the fire and I moved down the hill. And came down, how do you say, to the...came down this way [to Richmond]...after that, every[thing]...me and my husband's marriage...after we moved off the hill, it's like I said, everything just went down hill. I got into drugs, and...everything...

Juliet's description presents a descriptive metaphor of her drug use. As she moved from the East Bay hills to Richmond, Juliet also made her descent deeper into the drug world. She reports that it was the uncontrollable external factors of her world that led to her increased use of drugs.

As already discussed, violence and abuse were integral aspects of these women's lives. Their reasons for doing drugs included this physical depreciation. Bernie, who had an extensive history of sexual and physical abuse throughout her life, reported the following:

> All I've know all my life is just sex, sex, sex, drugs, drugs, drugs. Um...I started drinking at six. I mean, I wanted to do it because it made me feel like I was on another planet--like I was really out there, right? And I didn't have to deal with my parents...Even now, sometimes when I see my--like I saw my Dad last year and I started having nightmares all over again...I felt like "I gotta use some." I gotta use, I gotta use...I gotta get some, I gotta get some, I gotta get something...

Later in her life, Bernie was involved with several drug dealers and often exchanged drugs for sex.

> Nastiest thing you ever saw--I had sex with things that looked like slugs...I had to do something to these nasty things. The more things I do, the drunker I got or the higher I got. And it tear you up. I've been through some storms.

Mary reported that the death of her father was a major force in the shaping of her drug use. With the loss of her father, Mary turn to drugs "to

escape reality." This idea of drugs as an escape from reality is present in Marsha's and Bernie's story as well as most of the other women interviewed. Marcella described:

> Any little thing that happened. Any thing that made me upset. You know, it's just an excuse. also when I had drugs, it makes me feel good to forget about my problems. But when it's gone, your problem is still there.

The pleasurable feelings while on a "high" seemed to be a major way that these women could escape the horrible truths in their lives. Moreover, the unpleasant aspects of their lives gave them no reason to discontinue their drug habits. As Sheigla Murphy and Marsha Rosenbaum writes in their discussion of a lower class, Black crack user:

> [B]eing a member of the underclass means having few (if any) possessions, no resources with which to acquire them, and no reasonable expectation that circumstances will improve in the future. Missing are stakes in a conventional lifestyle or compelling reasons to control drug use, to"just say no."[168]

Finally, a critical contributor to drug use among the ten women interviewed was the guilt and shame of exposing their children to drugs. During the interviews, many of these women became emotionally upset and distraught when we discussed their feelings about their drug use and their children. Guilt and a sense of worthlessness pervaded the women's statements. Many suggested that these feelings led to increased use of drugs--often, in order to escape the guilt and pain. These issues will be more fully described and explored below.

Additionally, when these women lost their children to Child Protective Services, the pain from this loss again contributed to use of more drugs. As one woman states:

---

168 *Id.* at 386.

> I was trying to depress the pain that I had of losing my child. I didn't want to deal with it. I just felt like I hadn't nothing else to look for--I lost my child. So why stop using drugs now? That's how I felt.

Control .

During the interviews, the women were asked specifically about how they defined "control of drug use" and whether or not they were in control of their own drug use. Even though all of these women described heavy crack cocaine use at some point in their lives and included horrific accounts of the depths of their drug use, the responses to these questions on control were somewhat varied. While some women spoke of the complete lack of control in their drug use, others felt a sense of partial control.

At the extreme end, some of the subjects stated that they had completely lost control of their lives at the moment their crack cocaine use began. Adrianne, a mother of four whose partner pressured her to use crack, remarked:

> Control? There was no control. I was out of control when I took the first hit. When I took the first hit, I was out of control.

A more common description was the gradual loss of control paralleling the increased amount and frequency of drug use with time. For example, when I asked one woman if she had ever had control of her drug use, she replied:

> The beginning. Because I could just take a little, and say I don't want no more. But that only lasted for a little bit. And it--it was so little bit, I can't even remember...after that, I just had to have it. You know? I would do anything for it. I did some terrible things like prostitution, robbery...

Implied in this woman's answer is that the lack of control resulted in "terrible" actions. In this excerpt, she gives the examples of prostitution and robbery. Many women stated that the use of drugs during their pregnancies represented their loss of control.

In addition, the continued use of drugs despite warnings from both the criminal justice system and child welfare agencies was another manifestation of the women's loss of control. For one woman, Child Protective Services took her children when she failed to adhere to CPS guidelines regarding her drug use. She remarks:

> I didn't go along with what they said, so they ended being taken...(*Did the idea of CPS taking your kids stop you from using drugs?*) Nope...it was something I didn't have no control over. They was it was gonna happen...'Cause I, I tried--it was like I couldn't stop...so whatever this thing was happened was gonna happen. I didn't have no control over it. So that's what I felt.

Here we have an example of the powers of drug addiction overwhelming the maternal instincts toward her children. Not even the idea of losing custody of her children persuaded this woman to stop using crack cocaine. This interpretation, of course, assumes that the mother truly desires to be a parent to their children. One popular image of the drug using mother casts the drug addicted woman as a heartless, neglectful mother who does not care about the fate of her children and only wants more drugs. Later I will present several excerpts from my interviews, as well as evidence from other qualitative studies, which suggest that this image of the crack-addicted woman is not accurate. Despite their drug addictions, many mothers have definite ideas of what a good mother should do and should not do and deep senses of caring and responsibility toward their children. Yet, drugs rob the women of the ability and the resources to accomplish these ideals. Therefore, the descriptions of loss of control above highlight the power that drug addiction has over the will and actions of these mothers.

The inability to control themselves in terms of their actions (prostitution, toss-up, robbery, and other criminal acts) was one implied definition of "control" in these woman's lives. However, many woman also explained "control of drug

use" as the capacity to "hide" the drug use and appear functional in daily life. When asked to tell me what "being in control of drug use" is, one woman gave a particularly apt description of these two levels of control:

> [F]irst...that was, like, money. You know, like, when you can say no. Hold on to your money for a little bit. You see, then it got to where every penny--you know, you're digging the lining out of your pocket...some people think that's control. Or else, functional. Like you can work--I've never been able to...Control to me would be functional...some drug addicts--they get up and use drugs and they go to work. They see over their children...there are a lot of functional addicts...

A few of the mothers reported being in partial control of their drug use. Usually, this claim implied that although they continued to use drugs, they were able to occasionally put the drug down. One woman defined her partial control of her drug use in the following way:

> I feel like I am in control to a point, I am not going to rob you. I am not going to kill you. But, I am so paranoid I can't and that is not in control.

This woman draws the line of control before the point where she will commit a robbery or murder. However, she then admits that she usually becomes paranoid[169] with her drug use, and to her, the paranoia does not reflect control. Thus, with this further reflection, she seems to conclude that even though she would not commit robbery or murder because of her drug use, her mental state and actions while paranoid indicate the loss of control in her drug use.

"Drawing the Line."

In the preceding description of control, the woman draws a line demarcating "controlled" behavior and "out of control" behavior in her belief system. This "drawing the line" phenomenon was present in various forms in

---

169 Paranoia is a common reaction to the use of many drugs including the smoking of crack cocaine. Often referred in street lingo as "tweaking," paranoia consists of feeling watched or followed.

many of the women's accounts of their drug use. "Drawing the line" defined the boundaries of their drug use. In her interview, Mary described living in abandoned houses, selling herself for drugs, spending many years in crackhouses, neglecting her children, and eventually losing custody of all of her children; however, she remarks:

> I mean, in spite of my drug use, I try not to lose all my morals. You know what I mean? I tried to hold on like I'm not gonna...I never would neglect my hygiene...they got some pretty low people that do drugs. It was like, you know...incest?...I never...that was the morals I would...I'd die with...I'll die with certain morals, you know. I mean 'cause a lot of people neglect themselves when they got on drugs. Look bad. And I'll never do that. Never. I don't care how bad I was...I'm gonna shower and get cleaned, you know? There's certain things that I just wouldn't do.

For Mary, although crack cocaine had led her to commit some abominable things and had resulted in terrible situations, the simple boundary that she had set for herself--maintaining her hygiene so at least she would never looked like a "drug addict"--meant that she never would be as low as an addict.

Adrianne "drew the line" in terms of her sexual behavior. After her husband introduced her to crack cocaine, and she became hooked, Adrianne was selling herself for drugs. After she presented this information in her interview, Adrianne said:

> Yes, I did do it though [do tricks for drugs], but just with people I wanted to do it with.

She then went on to describe the drug dealers with whom she had exchanged sex for drugs as people that she "wanted" to have sex with. The line that Adrianne drew allowed her to distinguish herself from a prostitute or from a depraved drug addict who would do anything for drugs. By believing that she had created a "standard" of whom she would have sex with, Adrianne protected herself from

thinking that she was desperate enough to sell her body to anybody for drugs. The line that she drew helped her maintain her dignity as a person.

In setting these boundaries, the women were able to create a psychological sense of control although their actions reflected a complete loss of control. This false sense of control enabled the women to set themselves apart from the "drug addicts" that they saw on the streets. Since the women probably had seen the worst of drug addicts, this "deceit" was a way for them to reconcile their feelings about drug use. Moreover, it was a way for them to maintain their self-respect--their dignity. A part of them realized that they were letting themselves succumb to drugs, but as in Mary's case, merely maintaining hygiene and appearance acted as a camouflage for this downward slide.

Drawing the line also allowed the women to maintain some degree of respect in their relationships with others. Their drug use often precluded them from giving other people the amount of respect they deserved. Endangering their own fetuses with drug use and exposing their children to the world of drug users are, perhaps, the most prominent examples of how drug use had stripped the women of the ability to respect others. By drawing a line for their drug use in terms of frequency or situation, some women were able to simulate "control" of their drug use. For instance, Marsha comments:

> You know, when I'm around kids or people who don't do drugs, I don't be high. With my family, I do not. We had social things, Christmas, stuff like that. I am not high. I give them that respect.

Marsha's drug use has already generated major health problems, homelessness, a history of criminality and the loss of her only daughter. Yet, she claims to be able to appreciate the needs of others, and especially her relatives, by not being high in their presence. In the later section on mothering, we shall see how these women similarly "drew a line" to protect their children from their drug use.

To some degree, the self-deceit seen in these women are not that different from the self-deception that all of us use in our everyday lives to fool ourselves into believing that we are, indeed, in control and to protect ourselves from the consequences of being out of control. Yet, what is remarkable about the "drawing of lines" in these drug-using women is the level at which this psychological justification is effective. Despite the obvious examples of depravity resulting from drug use, this self-justification was still effective in deluding these women.

Rationality and the Ability to Think.

The ability to think rationally is very important to the debate about criminalization of drug use. The goals of deterrence and rehabilitation in criminal punishment in part assume that the woman is able to reflect upon the law and think rationally about any action she commits. Thus, the examination of these ten women's ability to think and their degree of rationality during drug use was a major part in the analysis of the interviews.

I approached this issue by asking each woman what she thought about when she was using drugs, both during the high and between highs. Overwhelmingly the women referred to drugs and how they would get more drugs as their dominant thoughts during their "highs" and periods of intense drug use. They were preoccupied with obtaining more drugs and regaining that "high." For example:

> Totally blocked it out. there's no future in drugs. And as far as thinking ability, um...distorted. Forgetful...
>
> ...[T]he only thing I could think of was just want another hit. That's it and that's all. That's the bottom line. Just want another hit. And then when it's all gone, you be trying to sell--trying to figure out how to get some more...I tell you what--if I made any kind of decision while I'm smoking, it couldn't [be] the right decision...And then afterwards, it be like, boy!...I'd be pissed off at myself.

> Knowing that only person that put myself in that position is me...You know I'm the one that screwed up.
>
> When you are caught up in drugs your mind doesn't think about that. Your mind skips that part. You don't be in reality. You don't think about your mind. You have a one track mind while indulging in crack...While indulging I had a one track mind at that's all I could deal with. Anything else that came at me--it was bothering me--I can't concentrate on that. My mind would not let me.

These excerpts highlight three important concepts in a drug addict's thought processes. First, while these women are intoxicated, they are unable to consider the very reality from which they are escaping. As described in preceding sections, the use of drugs to escape reality was one of the major motivations to use drugs. Under the influence of drugs, these women were not even able to consider their problems. Second, the statements of the women also indicate a sense of regret after the drug high wore off. In the second excerpt the woman remarked, "I'd be so pissed off at myself." The inability to think rationality while under the influence led to poor decisions and consequently, a sense of failing after the high. Finally, the women interviewed were able to acknowledge their own fault for their actions while using drugs. Many of the women spoke of having nobody else to blame but themselves. Yet, the sense of self-hatred that resulted from blaming themselves often created massive guilt. Drug use then allowed the women to escape these feelings of guilt, and the vicious cycle was perpetuated.

An important question to answer is whether or not women are rational in between drug highs. The answer seems to depend on the degree of drug use. Women in the study described being irrational in between rapidly successive highs. However, when "coming down" from a period of frequent drug use, the women appeared to be rational--at least enough to consider their actions during their drug use.

Kearney, Murphy, and Rosenbaum reported similar results in their analysis of crack-using mothers. However, their analysis concluded that drug use was a way to escape the pressures of mothering, and the subsequent guilt and shame from drug use continued the cycle of drug use. They state:

> When they woke up after sleeping off a binge, mothers were miserable with guilt and worry...Thus, for many mothers, a 'vicious cycle' began, consisting of using to relieve the pressures of mothering, coming down from the crack high to face the financial and moral damage of drug use to mothering, and using again to escape increasing worry and guilt.[170]

Among the subjects in this study, however, while eventually drug use did result in sustained drug use, there were no descriptions of drug use as a way to escape the pressure of mothering. The women did report using drugs as a way to deal with the guilt of failing to be a good mother. Yet, as I later will discuss, the perceived requirements of being a mother often interrupted the cycle of drug use.

VII. The Women & Their Children:

Before considering the issues surrounding pregnancy and prenatal care, I would like to examine briefly information in the interviews concerning the impact of drugs on the lives of these women's children. This next section discusses the sequelae of drug exposure for the children, both in terms of actual physical effect and of subsequent social environment associated with their mother's drug use.

Physiological Impact of Drug Exposure.

Given the large amounts of crack cocaine smoked by this group of women, it is not surprising to find many reports in these interviews detailing the physiological consequences of drug exposure in the children. However, while

---

170 Kearney, *supra* note 147, at 355.

several women reported behavioral and psychological problems in their children, which they attributed to their drug use, just as many women denied any negative effect of drugs on their children. Below are many accounts which seem to suggest that the denial of serious effects or the minimization of such effects were important mechanisms of coping for these women. Also interesting is that none of the women reported extremely serious problems caused by prenatal drug exposure. Obviously this finding is most likely due to the sample population. Women who knew that they had severely harmed their children were probably unlikely to agree to be interviewed and to discuss these hurtful issues. At the woman's day shelter in Berkeley, I was referred to one woman as a possible subject by several other women. However, upon reading my study's flyer on the wall, she immediately broke into tears, and remained distraught throughout the morning. She told me that she was currently dealing with the recent birth of her infant son and was unable to participate in the interview. In watching her throughout the morning at the shelter, I felt a great sense of guilt and sadness. I believe that others like her who are dealing with recent problems with their drug-exposed infants or with extremely awful effects of drug exposure on their children would refuse to be interviewed as this woman did.

Alyssa, a twenty-nine year old doe-eyed woman who lost the custody of her three daughters, reported in her interview:

> Through the actions from behind my smoking this with my last pregnancy, my baby has partial hearing in her right ear...Because it wasn't good I did that to them. My oldest daughter, she's real hyper. She's real fast and real hyper from the crack. My middle daughter is slower, moving slower but apparently she's gotten it all together. One thing I could say is that it didn't impair this [mind] because my second daughter is not even in school and she's at a first grade level...my baby. She's ten months old and she's so advanced already. So it didn't impair this...

Alyssa's daughters are examples of how crack cocaine exposure during pregnancy has created both physiological deficits as well as behavioral issues. However, Alyssa somehow derives comfort from knowing that despite these consequences of her smoking, her children have been able to retain appropriate intellectual capacity.

Another woman with two young daughters spoke of her current ordeal:

> Right now, that's what I'm going through 'cause we think the drugs did affect my daughter....She's real hyper. I think she got her rebelliousness from me. But ah...I think her speech is a little slow to me, I think her speech is a little slow. Um, sometimes she's just--for a kid to take a straight pin and just poke it in and out and stand there screaming at school or just constant...something's wrong. So I'm dealing with that right now.

At first, in this woman's description, we are led to believe that the drugs have had rather minor effects on her daughter. Yet this woman then goes on to report symptoms of severe psychological and behavioral disturbances in her five-year-old daughter. Her statement, "something's wrong" may be an incredible understatement of the real problems her daughter faces. Denial or minimization of the harsh truth seems to be a crucial way that this woman copes with the knowledge that she seriously harmed her baby.

In my conversation with Juliet, she reported a disturbing effect that crack cocaine exposure has had on her three-year-old son:

> Like my three year old--like he wakes up during the middle of the night and just look like--hollers for no reason. My three-year-old. I don't know if they nightmares or what. But he just wake up and like...probably like 'cause I used when I was pregnant with the baby.

At the other end of the spectrum was Mary's story. She felt like one of the "lucky ones" in that her son was not affected greatly by her severe drug use.

> He [son] doesn't seem...I have three [children], you know, like I said, and I didn't use with the other ones. And he seems just as...I

> don't see any effect at all. You know, physical or mentally. Thank God!! You know, I don't see any effect. Any. None. You know, maybe there's some beyond my...beyond my ability to detect. But it'd have to be very little where, you now, something very...I don't know, I just don't see any effect. I was one of the lucky, fortunate ones.

Throughout her description, Mary's mood was full of relief and gladness. However, despite this optimistic response, she later reemphasized that the perceived lack of problems were limited by her own ability to "see" and "detect" them. Thus, it appears that despite the probable lack of consequence in her son, Mary is not completely free of the worry that her drug use might have negatively affected her son.

Other Ramifications of Drug Use on the Children.

Aside from the direct physical and psychological effects of drug exposure, many women also described the secondary effects that drug use had on their children. Bernie, who had an extensive history of sexual abuse when she was a child, reported similar problems for her children. All of her four children have been sexually molested or abused during their lives. As she remarks:

> And during that six months, it was total hell for those kids. And so, one child was molested by her new friend...your oldest daughter says that somebody had touched her.

Although family members contributed to this abuse, Bernie's children also suffered at the hands of crack addicts and drug dealers. The abuse in the children's lives reflected the type of environment fostered by Bernie's drug use. The lack of resources coupled with Bernie's addiction to drugs limited her ability to escape this climate.

Earlier, I discussed how many of these women were forced to become surrogate parents to their siblings. The use of drugs by these women similarly forced their children to assume the premature roles of parent. As Bernie described:

> I'd give Michael [oldest son] a packages of them Ramen noodles and say "go for it, homie." And he'd--he did everything. Changed the baby. Taught the baby how to walk..I was with the baby and missed the baby walking...I was smoking...Michael taught him how to use the potty. He taught him how to talk--Michael was his daddy and his mommy. Michael watched over all of them. My oldest child--he became the daddy of everybody.

Later Bernie described how she reclaimed her role as parent once she rehabilitated from her drug use. She emphasized how she wanted her son Michael to forget about being a parent and concentrate on being a child. Unfortunately, Bernie's ability to recover from drugs and to assume her parental role is a rare outcome in this population.

Two of the women recounted with shame their abuse and neglect of their children. The descriptive data found here represent a departure from information collected in the PNA study. One in eight women in the PNA study reported not having their child living with them because of intervention by Child Protective Services. Most of these CPS events are for neglect, failure-to-protect, or abandonment. Only one mother reported that she physically abused her child. In the qualitative study conducted by Kearney, Murphy and Rosenbaum, although the investigators described the loss of children due to the mother's inability to meet mothering standards, they did not offer any descriptive accounts of abuse or neglect.

Yet, even though the women in my study voluntarily mentioned incidents of neglect and abuse, these were relatively minor incidents. The most serious acts mentioned were abandonment of their children usually with relatives or friends, while the women were on "drug runs," and neglecting their children while on a "high." For instance, Mary described the "worst thing" she had done to her children:

> [T]he worst thing, I think is when I had my daughter in the room and I was getting high and I wouldn't let her come out. I don't know. Stuff like that, you know, really tear me up when I think about them.

Even Bernie, who had grown up and lived in an environment that was teeming with physical and sexual abuse, denied inflicting any abuse on her children (although her sisters who had grown up with the same family environment molested her children).

Many of the women did not speak of "abuse or neglect" per se, but instead referred to periods of time where their children did not have appropriate growing environments. When I asked Adrianne how she treated her children during her years of heavy crack cocaine use, she replied:

> Bad. 'Cause, like, they had to stay outside...when the--they just used to stay outside period. Until it's time to come in and go to bed. Or if they came in, they had to sit down and watch T.V. and then with her [daughter], She--we ran the streets so much from one person's house to another one...So we ran the streets...a lot.

An even more subtle reflection of emotional and/or physical neglect was the insecurities that the woman saw in their children. When I interviewed Adrianne, two of her children were also in the room.[171] Adrianne recounted how her eldest eight-year-old daughter has reacted:

> Recently, I was going to go back and stay with their daddy. And she [daughter] told me no because all he do is beat me up--that's all she said...I guess she do have thoughts around it, but she really hasn't said nothing 'cause every once she pop up with a new question...like, she asked me--she told me when we used to throw them outside, she used to sneak through the door...she was asking me why were not letting them in the house. So I guess she has feelings around it. But she just talk once and every blue moon.

---

[171] It was a school holiday, and she did not have anybody else to take care of them during our interview. Prior to the interview, I did make sure that it was alright that we discuss these rather sensitive topics in front of the children. Adrianne thought it was fine especially since these two older children had been old enough during the time of her heavy drug use to realize what had happened.

Adrianne's daughter did not fully realize why her mother had treated her the way she did. A strange mixture of child-like curiosity and confusion is ingrained in her questions. Why did you lock us out of the house? Why did you not care about us? Why did you smoke crack? During the interview with Adrianne, her daughter would interject every now and then with questions like "Are you going back to him [abusive father]?" and "Do you want to go back to jail?" In the past two years, Adrianne and her children have enjoyed relative peace. She has been clean for two years, is going to a local college to learn basic job skills, and has recovered the custody of all her children. Yet, there was a deep sense of fear and unsteadiness in many of Adrianne's daughter's questions--namely, are you [we] going to have to go back to that type of life?

VIII. Motherhood:

As described above, all of the women in this study had either lost or relinquished custody of their children at some time during their years of drug use. To fully analyze this phenomenon, we must consider how these women viewed themselves as mothers. This next section examines how the women perceived being a good mother, how they viewed themselves in terms of being mothers, and finally, how they viewed themselves when they failed as mothers. The recent qualitative study on mothering conducted by Margaret Kearney, Sheigla Murphy, and Marsha Rosenbaum will serve as a basis for the structure in this discussion. I will attempt to show that the four contexts of mothering presented by the above investigators are again supported by my ten interviews. In addition, the psychological issue of guilt and the social construction of religion seemed also to influence the mothers in this study in their perceptions of mother hood.

The Ideals of Motherhood.

The investigators of the MCC study emphasized the nurturing and modeling they observed in the mothers they interviewed. The mothers tried to satisfy their children's material and emotional needs. They were careful to be "models" to their children.

Many women in this study expressed their love of and pride in their children. Bernie described her son:

> He's such a beautiful little boy. He preached at age four. He--He's working on the eighth grade level and he's only twelve. He loves God. He loves school. He loves people. He helped what they call the lower person. He's a good young man. He's a good--I love him. Every minute that he's around me, I love him

Bernie's maternal love shined through during the interview despite the fact that the father of her son was her own father and despite her rampant drug use during the pregnancy. Other women described buying gifts for their children as expressions of "nurturing." One example of this was Natalie's story. Although she gave her son up for adoption when he was four months old, she described the extravagant gifts of toys and clothing she provided him during the first four months. Underlying Natalie's description was the urgent impulse to satisfy her nurturing ideals and to provide her son with the best before the imminent failure to be a good mother. The women's ultimate inability to care for their children adequately will be discussed more fully below.

Although some women described the neglect of their children, most were aware of what they <u>should</u> be providing to their children as mothers. Many of the women described how they tried to maintain these goals of motherhood. For example:

> You know, I'm trying to raise my son up. You know, I don't neglect him at all. At all. Whatever he needs, he gets.

> I took care of my responsibility which was my son. I made sure that his security was #1 because I would never want him to say mommy, mommy, I don't love you. I don't love you because you use drugs. Never once, boy. I tell, the torment, to worry about him--I just put that aside. So then I smoked and I didn't feel about things like that.

Thus, although during their motherhood, their drug use and their limited resources prevented them from achieving all the goals of mothering, these women were quite aware of their responsibilities as a mother. Moreover, these mothers used the fulfillment of these goals as evidence for their status as a "good mother" despite their uncontrolled drug use. As one mother in the MCC study stated, "I may be a crack monster, but at least I have morals about myself."[172]

Alyssa's own interactions with her mother reflected her ideas of motherhood. As the only subject in the study whose mother used drugs during her pregnancy, Alyssa described a lot of confusion and anger over her mother's actions. However, Alyssa herself had fallen to the world of crack cocaine, and she sometimes found herself doing drugs with the woman for whom she had much antagonism and no respect--her mother. Yet, in several passages during the interview, Alyssa comments on her discomfort with "getting high" with her mother.

> Well, once I did it with my mother. I didn't like it. I already knew I didn't like it because it's a tweek feeling...it makes you be irrational, you don't really know what you're doing..Once I did it with my mother and she was feeling that feeling too and then I am feeling and I didn't like the feeling because I shouldn't have been feeling that feeling with my mother. So, it affected me terribly. I was like I don't know, I can't even go home like this. I can't go on doing it with her.

In this somewhat confusing account, Alyssa indicated her discomfort with this impression of her mother--as someone to get high with. She was drawn to using

---

172 Kearney, *supra* note 147, at 355.

drugs with her mother by the powerful forces of addiction, yet she struggled with whether this is a "right" act to be doing with her mother. Her statement, "I shouldn't have been feeling that feeling with my mother, " indicates her discomfort with her mother's failings in setting an appropriate example as a mother.

Two central themes in Alyssa's relationship with her mother were trust and respect. Abandoned by her sixteen-year-old heroin-using mother, Alyssa has struggled with the ability to trust and respect anybody and especially her mother. Yet, the above passage suggests that although she was denied respect and caring in her childhood, Alyssa is acutely aware of these concepts in being a good mother. Her mother clearly does not respect herself or Alyssa since she is willing to get "high" with her own daughter--an activity which Alyssa views as inappropriate. As reflected in her current situation with her own children, Alyssa is struggling to recover this trust and respect so that she can be a mother to her children.

"Changing Mothering Contexts: Downward Slide.[173]

In their examination of 68 crack-using mothers, Kearney, Murphy and Rosenbaum described four contexts of mothering on a continuum of increasing crack use.[174] On the first level, drug use was a method to achieve "relaxation" recreationally. Similarly, in these ten interviews, initial recreational use was reported by most of the women. They described being in control of their drug use, and being able to adequately care for and nurture their children. As the amount of drug use increased, the mothers described increasing difficulty with these mothering goals. At this second level, as in the MCC study, mothers were even more careful to delineate specific details of how they were able to still

---

173 This terms is borrowed from Kearney, Murphy & Rosenbaum's discussion on mothering on crack cocaine.

174 Kearney, *supra* note 147, at 356, 357.

provide for their children. Issues of adequate hygiene and nutrition became prominent in the women's reports almost as proof of their mothering abilities. As one woman states:

> I used drugs with Kevin...after he was big enough, grown...I kept his clothes clean. I did all the motherly things. But he knew that I used drugs and he says momma I want you to stop but at least you don't smoke up all the money. I know some kids parents smoke up all their money. They come home from school and their clothes are not clean and their food is not cooked...I did his laundry, I kept his food cooked.

Another example of this level of motherhood was how Mary was able to escape one world of drug use early in her experience with drugs. In the context of mothering, Mary finally realized the ramifications of her partner's drug dealing. For the welfare of her children, she found the strength to escape this relationship. She states:

> And then I figured out that he was using, so I...what made me leave him was that my daughter picked up a syringe in the kitchen one morning. I go, that's it! [sic] And I left...I guess the good Lord was with me through it all. Because I decided when my daughter picked up the--she was little tot--maybe two...I go that's it...I didn't wait around for him to make up...I'm gone!

Mary had been in this questionable relationship for many years. Fortunately, at this point in her drug use, she still retained enough resources and self-motivation to be able to escape the relationship.

In the third context of mothering, drug use had overcome the women's good intentions to be good mothers, and the women had either lost or given up their children. Again, findings in this present study paralleled the observations of Kearney, Murphy and Rosenbaum. Many of the women I interviewed described being at this stage in their drug use. Some of them stated they they lost their children when relatives reported them to the authorities.

> My mother. She called. She called the people. The social service protective service because I did abandon my child for overnight. and um [the father of child] went and got him and he's had him ever since. He did get taken...My son did...Because my mother told 'em that I abandoned him, and she wasn't able to keep him...And you know, I'm still not together.

This woman, who still did not have custody of her children, admitted that her drug use remains out of control and consequently that she is still not able to be a mother.

As in the MCC study, there were many examples of women interviewed who voluntarily relinquished their children. This "giving up" of their children symbolized more than just their "giving up" to their drug use, but also indicated self-realization of not being able to fulfill the role of mother.

> It [drug use] just got progressively worse and worse. 'Cause I ain't--I started neglecting my house. Well, when I got on it..right after the first year, I'd see it was really bad. That's when I let my son go. And then, then my daughter. And then the dog.

> My children...when I got kinda..um...when I start using cocaine, then...um...it's this thing I have 'bout respecting children so I automatically gave my children up because I didn't want them to--I mean, because I got kinda bad, couldn't really hide it. And by my oldest child being a son and a teenager, I didn't want him to, you know, see this either, so I called my sister-in-law. "Come get him!"

This issue of respect for the children manifested itself in other ways. One woman who had left her children with her sister and brother-in-law when she went on a drug spree recognized that her children were not safe with her sister's family (they were using drugs also). This woman called CPS herself to report the situation and eventually lost custody of her children.

Earlier, I discussed various situations where a form of "neglect and abuse" was described by the women. In the examination of these women's mothering strategies, one central theme in many of their reports was isolation. The apparent neglect and abuse of their children stemmed partly from the women's attempts to

isolate their children from the drug use in their environment. Thus, locking their children in closets or rooms, albeit abusive, was a mechanism for these women to separate their drug use from their children. The MCC study also elicited this strategy from many of the women in their study. In fact, the researchers suggest that the ultimate inability to compensate for drug use by this separation was the reason for relinguishing or losing custody of their children. The study says:

> For almost 70% of the mothers interviewed for this study, strategies for upholding mothering standards eventually broke down. When mothers perceived that their mothering was inadequate, they either reduced their drug use or intensified their efforts at defensive compensation, but many were unable to pull themselves out...At this point, some mothers decided to entrust their children to another caregiver...[175]

For mothers in both the MCC study and in this present study, the relinquishment of custody was the final attempt at being a good mother and the most extreme method of separating their children from drugs.

The investigators in the MCC study also described escalating drug use that occurred after the loss of the children. They state:

> Drug use escalated because women had no mothering responsibilities and much pain and sadness. In their desire for their children's health and happiness, mothers already labeled as unfit by the child welfare system had little confidence in their mothering abilities and were reluctant to remove children from stable homes...Sometimes continued drug use seemed a more feasible option.[176]

Correspondingly, the women in my study also recounted similar effects on their drug use from the loss of their children. Bernie spoke of how she reacted to the loss of her children:

---

175 *Id.*, at 355.
176 *Id.*, at 357.

> When they took my kids from me--I went on a drug...I went crazy. I did drugs like it was nothing, I mean, I would smoke crack from eight in the morning to eight in the morning. And I wouldn't put little itty-bitty pieces of crack on the pipe, I would put the whole twenty piece rock. And I'd just go inhaling and inhaling, and I would get a fifty dollar bag, which was, like, four, five rocks...I just smoked and smoked and smoked.

This description of wild, out-of-control drug use seemed to reflect Bernie's wild, out-of-control feelings of pain and loss from not having her children. Moreover, as with other women, Bernie's drug use was a way to numb herself to the feelings of guilt.

In fact, similar to the guilt from various drug-influenced actions (i.e. prostitution), guilt from failing to fulfill their ideals of motherhood was a common thread in many of the women's chronicles of drug use. For example, Juliet gave a chilling description of her three-year-old son's nightmares, which she attributes to drug exposure.

> During the whole time that I'm there [at husband's house], I'd be feeling guilty about--when something go wrong 'cause like, he's okay...he started off, you know, how they can have learning disabilities, right? He was going to a special school...and overcame it, right?...but it's just that--what chills me is when he gets up in the middle of the night and does all this screaming...GUILTY! It makes me feel really bad inside.

Marcella tearfully spoke of her feelings from losing seven pregnancies because of drug use:

> Bad. Bad. Seriously bad. You know?...To hurt somebody's life...Just--I didn't give a damn. It hurts. It hurts so bad. Well, I think about how old my child would have been now if I would've had her...It hurts. I hate it...I hate myself...That's when it got me using drugs. I sit back and think about it, and it hurts.

In both Marcella's and Juliet's narratives are a deep sense of guilt and pain from affecting their children with their drug use. They ultimately feel the need to turn

to the oblivion of drug use in order to escape the guilt from failing to be a "good mother."

The MCC study explains the fourth context of mothering as the depletion of resources and thus, the inability to continue drug use. Having already lost custody of their children and in this lowest state, the mother then struggles to improve the situation. Often, at this point, the woman is fighting to regain custody of her children. Several of the women in this present study were in this context of mothering at the time of the interview. Specifically, Laurie, a twenty-three-year-old mother who had been clean and sober for one year and was currently residing in the transitional housing program, talked about her "mission" to regain custody of her older daughter. When I asked her if her goal was to get her daughter back, she said the following:

> No, because I <u>am going</u> to get my daughter back. And that's not no "if." That's not an "if." I will receive my oldest daughter back. I'm here right now to get an education--learn some skills on how to take care of a child...I'm here to better my life.

Laurie was one of the fortunate ones because she was enrolled in this transitional housing program that would give her "skills" and the resources to rebuild her life and eventually get her daughter back.

"Bettering her life" was also Alyssa's goal at the time of our interview. All three of her daughters were in foster care, and Alyssa spoke of trying to get her life back together so that her daughters could return to live with her. Yet, unlike Laurie, Alyssa had been less successful in finding support in her struggle to improve herself. Without this support, Alyssa had been unable to regain her resources or to achieve skills to "better her life." She was only able to cease using drugs for weeks or months at a time. Currently, Alyssa was fighting a losing battle to recover from her drug use, and reconstitute her life.

Religion & Mothering.

As I have described, guilt was a dominant theme in the women's responses to their drug use and the harm to their children. Yet, an interesting factor in this guilt of failing motherhood was religion. Two women, in particular, remarked that their deep sense of pain and guilt arose partly from their Christian faith. One woman described her own mother's opinion of the drug use during her pregnancy:

> My mother, she'd go that what you got--a devil's baby in your stomach.

This woman discussed how she thought she had committed the greatest sin and how God would punish her for her acts. Here was an example of guilt resulting not only from the failure of mothering, but also from failure in her religious faith.

These failures resulted in a great sense of guilt and triggered mechanisms of denial in order to cope with the conflict. Perhaps the most telling exchange during the interviews that exemplified this deep sense of religious guilt compounded with guilt from failing to be a "good mother" was told by one mother of three:

> Now that scares me...I don't want to die. And I don't want to go to hell--I want to go to heaven...You know, and I'm doing wrong [in being a mother], and I know...I was brought up in the church, and I know right from wrong. And God's calling me to come to him. And to leave all this life alone...I'm scared to die..I don't want to die not unsaved. I wanted to be saved before I die.

For this woman, the sin of not being a good mother to her children, especially in terms of her drug use, was almost overwhelming to her. Redemption and salvation were religious goals that were not available to her if she continued to "sin" and remained "unsaved." The inability to fulfill these religious ideals combined with the inability to achieve mothering goals resulted in a great sense inertia in changing her lifestyle.

On the other hand, I must mention how religious goals were helpful for some women in providing the motivation to change. One women spoke of the large role that Christianity played in her recognition of her drug problems and her recent two-year period of sobriety.

IX. Pregnancy & Prenatal Care:

One of the major goals of this analysis was to determine how much prenatal care these women received and what factors contributed to whether or not they received care. Important in this discussion are the characteristics of the woman's drug use during each of her pregnancies. This first section considers these characteristics of drug use during pregnancy, and the following sections examine the issues of prenatal care and the contributors to receiving care.

Drug Use During Pregnancy.

In this sample of ten women, the use of drugs during pregnancy was affected by numerous factors including the timing of pregnancy and the social factors surrounding the pregnancy. Perhaps the clearest association between drug use and pregnancy depended on the level of drug use by the mother at the time she became pregnant. Many of the older women reported little or no drug use during their earlier pregnancies when their drug addiction was not as severe, but reported heavy use in their later pregnancies as the types of drugs they used changed and as their addiction became stronger. In my interview with Letitia, she reported being able to quit smoking crack cocaine once she found out she was pregnant with her first son. Yet in her second pregnancy, she continued to smoke throughout the pregnancy. I asked her how the two pregnancies differed in this respect:

> By this time, I was really gone. I was off into smoking crack...By this time I was going--tossing up--doing anything to get some dope.

For many of the younger women, their drug use was well established by the time of their first pregnancy. For twenty-three-year-old Laurie, the drug use in her first pregnancy was combined with issues of teenage pregnancy and lack of social support. Given these additional factors, she could not overcome her addiction.

As the woman's control of her drug use slipped away, so did many of her resources and support. The loss of these combined with the increased dependency on drugs often made it impossible for the woman to stop using drugs during pregnancy. The desperation stemming from the inability to cease their drug use despite their pregnancies was pervasive in many of the woman's accounts:

> I know I had done wrong, but I still had the strong craving. So I cut back trying to spare my baby's life. I was able to cut down, but I wasn't able to stop. I wasn't able to stop.
>
> I ended up pregnancy. And I just kept smoking. I was like, I should quit--something gonna happen to me. I couldn't help myself. I said I'm just going do a little bit. I'm not going to do a lot. And I smoked every day up until [the birth].
>
> [T]he last one--I think he got everything...My mother calls him "Miracle Baby." Because I was like really bad and plus I used to get beat up a lot when the guy--the father--used to beat me up a whole lot. Plus the drugs. And then, drugs. In this process when I lost my house. It was just one thing after another.

In the last passage above, we also see the strong influence that the woman's social environment had on her ability to stop using drugs during her pregnancy. The physical abuse by her partner and the addictive crack cocaine were insurmountable barriers for this woman.

The women also described major psychological barriers which contributed to their inability to stop using drugs during pregnancy. First, many women commented that early in their lives, they were unaware of the negative effects of

drugs on their fetuses. One woman stated that she didn't stop smoking because she didn't know that crack cocaine would be bad for her baby. In the two pregnancies later in this woman's life, she still was not able to stop her drug use. Although she was aware of the drug's effects, she could not overcome her addiction.

The second barrier to stopping drug use, especially at times of heavy drug use, was being unaware of the pregnancy until the second trimester. Drug use dulled their ability to perceive the pregnancy. When they found out they were pregnant, they had already exposed their infants. An obvious criticism of this conclusion would be that the women were just finding an excuse for their inability to stop drug use. However, once some of these women realized that they were pregnant, they did seek prenatal care.

Finally, for one woman, the use of drugs was her only way to control the environment for her developing child. Bernie's life, as described in detail above, was full of sexual, physical, and emotional torture. When Bernie became pregnant with her second child, whom she felt to be a girl, she reports using drugs and alcohol as way to "kill" her baby. She recalls:

> When I was pregnant with Kristin, I took Starline and Mescaline. I was popping acid, snorting cocaine, and drinking 180 proof vodka and gin straight out the bottle. And I did that for five months of her pregnancy...I started feeling this movement. And I said "Damn!" I'm pregnant, I didn't even know she was in me--you know? and I was getting high 'cause all these drug dealers was doing it to me.

Bernie claims to have been unaware of her pregnancy because of the pain from her social environment and the oblivion from her drug use. Bernie continues:

> When I was pregnant with her, somebody told me if you drink 180 proof vodka, you'll lose the baby...Me is stupid. I drinked as much vodka. I mean, gallons...I didn't want to bring her in the life that I was in. I didn't want Kristin to be here...I didn't want [her] to be raped. I didn't want [her] to be forced to do drugs.

At first glance, Bernie appears to be a crazy and sick drug abuser who doesn't care about her children and only wants more alcohol and drugs. However, after considering the amount of trauma to her own life, this desire to "kill" her baby through her drug use is motivated not by selfishness, but by the desire, albeit desperate and poorly thought-out, to improve her child's environment. Given the complete lack of support and resources in Bernie's life, the only way that she thought she could improve her daughter's life and prevent the same atrocities that had occurred in her own life was through her drug use.

Amount of Prenatal Care.

Six of the ten women reported receiving adequate prenatal care during at least one of their pregnancies. However, all of these pregnancies occurred when these women were not heavily into drugs. Every one of these women reported late or inadequate care in prior or subsequent pregnancies when their drug use escalated. Three women reported receiving no prenatal care at all during at least one of their pregnancies.

Similar to the mother's ability to stop drug use, the amount of prenatal care received during each pregnancy correlated with the depth of reported drug involvement at that time. Drug use combined with the already stated social environment and psychological barriers paralleled the woman's lack of prenatal care. For instance, one woman indicated:

> I just didn't get it [prenatal care]. I just didn't go get none. I think the drugs had everything to do with me not...See, I was young. I was only seventeen. I'd just had learned the birds and the bees, and I ended up pregnant...

Another woman said:

> With this one [oldest daughter], I was just starting off in my addiction, and so I went and got my care for her. But with him [son], I think--I was so far gone, I didn't really care.

The availability of social support and encouragement to seek prenatal care was a second factor in determining whether or not the woman received prenatal care during her pregnancy. One woman, who had been using LSD and popping acid during her daughter's pregnancy, stated that she would not have gone to the doctor's office if her mother, who was a nurse, had not urged her. In fact, her mother literally took her to the doctor's office. Yet, in this woman's description of what her mother did, the support and love from her mother during this time were the primary reasons for this successful intervention.

For two of the women, either treatment programs or the criminal justice system precipitated their entrance into prenatal care. One woman, who was three months pregnant at the time, was fortunate enough to be able to enter a residential treatment program which provided full prenatal care services. Another spoke of the care that she received once she was arrested for selling drugs. As part of her sentence, she was required to receive medical care for her pregnancy.

Perception of Prenatal Care.

All of the women were asked what they believe prenatal care was and whether or not this care was essential for a pregnancy. The answers to both of these questions were quite varied.

In defining prenatal care, most of the women were aware that the medical care involved was a way to make sure the baby was developing correctly.

> To make sure the baby is alright. To make sure you are alright. And being in the right frame of mind. Basically, that's it.

> First of all, while being pregnant and to make sure that the baby is okay during the pregnancy. It's very crucial that the baby gets what it needs while you are pregnant. Make sure you do what you have to do in order to take care of the baby while you're pregnant and to make sure that the baby is okay.

> Well, to assure you that your baby's developing right, properly, you know. Um, just to keep tabs on that , I guess. Kinda keep on your toes about your consciousness of the child and stuff like that.

However, in many of the women's descriptions of prenatal care, there seemed to be a strong emphasis on the "baby." The descriptions of the mother's role centered around the health of the "baby" rather than herself. The reasons for this "child centered" outlook on prenatal care are unclear. It may be that the women's education from treatment programs and media have focused on the health of the child rather than the health of the mother. Many public service announcements on television take this approach. On the other hand, this "child centered" outlook may also reflect the deep sense of concern that the mothers have for their unborn child. In their narratives, many women spoke of their worries in terms of the negative effects of drugs on their children. Concern about the effects of drugs on their children translates into this skewed perception of prenatal care being only for the baby. Prenatal care thus becomes a mechanism to check on their biggest worry from their drug use--the effect on their children. We must also not forget that these women are drug users, and to a certain extent, either consciously or subconsciously, their own health and well-being has already been compromised through their own weaknesses. The women may lack the ability to consider themselves since they have already inflicted self-harm through their drug use.

Another disturbing commentary on the abuse and trauma that pervades these women's lives was the perception of prenatal care as being any medical care received by the mother during the pregnancy. One mother considered medical care of the developing fetus after a partner abused her a part of "prenatal care." Mary remarked:

> You know, a lot--to be honest, a lot of prenatal care was, like, when I got jumped on. and I'd go--they'd monitor me. You know, listen to the heart beat. Put him on a sonogram and look at him and stuff.

> So a lot--'cause I'd go [to the hospital] every time I got jumped by him, you know.

The physical abuse in Mary's life became the reason for the seeking of prenatal care in Mary's mind. The emergency room visits after being "jumped on" constituted most of the care during her pregnancy.

When questioned about the need for and worth of receiving prenatal care, most of the women indicated a deep sense of faith and belief in prenatal care. However, although many of the women did not receive proper care during their pregnancies, their children were not greatly harmed by the lack of such care, even despite the women's heavy drug use. These women tended to use their experiences as an example that prenatal care was "up to the individual." For instance, the narratives included this statement:

> (*Do you think prenatal care is important to a healthy pregnancy?*) No, not really..because although Michelle didn't have no prenatal care, she still came out okay. I mean I know the vitamins is for the iron and other nutrition that the baby needs. But she still came out okay...she still came out normal like the other two kids did. So I guess it's all up to the person if they want to go out...It think it's all up to the person.

Although this woman had earlier agreed to the benefits of prenatal care, she made contradictory comments when we discussed the birth of Michelle. This observation suggests that her earlier comments may be rhetoric she heard from media or other programming and that she really did not believe in prenatal care. An important concept in this woman's perception of prenatal care is its basis in the positive outcome of her daughter's drug-exposed pregnancy. This woman had been smoking crack cocaine during her pregnancy. Even though she probably was aware for the need to get medical care, she did not seek this care. Yet, her baby daughter came out fine. What we have here is a perfect situation for the woman to downplay the necessity of prenatal care. Given the good outcome, the woman has "proof" that prenatal care does not really matter. By

minimizing the benefits of prenatal care, she is able to reconcile the opposing internal belief systems. Moreover, given the good outcome despite the lack of care, she can reduce the level of guilt she feels about not receiving care.

Compensation for Lack of Prenatal Care.

One of the emerging phenomena in these ten interviews was the use of compensatory actions by women to "rectify" the lack of prenatal care in their pregnancies. Women made direct remarks about how they resolved the conflict of interests between wanting to have a healthy baby and lacking the appropriate care and attention during the pregnancy. Women spoke of drinking water, eating well, and taking their vitamins as ways that they could ensure a healthy outcome of their pregnancy despite their drug use and the lack of adequate prenatal care. For example:

> [I smoked] a great, great deal [of crack] but I ate right every single day. [I smoked] all day long, but I took my prenatal vitamins. My baby father used to buy me a whole gallon of apple juice and cranberry juice and I ate. I ate real good, took my prenatal vitamins, and I drank the cranberry juice, which helps bring back a lot of what the crack takes out of you.
>
> I tried to compensate. Like I would take vitamins and water. I wasn't really trying to be aware of the damage that [drugs] could do.
>
> I had the prenatal pills. I think that if I take them, that it would--you know, it would overlook the drugs. And you know, as I'm doing drugs, I'd be taking the pills--make her, it wouldn't hurt her. That's how I was thinking.

In light of the inability to stop using drugs (described above), this way of compensating for the absence of adequate medical attention and the presence of drug use was the women's way of atoning for their "sins."

The presence of these compensatory mechanisms suggests two important underlying beliefs in these women's attitudes about their pregnancies. First, these actions of compensation imply that the women are aware of the harmful

effects of their drug use. Their addiction to drugs has not eliminated their awareness of the health and well-being of their children. Second, these women acknowledge the need to negate these deleterious effects. These women are not uncaring women who are entirely oblivious to the needs of their unborn children. Rather, they are women who are in some sense "trapped" in their drug use, albeit an initially freely chosen use of drugs. Unable to stop their drug use, these women use the limited means they have to offset the drug effects on their children. Adequate nutrition and hydration are their only hopes to mitigate the harms to their fetuses.

"Postponement of Reality"

The term, "postponement of reality", for describing the women's attitudes toward their pregnancies, is borrowed from the emerging conclusions of a three-year qualitative study on pregnant drug users currently being conducted by Sheigla Murphy and Marsha Rosenbaum in San Francisco.[177] Essentially, this term describes the women's resolution of the inner conflict between the awareness of harm from drugs and their inability to cease using drugs. In a telephone conversation with Katie Irwin, who has been working with the co-principal investigators of this project, I found that their sample of 120 mostly crack-using pregnant and post-partum women reflected the same "denial" of pregnancy and reality as did the ten women that I interviewed. Ms. Irwin believed that this "denial" was not true denial since these women also exhibited efforts to mitigate the harm to their fetuses with compensatory actions similar to the ones I have described above. Thus, if the women were conscious enough of the deleterious effects of their drug use on their babies to find ways to mitigate

---

[177] Phone interview with Katie Irwin. April 25, 1994. The principal investigators, Sheigla Murphy and Marsha Rosenbaum, are currently conducting a three year study of three groups of pregnant women totalling 120 women.

the harms, then they at some level are aware of their developing babies and not completely "in denial" of the pregnancies.

In my ten interviews, I found that "postponement of the reality of pregnancy" occurred at various levels. Some women postponed the reality by not seeking prenatal care early in their pregnancy. For example, in Natalie's story, she claims that she did not know about her pregnancy until she was in her fifth month. Yet, later in the interview, she states that she "decided" to not seek care until her fifth month. Although one explanation of this contradiction is to question the reliability of Natalie's responses, under the postponement theory, Natalie delayed the reality of her pregnancy by not seeking prenatal care in those two months.

Perhaps the most descriptive account of this phenomenon can from twenty-eight-year-old Adrianne. She states:

> When I was using drugs when I was pregnant, I would pretend like I wasn't pregnancy. I could do mind over matter where I was pregnant but not really pregnant. This was with all of them [all her children]. I would be pregnant, but I would pretend I was not really pregnant. Until it was time for them to come out. And that was that. I don't really know how I did it...So the only person that I was really harming was just myself and not the baby. That's what I really thought for a while.

This segment from Adrianne's interview captures the essence of what "postponement of reality" is. As she herself states, by "pretending" that the baby did not exist, she could fool herself into believing that her drug use was not harming the baby.

Other evidence for the "postponement of reality" present in these interviews concerned how the women felt physically during their pregnancies or rather, how they did not feel during their pregnancies. At the women's day shelter, I talked with one counselor who told me that many of the women came to the shelter complaining about the physical discomfort and the bodily changes

they were experiencing from their pregnancies. The counselor remarked that the women often acted as if the pregnancy were their first although they had several prior pregnancies, which either ended in loss of custody or death of the child.

This manifestation of "postponement" was again reproduced in many of the interviews. When asked how she felt when her baby kicked, Laurie replied "uncomfortable." Even with more questioning, Laurie still related her "discomfort" as her sole feeling about the baby's kicking. In a regular pregnancy, the woman would usually convey feelings of pleasure and excitement when she felt her baby kick. Yet, for Laurie, these feelings did not "exist." This example demonstrates the woman's unconscious ability to reduce her pregnancy experience to mere physical discomfort. Laurie only recognized that her body was changing. She could not acknowledge the cause behind these changes--namely, that there was baby growing inside of her.

Another woman stated that during her first pregnancy she did "everything in her powers to ignore that baby." However, later in her second pregnancy, when she was sober and clean and in a treatment center, this woman reported:

> I went out. I bought a little night gown, newborn gowns and the receiving blankets. And I always took baths and talked to my stomach while I took my baths. Rubbed my stomach. I ate very healthy. Got plenty of rest. I even quit smoking cigarettes 'cause I thought it was gonna hurt my baby.

The contrast between the two pregnancies is striking. Postponement of the reality of her first pregnancy did not allow her to bathe in the excitement and glory of the impending birth, nor did it permit her to begin her mothering relationship with her baby (talking to the baby, etc.). All of these were acknowledgements of the actuality of the pregnancy, which did not relieve the woman of the discord between drug use and protecting her baby. The

pregnancy was only allowed to manifest itself completely when this conflict was not present.

This theory may also partly account for why most of the women reported receiving late prenatal care (in their second or third trimester of pregnancy) during at least one of their pregnancies. Under this assumption, the women did not seek care until the reality of the pregnancy could no longer be postponed--that is, the physical signs of their pregnant states were so blatantly obvious that "pretending" the pregnancy did not exist was no longer possible.

The "postponement" of reality of their pregnancies affected these women's decisions to seek prenatal care. After all, if the pregnancy did not "exist," then no care or attention was needed. A critical question in this analysis was the effect this postponement would have on the outcome of a criminalization policy. If the women are unable to even consider their pregnancies as realities then how will the threat of legal action on drug use during *pregnancy* dissuade these women from using drugs. In addition, the main question that this analysis considers, whether or not criminalization of perinatal substance abuse deters women from prenatal care, becomes a complex issue. A policy of criminalization may exacerbate this phenomenon of postponement by creating more incentive for the women to postpone the reality of her pregnancy. By not acknowledging their pregnancies completely, these women are spared the emotional burden and fear of being caught and sent to jail. However, this conclusion is only valid if we assume that the women are able to convince themselves totally of "postponement." Because most of the women did acknowledge their pregnancy later in its course, it seems that this "postponement" was not completely adequate to shield the women from their conflicts. Perhaps criminalization would be able to decrease drug use later in their pregnancies. However, as later I address, the

fear of the law did contribute substantially to their decisions not to seek prenatal care.

Above we discussed how failure of motherhood contributed to the vicious cycle of drug use. Unfortunately, "postponement of the reality of pregnancy" also contributed to this cycle. Drug use was part of these women's effort to "block out" their pregnancy.

Reasons for Not Seeking Prenatal Care.

Thus, the question we must now ask is, given this complex psychological attitude toward their pregnancy, what other reasons did these women have for not seeking care? The PNA study found that when given a long list of reasons why "a pregnant woman might not go for or get prenatal care," the women indicated concrete barriers such as transportation or finances were the foremost reasons. Less than 20% of the women reported not seeking prenatal care because of guilt or embarrassment from drug use, and another 20% indicated that over-involvement with drugs and alcohol prevented them from seeking care. The researchers concluded that socioeconomic issues, not psychological issues, were of greater concern to these women.[178] Yet in the previous section, I presented one important psychological phenomenon which, in part, may affect prenatal care decisions. The almost subconscious quality of "postponement" was one which the structured PNA study may not have been able to elicit.

Aside from the psychological issue of postponement, the immediate answer to why the women in this study did not seek prenatal care during their pregnancies was their drug use and not the concrete reasons cited in the PNA study. At some point during the interviews, all of the women referred to their drug use as a primary reason for not getting care. One women remarked:

---

178 *Supra* note 148.

> You get caught up with smoking that they--you not even gonna take the time off to go see no doctor.

Importantly, however, issues of transportation and money were discussed in terms of the women's drug use. In other women's responses, there was a link between their drug use and the lack of transportation and money.

> 'Cause I think I was so far gone and ah...it was so far from there to the doctor office. And I would have to walk 'cause I didn't have no money. Every time I had, I either drank it or smoked it up...And I wasn't going to walk that far just to go see the doctor office...Every dime, penny I had--it went towards drugs or drink. I didn't have no money to go catch the bus to go to the doctor to go my prenatal care.

Similar to the PNA study, other women cited guilt and embarrassment as reasons for not seeking care. These feelings usually surrounded their drug use.

> Cause I was doing drugs, and they would know that I was doing. by then, I was really feeling guilty--and I didn't really want to go to the doctor and let them know what I was doing. So I never went go back to the doctor.

Other women spoke of the social constraints in their environment. Alyssa spoke of the lack of support by the father and the time constraints from her other children.

> My baby's father. A lot of things, situations, getting bigger...my baby's father never lived with me so I was pregnant, had a daughter who was ready for school and a daughter that wasn't in school. I had to get up being pregnant. Get my daughter to school, walk her to the bus stop, get my other daughter dressed. I can't leave her in the house by herself.

Again, the women's histories of physical abuse played a part in their prenatal care decisions. One woman was too embarrassed to go to the doctor because of how she looked and felt after fights with her abusive husband.

> I stopped going 'cause then my husband was stepping on me. Me and my husband was fighting all the time. And I was calling in saying that I had a headache or--which I did, 'cause he jumped on me--that ain't no joke.

Fear of Criminalization and its Impact on Prenatal Care.

Overall, when first asked why they did not seek care or did not seek care earlier in their pregnancies, the women said that other reasons aside from fear of the law contributed to their lack of prenatal care. Yet, later in the discussion, almost all of the women stated fear of the law as a reason for not seeking care or not returning for subsequent care.[179] This finding roughly corresponded to the results of the PNA study. Approximately 11.6% of the subjects in the PNA study admitted fear of being reported to CPS, while 8.3% did not seek care because of fear of the law and immigration authorities.[180] Researchers of the PNA study concluded:

> However, the issues of substance use, the fear of losing one's children, concerns about doctor's reactions, and indeed the fear of the law, do each play a part in missed prenatal care for a significant minority.

In this present study, though not the primary reason in the women's decisions, fear of legal consequences seemed to be an underlying reason to not seek prenatal care. One women described this "bi-leveled" quality of the decision to not receive care:

> Psychologically, I was afraid but I know that I was on a substance drug and the first thing...you're pregnant using drugs...that was my psychological state of mind. My physical state of mind was I didn't care. I care but I was so overtaken by rape and trying to live in the shelter.

This women describes her "psychological" versus her "physical" state of mind. She mentions how the psychosocial factors of her life, including her rape and her

---

179 An important methodological issue here is whether or not leading questions pertaining to criminalization were used to elicit this response. Careful attempts during the interviews were made to avoid "leading" the subject. Answers to direct questions on criminalization were analyzed in section X.

180 *Id.*

homelessness, were the "physical" parts of her reasons not to seek care. Yet, the "psychological" state of mind from being pregnant and using drugs was the other level of her decision. This women later stated that the "psychological" reasons to not seek care stemmed from the fear of being "caught."

Despite this duality in many of the women's reasons for not seeking care, many women did speak directly about how the fear of criminalization/law impacted on their decisions to seek care.

> Let me see...why, why didn't I go see a doctor? I--'cause I didn't want to. Yeah. I decided I didn't want to see a doctor. I wasn't ready to stop smoking dope...And each time I would've went, I would've had urine--I would've had coke in my urine. So, no I didn't--that's why didn't want to go. Because I was gonna be dirty.
>
> I thought that they was gonna test me. And , they gonna take the baby, and then, I would never get a chance to hold him. I knew he was a boy. I never would get a chance to see him.
>
> That I didn't? [get care]...'cause I would be reported. going to jail, and them taking my baby. That was the main reason.
>
> 'Cause I was doing drugs, and they would know that I was doing. By then, I was really feeling guilty--and I didn't really--I didn't want to go to the doctor and let them know what I was doing...

In these excerpts, the women refer to their fear of various legal consequences. Losing custody of one's child, feeling guilty/shameful about their drug use, and fearing imprisonment were all issues brought to the surface. Moreover, these were all reasons cited for not seeking timely and appropriate prenatal care.

Another important response from these women was the impact of this legal fear on the quality and amount of prenatal care. Some women did not seek care at all during their pregnancies because of these fears. Compromised care resulting from the women's fears was even more commonly reported. First, many women reported going to seek prenatal care only when they were "clean."

Because they were often "dirty," these women received an inadequate amount of prenatal care. For example, Mary described her use of prenatal care:

> [When I went to prenatal care]...I was always, like I say, I was always clean, you know. And try to, when I go in...when I do things in public, or...or professional, I tried to be straight, you know, so. Um...it was kinda an insurance. I felt better. You know, you detect any problems, so I'm thinking everything's okay.

In Mary's third pregnancy, she did not receive prenatal care until her fifth month, and this prenatal care was very fragmented up to the birth of her son. Mary's drug use had escalated during this time, and the periods when she was "clean" were limited.

Another woman stated:

> I was trying to do it like this--like smoke for a while and then I'd stop smoking. You know, so when I wasn't smoking, I was trying to get to the doctor because I would start smoking again. That's--I think really that's how I tried to do it like that...'Cause I didn't want to get caught up with them...testing my urine for crack.

According to these two accounts, the fear of legal consequences, rather than deterring these women from seeking any care during their pregnancies, instead led to a complex analysis of the decision to obtain prenatal care. To seek medical care during pregnancy ceased to be a simple decision based on the welfare of the baby and mother, but instead, became a complicated assessment of legal risk, level of sobriety, and benefit to the baby.

This more complicated interpretation of prenatal care decisions drives the women toward more sophisticated actions. For example, almost all of the women reported the cessation of drug use prior to seeking prenatal care. Knowing that their prenatal care appointments were coming, the women stated that they would stop using for one to two days prior to the appointment so that they would appear "clean" at the exam. Alyssa described what she did during her three pregnancies:

> But what I would do was I would wait. You see, I know how long it takes before it gets out of your system. It don't take all that long if you eat the right proper food, boiled foods...and I know to take care of myself to get it out of my system in time enough for when I went to the doctor...At times when it was time for my prenatal care, I would back off. I would slow down and take care of myself and once I went in and everything was fine, I would use.

Alyssa's response also implied a certain "folklore" about how to "remove" the drugs from her system. Her reference to "boiled foods" suggested that there may be "street knowledge" in this population on how to rid the body of drugs faster. Despite this possible reference, information from the interviews do not provide any conclusive description or evidence of this "knowledge".

When asked why she engaged in this elaborate practice prior to her prenatal care visits, Alyssa answered:

> I was indulging because I was an addict at the time. Because I knew when I went to the doctors with one of my kids and I knew that there was a possibility if they saw too much in my system at a particular time they would turn me in...all ready for my kids to be removed by the time I delivered my baby.

While Alyssa did seek prenatal care during her pregnancy, her fear of legal consequences and of losing her baby led her to interrupt her normal drug use pattern.

Importantly, the ability to accomplish this "camouflage" was highly dependent on the degree of drug use. When their addiction became stronger several women were unable to cease using drugs prior to prenatal care visits. This inability to stop their drug use and their desire to appear "clean" usually meant not seeking prenatal care at all.

A final consequence of the fear of legal consequences was the lack of truth-telling to the health care professionals at the time of the prenatal care visit. Like

their efforts to appear "clean" at the time of medical visits, the women reported lying to their medical care professional about their drug use.

> Well, it's their job to report stuff like that. So that was my fear--they would. And that they was gonna take him, you know, if they knew. So I never admitted it. Never admitted it to 'em. I think I was approached and I denied it.

Obviously, this lack of truth-telling in medical care represents a severe compromise in the quality of prenatal care the women received and the benefit of the care to their drug-exposed pregnancies. Even though current child welfare and child abuse policies may already contribute to the fear of losing custody, and thus, to the compromise of medical care, a policy of criminalization would further decrease the amount and quality of care during pregnancy.

Other women who felt more successful in their efforts to conceal their drug use were more open about the truth with the health care professionals. For example, if the woman felt that she had successfully ceased using drugs prior to the prenatal care visit, she was more likely to tell the truth about her drug use. One woman stated that she always "told 'em 'cause it [the pregnancy] was clean at the time."

Trust of Health Care Professionals

Trust, or rather the lack of trust, was a critical aspect of the women's attitudes toward health care professionals. These women did not feel that they could trust their physician to maintain their confidentiality. First, the lack of trust in terms of reporting their drug use was deeply embedded in the women's reluctance to tell the truth. One woman remarked:

> Be trusted with the information about me and knowing that I'm on drugs??...I just thought they'd all work together. I felt--I'm taking drugs, I have a baby and I don't see how they could keep a secret. "Oh, she can't take care of this child. Let's put her in jail."

Another woman spoke of her lack of trust in terms of her own shame of using drugs during her pregnancy. Asked why she did not trust her physician, she replied:

> Because I thought I would lose the baby even before the baby was born, and I just didn't...I was ashamed. I was actually ashamed. I had started feeling like human again. Before, like I said, I had no feelings. I was a monster. But then when I started feeling the feelings that I should have and to tell somebody else--I thought they would handcuff me and take me away. Take the baby and I would never have the chance to see him. So I didn't tell because I was ashamed.

For other women, the lack of trust given to doctors also permeated other relationships.

> I wouldn't tell nobody [about my drug use]. I just didn't have trust of people period. I didn't let nobody know nothing about my life that they didn't really need to know.

Shame and guilt over their drug use and the fear of legal consequences were the main contributors to the lack of trust of health care professionals. For some women who reported trusting physicians because of prior experiences, this shame and fear often was great enough to sever any tenuous link of trust between the women and their doctors. The information from these ten interviews indicate that the lack of trust of physicians contributed greatly to their fear of legal consequences and their reluctance to seek prenatal care.

Lack of trust of physicians and other health care professionals clearly has serious ramifications for the quality of health care that women receive during their pregnancies. Substance-abusing women are likely to hide any history of their lives which related to their drug use, while this information often can be critical to the proper health maintenance and treatment of the women. Moreover, the doctor-patient relationship could also suffer from this lack of trust. Finally, if the receipt of prenatal care is to have any positive effect on the

outcome of drug-exposed pregnancies, women must be open about their habits and trusting of their physicians. The lack of trust that is suggested by these interviews jeopardizes any benefit on birth outcome that prenatal care may have on these high-risk pregnancies.

X. Opinions of Criminalization

A portion of the interview was devoted to the woman's opinions on the use and effectiveness of a policy criminalizing perinatal substance abuse. The questions in this section centered around both the women's own experiences as well as their general opinions about the effects of this policy. This next section examines the women's responses to these questions more fully.

General opinions.

Although all of the women reported some negative consequence of legal threats and actions, when asked of their general opinion on criminalization, the women were split in their responses. Most of the women stated that a policy of criminalization would have negative consequences on the woman and the baby. One woman stated:

> It [threat of the law] makes them go worse--the fear. The fear of somebody coming in taking something from you because you have a problem. People are invading their lives and telling them they are incapable of existing as a human being...it makes a woman worse.

Other women discussed their disapproval of a criminalization policy in terms of the lack of effect that such a policy would have. In Marsha's opinion, criminalization would not have an effect because women are not afraid of the prospect of imprisonment. She states:

> People that's out there that use drugs, they don't care if they get bust. I mean, what they gonna do? Put 'em in jail for sixty days? Ninety days?

Bernie stated with great emotion her opinion of this issue.

> Hah! That wouldn't do Jack Dempsey. That's just saying I'll baby sit for you for a while until you do it right...I goes beyond threatening them with the law. They don't give a damn about the law. I didn't. I'd got to the police and say "puh."

The intimidation of jail seemed not to be a great incentive for these women to stop their drug use. One explanation for this lack of intimidation rests in these women's environments of poverty and deprivation. Depressingly, many of the women's current dire living situations make the thought of going to jail not an entirely negative prospect. At least while they are in jail, these women have shelter, food, and other minor comforts which they do without while on the streets. One woman who had been homeless for four years stated:

> Well, to me, that [being in jail] was the best time of my life--that week I was in there. It was like vacation to me...all I did was eat, sleep, and read. That was the best time...there was nobody beating me up. So that was the best time. That was the best week of my life.

Another women also made this disturbing analogy of her jail time to a "vacation."

> And so, it was like when I went to jail, or I got sick and had to go in the hospital--that was my only time. That was like a little vacation for me. 'Cause I knew I had a place to go to sleep. I had a clean bed. I had food. And I was gonna have clean clothes.

Viewing jail time as a vacation was a disturbing commentary on the quality of life of these women. It is indeed a deprived life when time spent incarcerated is preferable to being free.

Moreover, as described above, these women are pratically "slaves" to their drug addiction. While in jail, women reported enjoying a "vacation" from their drug use and the activities related to their drug use. Because drugs were less available in prison, these women could escape the pressures of finding money to buy drugs and of doing drugs.

> That's the trip. When you're in jail, you don't want it. When you come of jail, you want it. When you're in jail, you don't have to go about doing no drugs.

Aside from not fearing the law, another reported reason for the ineffectiveness of criminalization was the inability of such a policy to change the woman's drug habit. Laurie remarked:

> Because if they don't want to stop, they don't want to change. They're not gonna do it...you got to do it for yourself 'cause it's not going to work.

The anticipated results of criminalization were reported to have little effect on the drug addictions of these women. For example, one woman gave a compelling description of this phenomenon in her own drug use:

> It [getting into trouble] scared me. Yes it did. It would last a couple of weeks and then I would stop thinking about it and use it because the craving was stronger. Yes, the fear [was there]. But the craving was stronger than the fear...I says, I could try it again and then the paranoia of the fear would play back in the picture after I took the hit so then I would throw the crack away. I would.

Despite these negative opinions of a policy of criminalization, other women surprisingly gave their support for this policy. One women stated that her own jail time had made her more conscious of her drug use and the effect on her pregnancy; however, she admits that the experience of jail still was not enough incentive to stop her drug use.

> Yeah, you think about it. You sit up there and lay up in there [jail]. Yeah, it kinda like rehabilitates you to an extent. Not to make you quit but more cautious.

Surprisingly, three of the women actually proposed criminalization when asked for the best policy in handling the problem of maternal drug abuse. They stated:

> I think being locked up is real good. It is a good idea. 'Cause there's no access to no dope...'Cause a lot of them ain't go get no

> recovery. They're not gonna get into no program. So the best way for them to join up is to go to jail until they have their baby...
>
> Lock them up. Put them in jail. Until they had their baby...I think that's good because, because that way they can't fuck up nobody's life.
>
> What other way is there? Somebody using drugs and addicted to them--there no other way but to lock them down. And get the right care that they need.

While these affirmative opinions of criminalization do come from these women's personal experiences, importantly, there is a sense of "last resort" in the above excerpts. Jail is an option to the women if treatment and medical care fail to stop the women's drug use. Moreover, the opinions of these women also arise from experiences of inadequate and unavailable drug treatment. When asked whether residential treatment was a preferable alternative to jail, these women all responded affirmatively. Another consideration possibly motivating these opinions is that all three of these women indicated great shame and guilt over the effects of their drug use on their pregnancies and their children. One of these women who attributed her seven unsuccessful pregnancies to her drug use stated that she would rather have been incarcerated than to have had to suffer through those seven losses. Nonetheless, although there seemed to be many issues that factor into these women's opinions, the option of criminalization does seem to be a viable alternative at least in the eyes of some of the women interviewed.

Deterrence to Drug Use.

When asked whether the threat of prosecution or the actual experience of incarceration ever influenced the women to not use drugs, the answer was almost invariably no. For instance, a woman remarked:

> No. They don't. I don't like going [to jail], but it don't--you mean, does it scare you? does it make enough that you don't want to do

[drugs]? No. Because I can deal with it. Shit!...it does not scare me enough to stop doing drugs.

As additional evidence of the absence of deterrence, many women reported the immediate use of drugs after they were released from jail. Several women commented on seeking and using drugs hours after their release. Despite their "enjoyment" of their vacation from drugs and the threat of more jail time, the women were not at all inhibited by their jail experiences.

Both as a reflection on the power of drug addiction and the relatively positive perception of jail time (stated above), this lack of deterrence has important consequences for the goals of a policy of criminalization. The evidence from these ten interviews cast serious doubts on the ability of a policy of criminalization to actually reform substance-abusing women and to deter them from further drug use.

XI. Treatment Issues:

This chapter considers the women's responses to questions concerning their use of drug treatment and rehabilitation services. All of the women interviewed had experienced some form of drug treatment. The treatment experiences ranged from intensive residential programs to brief encounters with Alcoholics Anonymous and Narcotics Anonymous meetings. A detailed analysis of these treatment experiences is beyond the scope of this present paper; however, I will try to highlight the general themes of self-esteem, relapse, and self-recovery.

Reclaiming Self Esteem.

During the periods of time where the women were successful in staying free from drugs, they reported a great sense of pride and self-esteem in being able to say no to drugs. Women reported feeling like "themselves," or "the way it

used to be." Better hygiene, weight gain, and improved appearance were all cited as reasons for their improved impression of themselves. One woman euphorically described a brief period of recovery:

> Oh, beautiful, man. I felt like somebody. You know? I just feel good. You know? I was thinking clearly. Just to eat. Watch T.V. Popcorn. Videos. You know, go places. Picnics and...it was reality. that's what it was--it was reality. It was something I used to do...When I wasn't using drugs...you know, it's like to--to be myself--to live for real.

In light of these women's backgrounds of deprivation, the ability to cease using drugs even for a month represented a huge step in "reclaiming" their self-esteem and self-worth.

Relapse.

In contrast, the "high" of being clean accentuated the "low" of relapse. All of the women interviewed reported relapses of their drug use subsequent to receiving treatment. Even those women who were currently clean and sober and residing in the transitional housing program recounted past experiences with treatment and relapse. Adrianne spent a great deal of time describing her treatment encounters and the relapse experiences after each attempt at treatment. Adrianne's relapses occurred when she returned to her abusive boyfriend. She states:

> Well, the first time--it take me a month [to relapse]. Second time, it took me two weeks. You know, it's, like, it wasn't--I say it's hard not to--It's hard to stop doing the drugs.

When these women relapsed back into their drug use, they viewed the relapse as a "weakness" and reported feelings of guilt and shame. One woman remarked:

> I stayed clean with him [first son]. Until I had a relapse though. Oh shoot. It's just like they described it. I mean, you feel guilty. Like you let yourself down. I mean...just like you just let

> everybody down. Especially yourself. Ooooh, it's a bad feeling. I ain't been, um, I ain't been clean since.

Women who had relapsed despite desperate efforts to stay clean reported using more drugs to diminish the sense of guilt and weakness.

The belief in residential treatment programs was another common theme among the women who had relapsed. For example, these women stated:

> You know, that's when I realized I needed to go into a residential building/home because you know, after the out-patient, I went right back. After the program, I was right back using in 24 hours.

> I was going there for a while, but I back slid and that an outpatient type of thing. I need to be in isolation for awhile. I know myself and I know when I isolate myself in my home, I'm okay...I need inpatient.

Although these women espoused their beliefs in in-patient residential drug treatment programs, many woman who were in residential programs still reported relapses after they left the programs and returned to their old neighborhoods. This is further evidence to support, not only the powerful physiological addiction of drugs, but also the overwhelming psychological need to use drugs often triggered by environment and circumstance.

Belief in Self-Recovery.

Although insufficient funds, lack of child care for other children, over-involvement in drugs, fear of losing children, and unavailability of programs were the most frequently mentioned barriers to receiving drug treatment, a more subtle barrier to care was evident in the women's statements. For many of the women currently not in any formal social service program, there was a belief in their ability to achieve recovery without formal treatment or services. Data from the PNA study suggested a similar finding. The study reports that close to three-fourths of the women reported that they had been able to cut down or quit their

drug use without formal help or treatment.[181] In this present study, for instance, the women commented:

> Like me, I'm going to seek it on my own. Rehabilitate myself. Unlike them. You know, into a totally different atmosphere where I don't know anybody. I can't run the streets like I do, you know. Where I can just be myself again. Just be myself.
>
> Right now, I'm seeking help for myself. Over the years I've been doing coke, I've finally--you know, I've tried to stop and been determined to stop using--but right now, I'm--this is where my thought and everything--I'm tired of it. I want to stop. I want to get better. So I'm basically gonna take myself and help myself get better.
>
> Basically for me, I would not go back into a home resident program anymore. Because what they're teaching you, you can teach yourself. Basically, it's take one day at a time.

Despite the optimism reflected in their ability to help themselves to recover, their treatment and drug use histories suggest that these periods of "self-recovery" end with the women's inability to withstand the social forces of using drugs. Moreover, the belief in "self-recovery" often mirrors the woman's immediate amount of resources and support. In the interviews, there was a consistent trend for these women to relapse once their resources were spent and their support limited.

The belief in self-recovery may stem from the women's frustrations with gaining entrance in drug programs, as well as with losing faith in these programs once the women relapse. Many women made extreme efforts to gain entrance to these program, but despite their desire to recover, they still reverted back to their drug habits after leaving the programs. For the women interviewed who were currently still "on the streets," the frustration of not being able to get into a treatment program also contributes to this belief in self-recovery.

---

181 *Id.*

Of the women in the study who were no longer using drugs at the time of the interview, all of them had done so with the help of formal support. Although clearly drug treatment was an important factor in this assistance, support with other issues such as homelessness and employability played a crucial role in the recovery of these women. For example, after four years of homelessness and being without her four children, Bernie was able to stop using drugs only when given the opportunity to correct the problems of poverty in her life. By giving Bernie and her four children a stable place to stay and providing job training to improve her employability, the transitional housing program was able to turn Bernie's life around.

XII. Hope: Pregnancy & Children:

The analysis of these ten interviews is not complete without a few remarks on the theme of hope. Despite the dire circumstances of many of the women's lives, there was a sense of hope in much of what they reported. Although for some, this optimistic attitude was tempered by the negative and depressing aspects of the women's environments, the women's pregnancies and their children played an important role in maintaining their sense of hope and promise for the future. For example, Laurie commented:

> I was not fixing to have no--another baby to let somebody else take. And that's all it is to it. That's just too much pain to have that baby and then they are so cute when you have them. To get attach to them, for somebody else to take? Uh-uh. I experienced it once and I didn't have to make the same mistake again...And I stuck to what I said. And I'd go any lengths to stay clean and to keep my child. I'm working on my oldest one--to try to get her back.

For Laurie, the goal of regaining custody of her older daughter has allowed her to hope for the future. Laurie is now currently in the transitional housing program, and working on gaining some office work skills.

The effect that pregnancy had on the lives of many of these women is further evidence that pregnancy is a promising time at which to intervene in these women's drug use. For example, many of the recovered women described turning points in their drug use centered around their children and their pregnancies. For example, Bernie's incredibly traumatic life was turned around when she had lost all of her children and hit a low point in her life. She states:

> They [her children] stayed in foster homes for a while, and I decided to get myself together. I smoked my last crack for all night--I mean, I smoked all night. And I said if I can't kill myself--God, if you allow me to live in the morning, I'm gonna change.

Another women talked about how she was finally able to admit her drug problems and seek help because of the obligation she felt for her son.

> I believe he [son] needed it. Something inside of me was saying get help, get help. Do something, don't just sit up here pregnant--they kept showing these films and these commercials on TV about these women with these bit old bellies and smoking and drinking. I said, "Oh my God, I can mess him up." I was scared.

Pregnancy does indeed represent a unique point in the lives of substance-abusing women--a point at which appropriate intervention can make a difference in the women's lives. In the interviews of this present study, the value of maternal instinct toward children was critical to the women's rehabilitation. However, the time of pregnancy and childraising also represents a very fragile point in these women's lives where guilt, shame, and esteem play heavily in their decisions. This is most evident in the women's confusion and dilemma over the welfare of their developing fetuses and their children despite their uncontrollable drug use. The fragility of this phase of the women's lives suggests that only carefully planned and designed intervention will be effective.

XIII. Conclusions from the Interviews:

These ten interviews provided a glimpse into the complexity and difficulty of these women's lives. As documented in other studies, drug use among these women does not have a single cause, but is the final result of family background, social experience, and personal misfortune. Their stories, which included sexual and physical abuse, peer pressure, dysfunctional family and romantic relationships, limited economic resources, and low self-esteem and confidence, are dominated by pain and failure and by their attempt to escape this pain through drugs. While we cannot excuse these women for their use of drugs, this information helps us to understand their lives and their drug use.

Although popular images of substance-abusing women portray them as callous, unfeeling, and uncaring mothers, the stories that emerged from these ten interviews provide depth of understanding and insight regarding their lives. The theories on these women's attitudes toward their pregnancies and toward their children suggest that the women indeed care about their children, but may lack the abilities and resources with which to produce this care. With this conflict between wanting to stop drug use during their pregnancies and not having the ability to do so, the women are pushed into shame and guilt. These frustrations are lessened by the women's efforts to minimize the reality of pregnancy. The tendency toward "postponement" greatly affects the mother's attitude toward her own pregnancy, her seeking of prenatal care, and her use of drugs during her pregnancy.

This qualitative analysis also contributes important findings concerning these women's attitudes about a policy of criminalization and their ideas of how their own actions would change given such a policy. Although numerous other factors, such as degree of drug involvement, financial ability, and belief in medical care, undoubtedly factor into a woman's decision to seek prenatal care,

from the accounts in these interviews, the fear of the law or of custody agencies does represent an important barrier to seeking prenatal care. Moreover, the fear of such consequences also contributes to the inadequacy and poor quality of care received by this population. The above theory of "postponement" also affects the results of criminalization--both intended and unintended. While proponents hope that the fear of criminalization will deter women from drug use during pregnancy, the unconscious psychological "postponement" of pregnancy short-circuits this intended effect of policy. In fact, the fear of the law supplies further reasons for the woman to postpone her pregnancy. The worries and guilt created from such a law may further blind these women to the realities of their pregnancies. Thus, an unintended result of this policy would include actions of a mother "unaware" of her pregnancy. These would include the failure to seek prenatal care, the failure to form attachment to the developing baby, and the failure to cease drug use.

It is noteworthy, however, that a few of the women in this analysis supported criminalization. The analysis also shows that for many women, motivations to cease drug use are high during pregnancy and that detection of maternal drug use is possible. Thus, criminalization of perinatal substance abuse may represent an effective method of intervention in the women's drug use. However, while some women did support criminalization, they described rehabilitation during incarceration as the primary benefit of criminalization. The economic practicality of using correctional facilities as outlets for dispensing drug treatment is questionable. Moreover, this argument still does not account for the negative effects on prenatal care decisions.

Limitations of the Study.

In interpreting the impact that this qualitative information has on current policy and thinking, we must keep in mind the limitations of this present study.

Both the nature and size of the study contribute to the limitations of this research. First and perhaps most obvious is the study's small sample size and its narrow sample characteristics. While the homogeneity, in terms of race/ethnicity and socioeconomic status, offered greater validation of the recurrent themes found in the qualitative interviews, results and theories obtained from this study may be useful only for this small segment of the substance-using population and may not be applicable to all female drug users.

Second, because none of the women was currently using drugs and pregnant, a certain amount of recall bias exists in their responses. Moreover, the experience of treatment and/or counseling may have affected how these women recall their pregnancy experiences. Although attempts were made to interview women without histories of treatment, this endeavor proved to be very difficult. Most of the accessible women had experiences, however brief, with drug treatment and recovery.

Third, although the analysis included attempts to verify the validity of the women's statements, there is no assurance that what these women spoke of were accurate reflections of what they thought. My expectations of and attitude during the interviews could have influenced their responses. Moreover, it is very plausible, given the social and legal disapproval of maternal drug use, that these women only told me what they thought I wanted to hear. In fact, one women in particular painted herself as a misunderstood and victimized mother who cared for her children despite obvious incongruencies in her story. She tended to "color" her stories to maintain her self-esteem and to preserve her self-interest. Self-interest may have also skewed the women's opinions on criminalization. Nevertheless, attempts were made during the interviews to guide the women away from giving the "right" and "acceptable" answers. Given the detailed nature of the women's discussions, I believe that these interviews do provide an

accurate glimpse into these women's psyches and experiences. I spent a significant amount of time with these women outside of the interviews, and our conversations off-record validated much of the information in the interviews. Most importantly, much of the findings in this present study echo the results of other qualitative analyses on this subject.[182]

CONCLUSIONS

The unfortunate situation of mothers using drugs and harming unborn fetuses evokes basic human emotions in all of us. In the past ten to fifteen years, the problem of maternal substance abuse has been exacerbated by this nation's increased problems with new forms of illicit substances such as crack cocaine. The advent of crack cocaine caused widespread concern over the drug's effect on developing fetuses. Clearly this problem creates burdens, both physical and financial, for the public and for the welfare, judicial, and medical branches of this society. The problem of perinatal substance abuse creates huge burdens on both the social welfare system and the health care system. The increasing price tag of drug-exposed infants and children is an expenditure that this society cannot support indefinitely. However, the dire predictions of the 1980's describing the devastating impact of drug exposure during pregnancy have not all come true. Recent researchers have noted that some of the effects of prenatal drug exposure can be ameliorated with appropriate medical, behavioral, and developmental intervention. Yet, because of the nation's focus drug use, maternal substance abuse has become one primary focus of lawmakers and policymakers.

Some endeavors have focused on providing drug rehabilitation and treatment services. Others, perhaps more frustrated with the situation, have increasingly turned to the legal system for answers to the problem of perinatal

---

182 Kearney, *supra* note 147, at 357.

substance abuse. From the analysis of legal theory and criminal law discussed in part two, I have concluded that criminalization might well survive a legal and/or constitutional challenge. The most recent failure of efforts at proseuction has been due primarily to its attempted extension of existing laws to reach the conflict of maternal substance abuse. Because legislatures did not pass these statutes with this intent, courts are reluctant to support this use. The enactment of specific statutes covering drug use in pregnancy would bypass these concerns of legislative intent, adequate notice, and ex post facto considerations. Nonetheless, voluntariness and intent of the mother would still be significant arguments against the legality of this approach. Even if the legal debate provides us with strong support for adopting these new statutes, we must consider the productivity, efficacy, and prudence of this policy. Thus, the real-life ramifications of criminalization, both intended and unintended, are crucial in this debate.

For example, the increased reliance on criminalization and the judicial system to solve our problem of maternal substance abuse raises huge concerns in terms of these women's prenatal care practices. Prenatal care is a critical aspect of a woman's healthy pregnancy. For the high-risk group of drug-using pregnant women, prenatal care becomes even more important. Nonetheless, current evidence suggests that drug use and factors associated with illicit drug use, such as low socioeconomic class, prevent these women, who desperately need care, from obtaining adequate medical care during their pregnancies. Importantly, the fear of prosecution may drive women away from seeking prenatal care. These fears may even translate into avoidance of other medical care and reluctance to enter drug treatment. Although the provision of care in jail may be one way of addressing this lack of care, such care is not helpful if the women cannot be identified. Moreover, fear of criminalization may also

negatively affect the quality of prenatal care and the sanctity of the physician-patient relationship.

The current study sought to assess some of these "unintended" consequences of a criminalization policy. I hoped that the qualitative approach would not only answer this specific question, but also yield answers to larger questions about these women's lives and opinions. The findings in part three of this paper suggest that just as drug use in America is a complex issue with roots in many aspects of human nature and societal issues, maternal drug abuse is also a problem deeply embedded in the web of human complexity. Importantly, other studies, both quantitative and qualitative, validate much of the findings found in this qualitative study.

The lives of the ten women interviewed provide important commentary on the environment and context of drug use, especially by mothers. These women's experiences were heavily influenced by the other people in their lives as well as by the social circumstances of their daily existence. Factors including poverty, racism, gender bias, violence, unemployability, and lack of education make significant contributions to these women's plight. Thus, while criminalization may satisfy others' desire to see these women punished, it does not address these deeper roots of drug use. Only a multi-disciplinary approach in support and treatment will be ultimately successful in eliminating drug use from their lives.

Definite data from this initial examination of this population support the view that criminalization has deleterious effects on these women's prenatal care decisions. Important in this interpretation is the concept of "postponement." The mothers did care about and provide for their developing fetuses or their children as exemplified by their accounts of trying to compensate for their drug use. Yet, unable to resolve the conflict between their maternal instincts to protect their

child and the addictive power of drugs, these women somehow psychologically "postponed" the reality of their pregnancy to avoid the guilt and shame of their drug use. Increased fear of legal consequences may further intensify the motivations to "postpone" pregnancy.

Ample evidence from these qualitative interviews suggested that the fear of legal and criminal consequences had already played a large role in these women's previous prenatal care decisions and the quality of their care. Although over-involvement in drugs and lack of resources were the initial answers to why they did not receive prenatal care, with more probing, almost all of these women mentioned the fear of the law or police as a reason for not seeking care. This fear also contributed to the quality and amount of prenatal care. Sobriety levels often controlled the frequency of prenatal care visits. Many of the women also reported efforts to stay "clean" the day before visits to the clinic. Importantly, few women stated that they trusted the physicians and other health professionals. Viewed as additional "watchdogs," health care personnel were only told of health information not related to drug use. Thus, reported fear of legal consequences seriously compromised the quality and nature of the physician-patient relationship.

Society must address the formidable problems of drug use among pregnant women and the effects of prenatal drug exposure for infants. However, criminalization and prosecution of these women is counter-productive. While locking these women in jail alleviates our sense of moral outrage, it is not effective in producing long-lasting change. The unintended effects of a policy of criminalization, such as deterrence to prenatal care and possible increased drive toward drug use, are serious drawbacks to this policy. Future research, both qualitative and quantitative, is essential to developing a solution to this societal problem. Qualitative research, in particular, can increase our knowledge about

drug-using women as well as expand our understanding of their reflective and decision-making processes.

Maternal substance abuse will continue to devastate communities unless solutions are carefully developed and examined. However, our attitude should not be one of weakness and despair, but of strength and hope. Many of the women interviewed who were on the road to recovery spoke of the impact that their pregnancy and their children made in their personal "awakenings" from drug use. We can use the women's powerful feelings toward their children in creating appropriate and effective interventions. One of the women in this study, Bernie, was able to pull herself out of a life of drugs, sexual abuse, and emotional turmoil. When asked how she found the strength to leave the world of crack cocaine, Bernie replied:

> At this time, I still had this "addict" mentalities, but every time I felt like using, I'd wake up sweating. I'd look at those four innocent babies in the bed, and I'd turn over and go back to sleep. I said, no, Bernie--you got to do this for them.

BIBLIOGRAPHY

"Advance Tables for 1989 from the Health Data Summaries for California Counties." Health Data and Statistics Branch. Sacramento, California. Department of Health Services. 1991.

Alameda County Perinatal Pilot Project: Project Overview. Alameda County Perinatal Substance Abuse Coordinating Council & Alameda County Board of Supervisors. 1990.

Alters, J. "Women and Crack: Equal Addiction, Unequal Care." BOSTON GLOBE. November 1, 1989; 1: 1.

American Civil Liberties Union Foundation, Reproductive Freedom Project, New York. State-by-state case summary of criminal prosecutions against pregnant women and appendix of public health and public interest groups opposed to these prosecutions. Memorandum issued October 3, 1990.

American Medical Association Board of Trustees. "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women." JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. 1990; 264: 2663-2670.

Aristotle. NICOMACHEAN ETHICS. Translated by: Terence Irwin. Indianapolis: Hackett Publishing Company. 1985; V, 1132a2-7.

Aved, Barbara M et. al. "Barriers to Prenatal Care for Low-Income Women." WESTERN JOURNAL OF MEDICINE. 1991; 158: 493-498.

Behnke, Marylou & F.D. Eyler. "The Consequences of Prenatal Substance Use for the Developing Fetus, Newborn, and Young Child." INTERNATIONAL JOURNAL OF THE ADDICTIONS. 1993; 28: 1341-1391.

Benfield, D. Gary. "Substance Abuse in Pregnancy: A Major Ethical Challenge for Pediatricians." PEDIATRIC ANNALS. 1991; 20: 564-570.

Bentham, Jeremy. "Principles of Penal Law." In: Kadish, Sanford H. & Paulsen, Monrad G. *Criminal Law and its Processes: Cases and Materials*. Boston: Little, Brown and Company. 1975; 26-27.

Berhrman, R.E. et al. "Recommendations and Analysis." THE FUTURE OF CHILDREN. 1991; 1 : 10-11.

Besharov, D.J. "Crack Children in Foster Care: Reexamining the Balance Between Children's Rights and Parents' Rights." CHILDREN TODAY. July-August 1990; 21-25, 35.

Bowsher, C.A. "Drug-exposed infants: A generation at risk." Statement before the Committee on Finance, United States Senate. Washington, DC: U.S. General Accounting Office (GAO/HRD-90-46) June 28, 1990.

Broekhuizen, F.F., J. Utrie & C. Van Mullem. "Drug use or inadequate prenatal care? Adverse pregnancy outcome in an urban setting." AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY. 1992; 166: 1747-1756.

Brown, Elizabeth R. & Barry Zuckerman. "The Infant of the Drug-Abusing Mother." PEDIATRIC ANNALS. 1991; 20: 555-563.

Brown, S.S., ed. PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS. Washington D.C.: National Academy Press. 1988.

California v. Stewart, No. M508197 (San Diego Mun. Ct., Feb. 23, 1987).

Chambers, Marcia. "Charges Against Mother in Death of Baby are Thrown Out." NEW YORK TIMES. February 27, 1987; 25A.

Chambers, Marcia. "Dead Baby's Mother Faces Criminal Charge on Acts in Pregnancy." NEW YORK TIMES. January, 1986.

Chance, Barbara & Anne M. Watts. "Effects of cocaine abuse." NURSEWEEK. January 11, 1993.

Chasnoff , I.J., W.J. Burns, S.H. Schnoll & K.A. Burns. "Cocaine use in pregnancy." NEW ENGLAND JOURNAL OF MEDICINE. 1985; 313: 666-669.

Chasnoff, I. J. & D.R. Griffith. "Cocaine: Clinical Studies of Pregnancy and the Newborn." ANNALS OF THE NEW YORK ACADEMY OF SCIENCE. 1989; 562: 260-266.

Chasnoff, I. J. "Drug Use and Women: Establishing a Standard of Care." ANNALS OF THE NEW YORK ACADEMY OF SCIENCE. 1989; 562: 208-210.

Chasnoff, I.J., C.E. Hunt, R. Kletter, & D. Kaplan. "Prenatal cocaine exposure is associated with respiratory pattern abnormalities." AMERICAN JOURNAL OF DISEASES OF CHILDREN. 1989; 562: 208-210.

Chasnoff, I.J., D.R. Griffith, S. MacGregor, K. Dirkes, & K.A. Burns. "Temporal patterns of cocaine use in pregnancy." JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. 1989; 261: 1741-1744.

Chasnoff, I.J., K.A. Burns & W.J. Burns. "Cocaine use in pregnancy: perinatal morbidity and mortality." NEUROTOXICOLOGY AND TERATOLOGY. 1987; 9: 291-293.

Chasnoff, Ira J. "Drug Use in Pregnancy: Parameters of Risk." THE PEDIATRIC CLINICS OF NORTH AMERICA. 1988: 35(6): 1403-1412.

Chasnoff, Ira J. "Drugs, Alcohol, Pregnancy, and the Neonate--Pay Now or Pay Later." JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. 1991; 266: 1567-1568.

Chasnoff, Ira J. et al. "Cocaine/Polydrug Use in Pregnancy: Two-Year Follow-up." PEDIATRICS. 1992; 89: 284-289.

Chasnoff, Ira J., ed. DRUGS, ALCOHOL, PREGNANCY AND PARENTING. Boston: Kluwer Academic Publishers. 1988.

Chavkin, Wendy & Stephen R. Kandall. "Between a 'Rock' and a Hard Place: Perinatal Drug Abuse." PEDIATRICS. 1990; 85(2): 223-225.

Chavkin, Wendy, M.H. Allen & M. Oberman. "Drug Abuse and Pregnancy: Some Questions on Public Policy, Clinical Management, and Maternal and Fetal Rights." BIRTH. 1991; 18(2): 107-112.

Chavkin, Wendy. "Drug Addiction and Pregnancy: Policy Crossroads." AMERICAN JOURNAL OF PUBLIC HEALTH. 1990; 80: 483-487.

Chavkin, Wendy. "Drug Use in Pregnancy: An Urgent Problem for New York City." For the Reproductive Health Subcommittee of the Committee for Public Health, New York Academy of Medicine. March 10, 1989.

Chavkin, Wendy. "Mandatory Treatment for Drug Use During Pregnancy." JAMA. 1991; 266: 1556-1561.

"Children of Cocaine: Facing the Issues." Center for Early Education and Development. University of Minnesota. April 1990: no. 4.

"Children of Substance Abusing/Alcoholic Parents Referred to the Public Child Welfare System: Summaries of Key Statistical Data Obtained from States, " American Public Welfare Association. Final Report submitted to American Enterprise Institute. Washington, D.C. February, 1990.

"Coalition on Alcoholic and Drug dependent Women and Their Children: State Legislative and Policy Proposals." American Civil Liberties Union. April 1990.

Cole, Helene M., ed. "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women." JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. 1990; 264: 2663-2670.

Coles, C.D. & K.A. Platzman. "Behavioral Development in Children Prenatally Exposed to Drugs and Alcohol." INTERNATIONAL JOURNAL OF THE ADDICTIONS. 1993; 28: 1393-1433.

Comorgen, G.H.C. et al. "Routine urine drug screening at the first prenatal visit." AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY. 1992; 166: 588-590.

"Coordinating Federal and Drug Policy for Women, Infants, and Children." Hearing before the Senate Committee on Governmental Affairs. 101st Cong. 1st Sess. 1989.

"Crack Babies: Selected Model Practices." Office of Inspector General. United States Department of Health and Human Services. June 1990.

Daghestani, Amin N. "Psychosocial Characteristics of Pregnant Women Addicts in Treatment." In: Chasnoff, Ira J., ed. DRUGS, ALCOHOL, PREGNANCY AND PARENTING. Boston: Kluwer Academic Publishers. 1988: 7-16.

DeBettencourt, Kathleen B. "The Wisdom of Solomon: Cutting the Cord that Harms." CHILDREN TODAY. July-August 1990: 17-20.

Dennison, James. "The Efficacy and Constitutionality of Criminal Punishment for Maternal Substance Abuse." SOUTHERN CALIFORNIA LAW REVIEW. 1991; 64: 1103-1118.

"Deterrence and Incapacitation: Estimating the Effects of Criminal Sanctions on Crime Rates." National Research Council. 1978. In: Kadish, Sanford H., Schulhofer, Stephen J. & Paulsen, Monrad G. CRIMINAL LAW AND ITS PROCESSES: CASES AND MATERIALS. Boston: Little, Brown and Company. 1983; 198-202.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS. American Psychiatric Association. Rev. 3d ed. 1987.

Dorris, Michael. The Broken Cord. Harper Collins Publishers. 1989.

Dougherty, Charles J. "The Right to Being Life with Sound Body and Mind: Fetal Patients and Conflicts with Their Mothers." UNIVERSITY OF DETROIT LAW REVIEW. 1985; 63: 89-117.

"Drug Abuse in the United States: a policy report." In: Proceedings of the House of Delegates, 137th annual meeting of the Board of Trustees of the American Medical Association. June 26-30, 1988.

Dunn-Malhotra, Ellen. "Medicaid Waivers Promising for Some Drug-Exposed Children; Don't Help Most." YOUTH LAW NEWS. 1990; 11: 27-31.

Durand, David J., A.M. Espinoza & B.G. Nickerson. "Association between prenatal cocaine exposure and sudden infant death syndrome." JOURNAL OF PEDIATRICS. 1990; 117: 909-911.

Edgar, Harold. "Mens Rea." In: Kadish, Sanford H. ENCLYCLOPEDIA OF CRIME AND JUSTICE. New York: Free Press. 1983: 1028-1040.

Elliott, K.T. & D.R. Coker. "Crack Babies: Here They Come Ready of Not." JOURNAL OF INSTRUCTIONAL PSYCHOLOGY. 1991; 18: 60-64.

English, Abigail & Marcia Henry. "Legal Issues Affecting Drug-Exposed Infants." YOUTH LAW NEWS. 1990; 11: 1-2.

Feinberg, J. DOING AND DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY. Princeton, N.J.: Princeton University Press. 1970.

Feinberg, Joel. "Wrongful Conception and the Right not to be Harmed." HARVARD JOURNAL OF LAW AND PUBLIC POLICY. 1985; 8: 57.

Field, Martha A. "Controlling the Woman to Protect the Fetus." LAW, MEDICINE AND HEALTH CARE. 1989; 17: 114-129.

Fink, Janet R. "Reported Effects of Crack and Cocaine on Infants." YOUTH LAW NEWS. 1990; 11(1): 37-39.

Finkelstein, Norma. "Treatment Programming for Alcohol and Drug-Dependent Pregnant Women." INTERNATIONAL JOURNAL OF THE ADDICTIONS. 1993; 28: 1275-1309.

Florida v. Johnson, No. 389-890-CFA slip op. (Seminole Cty., Fla. Cir. Ct. July 13, 1989).

Fogel, Catherine Ingram. "Pregnant Immates: Risk Factors and Pregnancy Outcomes." JOURNAL OF OBSTETRIC, GYNECOLOGIC, AND NEONATAL NURSING. 1993; 22: 33-39.

Fulroth, R., B. Phillips & D.J. Durand. "Perinatal outcome of infants exposed to cocaine and/or heroin in utero." AMERICAN JOURNAL OF DISEASES OF CHILDREN. 1989; 143: 905-910.

Funkhouser, A.W., et al. "Prenatal care and drug use in pregnant women." DRUG AND ALCOHOL DEPENDENCE. 1993; 33: 1-9.

Gallagher, Janet. "Prenatal Invasions and Interventions: What's Wrong with Fetal Rights." HARVARD WOMEN'S LAW JOURNAL. 1987; 10: 9-58.

Garcia, Sandra Anderson. "Drug Addiction and Mother/Children Welfare: Rights, Laws, and Discretionary Decision Making." JOURNAL OF LEGAL MEDICINE. 1992; 13: 129-203.

Garcia, Sandra Anderson. "Maternal Drug Abuse: Laws and Ethics as Agents of Just Balances and Therapeutic Interventions." INTERNATIONAL JOURNAL OF THE ADDICTIONS. 1993; 28: 1311-1339

Gawin, F.H. and E.H. Ellinwood. "Cocaine and Other Stimulants: Actions, Abuse, and Treatment." NEW ENGLAND JOURNAL OF MEDICINE. 1988; 318: 1173-1182.

Gay, G. "The deadly delights of cocaine." EMERGENCY MEDICINE. 1983; 2: 67-81.

Gittler, J & M. McPherson. "Prenatal Substance Abuse." CHILDREN TODAY. July-August 1990: 3-7.

Glink, Shona B. "The Prosecution of Maternal Fetal Abuse: Is This the Answer?" UNIVERSITY OF ILLINOIS LAW REVIEW. 1991; 2: 533.

Goldfarb, Neil I. et al. "Impact of a Mandatory Mediaid Case Management Program on Prenatal Care and Birth Outcomes." MEDICAL CARE. 1991; 29: 64-71.

Goldsmith, Stephen. "Prosecution to Enhance Treatment." CHILDREN TODAY. July-August 1990: 13-16, 36.

Gomby, Deanna S. & Patricia H. Shiono. "Estimating the Number of Substance-Exposed Infants." THE FUTURE OF CHILDREN. 1991; 1: 17-25.

Gore, Tipper. "A Portrait of At-Risk Children." JOURNAL OF HEALTH CARE FOR THE POOR AND UNDERSERVED. 1991; 2(1): 95-105.

Gorecki, Jan. A THEORY OF CRIMINAL JUSTICE. Columbia University Press. 1979: 40-41.

Gould, Jeffrey B. & Susan LeRoy. "Socioeconomic Status and Low Birth Weight: A Racial Comparison." PEDIATRICS. 1988; 82: 896.

Greenawalt, Kent. "Punishment." In: Kadish, Sanford H. ENCYCLOPEDIA OF CRIME AND JUSTICE. New York: Free Press. 1983: 1336-1346.

Greenlaw, Jane L. "Treatment Refusal, Noncompliance, and Substance Abuse in Pregnancy: Legal and Ethical Issues." BIRTH. 1990; 17(3): 152-156.

Grimm, Bill. "Drug-Exposed Infants Pose New Problems for Juvenile Courts." YOUTH LAW NEWS. 1990; 11(1): 9-14.

Hall, Marion H. "Commentary: What are the Benefits of Prenatal Care in Uncomplicated Pregnancy." BIRTH. 1991; 18: 151.

Handler, Arden, et al. "Cocaine Use during Pregnancy: Perinatal Outcomes." AMERICAN JOURNAL OF EPIDEMIOLOGY. 1991; 133(8): 818-825.

Healthy Start Proposal--Oakland's Infant Mortality Reduction Initiative: 1991-1996. Alameda County Health Care Services Agency. July 15, 1991.

Hobel, Calvin J. "Perinatal Care of High Risk Prevention of Low Birthweight." Presented at the Region IX conference on Infant Mortality, Scottsdale, AZ. September 19, 1985.

Hoffman, Jan. "Pregnant, Addicted- and Guilty"? THE NEW YORK TIMES MAGAZINE. August 19, 1990: 33-35, 44, 53, 55, 57.

Hopkins, Ellen. "Childhood's End: Babies born to Crack Addicted Mothers." ROLLING STONE. October 18th, 1990: 66-72, 108, 110.

Horowitz, Robert. "A Coordinated Public Health and Child Welfare Response to Perinatal Substance Abuse." CHILDREN TODAY. July-August 1990: 8-12.

Howard, Judy. "Chronic Drug Users as Parents." HASTINGS LAW JOURNAL. 1992; 43: 645-660.

Hutchinson, Janice. "What Crack Does to Babies." AMERICAN EDUCATOR. 1991; 15: 31-32.

Inciardi, James A. "The Crack Epidemic Revisited." JOURNAL OF PSYCHOACTIVE DRUGS. 1992: 24: 305-306.

Jackson, James E. "Review of Maternal and Perinatal Health." Lecture, August 18, 1991.

Jameson, Wendy & Neal Halfon. "Treatment Programs for Drug-Dependent Women and Their Children." YOUTH LAW NEWS. 1990; 11(2): 20.

Jamieson, Denise J. & Paul A. Buescher. "The Effect of Family Planning Participation on Prenatal Care Use and Low Birth Weight." FAMILY PLANNING PERSPECTIVES. 1992; 24: 214-218.

Johnsen, Dawn E. "The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection." YALE LAW JOURNAL. 1986; 95: 599-625.

Johnsen, Dawn. "Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty." HASTINGS LAW JOURNAL. 1992; 43: 569-613.

Johnson v. Florida, 598 so.2d 419 (Fla. Ct. App. 1991).

Johnson v. Florida, 602 S.2d 1288 (Fla. 1992).

Johnson, E. "From the Alcohol, Drug Abuse, and Mental Health Administration." JAMA . 1992; 268: 854.

Jones, Julia E. "State Intervention in Pregnancy." LOUISIANA LAW REVIEW. 1992; 52: 1159-1181.

Kadish, Sanford H. & Monrad G. Paulsen. CRIMINAL LAW AND ITS PROCESSES: CASES AND MATERIALS (Third Edition). Boston: Little, Brown and Company. 1975.

Kadish, Sanford H. ENCYCLOPEDIA OF CRIME AND JUSTICE. New York: Free Press. 1983.

Kadish, Sanford H., Stephen J. Schulhofer & Monrad G. Paulsen. CRIMINAL LAW AND ITS PROCESSES: CASES AND MATERIALS (Fourth Edition). Boston: Little, Brown and Company. 1983.

Kandall, Stephen R. & J. Gaines. "Maternal Substance Use and Subsequent Sudden Infant Death Syndrome (SIDS) in Offspring." NEUROTOXICOLOGY AND TERATOLOGY. 1991; 13: 235-240.

Kandall, Stephen R. & Wendy Chavkin. "Illicit Drugs in America: History, Impact on Women and Infants, and Treatment Strategies for Women." HASTINGS LAW JOURNAL. 1992; 43: 615-643.

Kant, Immanual. THE PHILOSOPHYOF LAW: AN EXPOSITION OF THE FUNDAMENTAL PRINCIPLES OF JURSIPRUDENCE AS THE SCIENCE OF RIGHT. Translated by W. Hastie. Edinburgh: T & T. Clark. 1887.

Kantrowitz, Barbara et. al. "The Crack Children." NEWSWEEK. February 12, 1990; 62-63.

Kearney, Margaret H., S. Murphy & M. Rosenbaum. "Mothering on Crack Cocaine: A Grounded Theory Analysis." SOCIAL SCIENCE AND MEDICINE. 1994; 38: 351-361.

Keyes, Lisa Janovy. "Rethinking the Aim of the 'War on Drugs': States' Roles in Preventing Substance Abuse by Pregnancy Women." WISCONSIN LAW REVIEW. 1992; 197: 197-211.

Klein, D., E. Zahnd, S. Holtby & R. Barth. "Perinatal Needs Assessment Study: Preliminary Report." Submitted to the State of California Department of Alcohol and Drug Programs. Western Consortium for Public Health. December 1993. Draft.

Kronstadt, Diana. "Complex Developmental Issues of Prenatal Drug Exposure." THE FUTURE OF CHILDREN. 1991; 1: 36-49.

LaFave, Wayne R. & Austin W. Scott. CRIMINAL LAW. St. Paul: West Publishing Co. 1986: 10-15, 216-223.

Lappe, Marc. "The Moral Claims of the Wanted Fetus." HASTINGS CENTER REPORT. 1975; 5: 11.

Larson, Carol S. "Overview of State Legislative and Judicial Responses." THE FUTURE OF CHILDREN. 1991; 1: 72-84.

Lesser, Arthur J. "The Origin and Development of Maternal and Child Health Programs in the United States." AMERICAN JOURNAL OF PUBLIC HEALTH. 1985; 75: 590-598.

Livesay, Susan, et al. "Cocaine and Pregnancy: Maternal and Infant Outcome." ANNALS OF THE NEW YORK ACADEMY OF SCIENCES. 1989; 562: 358-359.

Lockwood, Susan E. "What's Known--and What's Not Known--About Drug-Exposed Infants." YOUTH LAW NEWS. 1990; 11(1): 15-18.

MacGregor, Scott N. et al. "Cocaine Abuse During Pregnancy: Correlation Between Prenatal Care and Perinatal Outcome." OBSTETRICS AND GYNECOLOGY. 1989; 74: 882-885.

Macro Systems, Inc. "Programs Serving Drug-Exposed Children and their Families: Volume I, Cross-Site Finding and Policy Issues." U.S. Department of Health and Human Services. January 21, 1991.

Macro Systems, Inc. "Programs Serving Drug-Exposed Children and their Families: Volume ii, Site Visit Summaries and Program Descriptions." U.S. Department of Health and Human Services. January 21, 1991.

Mahoney, Brett. "Thomas' bid blocked for new drug treatment home." OAKLAND TRIBUNE. November 26, 1991: A3.

March of Dimes. "Cocaine use during pregnancy". Public Health Education Information Sheet. March of Dimes Birth Defects Foundation. 1989.

"Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of 'Fetal Abuse'." HARVARD LAW REVIEW. 1988; 101: 994-1012.

"Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus." SOUTHERN CALIFORNIA LAW REVIEW. 1987; 60: 1209-1223.

Mathieu, Deborah. "Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Choice." HARVARD JOURNAL OF LAW AND PUBLIC POLICY. 1985; 8: 19.

Matthiessen, Constance. "A Fighting Chance." IMAGE MAGAZINE: SAN FRANCISCO EXAMINER. May 3, 1992.

Mattingly, Susan S. "The Maternal-Fetal Dyad: Exploring the Two-Patient Obstetric Model." HASTINGS CENTER REPORT. Jan-Feb 1992: 13-18.

Mayes, Linda C. et al. "The Problem of Prenatal Cocaine Exposure: A Rush to Judgment." JAMA . 1992; 267: 406-408.

McCarthy, Peggy. "Prenatal Drug Exposure Shadows Children in School." NEW YORK TIMES. March 24, 1991; 1: 10.

McCullogh, Charlotte B. "The Child Welfare Response." THE FUTURE OF CHILDREN. 1991; 1: 61-71.

McGinnis, Doretta Massardo, "Prosecution of Mothers of Drug-Exposed Babies: Constitutional and Criminal Theory." UNIVERSITY OF PENNSYLVANIA LAW REVIEW. 1990; 139: 505-540.

McLaughlin, Joseph F. et al. "Randomized Trial of Comprehensive Prenatal Care for Low-Income Women: Effect on Infant Birth Weight." PEDIATRICS. 1992; 89: 128-132.

McNulty, Molly. "Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to their Fetuses." REVIEW OF LAW & SOCIAL CHANGE. 1987-88; 16: 277.

Oberman, Michelle. "Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs." HASTINGS LAW JOURNAL. 1992; 43: 505-548.

Office of Inspector General. Office of Evaluation and Inspections. "Crack Babies." June 1990.

Ostrea, E.M. & A.L. Raymundo. "Has cocaine Abuse Increased Perinatal Morbidity in Maternal Drug Addiction"? ANNALS OF THE NEW YORK ACADEMY OF SCIENCE. 1989; 562: 376.

Paltrow, Lynn M. "Perspective of a Reproductive Rights Lawyer." THE FUTURE OF CHILDREN. 1991; 1: 85-92.

People v. Morabito, 580 N.Y.S.2d 843 (City Ct. 1992).

Phibbs, Ciaran S., D.A. Bateman & R.M. Schwartz. "The Neonatal Costs of Maternal Cocaine Use." JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. 1991; 266: 1521-1526.

Poland, Marilyn L., et al. "Punishing pregnant drug users: enhancing the flight from care." DRUG AND ALCOHOL DEPENDENCE. 1993; 31: 199-203.

Poland, Marilyn L., M.P. Dombrowski, J.W. Ager & R.J. Sokol. "Quality of Prenatal Care; Selected Social, Behavioral, and Biomedical Factors; and Birth Weight." OBSTETRICS AND GYNECOLOGY. 1990; 75: 607-611.

"Prenatal Care: Reaching Mothers, Reaching Infants." Institute of Medicine. Washington D.C.: National Academy Press. 1988.

"Punishing Women for their Behavior During Pregnancy: A Public Health Disaster." Reproductive Freedom in focus from the Center for Reproductive Law and Policy. February 2, 1993.

Racine, Andrew; T. Joyce & R. Anderson. "The association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City." JAMA. 1993; 270: 1581-1586.

Ratner, Mitchell S., ed. CRACK PIPE AS PIMP: AN ETHNOGRAPHIC INVESTIGATION OF SEX-FOR-CRACK EXCHANGES. New York: Lexington Books. 1993.

Reyes v. Superior Court, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977).

Rhodes, Ann Marie. "Maternal Liability for Fetal Injury?" MATERNAL CHILD NURSING. 1990; 15: 41.

Rist, Marilee C. "The Shadow Children." AMERICAN SCHOOL BOARD JOURNAL. 1990; 177: 18-24.

Roberts, Dorothy E. "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy." HARVARD LAW REVIEW. 1991; 104: 1419-1482.

Robinson v. California, 370 U.S. 660 (1992).

Rodning, Carol, L. Beckwith & J. Howard. "Prenatal Exposure to Drugs and Its Influence on Attachment." ANNALS OF THE NEW YORK ACADEMY OF SCIENCE. 1989; 562: 352-354

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

Romney, Tiffany M. "State's Interest in Protecting the Rights of a Fetus Versus the Mother's Constitutional Rights to Due Process, Privacy and Equal Protection." JOURNAL OF CONTEMPORARY LAW. 1991; 17: 325-344.

Ruhle, Nancy. "Perinatal Substance Abuse: Personal Triumphs and Tragedies." HASTINGS LAW JOURNAL. 1992; 43: 549-558.

Schramm, Wayne F. "Weighing Costs and Benefits of Adequate Prenatal Care for 12,023 Births in Missouri's Medicaid Program, 1988." PUBLIC HEALTH REPORTS. 1991; 107: 647-652.

Schwartz, Ivy L. "Low-Birth-Weight Effects of Demographic and Socioeconomic Variables and Prenatal Care in Pima County, Arizona." WESTERN JOURNAL OF MEDICINE. 1990; 152: 725-728.

Siddiqui, Tariq A. & R.C. Tsang. "Babies of Substance-Abusing Mothers: An Overview." PEDIATRIC ANNALS. 1991; 20: 527-530.

State v. Gethers, 585 So. 2d 1140 (Fla. App. 1991).

State v. Gray, 584 N.E.2d 710 (Ohio 1992).

State v. Gray, WL 125695 (Ohio App. Aug. 31, 1990) (unreported).

Steinbock, Bonnie. "The Relevance of Illegality." HASTINGS CENTER REPORT. Jan-Feb. 1992: 19-22.

Steven, Sonya & Ann S. Ahlstrom. "Perspective from a Minnesota County Attorney's Office". THE FUTURE OF CHILDREN. 1991; 1: 93-99.

Swartz, Martha. "Pregnant Woman vs. Fetus: A Dilemma for Hospital Ethics Committees." CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS. 1992; 1: 51-62.

Toufexis, Anastasia. "Innocent Victims." TIME MAGAZINE. May 13, 1991: 56-60.

Tracy, Carol E. & Harriet C. Williams. "Social Consequences of Substance Abuse Among Pregnant and Parenting Women." PEDIATRIC ANNALS. 1991; 20: 548-553.

Treaster, Joseph B. "For Children of Cocaine, Fresh Reasons for Hope." NEW YORK TIMES. February 16, 1993: B12.

Vaughn, A.J. et al. "Community-Wide Estimation of Illicit Drug Use in Delivering Women: Prevalence, Demographics, and Associated Risk Factors." OBSTETRICS & GYNECOLOGY. 1993: 82: 92-96.

Vega, William A., A. Noble, B. Kolody, P. Porter et al. "Profile of Alcohol and Drug Use During Pregnancy in California, 1992: Perinatal Substance Exposure Study, General Report." State of California, Department of Alcohol and Drug Programs. September, 1993.

Vega, William A., B. Kolody, J. Hwang & A. Noble. "Prevalence and Magnitude of Perinatal Substance Exposures in California." THE NEW ENGLAND JOURNAL OF MEDICINE. 1993: 329: 850-854.

Weathers, W.T. et al. "Cocaine Use in Women From a Defined Population: Prevalence at Delivery and Effects on Growth in Infants." PEDIATRICS. 1993; 91(2): 350-354.

Wehling, C. "The Crack Kids are Coming." PRINCIPAL. 1991; 70: 12-13.

Weissman, M.F., P.B. Slobertz, M Meritz & P. Howard. "Clinical Depression Among Narcotic Addicts Maintained on Methadone in the Community." AMERICAN JOURNAL OF PSYCHIATRY. 1976; 133: 1434-1438.

Welch v. Commonwealth, No. 90-CA-1189-MR (Ky. App. Feb. 7, 1992).

Willwerth, James. "Should We Take Away Their Kids"? TIME MAGAZINE. May 13, 1991: 62.

Wilson, Geraldine S. "Clinical Studies of Infants and Children Exposed Prenatally to Heroin." ANNALS OF THE NEW YORK ACADEMY OF SCIENCES. 198; 562: 183-194.

Zimmerman, Ernest F. "Substance Abuse in Pregnancy: Teratogenesis." PEDIATRIC ANNALS. 1991; 20: 541-547.

Zuckerman, B., D.A. Frank, R. Hingson et al. "Effects of Maternal Marijuana and Cocaine Use on Fetal Growth." NEW ENGLAND JOURNAL OF MEDICINE. 1989; 320: 762-768.

Zuckerman, Barry. "Marijuana and Cigarette Smoking during Pregnancy: Nenonatal Effects." In: Chasnoff, Ira J., ed. DRUGS, ALCOHOL, PREGNANCY AND PARENTING. Boston: Kluwer Academic Publishers. 1988: 73-89.