



National Advocates
for Pregnant Women

N A P W

Confronting Pregnancy Criminalization

*A Practical Guide for
Healthcare Providers,
Lawyers, Medical Examiners,
Child Welfare Workers,
and Policymakers*

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For decades,

women¹ across America have been subjected to criminalization and deprivations of liberty that only occurred because of their status as pregnant or postpartum women.

Women have been targeted by police and prosecutors, healthcare providers, child welfare workers, and judges who have sought to deprive them of virtually every constitutional right—all justified by the false assertion that such deprivations advance, rather than undermine, fetal protection.

Introduction

Since 1973, National Advocates for Pregnant Women (“NAPW”) has documented more than 1,700 instances across the country in which women have been arrested, prosecuted, convicted, detained, or forced to undergo medical interventions because of their pregnancy status or outcomes.² The rate at which state actors are criminalizing pregnant women is accelerating rapidly. NAPW has documented roughly three times as many deprivations of liberty from 2006-2020 than it has from 1973-2005.³ The women subjected to pregnancy-based prosecutions and forced medical interventions are overwhelmingly low income, disproportionately Black and Brown, and the majority are drug-using.⁴

Pregnant and postpartum women have faced criminal charges for experiencing miscarriages and stillbirths, for self-managing abortions, for using both criminalized and lawfully prescribed substances, and for engaging in other acts or omissions perceived as creating a risk of harm to their pregnancies. Prosecutors have sought punishment on the theory that subjecting a fetus to a perceived risk of harm in utero constitutes felony “child abuse” or that experiencing a pregnancy loss is murder. Prosecutors have also brought charges against women who gave birth to perfectly healthy babies but allegedly risked some harm to them while pregnant.⁵ In these cases, the very act of becoming pregnant transforms otherwise lawful acts, health conditions, and everyday activities and decisions that are permissible for non-pregnant persons into crimes.

With limited exceptions, the laws used to prosecute pregnancy-related crimes were never intended to encompass the actions of pregnant women in relation to their own pregnancies.⁶ In many cases, prosecutors have used feticide laws that were intended to protect pregnant women from attacks by another person as a basis for proceeding against the woman herself.⁷ For instance,

Bei Bei Shuai of Indiana was prosecuted for feticide after she attempted suicide while pregnant, despite the fact that suicide is not a crime in Indiana.⁸ Even where a state law explicitly prohibits its application to pregnant women, prosecutors have nevertheless used the statute against them. In Missouri, the State’s “personhood” provision, which grants all legal rights to fetuses at conception, directs that the provision may not be applied “against a woman for indirectly harming her unborn child by failing to properly care for herself or by failing to follow any particular program of prenatal care.”⁹ Despite this, Missouri prosecutors have charged scores of women for being pregnant and subjecting “unborn children” to perceived risks of harm,¹⁰ including one who admitted to using marijuana once while pregnant¹¹ and another who drank alcohol.¹²

In addition to disregarding explicit statutory limitations, prosecutors have persistently ignored court rulings. Even where courts have held that certain statutes do not authorize prosecution of women in relation to their own pregnancies, prosecutors continue to file such charges. For instance, although the Arkansas Supreme Court held that pregnant women cannot be prosecuted under a law criminalizing the “introduction of a controlled substance into the body of another person,”¹³ prosecutors have continued to charge women under this provision.¹⁴ And in California, despite court rulings over many decades rejecting the use of the State’s criminal code to prosecute women in relation to pregnancy outcomes, a prosecutor recently charged two women who experienced pregnancy losses with violating the State’s feticide law,¹⁵ notwithstanding statutory text expressly forbidding application of the provision to prosecute any “act [that] was . . . consented to by the mother of the fetus.”¹⁶

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Introduction

only ways in which women face punitive measures on the basis of their pregnancy status. Pregnant and postpartum women have also been targeted by child welfare actors and healthcare professionals. Women of color, low-income women, and women who are suspected of using drugs or have used drugs are disproportionately impacted. In particular, pregnant Black women are more likely to be drug tested by hospital staff and reported to child welfare authorities, despite the fact that Black and white pregnant women use drugs at approximately the same rates in the U.S.¹⁷ The disproportionality lies not only in the initial reporting, but also in child welfare investigations, case conclusions, and interventions, including child removal and termination of parental rights.¹⁸

The consequences of this punitive treatment extend far beyond the individual women investigated, arrested, and prosecuted. When pregnancy outcomes are subject to prosecution and candid communications with health-care providers are used as the basis for child welfare and law enforcement actions, women are

deterred from seeking medical care and supportive services that would improve pregnancy outcomes.¹⁹ For example, research revealed that the prosecution of pregnant women under Tennessee's fetal assault law (which was in effect for only two years) resulted in twenty fetal deaths and sixty infant deaths in 2015 alone.²⁰ The more power states have to pursue these cases, the more dire these consequences will become.

This guide is designed to educate law enforcement, defense attorneys, medical examiners, hospital staff, legislators, and others about the powers they have to disrupt the criminalization of pregnancy. In addition to providing more specific information in Section II about the ways in which pregnant women are targeted and penalized, we have established discipline-specific guidelines for each of the actors identified above. The aim of these guidelines is to equip each actor with knowledge about the realities and consequences of pregnancy-based prosecutions, as well as an understanding of their role and the powers they have to disrupt this cycle.

National Advocates for Pregnant Women (NAPW) works to secure the human and civil rights, health and welfare of all people, focusing particularly on pregnant and parenting women, and those who are most likely to be targeted for state control and punishment—low-income women, women of color, and drug-using women.

Contact National Advocates for Pregnant Women for resources, support, and information:

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**Pregnant
Women Face
Criminalization
and State
Penalties in
Myriad Ways**

For far too many women in the United States, pregnancy is a site of criminalization and coercion rather than one of care and support. Despite a mounting body of evidence demonstrating the serious harms wrought by a system that penalizes pregnant and postpartum women, state actors and institutions in many jurisdictions continue to perpetuate these harms through the (mis)enforcement of both criminal and civil statutes.

These laws and policies serve to put pregnant women squarely in the crosshairs of criminal and civil liability that they would not otherwise face, but for their pregnancy status. The force of these laws falls disproportionately on the populations already the most vulnerable to compromised access to health care and for whom robust prenatal care is vital, including women of color and women who may be struggling with poverty, substance use disorders, or any number of mental health conditions. The current legal landscape is plagued by stories of women and families whose lives are torn apart by adverse child welfare rulings and criminal prosecutions, and state authorities' zealous and counterproductive actions enable such harms. Individuals who choose to support the health and just treatment of pregnant women and equip themselves with the knowledge and tools to chip away at the failings of the system can make a significant and lasting impact.

Criminal Statutes

Across the country, pregnant and postpartum women are criminalized based on improper interpretations and judicial expansions of state laws, all for the purported purpose of protecting a fetus. Yet, by criminalizing pregnant women for actions taken during the course of their pregnancies, states are worsening fetal, neonatal, and infant health, invading pregnant women's privacy, devaluing their bodily autonomy and rights, further contributing to racial and socioeconomic disparities, and harming entire communities and families. These prosecutions make pregnant women less likely to seek needed medical help out of fear that their doctors will report them to child welfare or law enforcement authorities—which in turn undermines, rather than advances, health outcomes for both women and infants.²¹

Prosecutors in at least 38 states utilize fetal protection laws—which recognize a fetus as a legal victim—to charge pregnant women with crimes when they experience a pregnancy loss or give birth to a baby who is believed to have been subjected to a risk of harm in utero.²² Those charges have included homicide, child abuse, and chemical endangerment of a child.²³ Although these laws are most frequently used to prosecute women who were pregnant and used drugs and later gave birth to healthy babies, they can and have also been used to encompass other health issues and conduct—including miscarriages²⁴ or stillbirths,²⁵ self-abortion,²⁶ attempted suicide,²⁷ and even being pregnant and failing to wear a seatbelt.²⁸ Not only do these laws criminalize medical matters that should be managed by healthcare providers, but they also allow prosecutors to surveil and police the non-criminal acts and omissions of pregnant women. The result is prosecutions fraught with prejudice and bias.²⁹ Alabama prosecutors' weaponization of the state's chemical endangerment law to prosecute pregnant women is a prime example of these harmful prosecutorial tactics. From 2006-2020, nearly 600 of the more than 1,300 cases documented by NAPW involving the prosecution of pregnancy occurred in Alabama, which has been called the "national capital for prosecuting women

on behalf of their newborn children.”³⁰ Between 2006 and late July 2015, at least 479 women were prosecuted for prenatal substance use.³¹ While the Alabama legislature never intended for the chemical endangerment law to apply to the acts of women in relation to their pregnancies, prosecutors have nonetheless criminalized scores of pregnant women through aggressive misapplications of the law.³²

Alabama’s chemical endangerment law was originally passed in 2006 to protect children from environments in which they could be exposed to drugs or controlled substances, specifically methamphetamine labs.³³ The law subjects defendants to varying degrees of punishment based on the extent to which the child is allegedly harmed—exposure alone is a class C felony and can carry as much as 10 years in prison, and exposure that allegedly results in death is a class A felony and can carry as much as 99 years, or life in prison.³⁴ Despite the law itself making no mention of pregnant women or fetuses, prosecutors have used it to charge pregnant women who test positive for drugs under the premise that the term “child” includes a fetus, and a womb is an “environment.”³⁵

Two women who were prosecuted for chemical endangerment based on the claim that they were pregnant and used drugs appealed their convictions to the Alabama Supreme Court in 2013. The court held that the meaning of the word “child” under Alabama law included a fetus at any stage of pregnancy.³⁶ Under this interpretation, a woman could be prosecuted for chemical endangerment for acts she took before she even knew she was pregnant.

It was not until 2016 that Alabama began to recognize an affirmative defense to a chemical endangerment charge—the use of a medication pursuant to a lawful prescription.³⁷ Disturbingly, in the ten years prior to the adoption of this defense, women in Alabama taking prescribed

These laws actually worsen fetal outcomes—the very opposite of the intended goal of fetal protective statutes.

drugs in their prescribed manner to address long-standing and pre-existing medical conditions still faced charges. Even in instances in which pregnant women use criminalized drugs, they only face prosecution because of their pregnancy status.³⁸ This means that prosecutors are using the chemical endangerment law to target acts that are otherwise legal but for the fact that there is an existing pregnancy.³⁹ Using the chemical endangerment law in this manner instills fear in pregnant women and leads them to avoid seeking critical healthcare during their pregnancies to avoid falling victim to a prosecution.⁴⁰ As a result, these laws actually worsen fetal outcomes—the very opposite of the intended goal of fetal protective statutes.⁴¹

Oklahoma is another state in which prosecutors have misapplied criminal statutes to criminalize pregnancy. From 2006 to 2020, more than 70 of the 1,300 cases documented by NAPW occurred in Oklahoma. The vast majority of those cases occurred in the last several years, including three manslaughter prosecutions related to a pregnancy loss brought in 2020 and 2021. There are primarily two ways in which Oklahoma criminalizes pregnancies. First, Oklahoma includes an “unborn child” as a human in its homicide law.⁴² Second, in a 2020 Oklahoma Court of Criminal Appeals decision, the court ruled that pregnant women can be charged with child neglect for exposing a fetus to controlled substances,⁴³ the maximum punishment for which can be life in prison.⁴⁴

The prosecution of pregnancy in Oklahoma has led to severe deprivations of liberty and other lasting effects on the women targeted. Of the 45 pregnancy-based prosecutions in Oklahoma since 2017, at least 15 of the women targeted spent time in jail or were sentenced to prison.⁴⁵ Most of these cases involved child neglect charges in connection with newborns testing positive for methamphetamine or other drugs, but at least three cases involved manslaughter charges.⁴⁶ One woman was charged with felony child neglect when her newborn tested positive for THC (the main psychoactive compound in marijuana), even though she had a medical marijuana license and was advised by her doctor that she could use marijuana during her pregnancy.⁴⁷ Brittney Poolaw, who suffered a pregnancy loss at 15-17 weeks, was sentenced to four years in prison for manslaughter, despite the State's medical expert testifying that the cause of death was unknown, and that genetic anomaly and placenta abruption may have been contributing factors.⁴⁸

The Oklahoma medical community vehemently opposes these prosecutions due to the negative effects they have on women and their children. In a public letter, more than 30 Oklahoma doctors condemned the criminalization of drug use in pregnancy⁴⁹ and expressed their concern "that prosecutors willfully ignore medical science in pursuit of these harmful prosecutions."⁵⁰ The letter acknowledges that the "criminalization of substance use in pregnancy deters mothers from seeking healthcare for themselves and their children" and that creating this fear in pregnant patients "will not move [Oklahoma] closer to healthier pregnancies and deliveries."⁵¹

Civil Statutes/ Child Welfare Proceedings

In addition to the use of criminal laws to target pregnant women, many states utilize civil statutes and child welfare proceedings to surveil, or in some cases, civilly commit, pregnant women and subject them to draconian penalties, including the termination of their parental rights, based on their actions during pregnancy. Although states that use civil statutes and child welfare laws to regulate the conduct of pregnant women do so under the guise of improving health outcomes and reducing infants' prenatal substance exposure, the American College of Obstetricians and Gynecologist ("ACOG") reports that such laws have the opposite effect; they place the physician in an adversarial relationship with their pregnant patients and discourage pregnant women from seeking medical care out of fear that their doctor will report them to child welfare authorities.⁵²

State Laws

Beginning in the late 1980s amid increased public panic regarding crack cocaine,⁵³ the child welfare system began separating children from their parents and placing them in foster care at unprecedented rates based on their parents' alleged substance use.⁵⁴ Such practices remain prevalent today despite the fact that studies have not shown a causal link between drug use and child abuse or neglect. Rather, several studies have found that treating substance use disorder as a form of child abuse or neglect has been more toxic to children and their families than the alleged effects of substance use on pregnancy and parenting.⁵⁵

A positive drug test has no bearing on a person's ability to parent⁵⁶ and child welfare workers are not trained in

reading toxicology reports or making determinations about the severity of a parent's substance use.⁵⁷ Furthermore, the U.S. Department of Health and Human Services has recently emphasized that “a diagnosis of [neonatal abstinence syndrome] or [neonatal opioid withdrawal syndrome] does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.”⁵⁸

Nevertheless, 24 states and the District of Columbia have civil child welfare statutes that consider substance use during pregnancy to be child abuse.⁵⁹ For example, Georgia law defines “prenatal abuse” to include maternal use of alcohol or controlled substances.⁶⁰ Medical professionals in Georgia are required to report suspected child abuse, including prenatal abuse.⁶¹ Laws like the one in Georgia discourage women from seeking prenatal care and thus undermine the health of women and babies. The best way to protect mothers and their neonates is to provide confidential, non-threatening healthcare that ensures access to evidence-based treatment (when needed) and keeps mothers and babies together.⁶²

Wisconsin's Act 292, commonly referred to as the “Unborn Child Protection Act” or the “Cocaine Mom Law” authorizes involuntary commitment for pregnant women based only on the suspicion that the pregnant woman has or *may in the future* consume alcohol or a controlled substance (i.e., has demonstrated a “habitual lack of self-control”) during their pregnancy.⁶³ Typically, a pregnant woman is taken into protective custody by either law enforcement or child welfare services and then detained for a period of time until it is determined she no longer poses a risk to the fetus. Act 292 is rooted in the racist and false narrative promulgated in the 1980s and 1990s about “cocaine moms” and “cocaine babies.” The Act continues in

full force today and, according to statistics published by Wisconsin's Department of Children & Families, for each of the past 5 years, approximately 460 women have been jailed, forced into medical treatment, or put on house arrest due to a suspicion that they are pregnant and have consumed or may consume drugs or alcohol.⁶⁴

Minnesota also employs a similarly draconian approach to the regulation of pregnant women and their bodies. Like Wisconsin, Minnesota authorizes the involuntary civil commitment of pregnant women who use substances.⁶⁵ The laws in Minnesota permit involuntary civil commitment of a pregnant woman if “clear and convincing evidence” shows that she is a chemically dependent person who engaged in habitual or excessive use of controlled substances for a non-medical purpose.⁶⁶

These laws are exactly the type that ACOG cautions against because they have the opposite effect of promoting maternal or neonatal health. Further, placing a pregnant woman in custody of the state also places a fetus in the custody of the state, where access to prenatal care and other medical care, community and family support, healthy food, and exercise are circumscribed.

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The Child Abuse Prevention and Treatment Act and Comprehensive Addiction and Recovery Act

The Child Abuse Prevention and Treatment Act (“CAPTA”) and the Comprehensive Addiction and Recovery Act (“CARA”) require states, in order to receive federal child abuse prevention funds, to develop policies for the “notification” by healthcare professionals to child welfare agencies regarding infants who are (i) affected by substance abuse; (ii) affected by withdrawal symptoms resulting from prenatal substance exposure; or (iii) have Fetal Alcohol Spectrum Disorder.⁶⁷ The implementation of CAPTA/CARA has generated confusion among healthcare professionals and child welfare workers because the anonymized and aggregated “notification” requirement has been misinterpreted to require testing and referral for an abuse or neglect investigation.⁶⁸

However, CAPTA/CARA’s notification provision requires only de-identified, aggregate data about the number of children born who fall under relevant categories; it does not require anyone to file a report with child welfare authorities for the purposes of an abuse or neglect investigation. Only a few states affirmatively recognize this distinction. For example, the New York Department of Health has clarified that the federal guidelines only require de-identified notification and has created a separate pathway by which to make such notifications distinct from reporting suspected child abuse and neglect cases.⁶⁹ Additionally, the New York Department of Health instructs that maternal substance use, alone, does not constitute abuse and neglect.⁷⁰ Civil statutes and child welfare laws that target prenatal substance use serve only to create greater barriers to care by discouraging pregnant women from

seeking medical care and/or being honest with their healthcare providers, out of fear of, among other things, separation from their children. ACOG recommends that “policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions.”⁷¹ ACOG advocates for the “development of safe, affordable, available, efficacious, and comprehensive alcohol and drug treatment services for all women, especially pregnant women, and their families.”⁷² Policy makers, medical professionals, child welfare agencies and workers, and law enforcement officials should take action to end the enforcement of harmful laws and regulations that unfairly target pregnant women, deny them their freedom and privacy, and undermine fetal and maternal health.

The Role of Medical Staff and State Mandatory Reporting Laws

Seeking medical care should never expose a person to criminal liability or civil penalties like the loss of custody. However, medical professionals play a significant role in the criminalization of pregnant women. As discussed above, punitive responses to substance use, pregnancy loss, self-managed abortion, or any other acts or omissions that create a perceived risk of harm during pregnancy generate negative health outcomes for pregnant women and children by discouraging pregnant women from seeking health care out of fear.⁷³

In particular, drug testing pregnant and postpartum women and their newborns, with or without informed consent, exposes them to needless trauma, potential family separation, and potential incarceration for seeking necessary medical care. This practice is pervasive, despite the fact that testing is rarely clinically indicated and

38 states

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reporting is often not legally required.⁷⁴ The results of a drug test can subject pregnant women to criminalization, and sends the message that they should be wary of seeking medical help. According to ACOG, penalizing pregnant women for drug use “makes medical care less accessible as pregnant women are more afraid to seek help for fear of state involvement, losing custody of their children, or losing their parental rights.”⁷⁵ ACOG also has stated that “[c]lear evidence exists that criminalization and incarceration for substance use disorder during pregnancy are ineffective as behavioral deterrents and harmful to the health of the pregnant [woman] and their infant.”⁷⁶

In *Ferguson v. Charleston*, the Supreme Court found that a public hospital’s practice of conducting drug tests without a pregnant woman’s consent for the purpose of turning the results over to police was unconstitutional if not authorized by a valid warrant.⁷⁷ That case involved a state hospital in Charleston, South Carolina where staff collaborated for nearly five years with the local police department to test pregnant women and new mothers for evidence of drug use—without a warrant or their consent. Instead of using this information to provide appropriate medical care and treatment, medical staff gave it to the police, who in turn arrested women right out of their hospital beds. The women were shackled and chained, some of them still pregnant, others weak and bleeding from having just given birth.⁷⁸

Ten women who were arrested after testing positive for cocaine filed suit, challenging as unconstitutional the hospital’s policy of identifying and testing pregnant patients suspected of drug use for criminal law enforcement purposes. The Supreme Court held that the hospital’s performance of a diagnostic test to obtain evidence of a patient’s criminal conduct was an unreasonable search if the patient had not

consented to the procedure.⁷⁹ The hospital’s proffered interest in deterring women from using drugs “cannot justify a departure from the general rule that an official nonconsensual search is unconstitutional if not authorized by valid warrant.”⁸⁰

Despite the holding in *Ferguson*, pregnant women continue to be subjected to medically unnecessary drug and alcohol testing by their health care providers without their knowledge or consent, and then reported to state authorities. In Alabama, for example, a positive drug test can have serious consequences for pregnant women—they can lose custody of their children, or face criminal convictions and prison sentences.⁸¹ As set forth above, between 2006 and 2020, prosecutors used Alabama’s chemical endangerment to charge nearly 600 women with endangering their fetuses. In many cases, law enforcement officials cited hospital-administered drug tests as probable cause for arrest.⁸² AL.com and ProPublica surveyed hospitals that deliver babies in Alabama,⁸³ and while 42 of the 49 hospitals declined to answer the survey about their testing policies,⁸⁴ the survey found that in six consent forms obtained from patients and a handful of hospitals, drug testing was specifically mentioned in only two.⁸⁵ None of these consent forms disclosed that positive results could trigger arrest and prosecution under the Alabama chemical endangerment statute.⁸⁶

The prevalence of medically unnecessary drug and alcohol testing is also partly due to mandatory reporting laws and medical providers’ misconceptions regarding the scope of such laws. These misconceptions contribute to the over-reporting of women and families of color into the family regulation system.⁸⁷ According to the Guttmacher Institute, as of May 1, 2022, 25 states and the District of Columbia require healthcare professionals to report suspected or confirmed prenatal

drug use to child welfare authorities.⁸⁸ In some states, like Oklahoma, healthcare professionals are mandated to report all instances in which an infant tests positive “for alcohol or a controlled dangerous substance”⁸⁹ despite the fact that alcohol or drug use alone in no way suggests abuse or neglect or reflects a person’s ability to parent.⁹⁰ In other states, healthcare providers are only required to report to child welfare authorities when they have reasonable cause to suspect that a child is neglected or abused, and because drug use alone does not support reasonable suspicion of abuse or neglect, prenatal drug use should not be reported.⁹¹ Nevertheless, this standard invites a great deal of discretion from the reporter. Placing this discretion in the hands of healthcare workers results in disparate outcomes, in particular for women of color.⁹²

Further exacerbating this disparity are states that empower healthcare providers to make subjective decisions about suspected prenatal drug use and conduct testing regardless of the patient’s consent. For example, eight states require healthcare providers to test for prenatal drug exposure based on suspicion alone: Indiana, Iowa, Kentucky, Louisiana, Minnesota, North Dakota, Rhode Island, and South Dakota.⁹³ Some statutes even go as far as to require physicians to report suspected substance use even when there is a negative toxicology test.⁹⁴ These statutes stand in direct opposition to the

recommendations of leading medical associations, all of which have staunchly warned against such reporting practices.⁹⁵ For instance, ACOG states that “[t]his routine practice, sometimes termed ‘test and report’ disrupts bodily autonomy of the pregnant [woman] and their newborn and is inconsistent with treating substance use disorder as a health condition with social and behavioral dimensions.”⁹⁶

In addition, and as discussed above, many medical providers and hospitals mistakenly believe that CAPTA/CARA requires them to report all substance-exposed newborns to child welfare agencies as being abused or neglected. Some states have tried to remedy this confusion by offering their own guidance about CAPTA’s requirement. For example, New York’s State Department of Health has issued guidance clarifying that CAPTA *does not* require hospitals to drug test pregnant women *or* file abuse or neglect reports against parents of drug-exposed newborns.⁹⁷ While only applicable to New York, the guidance importantly notes that these federal provisions do not change recommended practices for substance use screening during pregnancy or delivery.⁹⁸ New York’s guidance provides that toxicology testing should only be performed when medically indicated as part of the work up for the pregnant woman and infant to determine the appropriate medical treatment, and that before performing any tests, informed consent should be obtained from the

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pregnant woman or parent of the infant.⁹⁹

Given that many hospitals incorrectly interpret CAPTA requirements, the best and most ethical approach is to seek informed consent prior to testing.¹⁰⁰ In addition to providing the patient with information about the legal risk associated with drug testing and subsequent reporting in the event of a positive toxicology result, “[i]nformed consent also helps the medical care provider foster a trusting relationship with their patient and helps the patient to know what to expect in the course of receiving medical care.”¹⁰¹

Prosecutors across the country have relied on reports by healthcare providers to criminalize pregnant women for experiencing pregnancy loss or engaging in acts or omissions during their pregnancies that were perceived as risky. For example, Brittney Poolaw, whose case was mentioned above, was convicted of manslaughter in the first degree after seeking medical attention following a pregnancy loss.¹⁰² Poolaw, who was only 19 years old, went to a hospital after experiencing a miscarriage at 15-17 weeks, where she confided in medical personnel that she had used illegal substances, including methamphetamine.¹⁰³ Although no medical science supported the belief that her drug use caused the miscarriage, and despite testimony from the medical examiner that fetal abnormalities were likely the cause, Poolaw was convicted and sentenced to four years in prison.¹⁰⁴ Similarly, in Mississippi, Christina Yanacheak is serving a five-year jail sentence for felony child abuse after testing positive for criminalized drugs at the birth of her healthy baby.¹⁰⁵ Yanacheak, who had a substance use disorder, had remained sober for the majority of her

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pregnancy.¹⁰⁶ Despite the health of her baby, two child protection services (“CPS”) officials showed up at the hospital and took her son after they were notified by hospital staff of her newborn’s positive drug test.¹⁰⁷ CPS then notified the Sheriff’s office, which received medical records confirming the test results.¹⁰⁸ Based on the positive drug test alone, Yanacheak was arrested and charged with child abuse.¹⁰⁹ Yanacheak pled guilty and was sentenced to 10 years in prison, 5 suspended.¹¹⁰

Conclusion

While the legal landscape in a growing number of jurisdictions today presents daunting challenges for the health and rights of pregnant women, there are nonetheless paths available to counter these injustices. The health and just treatment of pregnant women and their families depends on individuals in the community choosing to disrupt these cruel cycles of surveillance and criminalization. The following guidelines were written to provide healthcare practitioners, government personnel, legal representatives, and other individuals in positions of power with the knowledge to fight against the laws and policies aimed at penalizing pregnancy.

**Guidelines
for Law
Enforcement—
Police &
Prosecutors**

Please contact NAPW at info@advocatesforpregnantwomen.org for assistance relating to any information in this section or the Guide generally.

Law enforcement in general, and prosecutors in particular, are uniquely positioned to effect change given the latitude they have to exercise discretion over which cases to investigate and charge.

The role of the prosecutor is one of a “problem-solver,”¹¹¹ responsible for “pursuing justice in individual cases and in the criminal justice system as a whole.”¹¹² Leading organizations and associations of prosecutors including the American Bar Association, the Association of Prosecuting Attorneys, and Fair and Just Prosecution, as well as individual elected prosecutors across the country, have taken the position that the criminal prosecution of people based on pregnancy outcomes and healthcare decisions undermines justice.¹¹³

Law enforcement officials have subjected pregnant and postpartum women to trauma, family separation, and incarceration for completely innocent and noncriminal acts, such as falling down the stairs, seeking medical help, and experiencing a stillbirth. These cases send the dangerous message to pregnant women that any and all acts, omissions, or statements during pregnancy could be misconstrued and subject them to criminalization, and that they should therefore be wary of seeking social services and medical help. Far from serving the interests of justice, these prosecutions deter pregnant women from seeking necessary care and thus jeopardize both maternal and infant health. Even when charges are ultimately dismissed, arrests alone can cause lasting harm to women and their families.

The ability of law enforcement to exercise discretion in criminal cases is a critical tool that can be used to disrupt and prevent the penalization of pregnant and postpartum women on the basis

of pregnancy outcomes or for actions that are perceived as harmful to their pregnancies. In particular, a prosecutor’s position in the criminal justice system, coupled with their discretion, empowers them to implement policies and practices that can change the way in which prosecutions on the basis of pregnancy are handled by the larger law enforcement community. By declining to accept certain cases, prosecutors can influence the way police investigate and make arrests.

Together, prosecutors and police can send a powerful message and safeguard the rights and wellbeing of pregnant women and their families by declining to investigate, arrest, and prosecute these types of cases. In exercising this discretion, law enforcement actors should consider the following guidelines:

- 1. Consider the fact that substance use disorder is a health issue, not a crime, and oppose efforts to use the criminal system as a path to substance use treatment.**
 - » From the outset, it is important to understand that not all individuals who use substances, prescribed or not, are “addicted” or need treatment. A positive drug test cannot determine whether a person: occasionally uses a drug; has a diagnosable substance use disorder; or is more or less likely, if they are parents, to abuse or neglect their children.¹¹⁴ Even when treatment is needed, there is a lack of family-friendly treatment options readily available to women that would suit their needs.¹¹⁵
 - » The medical community has understood for decades that addiction, or substance use disorder, is a public health issue—a treatable mental disorder with genetic components that can and should be managed by healthcare providers—not a criminal issue warranting punishment.¹¹⁶ Medical and public health experts have also widely acknowledged that criminalization and incarceration are not effective in deterring substance use or treating people with drug dependency problems.¹¹⁷

Substance use disorder in pregnant and breastfeeding women should not be understood nor treated any differently.

- » Every major medical and public health organization opposes punitive approaches to address the issue of pregnancy and drug use because it is dangerous to maternal, fetal and child health.¹¹⁸ The threat of arrest or prosecution makes pregnant women afraid to access health and medical services, which puts pregnant and postpartum women and their babies at increased risk of harm.¹¹⁹ In fact, “[f]or pregnant substance users, the receipt of adequate prenatal care is especially critical. Several studies have reported that increasing the adequacy of prenatal care utilization in pregnant substance users reduces risks for prematurity, low birth weight, and perinatal mortality.”¹²⁰
- » The fear of law enforcement involvement also dissuades people from having open and honest conversations with their healthcare providers about drug use. This can result in substance use disorders going undetected and interferes with the ability of healthcare providers to determine appropriate treatment options.¹²¹ For example, “[t]he standard of care for treating pregnant women with substance use disorder is often medication-assisted treatment,” which cannot be implemented by healthcare providers when their patients are too afraid to speak openly about their substance use.¹²²
- » Marginalized communities are disproportionately affected in these cases, which exacerbates racial disparities in punishment.¹²³ Pregnant women of color are disproportionately drug tested despite the fact that drug use occurs at approximately the same rate by Black and white women in the United States.¹²⁴ For example, a study in the *New England Journal of Medicine* documented that throughout a six-

month period Black women in Pinellas County, Florida were reported to health authorities for substance use during pregnancy at approximately 10 times the rate of white women—despite similar rates of substance use.¹²⁵

2. Review the science behind pregnancy loss and the risks associated with substance use during pregnancy.

- » There are many misconceptions about pregnancy risks and harms that are not supported by scientific evidence. When prosecutors are evaluating and considering the strength of evidence in cases involving pregnancy loss or perceived harm to a fetus, it is important that the evidence is supported by accurate and reliable medical science.
- » Pregnancy loss is extremely common. Miscarriages, defined as pregnancy losses before 20 weeks of gestation, occur in an estimated 10% to 15% of all clinically confirmed pregnancies.¹²⁶ This number is even higher when accounting for all pregnancies, with an estimated 26% of all pregnancies ending in miscarriage.¹²⁷ Miscarriage is often a random event entirely beyond a woman’s control. About half of all miscarriages are caused by chromosomal abnormalities, which usually happen by chance.¹²⁸ Stillbirths, defined as pregnancy losses after 20 weeks, are less common, but still occur in 1 in 160 deliveries in the United States and are one of the most common adverse pregnancy outcomes.¹²⁹ It is difficult to determine the cause of a stillbirth; in most cases, even where an autopsy examination occurs, stillbirths remain unexplained.¹³⁰
- » No type of illicit substance exposure causes pregnancy loss. Scientific research does not support the belief that prenatal exposure to drugs causes miscarriage or stillbirth. Certain risks, like inadequate nutrient

Together,

prosecutors and police can send a powerful message and safeguard the rights and wellbeing of pregnant women and their families by declining to investigate, arrest, and prosecute these types of cases.

support and fetal growth restriction, have been found to be more common in pregnancies involving substance use; however, medical studies have acknowledged that many of the socioeconomic factors associated with those who use substances may actually be the cause of these risks.¹³¹

For example, “those who consume substances are more likely to not seek adequate prenatal care, suffer from mental illness, have a lower socioeconomic status, experience intimate partner violence and trauma, or inflict maternal self-harm.”¹³² All of these variables are exacerbated when women are too afraid to seek help from medical or social services for fear of law enforcement involvement.

- » Substance exposure does not directly cause specific impairments to children who are prenatally exposed. Certain risks, like low birth weight, do not have long-term negative health impacts when properly addressed.¹³³ Some newborns prenatally exposed to opioids, legal or illegal, may experience withdrawal symptoms. These symptoms are treatable and temporary, and these babies do not develop any differently from other children.¹³⁴ Such withdrawal symptoms are no different than those that have been recognized in newborns following exposure to certain SSRIs,¹³⁵ which are taken by or prescribed to approximately 6% to 8% of pregnant women in the United States.¹³⁶
- » Social determinants of health (such as poverty, racism, and lack of access to adequate healthcare prior to pregnancy) are far more indicative of pregnancy outcomes than anything a pregnant woman does or does not do during pregnancy.¹³⁷
- » Testing positive for a substance is not the same as having been harmed or even affected by the substance. The U.S. Department of Justice has stated

that “[d]rug tests detect drug use but not impairment. A positive test result, even when confirmed, only indicates that a particular substance is present in the test subject’s body tissue. It does not indicate abuse or addiction; recency; frequency, or amount of use; or impairment.”¹³⁸

- » The U.S. Department of Health and Human Services likewise states, “[a] diagnosis of NAS [neonatal abstinence syndrome] or NOWS [neonatal opioid withdrawal syndrome] does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.”¹³⁹

3. Consider the impacts of arrest and incarceration.

- » Women are more likely than men to be the primary caregivers of their children.¹⁴⁰ Caregiving responsibilities are rarely taken into consideration when determining the length of incarceration, as sentencing guidelines generally do not factor in a defendant’s parental status.¹⁴¹ Separation from an incarcerated parent can compromise and have lasting effects on children’s health and development.¹⁴²
- » As fewer female facilities exist, incarcerated women are likely to be further pulled away from their families.¹⁴³ This distance can damage family structures and relationships. Importantly, “incarceration and physical separation from children are grounds for termination of parental rights in 25 states.”¹⁴⁴
- » Even if a person is not ultimately charged or convicted, arrest alone has damaging effects. Individuals who pass through the criminal system experience increased levels of chronic stress over their lifetimes,¹⁴⁵ stigma in society,¹⁴⁶

lowered income and employability,¹⁴⁷ and can be financially impacted by bail fees, legal fees, and lost wages.¹⁴⁸

4. Consider collaborating with and seeking input from additional stakeholders.

- » As required by the ABA, prosecutors must “be knowledgeable about, consider, and where appropriate, develop or assist in developing alternatives to prosecution or conviction that may be applicable in individual cases or classes of cases.”¹⁴⁹ Additionally, “prosecutor[s] should be familiar with the services and resources of other counties and agencies, public or private, that might assist in the evaluation of cases for diversion or deferral from the criminal process.”¹⁵⁰ To fulfill these obligations, it is critical for law enforcement to seek input from other stakeholders, including public health agencies and other medical actors, defense attorneys, community-based organizations, and people who have been victimized by laws that seek to punish them based on their pregnancy status.
- » Prosecutors should also consider seeking input and collaborating with associations of prosecutors that oppose the prosecution of pregnancy loss, like Fair and Just Prosecution and the Association of Prosecuting Attorneys (“APA”), for resources and insight on alternative approaches used to address pregnancy and substance use. The APA has launched a platform as part of its new initiative, “Addressing Disparities to Reproductive Health,” to provide medical information and scientific research on reproductive health, including pregnancy loss, in an effort to reduce reproductive health-related investigations and prosecutions. This platform is accessible through APA’s website here.¹⁵¹
- » Prosecutors and police should consider working together in their efforts to prevent the criminalization of pregnancy. Well-established channels of communication among law enforcement on the issues implicated in these cases are a vital tool for educating all law enforcement actors involved. When law enforcement leadership comes to a consensus, officers are more likely to respond. Additionally, open communication ensures law enforcement resources are being used efficiently. For example, if a prosecutor’s office establishes a policy against prosecuting certain cases, that policy should be communicated to police so officers do not continue to make arrests and recommend criminal charges for cases that the prosecutor’s office will not pursue.
- » Attorneys General should also consider engaging with stakeholders to identify criminal statutes that have been or may be misapplied as “punitive tools against those experiencing pregnancy loss.”¹⁵² In January 2022, California Attorney General Rob Bonta issued a legal alert to all California district attorneys, police chiefs, and sheriffs making clear that California’s murder statute, which includes the killing of a fetus, “was intended to hold accountable those who inflict harm on individuals who are pregnant, resulting in fetal death, not to punish people who suffer the loss of their pregnancy.”¹⁵³ In April 2022, Attorney General Bonta issued a letter to fellow democratic Attorneys General across the country, encouraging them to conduct a review of the laws in their states and issue similar legal alerts to district attorneys, police chiefs, and sheriffs making clear that state law does not criminalize pregnancy outcomes.¹⁵⁴

Guidelines for Defense Attorneys

Women facing prosecution for acts or omissions that create perceived risks to their pregnancies are often in incredibly vulnerable positions. Their bodies are used as evidence against them. They may feel stigmatized, dehumanized, violated, and dismissed. They may have confided in medical professionals or sought medical care only to have their confidential discussions with their caregivers and their medical records turned over to law enforcement.

In a criminal legal system that incentivizes law enforcement to secure arrests and convictions, defense attorneys should be acutely aware of the aggressive tactics that law enforcement may use against their clients and be ready to question their own assumptions about pregnancy, the impact or not of drug use on pregnancy, and stereotypes about maternal behavior.

Particularly in the reproductive arena, police, prosecutors and judges may be motivated by personal beliefs or political influences causing them to seek out and favor evidence to fit their theory of criminalization or distort criminal statutes that were never intended to be applied to pregnancy.

In defending cases of pregnancy criminalization, defense attorneys should consider the following:

1. Pursue early and aggressive bail applications.

- » When given the choice of immediate release in exchange for a guilty plea, many clients will feel pressured to take a plea deal, particularly if they have children at home. This is especially true the longer a client remains in jail while awaiting trial.¹⁵⁵ In Tennessee, Anna Yocca pleaded guilty to a felony charge of attempted procurement of a miscarriage in no small part due to the fact that she had already spent more than a year in jail.¹⁵⁶
- » In order to avoid this pressure, work to keep the client out of jail by pursuing an early and aggressive bail application. Be prepared to counter arguments that your client presents any danger to the community. Some judges apply exorbitant bail in order to inhibit a defendant from becoming pregnant again or to prevent the defendant from using drugs. In some cases, your client may be able to seek financial assistance from dedicated reproductive legal defense bail funds.¹⁵⁷
- » If substance use disorder is a concern, be prepared to present a drug treatment organization that is able to accept your client into their program immediately following release. Any constitutional issues with the arrest or the prosecution should be expressed in the bail application (see below for more on constitutional issues) and, potentially, in an appeal or *habeas* petition contesting an inappropriate bail decision.

Proving causation

between a mother's acts or omissions and a miscarriage is virtually impossible, and a court should be made aware of this in no uncertain terms as early and often in the process as feasible.

2. Challenge evidence and use experts.

- » In many cases, the criminal charge is based on the erroneous assumption that a woman engaged in acts or omissions that harmed the fetus. Defense attorneys should challenge the causal link between the alleged behavior and the alleged harm to the fetus in as many ways as possible, in light of the fact that miscarriages are extremely common and can be caused by myriad factors.¹⁵⁸
- » Proving causation between a mother's acts or omissions and a miscarriage is virtually impossible, and a court should be made aware of this in no uncertain terms as early and often in the process as feasible. This may include obtaining experts like forensic pathologists and OBGYNs to challenge any causal links allegedly based on the evidence. Obtaining the medical records of the client is essential both to show the lack of causation of the alleged harm and to show that a condition could have been caused by something else.
- » For instance, in Mississippi, Rennie Gibbs was indicted for murder based on the belief that she caused her stillbirth by using cocaine. She endured seven years of legal proceedings before the charges against her were finally dropped. Medical experts who later examined the autopsy reports concluded that the more likely cause of death was umbilical cord compression.¹⁵⁹ Michelle Roberts, in Virginia, was charged with murder of her fetus because the skull of the buried and decomposed remains had holes. The charges were dismissed after the defense experts demonstrated that the deceased fetus, in fact, had a known condition that resulted in late closure of the natural separation of the parts of the fetal skull, and that the injuries were clearly not due to Roberts' behavior.¹⁶⁰
- » It is also critical to challenge the expertise of the opposing expert

and file *Daubert* motions to address the relevancy and reliability of their opinions.¹⁶¹ For example, law enforcement officials are improper experts to give opinions on medical and scientific facts.¹⁶² Similarly, the average medical doctor, including a pediatrician, is not a trained researcher and is not qualified to say a certain drug has caused a certain outcome.¹⁶³ In Mississippi, Lattice Fisher was charged with murder based on a finding that that her fetus was born alive when the medical examiner relied on the discredited "lung float test."¹⁶⁴ After defense experts challenged the reliability of this archaic test, the DA presented the case before a new grand jury using accurate scientific information, and the grand jury "no billed" the matter so the charges were dismissed.¹⁶⁵

- » The prosecution's purported scientific evidence can carry substantial weight, and if unchallenged, may dangerously prejudice the client. In South Carolina, Regina McKnight was convicted of homicide by child abuse after her pregnancy ended in a stillbirth based on testimony from the prosecution's experts that she caused the stillbirth by using cocaine.¹⁶⁶ Although it was later proven that the stillbirth was the result of an infection, McKnight served more than eight years in prison. When McKnight's conviction was overturned, the South Carolina Supreme Court noted that "recent studies show that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor."¹⁶⁷
- » If an autopsy has been performed, the defense attorney should reach out to the medical examiner who performed the death investigation to review the medical examiner's report. The defense attorney should

ask the medical examiner to explain why they reached the conclusions they did, including any scientific literature relied upon when reaching those conclusions. Additionally, a defense attorney should obtain their own forensic pathologist expert for testimony and, if the defendant is indigent, make an application to the court for funding to obtain the expert, if necessary. These are critical steps for defense attorneys to get clarity on the forensic evidence involved in their client's case prior to and during trial.

3. Make pre- and post-preliminary hearing/indictment motions to dismiss *in limine* with state and federal constitutional and statutory arguments and preserve all arguments for appeal.

- » While the focus of these cases will often center around the evidence, do not assume that the prosecution is actually authorized under the state's law. Be sure to include all arguments based on the federal constitution and federal law in order to preserve any future potential federal *habeas corpus* challenges following a conviction. It is critical to consider all constitutional and statutory arguments. Every argument possible should be raised before and at trial, and should be preserved for appeal.
- » If the client is charged with child endangerment, child abuse, feticide, or under a general murder statute, consider arguing that the prosecution extends beyond the plain language of the statute. It is possible that the statute does not define "child" to include a fetus¹⁶⁸ or that the statute either explicitly excludes pregnant women¹⁶⁹ or does not explicitly include the acts of pregnant women in relation to their own pregnancies.¹⁷⁰ In many instances, states may have considered—but rejected—an expansion of the statute to include fetuses under the definition of children.¹⁷¹ In such cases,

argue that your client had no notice of potential prosecution under the state's construction of the statute in violation of her constitutional right to due process under the Fourteenth Amendment as well as the relevant provision of the state constitution.

- » Argue that imposing liability on women for being pregnant and engaging in certain acts or omissions is discrimination on the basis of sex and violates equal protection principles.¹⁷² In most cases, but for the pregnancy, the conduct itself would not be considered criminal. There is no comparative liability for men. While all states and the federal government criminalize possession of illicit drugs, most states do not explicitly criminalize drug use and evidence of drug use on its own is rarely sufficient to sustain a possession charge.¹⁷³ As such, a father's drug use (absent additional circumstances) would not be criminalized or monitored in a comparable way to that of a pregnant woman.

4. Consider Fourth Amendment arguments.

- » Despite having the general right to refuse any medical procedure involving themselves or their children, including a drug test, many pregnant or postpartum women and their newborns are drug tested without their knowledge and explicit, informed consent.¹⁷⁴ Often these tests are done in "secret" despite the Supreme Court having ruled that it is unconstitutional to use the results of drug testing obtained under the guise of medical care for law enforcement purposes without informed specific consent to search for evidence.¹⁷⁵ Depending on the circumstances, consider arguments based on a lack of informed consent for a drug test, or that consent was limited to medical purposes and care only.

5. Bring public attention to the case.

- » Where permitted and appropriate, defense attorneys can seek attention from local and national media.¹⁷⁶ Attorneys often shy away from media attention, but public outcry and organizing can be an effective tool to put pressure and scrutiny on law enforcement. Marshae Jones, an Alabama woman who lost a pregnancy after she was shot in the stomach during an altercation, was charged with manslaughter for allegedly causing the death of her fetus by initiating a fight while knowing she was five months pregnant.¹⁷⁷ A week after her story drew national attention, the district attorney announced that she would not be prosecuted.¹⁷⁸
- » Public outcry not only puts pressure on the prosecution, but it can also alert the community and other stakeholders to what is happening. Purvi Patel, an

Indiana woman who was charged under a feticide statute after purchasing and taking mifepristone and misoprostol to terminate her pregnancy, had her conviction overturned on appeal in part because of the different interest groups that got involved in her case, drawing national attention and outrage. Over 25 amicus briefs were filed on her behalf.¹⁷⁹

- » Defense attorneys should seek amicus briefs even at the trial level, even if it's not typical practice.¹⁸⁰ Amicus briefs function to bring national attention to a case and draw in other avenues of help for the defendant.¹⁸¹ They also have been critical for establishing the dangerous medical and public health implications of the criminalization of pregnancy. Amicus briefs should be collected from a variety of groups, prioritizing local groups, especially medical groups,¹⁸² human rights organizations, and experts generally.

Public outcry

not only puts pressure on the prosecution, but it can also alert the community and other stakeholders to what is happening.

Guidelines for Child Welfare Agencies & Workers

The purpose of the child welfare system is to protect children from harm. That purpose is not achieved through the criminalization and penalization of pregnant women who use substances or who have substance use disorders, and the subsequent separation of mothers and babies when there are no indications of abuse present.¹⁸³

Studies fail to establish a causal link between drug use and child maltreatment. However, several studies establish that family separation imposes significant harms on children.¹⁸⁴ Evidence indicates that policies and practices of separating families based on alleged effects of drug use during pregnancy have a greater negative impact on children than supporting and maintaining the family unit.¹⁸⁵

Child welfare agencies and workers have the power to disrupt the cycle of removing children from mothers on the basis of a positive drug test, the diagnosis of Neonatal Abstinence Syndrome or Neonatal Opioid Withdrawal Syndrome (which are transitory conditions best addressed through keeping the mother and baby together),¹⁸⁶ or in some states, a mere verbal screening suggesting intrauterine substance exposure, where there are no indicators of abuse or neglect. The testing of pregnant women and/or newborns at birth for substances varies by state. New York State's Department of Health, in stating that drug testing is not required by hospitals except under very limited circumstances, notes that the American College of Obstetricians and Gynecologists ("ACOG") does not recommend drug testing during pregnancy,

delivery, or for the newborn.¹⁸⁷ ACOG specifically admonishes that testing should not be "the sole factor in determining family separation."¹⁸⁸

However, other states, such as Minnesota, require testing of a newborn if substance use is suspected during pregnancy, and testing of a pregnant woman after delivery if "the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose."¹⁸⁹ According to the state, indicators for substance testing can include: unexplained premature delivery, presenting at the hospital in second stage of delivery, or low birth weight of the infant, despite the fact that these "indicators" may have absolutely nothing to do with drug use and a positive toxicology result would not change any possible course of treatment for the newborn.¹⁹⁰ Its sole purpose is to surveil the mother.¹⁹¹

In cases in which a pregnant woman or newborn tests positive for a substance (or where testing is not required and a mere verbal screening could indicate substance use), requirements for reporting to child welfare agencies vary by state.¹⁹² Many medical professionals and child welfare workers misunderstand the requirements under the Child Abuse Prevention and Treatment Act ("CAPTA") and the Comprehensive Addiction and Recovery Act ("CARA").¹⁹³ For example, CAPTA/CARA requires states, in order to receive federal child abuse prevention funds, to develop policies for the "notification" to child welfare agencies of infants who are (i) affected by substance abuse; (ii) affected by withdrawal symptoms resulting from prenatal substance exposure; or (iii) have Fetal Alcohol Spectrum Disorder. Some medical personnel have conflated the "notification" requirement with a requirement of testing and referral for an abuse investigation.¹⁹⁴ In reality, notification requires only de-identified, aggregate data about the number of children born who fall under the relevant categories. The notification requirement can and should be done in a manner that does not make the family vulnerable to child welfare involvement.

Child welfare agencies and workers should be aware of these distinctions and understand the notification requirements of their specific state. Child welfare workers should know what they (and others) are legally required to do, rather than assume that a report of prenatal substance exposure or a positive drug test alone is evidence of child abuse.

Upon receiving a referral, child welfare agencies and workers can promote the goal of protecting children from harm in a number of ways. Absent a legal obligation to do so or other indicators of child abuse, a report based on suspected prenatal substance use or on a positive neonatal or maternal drug test should not result in an abuse investigation by child welfare agencies.¹⁹⁵ Child welfare agencies and workers can also promote maternal and child health and wellbeing in the following ways:

1. Treat substance use disorder as a health issue, not child abuse.

- » As a starting point, understand that a person’s drug use is not an indicator of that person’s ability to parent. A positive drug test merely indicates that a chemical compound is present in the bodily fluid collection.¹⁹⁶ Child welfare agencies and systems have placed undue emphasis on drug testing as the sole indicator of parenting abilities and as a basis for separating parents and children.
- » A positive drug test cannot determine whether a person: occasionally uses a drug; has a substance use disorder; suffers any physical or emotional disability from that substance use disorder; or is more or less likely, if they are parents, to abuse or neglect their children.¹⁹⁷
- » Punitive responses to substance use during pregnancy generate negative

health outcomes for pregnant women and children by encouraging the avoidance of health care out of fear.¹⁹⁸ According to ACOG, “[p]enalizing parents through civil neglect petitions based on the pregnant [woman’s] drug use makes medical care less accessible as pregnant people are more afraid to seek help for fear of state involvement, losing custody of their children, or losing their parental rights.”¹⁹⁹

- » Child welfare agencies should maintain clear policies in support of medication-assisted treatment and ensure that other actors (hospitals, law enforcement, schools) understand the agencies’ policies to avoid unnecessary referrals and surveillance. For example, ACOG and the CDC expressly recommend and support medication for opioid use disorder during pregnancy, and state that infant withdrawal is an expected condition that can follow maternal treatment for opioid use.²⁰⁰ The presence of withdrawal symptoms in an infant is temporary and treatable and is not evidence of child abuse.²⁰¹
- » Drug testing does not assess child risk and safety, and agencies should not rely on drug tests alone to inform their decisions.²⁰² For example, in New York, “[e]vidence that a newborn tests positive for a drug or alcohol in its bloodstream or urine . . . is not sufficient, in and of itself, to support a determination that the child is abused or maltreated.”²⁰³ The U.S. Department of Health and Human Services likewise states, “[a] diagnosis of [neonatal abstinence syndrome] or [neonatal opioid withdrawal syndrome] does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.”²⁰⁴

Child welfare agencies

should help families identify their strengths and encourage and promote community-based and peer support connections that support and protect the family unit.

- » If a child welfare worker believes that treatment for substance use disorder is necessary, he or she should first seek an assessment for substance use disorder from the individual's medical provider of choice, not make their own assumptions about the need for treatment or rely on an assessment from an agency-affiliated provider or program.
 - » Child welfare workers should first defer to the family as to what services the family believes will support maintaining the family unit. Supportive services (i.e., housing, food, job placement or training, medical care, etc.) should be community-based and accessible to the family (i.e., does not impose costly and time-consuming travel burdens). Acceptance and use by the family of supportive services should be entirely voluntary and should not be mandated by child welfare workers or their agencies. If child welfare workers are mandated to consider or impose substance use treatment, they should consider the least restrictive or invasive options tailored to the particular situation, and whether the available resources provide evidence-based and accessible care.
 - » Child welfare workers and agencies should be aware of the resources available to their agencies under certain grant programs. For example, the Substance Abuse Prevention and Treatment Block Grant gives priority or preferred access to pregnant women to receive treatment for substance use disorders.²⁰⁵ However, mere priority or preferred access does not necessarily translate into accessible, evidence-based care that addresses the specific needs of the affected family.²⁰⁶
- 2. Prioritize support and services over removal in the interest of infant health.**
- » Studies show that keeping children with their families results in better long-term outcomes for the children than family separation.²⁰⁷ Child welfare workers should prioritize preserving the family unit rather than defaulting to child removal to foster care.
 - » In the case of a referral received while a newborn is still hospitalized, the prevailing best practice for treating substance-exposed newborns is to keep the newborn and mother together (known as “rooming in”), encourage breastfeeding, and provide trauma-informed care to the mother-infant dyad. Studies show that these practices improve medical outcomes, decrease length of hospital stays, and improve [bio]psychosocial outcomes.²⁰⁸
 - » Providing all new mothers with lactation assistance is critical. One study that followed a large birth cohort over 15 years determined that breastfeeding was associated with substantially lower odds of maternal maltreatment.²⁰⁹ In fact, breastfeeding for four or more months was associated with a four-fold reduction in substantiated reports of neglect.²¹⁰
 - » Child welfare agencies should help families identify their strengths and encourage and promote community-based and peer support connections that support and protect the family unit. And if there are no concerns other than a positive drug test, then there should be no agency and child welfare worker involvement. Supportive services should protect the family and promote reunification.

3. Understand the role of discrimination and bias in referrals to child welfare agencies.

- » Recognize that overt racism and implicit and unconscious biases contribute to Black women being disproportionately referred to child welfare agencies for perceived or actual substance use disorders.²¹¹ Such referrals often result in higher surveillance and removal rates and lower family reunification rates for Black mothers and their families.²¹² Some reports indicate that up to 53% of Black children have experienced a child welfare agency investigation by the time they are 18 years old.²¹³ Although Black children account for approximately 14% of the population of children, they make up 23% of the foster care population.²¹⁴
- » Implement unconscious bias, anti-racist, and cultural humility training of child welfare workers to improve ways in which the child welfare agency can take an unbiased approach in its work and educate other actors in the system (hospitals, law enforcement, schools) to recognize their own biases in making referrals.²¹⁵
- » Use consistent protocols for making decisions on reunification and case closure. Track and issue public disclosures regarding the total number of cases involving prenatal substance exposure and their outcomes to facilitate and promote evidence-based policies and approaches. Such data should be disaggregated by race and socioeconomic status. Consider further auditing to identify bias in approaches by individual case workers.

4. Inform parents of their rights during a child welfare investigation and/or proceeding.

- » Child welfare workers can reduce harm to families subject to child welfare investigations by rejecting the notion that withholding information about parental rights during an investigation or proceeding is in the best interest of the child.
- » Agencies and workers should be familiar with the legal rights of parents with respect to child welfare agency investigations and proceedings in their jurisdiction, and inform parents of those rights.
- » Maintain a list of *pro bono* legal services organizations in your jurisdiction that provide representation to parents in child welfare investigations and proceedings and share those resources with families.

Studies show that keeping children with their families results in better long-term outcomes for the children than family separation.

Guidelines for Healthcare Providers

Healthcare providers have an obligation to act in the best interests of their patients. This includes an “ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others.”²¹⁶ And yet, there is a long history of healthcare providers reporting pregnant women, predominantly women of color, to state authorities for things they think might be illegal or that they otherwise disapprove of.

Healthcare providers have abused their positions of trust and power to report pregnant women for all sorts of behavior. They have reported women who have delivered healthy babies but admitted to taking a substance during pregnancy, women who have sought emergency medical care after experiencing physical trauma, women who have not consented to certain procedures based on their religious beliefs, women who have disagreed with a doctor’s advice to undergo cesarean surgery, and women who were coping with the heartbreak of pregnancy loss, all based on the suspicion that the women played a role in harming, or attempting to harm, their pregnancies.²¹⁷ These reports have led to arrests, detentions in hospitals, forced surgery to which the pregnant patient did not consent, civil child welfare investigations, family separation, and termination of parental rights.

And against the backdrop of an unprecedented swell of anti-abortion legislation and the anticipated end of a constitutional right to abortion, healthcare providers have even voiced concerns about performing emergency procedures for pregnant women—like ending an ectopic pregnancy²¹⁸—despite an “ethical obligation to provide care in cases of medical emergency.”²¹⁹ Laws in certain states demand that healthcare providers intervene when they believe that a pregnant woman has exposed a fetus to some risk of harm.²²⁰ In other cases, doctors may feel personally obligated to report.²²¹ Regardless of the motive, the result is the same—healthcare providers inadvertently become agents of law enforcement, and in “the worst circumstances, this leads people to be treated as suspects instead of patients, subject to bedside interrogations and legal scrutiny.”²²²

The involvement of healthcare providers in punitive measures against pregnant women generates far-reaching negative health outcomes for pregnant women, their fetuses, and newborns alike. When healthcare providers report their patients to state authorities for pregnancy loss, positive toxicology results, suspected substance use, or any other acts or omissions that create a perceived risk of harm during pregnancy, it sends a powerful message to pregnant women everywhere that they cannot trust their healthcare providers, they should not be honest with them, and they should avoid seeking medical help—even in an emergency.²²³

Far from protecting the health or wellbeing of a pregnant woman or her fetus, these decisions by healthcare providers create dangerous and life-threatening barriers to access, which only serve to exacerbate the entrenched and well-documented racial disparities in maternal health outcomes.²²⁴ But healthcare providers, especially doctors, are an incredibly powerful lobby, and the more they push to disentangle their work from the criminal and civil child welfare systems, the more they can distance themselves from being de facto agents of law enforcement and family regulation systems.

Far from protecting the health or wellbeing of a pregnant woman or her fetus, these decisions by healthcare providers create dangerous and life-threatening barriers to access.

To do this, healthcare providers should consider the following guidelines:

1. Be familiar with mandated state reporting laws and applicable hospital guidance on drug testing and understand the potential consequences of reporting the results of such tests to state authorities.

- » The practice of drug testing labor and delivery patients and reporting test results to state authorities is pervasive, despite the fact that testing is rarely clinically indicated and reporting is often not legally required.²²⁵ To the extent possible, healthcare providers should not test pregnant and postpartum women. Drug testing pregnant and postpartum women, with or without informed consent, exposes patients to needless trauma, potential family separation, and potential incarceration for seeking necessary medical care.
- » Many hospitals and providers wrongly assume that the Child Abuse Prevention and Treatment Act (“CAPTA”) and the Comprehensive Addiction and Recovery Act (“CARA”) require the reporting of all substance-exposed newborns to child welfare agencies. CAPTA/CARA requires states, in order to receive federal child abuse prevention funds, to develop policies for the “notification” to child welfare agencies of infants who are (i) affected by substance abuse; (ii) affected by withdrawal symptoms resulting from prenatal substance exposure; or (iii) have Fetal Alcohol Spectrum Disorder. The “notification” requirement does not require testing and referral for an abuse investigation.²²⁶ Rather, notification requires only de-identified, aggregate data about the number of children born who fall under the relevant categories and should be done in a way that does not make the family vulnerable to child welfare involvement.
- » Healthcare providers should review their internal hospital guidance to determine whether the hospital has protocols addressing urine and biologic testing and should familiarize themselves with the mandatory reporting laws of their state. The following additional resources offer more specific information on state-by-state requirements:
 - The Guttmacher Institute has published *State Policies on Substance Use During Pregnancy*, an up-to-date chart outlining state law requirements, available here.²²⁷
 - Elephant Circle has also published *Mandatory Reporting, A Guide for Practitioners*, which is a comprehensive summary of state mandatory reporting laws, available here.²²⁸
- » Unless otherwise required by specific state law or hospital policy (see recommendation #5 below), providers should not report positive toxicology of a newborn or mother to authorities absent other indications of abuse/neglect. The fact that someone uses or has used drugs is not an indication of a person’s ability to parent, and reporting such information to state authorities can subject women to criminalization

or result in the termination of parental rights, which is more harmful to children than the alleged effects of drug use on parenting.²²⁹

- » Consider the obligations of healthcare providers to maintain patient privacy pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”).²³⁰ Unless specifically permitted by an exemption to HIPAA’s privacy rule, healthcare providers should not provide results of screening or biologic testing to any state agency without informed consent of the patient.

2. Understand that urine and/or biologic testing is not an effective means to diagnose potential substance abuse.

- » The fact of pregnancy itself does not provide a medical justification for testing. The limited circumstances in which it may be medically necessary for providers to obtain information about substance use include when such information is essential to a differential diagnosis and/or when it would change the course of medical treatment. Even

The fact of pregnancy itself does not provide a medical justification for testing.

in such circumstances, providers should give patients the opportunity to voluntarily disclose substance use through a confidential conversation in lieu of submitting to drug testing. Penalizing pregnant women for drug use “makes medical care less accessible as pregnant women are more afraid to seek help for fear of state involvement, losing custody of their children, or losing their parental rights.”²³¹

- » ACOG provides that a positive drug test only assesses current or recent substance use, and therefore it does not necessarily indicate whether a person has a substance use disorder. Moreover, “false positive test results can occur within immune-assay testing and the legal consequences can be devastating to the patient and her family.”²³²

Healthcare providers should work with hospital leadership to implement unconscious bias, antiracist, and cultural humility trainings of providers and all healthcare staff.

Healthcare providers should make an individualized assessment, ask themselves if and how information about substance use would alter their patients' care, and, when necessary, seek this information through open and confidential communication.

- » The U.S. Department of Health and Human Services likewise states, “[a] diagnosis of [neonatal abstinence syndrome] or [neonatal opioid withdrawal syndrome] does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.”²³³
 - » ACOG also recommends that healthcare providers “be aware of their laboratory’s test characteristics and request that confirmatory testing with mass spectrometry and liquid or gas chromatography be performed as appropriate.”²³⁴ In states in which reporting is required, healthcare providers should never report patients on the basis of a presumptive positive without conducting a confirmatory test.²³⁵ They should also ensure that their testing thresholds are not below those endorsed by the federal government to avoid false positives.²³⁶
- 3. Seek information about substance use only when medically necessary.**
- » Healthcare providers should never seek information about substance use when there is not a specific medical need for that information to make a differential diagnosis or because it would change the scope of care. Instead of seeking information about substance use from all pregnant women as a matter of course, healthcare providers should make an individualized assessment, ask themselves if and how information about substance use would alter their patients’ care, and, when necessary, seek this information through open and confidential communication (known as screening), rather than testing.
 - » ACOG recommends identifying patients with substance use disorders using validated screening tools, offering brief intervention (such as having a brief conversation, and providing feedback and advice), and referring for specialized care, as needed.²³⁷ Healthcare providers should also prioritize evidence-based interventions that keep the maternal-infant dyad together and are proven to shorten hospital stays and reduce the need for pharmacological care. These interventions include “rooming in,” skin-to-skin contact, and breastfeeding.²³⁸
 - » In hospitals at which screening for substance use disorder is employed by healthcare providers, ACOG states that “it is essential that screening be universal”²³⁹ and be applied to all people, regardless of age, sex, ethnicity, or socio-economic status.²⁴⁰ Screening pregnant women for substance use based only on factors such as poor adherence to prenatal care (which is often a proxy for poverty) or prior adverse pregnancy outcomes, can lead to stereotyping and stigma.²⁴¹
 - » Prior to engaging in any screening questions, patients should be informed of the risks, benefits, and alternatives to

any recommended tests or procedures. They should also be informed of their right to refuse to answer any questions and their right to request full, accurate information before or after any test or procedure is performed. Finally, they should be informed of the potential legal ramifications of informed consent, including possible child abuse and neglect proceedings.²⁴²

- » It is important to note that screening is distinct from testing. Screening questions should be asked by providers while maintaining a caring and nonjudgmental approach, and should be asked in a manner that protects patient autonomy, confidentiality, and the integrity of the patient-physician relationship to the extent allowable by applicable law.²⁴³ Testing, as discussed below, should only be performed when required by statute. Both screening and testing should only be performed after obtaining a patient's written informed consent.

4. If medically necessary, urine and other biologic testing should only be performed with the patient's written informed consent.

- » In the rare circumstances in which a provider determines urine or other biologic testing of the mother or baby is a medical necessity, such testing should be performed only with the mother's written consent, and in compliance with applicable state law.²⁴⁴ Providers should seek written informed consent irrespective of whether the test is being performed on the mother or the newborn. In seeking a patient's written informed consent, providers should assess the patient's ability to understand relevant medical information in the patient's native language, the implications of treatment alternatives, and their right to make an independent, voluntary decision.

- » If healthcare providers do not seek their patient's informed consent and conduct a toxicology screen, it may be an illegal search of the patient under federal law if the results are turned over to law enforcement.²⁴⁵
- » Pregnant women should be informed of the potential ramifications of a positive test result, including any mandatory reporting requirements and the possibility that a positive test can lead to abuse or neglect proceedings. For example, in Massachusetts, Angela, who was eight months pregnant, disclosed on a hospital intake form that she used marijuana to treat her anxiety.²⁴⁶ She and her husband, Chris, wanted to be honest with doctors in order to receive the most appropriate care possible.²⁴⁷ After giving birth, medical staff took a meconium and urine sample from the baby, but did not explain what they would be used for or seek Angela's written consent.²⁴⁸ When one of the newborn's samples came back positive for marijuana, the result was shared with child welfare authorities. In the months that followed, Angela and Chris received numerous home visits from the Department of Children and Families and were constantly fearful about losing their children to the system.²⁴⁹
- » When documenting the informed consent or lack thereof, healthcare providers should consider and be intentional with the language they use when charting interactions with patients. For example, consider writing "patient did not consent to urine testing," or "patient declined to consent to urine testing" as opposed to "patient refused drug testing." As with any other recommended medical procedure or test, a patient has the right to decline a drug test for any reason.²⁵⁰

5. Healthcare providers should engage with their hospitals' risk management teams to assess appropriate guidelines/reporting.

- » Healthcare providers play a critical role in establishing or revising existing hospital protocols to ensure that pregnant women's autonomy and privacy are protected. Healthcare personnel should get involved in the appropriate advisory boards at their hospitals, seek review of existing guidance (within their hospital and state), and/or establish hospital guidance to oppose mandatory testing and reporting policies because these practices compromise the clinical relationship between the provider and patient, undermine confidentiality, and erode trust in the medical system.²⁵¹ ACOG states that providers "have an ethical responsibility to their pregnant and parenting patients"²⁵² and "should protect patient autonomy, confidentiality, and the integrity of the patient-physician relationship to the extent allowable by law."²⁵³
- » Healthcare providers should also seek to establish hospital guidance to prevent the testing of pregnant patients in the absence of medical necessity and informed consent. Urine and other biologic testing should be performed only with the patient's informed consent and in compliance with applicable state law. Informed consent should be obtained from the

Healthcare providers should never make reports to child welfare authorities as a way to connect a patient with community resources.

- patient prior to any testing and such consent should be documented in writing. Guidelines should require providers to discuss the basis for testing with patients; with whom the test results can be shared; the consequences of a positive test result; and if applicable, the provider's obligations under applicable reporting law(s).
- » Healthcare personnel should work to develop clear policies against the involvement of law enforcement or use of the legal system as a mechanism for getting people into drug treatment. ACOG has stated that "[c]lear evidence exists that criminalization and the incarceration for substance use disorder during pregnancy are ineffective as behavioral deterrents and harmful to the health of the pregnant person and their infant."²⁵⁴ For example, empirical research found that Tennessee's fetal assault law, which specifically targeted women for using drugs while pregnant, "resulted in twenty fetal deaths and sixty infant deaths" in 2015 alone."²⁵⁵ Therefore, "it is important to advocate for patients, particularly in terms of working to improve availability of treatment and to ensure that pregnant women with substance abuse who seek prenatal care are not criminalized."²⁵⁶
 - » In developing these policies, doctors should also understand the role of discrimination and bias in urine and biologic testing and subsequent reporting to state authorities. Overt racism as well as unconscious biases contribute to women of color being disproportionately subjected to drug testing and subsequent reporting to state authorities for perceived or actual substance use disorders. This leads to the over-reporting of women and families of color into the family regulation system, which can result in the permanent separation of children from their parents and/or

surveillance and monitoring of families for years.²⁵⁷ Healthcare providers should work with hospital leadership to implement unconscious bias, antiracist, and cultural humility trainings of providers and all healthcare staff to improve the ways in which substance use and pregnancy are addressed and assessed on a universal basis.

6. If required to make a report to child welfare authorities, healthcare providers should understand the consequences of such reporting, be familiar with community resources that may be able to assist the family, and be cognizant of implicit and explicit biases.

- » Healthcare providers should never make reports to child welfare authorities as a way to connect a patient with community resources. Child welfare authorities have an investigatory role and will rely heavily on mandated reports, particularly from healthcare providers, when making determinations of abuse or neglect. Instead, healthcare providers should get to know the resources in their communities so they can make direct referrals for their patients. This is true even for ICU or ER providers—while they often have limited relationships with pregnant patients compared to pediatricians or OBGYNs, they can significantly reduce harm to families by connecting patients with resources directly.
- » Healthcare providers should also become acquainted with the resources in their community that may be able to assist a family facing a child welfare investigation. If required to make a report to child welfare authorities, healthcare providers can reduce harm to families by being up front about making the report and sharing such resources with the family.
- » When making a report, healthcare providers should be mindful of both explicit and implicit biases. In reality, even mandatory reporting decisions involve a certain amount of discretion, which is often exercised favorably for white communities and not for communities of color. Healthcare providers should also be careful not to conflate poverty with neglect.
- » It is important to communicate any positive information about a patient when making a report. As discussed above, child welfare authorities often rely heavily on reports made by healthcare providers. Reporting only that which is believed to constitute neglect may give a skewed representation of the patient. For example, if a patient has a positive toxicology result that necessitated a report to child welfare authorities but that patient went to all of her prenatal appointments and was in contact with the doctor throughout her pregnancy, it would be important to communicate that when making the report.
- » When making a report, healthcare providers should also ask the person receiving the report to repeat the information back to them. Given the long-lasting and traumatic impact a report can have on a family, it is important to ensure that the information being communicated is correct.
- » Many healthcare providers may feel like they should not speak with a patient's legal representation in order to remain neutral. However, it can be difficult for a defense attorney to adequately advise their client if parts of the narrative are missing. Healthcare providers can provide defense attorneys with important background information that, in the end, may help to prevent a family from being separated or a patient from being criminally punished.

Guidelines for Medical Examiners

In criminal cases, medical examiners wield tremendous influence because their opinions and determinations on a cause of death are often heavily relied upon by police in the investigation process, as well as by prosecutors, juries, and judges during court proceedings.²⁵⁸ A medical examiner who performs a fetal autopsy plays a pivotal role in ensuring that police and prosecutors are relying on evidence that is supported by accurate and reliable medical science. This is particularly important in the context of pregnancy loss, given that there are many misconceptions about pregnancy risks and harms that are unsupported by scientific evidence.

The American College of Obstetricians and Gynecologists (“ACOG”) recommends fetal autopsy as an important diagnostic component that can provide useful information in determining the causes of stillbirth.²⁵⁹ The information obtained can be medically instructive for future maternal care and help direct more successful pregnancy outcomes, both for the individual who has experienced the loss and for all birthing people as medical reporting data is leveraged for improved overall prenatal care.

While laws, regulations, and customs regarding stillbirth cases requiring examination by a medical-legal officer vary by jurisdiction, practitioners conducting these examinations should be aware of the legal ramifications their diagnostic reports can have on an investigation into a bereaved mother, in addition to the ways in which prosecutors have weaponized forensic science to criminalize women on the basis of pregnancy outcomes.²⁶⁰

Medical examiners should take care to conduct evaluations and administer reports in a manner that maintains strict professional standards, including with respect to causality, and that is sensitive to the potential use of such reports for purposes of criminal prosecution. In doing so, medical examiners should consider the following guidelines:

- 1. Understand how fetal death reports may be used against bereaved mothers to criminalize pregnancy loss.**
 - » Increasingly in many states, the wide application of existing criminal drug laws, the recognition of personhood status of fertilized eggs, embryos, and fetuses, and new laws explicitly criminalizing behavior tied to pregnancy subject pregnant women to arrest, criminal charges, or revocation of their probation when they, or their fetus or newborn, test positive for criminalized substances during pregnancy, following a miscarriage or stillbirth, or if they admit to using drugs at any point during their pregnancy.²⁶¹
 - » Fetal personhood laws in many states have expanded the existing statutory code such that every mention of a “child” or “person” includes a fertilized egg, embryo, or fetus. Prosecutors have used these laws to subject pregnant women to criminal charges, including homicide, child abuse, and child endangerment, among others, when a woman is suspected of engaging in conduct carrying a perceived risk of harm to the fetus during a pregnancy.

- » A post-mortem report listing maternal substance use as a causal or contributing factor in a fetal death may be used against the mother in a criminal prosecution. Given that the report may be used as inculpatory evidence in a criminal prosecution, the medical examiner should take extra care in drafting the report, including applying a higher standard of evidence. The CDC has stated, in such cases, “the medical examiner or coroner may wish to devote some thought to the degree of ‘proof’ necessary to properly certify death . . . He or she may wish to consider that the proof required in a criminal proceeding is of a higher degree of positivity than that required in a civil proceeding.”²⁶²

2. Recognize the deep systemic biases associated with substance use and pregnancy and counter these biases through factual reporting.

- » Despite entrenched misunderstandings about specific and unique harm caused by prenatal exposure to criminalized, controlled substances, medical research does not support the finding of a direct causal relationship between prenatal exposure to criminalized drugs and miscarriage or stillbirth. No criminalized substances have been found to be abortifacients.²⁶³ The risks associated with prenatal exposure to criminalized substances have been found to be comparable to or less than those associated with legal substances much more commonly used,²⁶⁴ like anti-depressants,²⁶⁵ alcohol,²⁶⁶ or caffeine.²⁶⁷
- » If a pregnant woman, or her fetus or newborn, tested positive for a substance, it does not mean that the fetus or newborn was harmed or even affected by that substance. As the U.S. Department of Justice has stated, “[d]rug tests detect drug use but not impairment. A positive test

result, even when confirmed, only indicates that a particular substance is present in the test subject’s body tissue. It does not indicate abuse or addiction; recency; frequency, or amount of use; or impairment.”²⁶⁸

- » When making a determination about fetal death, the practitioner should adhere to the strict professional standards relating to cause-of-death reporting described by the CDC in its Handbook on Death Registration and Fetal Death Reporting.²⁶⁹ These standards are intended to ensure the report provides “an etiological explanation of the order, type, and association of events resulting in death” and reflects the medical examiner’s “best medical opinion.”²⁷⁰
- 3. Consider the influence a medical examiner’s report can have on juries, judges, and prosecutors, and recognize the importance of the language used in creating a report.**
- » Medical examiners, in determining cause of death, “serve effectively as ultimate decision makers.”²⁷¹ Reports from medical examiners are often relied upon heavily by the triers of fact—judges and juries—in a criminal case.²⁷² The same is true for prosecutors, who often “work closely with death investigators and law enforcement to determine the cause of death and whether the state should seek charges.”²⁷³ The language used in a medical examiner’s report can have a profound effect on how triers of fact perceive and evaluate evidence,²⁷⁴ and how prosecutors shape the facts of the case.²⁷⁵ For example, the difference between labeling a condition as “associated with” versus “contributing to” versus “causing” a fetal death carries significant implications for a prospective criminal prosecution.
 - » Where the physical examination

Many historical methods deployed in the evaluation of still versus live birth, such as the lung flug test, are problematic as forensic indicators and should not be relied upon as a basis for concluding that a fetus was born alive or stillborn.

fails to provide a conclusive causal link between a condition and the fatal outcome, care should be taken to produce a report based on factual findings and evidence-based diagnosis with scientific foundation, and to refrain from drawing legal conclusions. Acknowledgment of diagnostic uncertainty is often the appropriate conclusion in cases of fetal death.

- » A practitioner’s “best medical opinion” in a case of fetal death should reflect the latest scientific research on the causal relationships in question and should be articulated with a heightened standard of care in line with medical and forensic ethical principles, in light of the possible legal repercussions for the bereaved mother. Critically, the absence of a conclusive causal link should be accompanied in a forensic pathologist’s report by an express acknowledgement of the diagnostic uncertainty. As noted in *Knight’s Forensic Pathology*: “Unless the pathologist has incontrovertible criteria of post-natal survival, e.g. well expanded lungs, food in the stomach, or vital reaction in the stump of the umbilical cord, [s]he is legally bound not to diagnose live birth.”²⁷⁶

4. Avoid using the “lung float test” and other similar tests, that have historically been used to determine whether a fetus was born alive, but that have been widely discredited by the scientific community.

- » Many historical methods deployed in the evaluation of still versus live birth are problematic as forensic indicators and should not be relied upon as a basis for concluding that a fetus was born alive or stillborn.²⁷⁷ For example, the “lung float test” has been widely criticized by both the legal and forensic scientific community, and should not be relied upon when making a determination as to whether a fetus

was born alive.²⁷⁸ It is undisputed that air can be introduced into the lung tissue as a result of postmortem changes entirely unrelated to taking in a breath.²⁷⁹ Nevertheless, prosecutors continue to rely on this test to prove that a fetus was born alive and to prosecute the mother on that basis.²⁸⁰ Given this, medical examiners should be extremely cautious in presenting any evidence of air in the lungs, as it may be misinterpreted by law enforcement, juries, and judges when investigating and making determinations in pregnancy-based criminal cases. If such evidence is presented, it should “include clear characterizations of the limitations of the analysis, including associated probabilities where possible.”²⁸¹

- » Microscopic examination of lung inflation to determine live birth versus stillbirth, while commonly deployed in forensic evaluation and relied upon by courts, is also problematic for similar reasons as articulated above with respect to the “lung float test.” For example, the lungs may be inflated due to a passive inrush of air during vaginal birth, rather than from breathing. Any analysis of lung inflation should be presented in concert with the numerous uncertainties inherent in using such a test.
- » Utilizing a fetus’s gestational age or weight at autopsy to offer an opinion regarding live birth versus stillbirth is also not valid. Stillbirth can come late in pregnancy, even at full term.²⁸² Seminal research in perinatal pathology has demonstrated that 28% of perinatal deaths occurred in fetuses who weighed more than 2500 grams and 30% were at a gestational age of more than 36 weeks which is nearly full-term.²⁸³

5. Understand the role that cognitive bias can play in determining a cause of death.

- » Medical examiners should take care to ensure that their findings are based on objective, scientific, or medical evidence—not additional information that they may learn in a particular case. In 2009, the National Research Council published a report on the influence of forensic science on the criminal justice system, which recognized that “forensic science experts are vulnerable to cognitive and contextual bias.”²⁸⁴ With regard to medical examiners, context bias refers to the risk that non-scientific contextual information about a case can impact a medical examiner’s findings.²⁸⁵
- » For example, in 2011, Hillary Tyler experienced a stillbirth in her hotel room.²⁸⁶ The medical examiner who performed an autopsy on the fetal remains could not conclusively determine the cause or manner of the death and listed both as “undetermined” in his initial report.²⁸⁷ The medical examiner was subsequently informed by detectives that Tyler had confessed the fetus was born alive and she had drowned it.²⁸⁸ This “confession” was obtained during an interrogation of Tyler before she had received any medical care—she was suffering from preeclampsia, had lost a large amount of blood, and required a blood transfusion and several medications.²⁸⁹ She later recanted her statements.²⁹⁰ Based on this information, however, the medical examiner concluded in his final report that the cause of death was “bathtub drowning” and the manner of death was “homicide.”²⁹¹ Tyler was convicted of second-degree murder.²⁹²
- » In most forensic disciplines, non-medical information gleaned from law enforcement investigators, witnesses, or through confessions

would be ruled entirely irrelevant. Death investigations, however, often necessitate consideration of a wide range of information. It is important that medical examiners understand that such information, even from their law enforcement colleagues, may not be reliable—investigators and witnesses can be wrong, confessions can be forced, and even physical evidence can be misinterpreted. As exemplified by Tyler’s case, it is critical that a medical examiner’s findings not be influenced by non-medical information that is not supported by medical evidence, or that has no bearing on the scientific findings.²⁹³ In particular, information from law enforcement can be “unreliable, difficult to ascertain, and conducive to conjecture” and therefore should not be relied upon when making scientific determinations.²⁹⁴

- » When background information is considered in a fetal death investigation, care should be taken to consider the full scope of the pregnant woman’s relevant history, particularly those characteristics associated with increased risk of stillbirth. The National Health Institute identifies a number of factors that increase stillbirth risk, spanning the spectrum of medical and non-medical maternal characteristics and reproductive history. Such factors include a pregnant woman’s age; socioeconomic status; prior instances of stillbirth; pregnancy with twins, triplets, or other multiples; use of assisted reproductive technology; being overweight or obese; being diabetic; and having high blood pressure before pregnancy, among other factors and pre-existing conditions.²⁹⁵ Additionally, a number of common infections have been associated with stillbirth, including influenza, chlamydia, herpes simplex, listeriosis, cytomegalovirus, Lyme disease, group B streptococcus, and *E. coli*, among others.²⁹⁶

Guidelines for Legislators and Policymakers

State legislators and policymakers hold direct authority over CPS agencies, law enforcement, and medical facilities, and therefore wield tremendous front-end power over key areas of intervention for pregnancy criminalization. Legislation used to criminalize pregnant women has taken the form of fetal personhood laws that redefine existing statutory codes to include fetuses as legal persons, feticide laws intended to protect women from violence caused by another, manslaughter and murder laws, mandated drug testing laws, mandated reporting laws, abortion bans, and child abuse or neglect statutes.²⁹⁷

Under these laws, women are exposed to civil and criminal liability for conditions and acts that are entirely legal for non-pregnant persons. Women are subjected to incarceration, CPS actions and termination of parental rights, forced medical interventions including drug testing and cesarean surgery, and the loss of autonomy over their own bodies and health care.

Proactive legislation and agency guidance is integral to protecting pregnant women and their families from inappropriate and harmful state or medical practitioner interventions. Legislators should oppose and repeal any statutes that subject pregnancy outcomes or prenatal conduct to law

enforcement or CPS scrutiny. Policymakers at state health and social services agencies should issue formal guidance and rules that constrain the authority of physicians and CPS workers to subject pregnant women to surveillance and control. Finally, legislators and policymakers alike should proactively push for codification and clarification of the rights of pregnant women and the limits of state or medical practitioner authority over them—especially where federal law remains silent. In passing legislation and issuing policies to protect the rights and health of pregnant women, legislators and agency policymakers should consider the following guidelines:

- 1. Oppose or repeal fetal personhood laws, feticide laws, and any other statutes that attach criminal liability to the conduct of pregnant women with respect to their own health, and pass laws that prohibit the detention of pregnant and postpartum women who are awaiting trial.**
 - » Health outcomes for newborns are not improved by incarcerating mothers,²⁹⁸ nor can the health of fetuses be separated from that of pregnant women who frequently do not receive adequate medical attention while incarcerated.²⁹⁹ Legislators should work to prohibit the criminalization of pregnancy outcomes, including abortion, stillbirth, and miscarriages, and create a private right of action allowing pregnant women to bring civil suits against those who violate their rights.³⁰⁰
 - » In particular, legislators should unequivocally oppose fetal personhood legislation. The treatment of fetuses of any gestational age as full legal persons essentially alters a state's entire body of criminal law, thereby creating unheard-of avenues for prosecuting pregnant women for acts well beyond the intended scope of such statutes.³⁰¹ Women suffering pregnancy loss have faced criminal charges under these statutes after experiencing physical trauma, including for being shot by someone else,³⁰² falling down stairs,³⁰³ getting into a car

accident,³⁰⁴ having a substance use disorder,³⁰⁵ and attempting suicide.³⁰⁶

- » Legislators should likewise oppose and repeal feticide statutes. Although these statutes were passed under the premise that they protect pregnant women from physical violence committed by others, feticide laws have been weaponized against pregnant women for any action or inaction that is perceived as creating a risk to fetal health. This is true even when statutes have explicitly excluded the actions of pregnant women in relation to their own pregnancies.³⁰⁷ Feticide statutes have the potential to expose women to criminal liability for even the most innocuous behavior, including medication use, exercise, diet, missing prenatal care appointments, or choosing not to follow a doctor's advice.
- » Even if a woman is not ultimately found guilty of the charges leveled against her, the time spent in jail awaiting trial can cause lasting harm to her and her family. Women who are incarcerated while awaiting resolution of their cases commonly accept guilty pleas just to get out of jail.³⁰⁸ Legislation should be passed to prohibit the detention of pregnant women or women with newborns under six months of age—at any stage of the criminal justice process prior to entry of judgment.

2. Limit unnecessary reporting of pregnancy outcomes and prenatal conduct to CPS and law enforcement.

- » Legislators should endeavor to disentangle the work of healthcare providers from law enforcement and family regulation systems. Healthcare providers play a significant role in the criminalization of pregnant women because they routinely engage in practices that expose pregnant and postpartum women to law enforcement and child welfare authorities. These practices include drug testing pregnant patients and infants without

consent, relaying sensitive medical information to CPS as evidence of abuse or neglect, physically detaining patients and newborns at hospitals to assist in the seizure of children,³⁰⁹ and wielding the threat of CPS reports and potential family separation as intimidation tools to impose medical procedures upon unwilling patients.³¹⁰

- » Legislators can reduce the involvement of healthcare professionals by limiting mandatory reporting obligations with respect to pregnant women. Legislators should ensure that mandatory reporting laws do not cover fetuses or the acts or omissions of pregnant people. Specifically, state statutes should not mandate reporting of drug tests administered on pregnant women and infants to law enforcement.³¹¹ Mandatory reporting of prenatal conduct backed by the threat of state action has significant negative effects on maternal and neonatal health.³¹² Medical groups such as the American College of Obstetricians and Gynecologists (“ACOG”),³¹³ American Medical Association (“AMA”),³¹⁴ and the National Perinatal Association³¹⁵ have denounced the reporting of prenatal conduct, in particular substance use, to law enforcement and CPS, and have warned that it discourages pregnant women from seeking timely medical treatment and being forthcoming with their physicians.³¹⁶ Such reporting erodes patient-provider confidentiality and renders pregnant women even more vulnerable to unnecessary and distressing intervention from the carceral and family regulation systems.³¹⁷
- » State agencies receiving federal funding under the Child Abuse Prevention and Treatment Act (“CAPTA”) and the Comprehensive Addiction and Recovery Act (“CARA”)³¹⁸ should clarify the scope and purpose of the notification requirements.³¹⁹ CAPTA/CARA requires

All patients

have a right to access or refuse any medical treatment without facing state scrutiny as to whether those decisions are in the best interest of another.

states, in order to receive federal child abuse prevention funds, to develop policies for the “notification” to child welfare agencies of infants who are (i) affected by substance abuse; (ii) affected by withdrawal symptoms resulting from prenatal substance exposure; or (iii) have Fetal Alcohol Spectrum Disorder. The purpose of this requirement is to provide support to infants and their parents, not to terminate parental rights or bring criminal charges. However, it has been conflated by medical professionals with a requirement of testing and referral for an abuse investigation.³²⁰ In reality, notification under CAPTA/CARA only requires de-identified, aggregate data about the number of children born who fall under the relevant categories and should be done in a way that does not make the family vulnerable to child welfare involvement.

- » Legislators can also take steps to ensure that CAPTA/CARA is not being used as a justification to over-report families to child welfare authorities. Legislators should ensure that their state statutes: (1) do not mandate the filing of abuse and neglect reports for the infants who are subject to CAPTA/CARA’s notification requirement; (2) clarify that the notification requirement does not apply to infants who are exposed to, but not affected by, prenatal substance use; (3) do not mandate reporting of positive toxicology to child welfare or law enforcement authorities; and (4) separate the process for receiving notifications under CAPTA/CARA from the process of reviewing and investigating reports of child abuse and neglect.³²¹
- » Legislators should also delegate the management of “plans of safe care” for substance-affected newborns under CAPTA/CARA to local community support organizations to further minimize the involvement of CPS.

State-arranged “plans of safe care” do not require CPS implementation or monitoring³²² and can instead be carried out through community organizations, family members, or other local support systems that are typically provided to new parents upon discharge from the hospital.³²³ This is an important step to prevent child welfare authorities from treating plans of safe care as mechanisms to investigate parental competence.

3. Treat family separation as a last resort for CPS and clarify that prenatal conduct does not serve as an indication of child abuse or neglect.

- » Child welfare laws can be essential points of intervention to protect pregnant women and their families from intrusive state intervention.³²⁴ Policymakers should restrict the use of family separation to only the most extreme circumstances or after exhaustion of all other remedies and support. Legislators should likewise work to repeal state laws that specifically allow or facilitate the termination of parental rights or the separation of families where a controlled substance is used during pregnancy.³²⁵ Despite the well-documented and devastating consequences of removal on families and children,³²⁶ including newborns, family separation continues as the default intervention deployed by CPS agencies in the United States. Such agencies spend more than three times as much money removing children from their parents’ care than they do supporting in-home preventive services.³²⁷
- » Agencies should set clear standards for what constitutes reasonable suspicion of child abuse or neglect. These standards should specify that fetuses are not “children” within the meaning

of such statutes and definitions of “abuse” or “neglect” do not encompass acts or omissions of pregnant women with respect to their own health, regardless of fetal benefit or harm. Additionally, agencies should: (1) issue guidance on the unreliability of positive toxicology reports³²⁸ and the myth and history surrounding “crack babies”;³²⁹ (2) mandate dismissal of child abuse or neglect reports that are based on pregnant women’s refusal to consent to drug testing; (3) clarify that substance use disorders can be sufficiently managed for healthy pregnancy outcomes;³³⁰ and (4) prohibit the separation of newborns from mothers on the basis of prenatal substance use.³³¹

4. Ban forced medical interventions against pregnant women and codify pregnant women’s rights to information about their medical care, including consent rights and the mandatory reporting obligations of healthcare providers.

- » All patients have a right to access or refuse any medical treatment without facing state scrutiny as to whether those decisions are in the best interest of another. For pregnant women, this right is severely undermined by state

Pregnant women are forced to face medical interventions that are unthinkable outside the context of pregnancy, and which have serious negative repercussions on women’s health and no discernable improvement on pregnancy outcomes.

intervention into their private medical choices based on a purported concern for fetal welfare. Pregnant women are forced to face medical interventions that are unthinkable outside the context of pregnancy, and which have serious negative repercussions on women’s health and no discernable improvement on pregnancy outcomes.³³²

- » No statute should force pregnant women into detention facilities for drug dependency treatment, and laws requiring drug testing on pregnant women or otherwise criminalizing prenatal substance use should be repealed.³³³ Substance use disorder is a health condition that requires treatment and can be managed during pregnancy. It should not be treated as a crime and does not require physical detention or punitive action, and it cannot be effectively managed in jail.³³⁴ Pregnant women with substance use disorders have been forced into involuntary detention and treatment programs³³⁵ and subjected to statute-mandated, nonconsensual drug testing where a healthcare professional suspected prenatal drug use.³³⁶
- » Another important point of legislative intervention is the issue of court-ordered cesarean surgeries and criminal investigations into patients who opt not to have one. No individual should be forced to undergo serious and invasive medical procedures, like surgery, or face being incarcerated. However, doctors have not only threatened to procure court orders forcing women to undergo cesarean surgery, but have actually succeeded in doing so.³³⁷ Pregnant women dealing with the heartbreak and trauma of pregnancy loss have faced homicide charges for refusing or delaying cesarean surgery.³³⁸ While some state appellate courts have ruled against lower court orders mandating cesarean surgeries,³³⁹ relying on court intervention does not offer the same protections as a statutory ban given the

Child welfare laws

*can be essential
points of intervention
to protect pregnant
women and their
families from intrusive
state intervention.*

protracted, emotional, and financially challenging nature of appealing such court orders. Furthermore, and most importantly, appeals are not likely to happen until after the woman has already suffered medical violence.³⁴⁰

- » Hospital policies allowing doctors to override a pregnant woman’s decision to refuse medical procedures should also be legislatively banned.³⁴¹ Policies like this have been unequivocally denounced by the AMA and ACOG, regardless of whether proceeding without patient consent would be beneficial to the fetus.³⁴² State health departments can also issue guidance and directives denouncing these policies as violations of patients’ rights. For example, in 2018, the New York State Department of Health denounced a hospital’s “Managing Maternal Refusals” policy as a violation of New York’s Patients’ Bill of Rights.³⁴³
- » Legislators should create or amend, as applicable, the State’s patient bill of rights to explicitly require the informed consent of pregnant women with respect to delivery room procedures, such as cesarean surgery,³⁴⁴ and in all instances of drug testing, including the testing of their newborns.³⁴⁵ These rights should also include the right to in-depth disclosures, both oral and written, of a hospital’s policies with respect to drug testing, mandatory reporting, and the procedures and protocols used by doctors for managing pregnancies and labor (which should be given well in advance of actual delivery).
- » Legislators can further protect pregnant women by imposing professional sanctions or malpractice liability on healthcare providers who fail to obtain informed consent, or who threaten pregnant women with CPS or law enforcement involvement if they do not submit to a medical procedure.

6. Resist efforts by other states to extend their own laws criminalizing pregnancy and pregnancy outcomes across state borders.

- » With the anticipated end of the constitutional right to abortion, certain states will work quickly and aggressively to expand the criminalization of pregnancy outcomes far beyond their own borders. For example, a bill has been introduced in Missouri to prevent pregnant women from seeking abortion care in neighboring states by creating a private right of action against anyone involved in facilitating this care.³⁴⁶ Legislators should actively resist efforts by other states to extend their own laws criminalizing pregnancy and pregnancy outcomes, including abortion, across state borders.
- » Laws governing extradition and cooperation with out-of-state law enforcement activities should be amended to bar the extradition of women who have sought reproductive healthcare legally administered in-state.³⁴⁷ To the extent possible, legislators should also direct their courts and public agencies not to issue summonses or expend resources in helping out-of-state law enforcement find and extract people from their state who are facing criminalization on the basis of pregnancy.³⁴⁸

Endnotes

I. Introduction

- 1 This document uses the phrase “pregnant women” throughout. However, we recognize that not all people who become pregnant are women, and that systems of oppression that seek to criminalize pregnancy are connected to those that also marginalize and target non-binary, trans, and gender non-conforming people.
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- 3 *Id.*
- 4 Lynn M. Paltrow & Jeanne Flavin, Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health, 38 J. HEALTH POLITICS, POL. & L. 299, 310, 311-13 (2013).
- 5 *Id.* at 310, 317-18.
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- 7 Paltrow, *supra* note 4 at 322-23.
- 8 *Shuai v. State*, 966 N.E.2d 619 (Ind. Ct. App. 2012).
- 9 MO. REV. STAT. § 1.205(4).
- 10 See Paltrow, *supra* note 4 at 309; National Advocates for Pregnant Women, Arrests of and Forced Interventions on Pregnant Women in Missouri (1991-2005), <https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2021/12/Missouri-Narratives.pdf> (providing case names and descriptions for the 29 arrests from 1991-2005 documented in the Paltrow article). From 2006-2020, NAPW has documented ten additional arrests based on pregnancy and perceived risks to the fetus. See *State v. Baker*, 618 S.W.3d 551 (Mo. Ct. App. 2020); *State v. Usnick*, 585 S.W.3d 298 (Mo. Ct. App. 2019); *State v. Hays*, No. 18LW-CR00898-02 (Mo. Cir. Ct. Stone Cnty. 2018); *State v. Head*, No. 18AM-CR00236 (Mo. Cir. Ct. Howell Cnty. 2018); *State v. Scroggs*, 521 S.W.3d 649 (Mo. Ct. App. 2017); *State v. Vaughn*, No. 12SN-CR01189 (Cir. Ct. Stone Cnty. 2012); *State v. Gruenewald*, No. 08SL-CR0087 (Mo. Cir. Ct. St. Louis Cnty. 2008); *State v. Decker*, No. 07BR-CR00030-01 (Cir. Ct. Barry Cnty. 2007); *State v. Lohnstein*, No. 0611-CR08757 (Mo. Cir. Ct. St. Charles Cnty. 2007); Mike Cullinan, Mother Sentenced to Five Years for Endangering Newborn, BOLIVAR HERALD-FREE PRESS (Oct. 13, 2006) (describing prosecution of Stacey Sturdevant for pregnancy and drug dependency).
- 11 *State v. Lewis*, No. 03CR113048 (Mo. Cir. Ct. Chariton Cnty. Dec. 13, 2004); see also *State v. Kloeva-Cook*, No. 05J5-CR00219 (Mo. Cir. Ct. Saline Cnty. Apr. 10, 2006) (involving a woman who drank tea made with mint and marijuana leaves to treat morning sickness).
- 12 *Missouri v. Lohnstein*, No. 0611-CR08757 (Mo. Cir. Ct. St. Charles Cnty. Oct. 17, 2007); *State v. Pinder*, (Mo. Cir Ct. Pulaski Cnty. 1991).
- 13 *Arms v. State*, 471 S.W.3d 637 (Ark. 2015).
- 14 See, e.g., *State v. Gilbreath*, No. CR-2017-1 (Cir. Ct. IZARD County Jan. 9, 2017); *State v. Norton*, No. CR-2016-40-4 (Cir. Ct. Fulton County July 28, 2016).
- 15 See *Becker v. Super. Ct. of Kings Cnty.*, No. F081341 (Cal. Ct. App. Aug. 7, 2020); *People v. Perez*, No. F077851 (Cal. Ct. App. Mar. 26, 2019).
- 16 CAL. PEN. CODE § 187(b).
- 17 See Kathi L.H. Harp & Amanda M Bunting, The Racialized Nature of Child Welfare Policies and the Social Control of Black Bodies, 27 SOCIAL POLITICS 258 (2020); Paltrow, *supra* note 4 at 333; Ira J. Chasnoff, et al., The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida, 322 N. ENGL. J. MED. 1202 (1990); see also DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 164-76 (2d ed. 2017).
- 18 See Margaret M. Thomas, et al., Inequities in Child Protective Services Contact Between Black and White Children, 1 CHILD MALTREATMENT 1, 2 (2022); Children’s Bureau, Child Welfare Practice to Address Racial Disproportionality and Disparity, U.S. Dep’t of Health and Human Services, Admin. for Children and Families, Children’s Bureau 3 (April 2021), https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf; Alan Ajan J. Dettlaff & Reiko Boyd, Racial disproportionality and disparities in the child welfare system: Why do they exist, and what can be done to address them?, 692 ANNALS AM. ACAD. 253, 253-54 (2020).
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- 25 See, e.g., Cecilia Nowell, *She Used Drugs While Pregnant. Should She Be in Prison? After having a stillbirth, Adora Perez was charged with murder*, The Cut (Sept. 20, 2021), available at <https://www.thecut.com/2021/09/feature-adora-perez-stillbirth-prison.html>.
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- 33 Amnesty International, *supra* note 31.
- 34 ALA. CODE § 26-15-3.2; ALA. CODE § 13A-5-6.
- 35 Amnesty International, *supra* note 31 at 37; Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, ProPublica (Sept. 23, 2015), <https://www.propublica.org/article/when-the-womb-is-a-crime-scene>.
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- 41 Boone *supra* note 20, at 487-89.
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- 45 McClung, *supra* note 24.
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55 *Id.* at 19, 22-23.

56 *Id.* at 31 n.85 (“A drug test is not a test for addiction and certainly not a parenting test.”).

57 *Id.* at 34.

58 U.S. Dep’t of Health & Human Servs., *HHS Announces a Standard Clinical Definition for Opioid Withdrawal in Infants* (Jan. 31, 2022), <https://www.hhs.gov/about/news/2022/01/31/hhs-announces-standard-clinical-definition-for-opioid-withdrawal-in-infants.html>; Shahla Jilani et al., *Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate*, *Journal of Pediatrics* (Dec. 20, 2021), [https://www.jpeds.com/article/S0022-3476\(21\)01227-0/fulltext#tbl3](https://www.jpeds.com/article/S0022-3476(21)01227-0/fulltext#tbl3).

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60 *See* GA. CODE 15-11-2(56) and 19-7-5(b)(4), (6) (6.1) (2020) (defining “child abuse,” *inter alia*, as “endangering a child” and defining “endangering a child” to include prenatal abuse by a parent).

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64 National Advocates for Pregnant Women, *Wisconsin’s “Unborn Children Protection Act” (Act 292)* (May 2022), <https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2022/05/Act-292-Fact-Sheet.docx.pdf>

65 Guttmacher Institute, *supra* note 59.

66 *See* MINN. STAT. § 253B.02(2) (2021) (defining chemically dependent persons as also meaning “a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following substances or their derivatives: opium, cocaine, heroin, phencyclidine, methamphetamine amphetamine, tetrahydrocannabinol, or alcohol); § 253B.09 (2021) (authorizing judicial commitment of chemically dependent persons).

67 Margaret Lloyd, et al., *The Policy to Practice Gap: Factors Associated with Practitioner Knowledge of CAPTA 2010 Mandates for Identifying and Intervening in Cases of Prenatal Alcohol and Drug Exposure*, 99 *J. CONTEMP. SOC. SERVS.* 232 (2018).

68 *Id.*

69 New York State, Department of Health, *NYS CAPTA CARA Information & Resources*, <https://health.ny.gov/prevention/captacara/index.htm> (last visited May 18, 2022) (“When there is reasonable cause, beyond substance use, to suspect a child is at risk of abuse or

neglect, hospitals and birth centers should continue to follow existing policies and protocols for making a report to the Statewide Central Register for Child Abuse and Maltreatment (SCR). Substance use alone, whether disclosed through development of a POSC, self-report, screening, toxicology, medical record note, or newborn symptoms, is not evidence of child abuse or neglect.”).

70 *Id.*

71 ACOG Opinion No. 473, *supra* note 52.

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80 *Id.*

81 Nina Martin, *How Some Alabama Hospitals Quietly Test New Mothers – Without Their Consent*, ProPublica (Sept. 30, 2015), <https://www.propublica.com>.

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org/article/how-some-alabama-hospitals-drug-test-new-mothers-without-their-consent/.

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83 *Id.*

84 *Id.*

85 *Id.*

86 *Id.*

87 See Harp, *supra* note 17 (stating that Black women are more likely than women of other races to be screened for drug use during pregnancy and to face legal consequences for prenatal drug use, including incarceration and loss of custody of their children).

88 Guttmacher Institute, *supra* note 59.

89 OKLA. STAT. 10A § 1-2-101.

90 See U.S. Dep’t of Justice, *Drugs, Crime, and the Justice System: A National Report from the Bureau of Justice Statistics* 119 (1992) (“A positive drug test cannot determine whether a person: occasionally uses a drug; has a substance use disorder; suffers any physical or emotional disability from that substance use disorder; or is more or less likely, if they are parents, to abuse or neglect their children.”); Susan Boyd, *Gendered drug policy: Motherisk and the regulation of mothering in Canada*, 68 INT’L J. DRUG POL’Y 109 (2019) (“Drug use in and of itself does not equal risk, nor is it the only factor that shapes family life — neoliberal social and economic policies also reproduce social inequality and other social ills (like drug laws, homelessness and inadequate wages and social benefits) that make parenting difficult for families.”).

91 See, e.g., MISS. CODE § 43-21-353 (requiring among others, physicians, nurses “or any other person having reasonable cause to suspect that a child is a neglected child or an abused child” to immediately report to the Department of Human Services); S. DAK. ANN. LAWS §26-8A-3 (applying a reasonableness standard when assessing a child who was prenatally exposed to “abusive use” of alcohol, marijuana, or any controlled drug or substance not lawfully prescribed by a practitioner); WISC. ANN. STAT. § 49.981 (applying a reasonableness standard to reporting abuse of fetuses).

92 See generally Movement for Family Power, *supra* note 54 (discussing the disproportionate surveillance of Black, American Indian, and Latinx women in the child welfare system).

93 Guttmacher Institute, *supra* note 59.

94 See MINN. STAT. § 626.5562 (stating that “a negative test result does not eliminate the obligation to report ... if other evidence gives the physician reason to believe the patient has used a controlled substance for a nonmedical purpose.”). In contrast, while Indiana law requires healthcare providers to ask all pregnant women questions about substance use, healthcare providers may not report the results of a positive screen to law enforcement or the Department of Child Services (“DCS”) unless they have the patient’s written consent or a court order, or see other signs of crime or child abuse. Indiana Dep’t of Health, *Substance Use and Pregnancy*, <https://www.in.gov/health/mch/substance-use-and-pregnancy/#:-:text=m%20taking%20drugs%3F-,A.,for%20complications%20from%20drug%20use> (last visited May 16, 2021).<https://>

www.revisor.mn.gov/statutes/2019/cite/626.5561

95 ACOG Policy Statement, *supra* note 75.

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105 *Id.*

106 Michelle Liu & Erica Hensley, *Delivering Justice: Why a Mississippi county is prosecuting some pregnant women and new moms*, Mississippi Today (May 11, 2019), <https://mississippitoday.org/2019/05/11/delivering-justice/>.

107 See *id.*; Eddie Robertson, *Sheriff: Jones County mother used cocaine while pregnant*, WDAM7 (Jan. 13, 2017), <https://www.wdam.com/story/34256357/sheriff-jones-county-mother-used-cocaine-while-pregnant/>.

108 *Id.*

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110 *Id.*

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112 Angela J. Davis, *The Prosecutor’s Ethical Duty to End Mass Incarceration*, 44 HOFSTRA L. REV. 1063, 1076, 1079 (2016); see also ABA Standards, *supra* note 111 at 3-1.2(b) (“The primary duty of the prosecutor is to seek justice within the bounds of the law, not merely to convict.”).

113 See Association of Prosecuting Attorneys, *Press Release: Association of Prosecuting Attorneys and Addressing Disparities to Reproductive Health Advisory Committee* (May 5, 2022), <https://www.apainc.org/press-release-association-of-prosecuting-attorneys-and-addressing-disparities-to-reproductive-health-advisory-committee-releases-statement-on-the-criminalization-of-abortion/>; ABA, *Resolution 107A* (Feb. 22, 2021), <https://www.americanbar.org/content/dam/aba/directories/policy/midyear-2021/107a-midyear-2021.pdf> (“Enforcement of laws that criminalize healthcare decisions . . . impose untenable choices on victims and healthcare providers, and erode trust in the integrity of our justice system.”); Fair and Just Prosecution, *Joint Statement from Elected Prosecutors* (June 2019), available at <https://www.fairandjustprosecution.org/staging/wp-content/uploads/2019/06/Joint-Statement-from-Elected-Prosecutors-on-Abortion-Laws-FINAL.pdf> (“In our view, resources are better utilized to prevent and address serious crimes that impact our community rather than enforcing laws such as these that divide our community, create untenable choices for women and healthcare providers, and erode trust in the justice system.”); Jason Williams, *Our System Criminalizes Black Pregnancy. As a District Attorney, I Refuse to Prosecute These Cases*, Time Magazine (May 12, 2021), <https://time.com/6049587/pregnancy-criminalization/> (“When people of color and people with low income are denied access to basic forms of health care, including prenatal and maternal care, as a consequence of prejudice, and when they’re arrested, charged and prosecuted for decisions that were made before, during or after pregnancy, it extends injustice in waves that have a ripple effect throughout families, neighborhoods and communities.”).

114 U.S. Dep’t of Justice, Drugs, Crime, and the Justice System: A National Report from the Bureau of Justice Statistics 119 (1992); see also Susan Boyd, Gendered drug policy: Motherisk and the regulation of mothering in Canada, 68 INT’L J. DRUG POL’Y 109 (2019) (“Drug use in and of itself does not equal risk, nor is it the only factor that shapes family life — neoliberal social and economic policies also reproduce social inequality and other social ills (like drug laws, homelessness and inadequate wages and social benefits) that make parenting difficult for families.”).

115 Laura Radel, et. al., *Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study*, U.S. Dep’t of Health & Human Servs. (Mar. 7, 2018), <https://aspe.hhs.gov/sites/default/files/private/pdf/258836/SubstanceUseChildWelfareOverview.pdf>.

116 See American Medical Association, Policy Statement H-420.970, Treatment Versus Criminalization – Physician Role in Drug Addiction During Pregnancy (2020), <https://policysearch.ama-assn.org/policyfinder/detail/addiction%20pregnancy?uri=%2FAMADoc%2FHOD.xml-0-3713.xml>; Nora D. Volkow, *How Science Has Revolutionized the Understanding of Drug Addiction*, Nat’l Instit. on Drug

Abuse (July 2020), <https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/preface>; ACOG Opinion No. 473, *supra* note 52; American Society of Addiction Medicine, *Public Policy Statement: Definition of Addiction* (Aug. 15, 2011), https://www.asam.org/docs/default-source/public-policy-statements/1definition_of_addiction_long_4-11.pdf?sfvrsn=a8f64512.

117 See Pew Trusts, *More Imprisonment Does Not Reduce State Drug Problems* (Mar. 8, 2018), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2018/03/more-imprisonment-does-not-reduce-state-drug-problems>; National Perinatal Association, Position Statement, Perinatal Substance Use (2017), https://www.nationalperinatal.org/_files/ugd/209d80_6c125977cd764f67933962492fd13b97.pdf [hereinafter “NPA Substance Use”]; Human Rights Watch, *Every 25 Seconds: The Human Toll of Criminalizing Drug Use in the United States* (Oct. 2016), https://www.hrw.org/sites/default/files/report_pdf/usdrug1016_web_o.pdf; National Center on Addiction and Substance Abuse at Columbia Univ., *Behind Bars II: Substance Abuse and America’s Prison Population* (Feb. 2010), https://www.prisonlegalnews.org/media/publications/natl_center_on_addiction_prisoner_substance_abuse_report_2010.pdf.

118 ACOG Policy Statement *supra* note 75; American Psychological Association, Pregnant and Postpartum Adolescent Girls and Women with Substance-Related Disorders (2020), <https://www.apa.org/pi/women/resources/pregnancy-substance-disorders.pdf>; American Academy of Family Physicians, Policy, *Substance Abuse and Addiction* (2019), <https://www.aafp.org/about/policies/all/substance-use-disorders.html>; American Psychiatric Association, Position Statement, *Position Statement on Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders* (2019), <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Assuring-Appropriate-Care-of-Pregnant-and-Newly-Delivered-Women-with-SUDs.pdf>; American College of Nurse-Midwives, Position Statement, Substance Use Disorders in Pregnancy (2018), <http://www.midwife.org/acnm/files/acnmldata/uploadfilename/00000000052/PS-Substance-Use-Disorders-in-Pregnancy-FINAL-20-Nov-18.pdf>; NPA Substance Use, *supra* note 117; American Society of Addiction Medicine, Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids (2017), https://www.asam.org/docs/default-source/public-policy-statements/substance-use-misuse-and-use-disorders-during-and-following-pregnancy.pdf?sfvrsn=644978c2_4; American Nurses Association, Position Statement, Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders (2017), <https://www.nursingworld.org/-4af078/globalassets/docs/ana/ethics/nonpunivetreatment-pregnantbreastfeedingwomen-sud.pdf>; American Academy of Pediatrics, Comm. on Substance Use and Prevention, Policy Statement, A Public Health Response to Opioid Use in Pregnancy (2017), <https://publications.aap.org/pediatrics/article/139/3/e20164070/53768/A-Public-Health-Response-to-Opioid-Use-in>; Association of Women’s Health, Obstetric and Neonatal Nurses, Criminalization of Pregnant Women with Substance Use Disorders (2015), [https://www.jognn.org/article/So884-2175\(15\)31770-6/fulltext](https://www.jognn.org/article/So884-2175(15)31770-6/fulltext); National Organization on Fetal Alcohol Syndrome, Position Statement, NOFAS Opposes Criminalizing Alcohol Use by Pregnant Women (2014)

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[hereinafter “NOFAS Position Statement”].

119 See ACOG Policy Statement, *supra* note 75; NPA Substance Use, *supra* note 117; Rebecca L. Haffajee et al., *Pregnant Women with Substance Use Disorders—The Harm Associated with Punitive Approaches*, 384 N. ENGL. J. MED. 2364 (2021); Boone *supra* note 20; Laura J. Faherty et al., *Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome*, JAMA (2019), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2755304>; Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. DRUG ISSUES 285 (2003) (finding that women identified fear of punitive actions from helping institutions and individuals as a major barrier to prenatal care); American Medical Association, Board of Trustees, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2667 (1990).

Frankie Kropp, et al., *Increasing Prenatal Care and Healthy Behaviors in Pregnant Substance Users*, 42 J. PSYCHOACTIVE DRUGS 73 (2010).

120 *Id.*

121 See ACOG Policy Statement, *supra* note 75; American College of Obstetricians & Gynecologists, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2021); NOFAS Position Statement, *supra* note 118; NPA Substance Use, *supra* note 117.

122 National Perinatal Association, *Position Statement, Perinatal Health Care Access and Disparities* (2019).

123 ABA, *supra* note 113.

124 See Ira J. Chasnoff, et. al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 N. ENGL. J. MED. 1202 (Apr. 26, 1990); Movement for Family Power, “Whatever They Do, I’m Her Comfort, I’m Her Protector.”: How the Foster System Has Become Ground Zero for the U.S. Drug War 19 (June 2020).

125 Chasnoff, *supra* note 124.

126 Carla Dugas & Valori Slane, *Miscarriage*, StatPearls (June 29, 2021), <https://www.ncbi.nlm.nih.gov/books/NBK532992/>.

127 *Id.*

128 March of Dimes, *Miscarriage*, <https://www.marchofdimes.org/complications/miscarriage.aspx> (Nov. 2017); see also American College of Obstetricians and Gynecologists, *Early Pregnancy Loss*, <https://www.acog.org/womens-health/faqs/early-pregnancy-loss> (Jan. 2022).

129 American College of Obstetricians and Gynecologists, *Obstetric Care Consensus, Management of Stillbirth* (2021), <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2020/03/management-of-stillbirth>.

130 J. Man et al., *Stillbirth and intrauterine fetal death: factors affecting determination of cause of death at autopsy*, 48 ULTRASOUND OBSTET. GYNEC. 566 (Oct. 25, 2016).

131 Corrie B. Miller & Tricia Wright, *Investigating Mechanisms of Stillbirth in Setting of Prenatal Substance Use*, 8 ACAD. FORENSIC PATHOL. 865 (2018).

132 *Id.*

133 See David Peleg, et al., *Intrauterine Growth Restriction: Identification and Management*, 58 AM. FAM. PHYSICIAN 453 (1998) (discussing that most infants who experience growth restriction in utero have normal rates of growth in infancy and childhood, and that management through prenatal and neonatal care is likely to produce the healthiest outcomes).

134 American College of Obstetricians and Gynecologists, *Comm. Opinion No. 711, Opioid Use and Opioid Use Disorder in Pregnancy* (2021), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy> [hereinafter “ACOG Opinion No. 711”]; Mark M. Maslovich & Lori M. Burke, *Intrauterine Fetal Demise*, StatPearls (Nov. 5, 2021), <https://www.ncbi.nlm.nih.gov/books/NBK532992/>.

135 Rachel Levinson-Castiel, et al., *Neonatal abstinence syndrome after in utero exposure to selective serotonin reuptake inhibitors in term infants*, 160 JAMA PEDIATRICS 173 (2006); Tim F. Oberlander, et al., *Pharmacologic factors associated with transient neonatal symptoms following prenatal psychotropic medication exposure*, 65 J. CLIN. PSYCHIATRY 230 (2004); Kari Laine, et al., *Effects of exposure to selective serotonin reuptake inhibitors during pregnancy on serotonergic symptoms in newborns and cord blood monoamine and prolactin concentrations*, 60 JAMA PSYCHIATRY 720 (2003).

136 Kayla N. Anderson, et. al, *Maternal Use of Scientific Antidepressant Medications During Early Pregnancy and the Risk of Selected Birth Defects*, 77 JAMA PSYCHIATRY 1246 (2020).

137 See, e.g., Hallam Hurt & Michel Martin, *Decades Later, Drugs Didn’t Hold ‘Crack Babies’ Back*, NPR (July 31, 2013), <https://www.npr.org/templates/story/story.php?storyId=207292639> (“We evaluated our participants every 6 to 12 months, when they were young infants and children. What we found was that the cocaine exposed and the non-exposed didn’t differ from each other . . .” (citing Laura M. Betancourt, et al., *Adolescents with and without Gestational Cocaine Exposure: Longitudinal Analysis of Inhibitory Control, Memory and Receptive Language*, 33 NEUROTOXICOL. TERATOL. 36 (2011)); Hallam Hurt & Laura M. Betancourt, *Effect of Socioeconomic Status Disparity on Child Language and Neural Outcome: How Early is Early?*, 79 PEDIATRIC RESEARCH 148 (2016) (“Potentially malleable environmental factors (parenting and home environment) were more influential on [Full Scale IQ] than gestational exposure to cocaine in these ‘inner-city achievers.’”); see also Tanya Maria Golash-Boza, *RACE & RACISMS* 333-34, 337 (Oxford U. Press 2015) (disparate birth outcomes for Black women are attributable to racial residential segregation, environmental health, and weathering on the body due to constant exposure to discrimination and inequities in healthcare access and treatment.).

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138 U.S. Dep’t of Justice, *supra* note 114; *see also* Susan Boyd, *Gendered drug policy*, 68 INT’L J. OF DRUG POLICY 109 (2019) (“Drug use in and of itself does not equal risk”); Mishka Terplan, Panel Presentation, *Pregnancy, Substance Use & the Child Welfare System*, Spring 2019 ABA Nat’l Conference on Parent Representation (April 12, 2019) (“[T]here’s nothing in a urine drug test that tells you anything about behavior . . . It’s not a motherhood test.”); Substance Abuse and Mental Health Services Admin. Center For Substance Abuse Treatment, *Drug Testing in Child Welfare: Practice and Policy Considerations*, U.S. Dep’t of Health and Human Serv. 1 (2010) (“A drug test alone cannot determine the existence or absence of a substance use disorder.”).

139 U.S. Dep’t of Health & Human Servs., *HHS Announces a Standard Clinical Definition for Opioid Withdrawal in Infants* (Jan. 31, 2022), <https://www.hhs.gov/about/news/2022/01/31/hhs-announces-standard-clinical-definition-for-opioid-withdrawal-in-infants.html>; Shahla M. Jilani et al., *Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate*, 243 J. PEDIATRICS 33 (Dec. 20, 2021).

140 Joukje Swinkels, et al., *Explaining the Gender Gap in the Caregiving Burden of Partner Caregivers*, 74 J. GERONTOLOGY 309, 313 (2019).

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142 Rebecca J. Shlafer, et. al., *Reproductive Justice for Incarcerated Mothers and Advocacy for their*

Infants and Young Children, 40 INFANT MENT. HEALTH J. 725, 733-34 (2019); *see* Human Rights Watch, “You Miss So Much When You’re Gone”: The Lasting Harm of Jailing Mothers Before Trial in Oklahoma (Sept. 26, 2018), available at <https://www.hrw.org/report/2018/09/26/you-miss-so-much-when-youre-gone/lasting-harm-jailing-mothers-trial-oklahoma%23>.

143 Shlafer, *supra* note 142 at 728.

144 Vanessa Vecchiarello, Comment, *The Criminalization of Pregnancy and its Effects on Maternal Health: Understanding State Interventions*, 47 FORDHAM URB. L.J. 1051, 1078 (2020).

145 Michael Massoglia, *Incarceration, Health, and Racial Disparities in Health*, 42 LAW & SOC’Y REV. 275, 278 (2008).

146 *Id.*

147 *Id.* at 279.

148 Artika R. Tyner, *The Racial Wealth Gap: Strategies for Addressing the Financial Impact of Mass Incarceration on the African American Community*, 28 GEO. MASON L. REV. 885, 887 (2021).

149 ABA Standards, *supra* note 111 at 3-1.2(e).

150 *Id.* at 3-4.4.

151 *See also* Fair and Just Prosecution, *supra* note 113.

152 Rob Bonta, Letter to Fellow Attorney Generals, Office of the Attorney General at 2 (Apr. 27, 2022).

153 *Id.*

154 *Id.*

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155 NAPW Webinar, *Defending Women Charged with Crimes in Relationship to Pregnancy*, YOUTUBE (Apr. 6, 2020), <https://www.youtube.com/watch?v=2rUia9P3Xro> [hereinafter “Defending Women Webinar”].

156 National Advocates for Pregnant Women, *Anna Yocca in TN Pleads Guilty Despite Unconstitutionality of the Charge* (Jan. 10, 2017), <https://www.nationaladvocatesforpregnantwomen.org/anna-yocca-in-tn-pleads-guilty-despite-unconstitutionality-of-the-charge/>.

157 See, e.g., If/When/How: Lawyering for Reproductive Justice’s Repro Legal Defense Fund, https://reprolegaldefensefund.org/get-help/#non-attorney_app.

158 Approximately 26% of all pregnancies end in miscarriage. Carla Dugas & Valori H. Slane, *Miscarriage*, StatPearls Publishing (Jan. 29, 2021), <https://www.ncbi.nlm.nih.gov/books/NBK532992/>.

159 See Rebecca Stone, *Pregnant women and substance use: fear, stigma, and barriers to care*, 3 HEALTH & JUST. 2 (2015), <https://healthandjusticejournal.biomedcentral.com/track/pdf/10.1186/s40352-015-0015-5.pdf>; Nina Martin, *A Stillborn Child, A Charge of Murder and the Disputed Case Law on ‘Fetal Harm’*, ProPublica (Mar. 18, 2014), <https://www.propublica.org/article/stillborn-child-charge-of-murder-and-disputed-case-law-on-fetal-harm>.

160 DeNeen L. Brown, *Va. prosecutors dismiss case against woman accused of “self-aborting”*, Washington Post (Oct. 5, 2018), https://www.washingtonpost.com/local/va-prosecutors-dismiss-case-against-woman-accused-of-self-aborting/2018/10/05/267c6cc4-c8e2-11e8-b2b5-79270f9cce17_story.html.

161 Defense attorneys can challenge the prosecution’s scientific testimony by filing Daubert motions, and can seek to remove irrelevant, unreliable, or prejudicial evidence by filing motions in limine. See also NAT’L RESEARCH COUNCIL, STRENGTHENING FORENSIC SCIENCE IN THE UNITED STATES: A PATH FORWARD 9 (Nat’l Acad. Press 2009), <https://www.ncjrs.gov/pdffiles1/nij/grants/228091.pdf> (“Two very important questions should underlie the law’s admission of and reliance upon forensic evidence in criminal trials: (1) the extent to which a particular forensic discipline is founded on a reliable scientific methodology that gives it the capacity to accurately analyze evidence and report findings and (2) the extent to which practitioners in a particular forensic discipline rely on human interpretation that could be tainted by error, the threat of bias, or the absence of sound operational procedures and robust performance standards.”).

162 See Lynn Paltrow & Kathrine Jack, *Pregnant Women, Junk Science, and Zealous Defense*, THE CHAMPION 30, 35 (May 2010), available at <https://www.hivlawandpolicy.org/sites/default/files/Pregnant%20women%20junk%20science%20and%20zealous%20defense.pdf> (discussing *In re Unborn Child of Starks*, 18 P.3d 342 (Okla. 2001), where a law enforcement officer was allowed to give opinions on medical and scientific facts, as well as testify that he would not approve of his pregnant wife being in a methamphetamine lab as evidence that the defendant’s presence at a methamphetamine lab was dangerous to her fetus).

163 See *id.* at 32 (discussing *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993), where the

court held a doctor’s testimony that a drug caused birth defects in certain children was inadmissible because the doctor failed to explain how he was able to eliminate all other potential causes of the birth defects, nor did he explain how he could state as a fact that the drug caused the birth defects).

164 NAPW, *Victory for Latice Fisher in Mississippi* (Sept. 24, 2020), <https://www.nationaladvocatesforpregnantwomen.org/victory-for-latrice-fisher-in-mississippi/>; see also Aziza Ahmed, *Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions*, 100 B.U. L. REV. 1111 (2020) (discussing that the “lung float test” has been widely criticized by both the legal and forensic scientific community, and should not be relied upon when making a determination as to whether a fetus was born alive); Letter from Gregory J. Davis, et al. to Hon. Judge Timothy McCrone (Feb. 24, 2020) (on file with National Advocates for Pregnant Women) (a letter from over 45 forensic pathologists stating that the lung float test “is not a scientifically reliable test or indicator of live birth”).

165 NAPW, *supra* note 164.

166 NAPW, *State v. Regina McKnight Background*, (Mar. 9, 2006), <https://www.nationaladvocatesforpregnantwomen.org/state-v-regina-mcknight-background/> (“The state’s case really rested on the claim that since they could not identify the cause of the stillbirth . . . it must have been cocaine. They made this diagnosis by exclusion without having done the tests and examinations that could have ruled out many more likely causes.”).

167 *McKnight v. State*, 661 S.E.2d 354, 358 n.2 (S.C. 2008).

168 See Krista Stone-Manista, *Protecting Pregnant Women: A Guide to Successfully Challenging Criminal Child Abuse Prosecutions of Pregnant Drug Addicts*, 99 J. CRIM. L. & CRIMINOLOGY 823, 831 (2009) (discussing *State v. Martinez*, 137 P.3d 1195 (N.M. Ct. App. 2006), where the court “held that the state’s child abuse law did not authorize a criminal child abuse prosecution of a woman who had used cocaine during her pregnancy”).

169 *Becker v. Super. Ct. of Kings Cnty.*, No. F081341 at 10 (Cal. Ct. App. Aug. 7, 2020). For more information on Chelsea Becker, who was charged for murder after she delivered a stillborn, see Azi Paybarah, *Judge Dismisses Murder Charge Against California Mother After Stillbirth*, N.Y. Times (May. 20, 2021), <https://www.nytimes.com/2021/05/20/us/chelsea-becker-stillbirth-murder-charges-california.html>.

170 “The majority of state appellate courts, when confronted with a prosecution of a pregnant woman under a state child abuse or endangerment statute, have chosen to treat the analysis as an exercise in statutory interpretation. And in almost every case, that exercise has ended with the conclusion that the state statute at hand was not intended by the given state legislature to cover, and cannot be read to cover, prenatal conduct of a pregnant woman affecting only her fetus.” Stone-Manista, *supra* note 168 at 838; see *N.J. Div. of Youth & Family Serv. v. LV*, 889 A.2d 1153, 1158 (N.J. Super. Ct. Ch. Div. 2005) (holding “that a woman who had refused to take certain HIV medications during her pregnancy had not committed child abuse because, inter alia, the relevant statute ‘does not and cannot be construed to permit government interference with a woman’s protected right to control her body and her future during her pregnancy’”).

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171 See, e.g., Frank James, *Mississippi Voters Reject Personhood Amendment By Wide Margin*, NPR (Nov. 8, 2011), <https://www.npr.org/sections/itsallpolitics/2011/11/08/142159280/mississippi-voters-reject-personhood-amendment>.

172 Vanessa Vecchiarello, Comment, *The Criminalization of Pregnancy and its Effects on Maternal Health: Understanding State Interventions*, 47 Fordham URB. L. J. 1051, 1068 (2020).

173 See *State v. Flinchbaugh*, 232 Kan. 831 (1983). Arizona, Delaware, and Ohio are three states that explicitly criminalize drug use. See ARIZ. REV. STAT. ANN. § 13-3408(A)(1); DEL. CODE ANN. tit.16 § 4763; OHIO REV. CODE ANN. § 2925.11.

174 Birth Rights Bar Association and NAPW, *BIRTH RIGHTS 18* (2020), available at <https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2020/05/BIRTH-RIGHTS-A-resource-for-everyday-people-to-defend-human-rights-during-labor-and-birth.pdf> [hereinafter “Birth Rights”].

175 See *Ferguson v. City of Charleston*, 532 U.S. 67 (2001); Birth Rights, *supra* note 174 at 29.

176 Defending Women Webinar, *supra* note 155.

177 May Crossley, *Reproducing Dignity: Race, Disability, and Reproductive Controls*, 54 U.C. DAVIS L. REV. 195, 198-203 (2020). https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2021/09/20210920133356568_19-1392-Amici-Brief.pdf

178 P.R. Lockhart, *The Alabama woman indicted after a miscarriage will not be prosecuted*, Vox (Jul. 3, 2019), <https://www.vox.com/identities/2019/7/3/20681511/marshae-jones-alabama-miscarriage-shooting-charges-dismissed>.

179 National Advocates for Pregnant Women, *IN: Purvi Patel* (Oct. 30, 2015), https://www.nationaladvocatesforpregnantwomen.org/in_state_of_indiana_v_purvi_patel/.

180 Defending Women Webinar, *supra* note 155.

181 *Id.*

182 See American College of Obstetricians and Gynecologists, *Amicus Briefs*, <https://www.acog.org/advocacy/in-the-courts/amicus-briefs> (last visited May 18, 2022); see also American College of Obstetricians and Gynecologists, *Statement of Policy: Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period* (2020) <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period>.

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183 See Harp, *supra* note 17; Hyunil Kim, et al., Lifetime Prevalence of Investigating Child Maltreatment Among US Children, 107 AM. PUB. HEALTH ASSOC. 274 (2017); see also NAPW, Testimony of National Advocate for Pregnant Women to the Senate Judiciary Committee of the Ohio Senate in Opposition to SB.216 (Feb. 10, 2022), <https://www.nationaladvocatesforpregnantwomen.org/testimony-of-national-advocates-for-pregnant-women-to-the-senate-judiciary-committee-of-the-ohio-senate-in-opposition-to-sb-216/>.

184 See Movement for Family Power, “Whatever They Do, I’m Her Comfort, I’m Her Protector.”: How the Foster System Has Become Ground Zero for the U.S. Drug War 19 (June 2020); Sara Goydarzi, Separating Families May Cause Lifelong Health Damage, Scientific American (June 2018), <https://www.scientificamerican.com/article/separating-families-may-cause-lifelong-health-damage/> (noting that “[t]he younger you are when you’re exposed to stress . . . , the more likely you will have negative health outcomes caused by dysregulation of stress response.”); see also Joseph J. Doyle, Jr., Child Protection and Child Outcomes: Measuring the Effects of Foster Care, 97 AM. ECON. REV. 1583 (2007) (finding higher delinquency rates, higher teen birth rates, and lower earnings among children removed to foster care as compared to similarly situated children who remained at home).

185 *Id.*

186 U.S. Dep’t of Health & Human Servs., *HHS Announces a Standard Clinical Definition for Opioid Withdrawal in Infants* (Jan. 31, 2022), <https://www.hhs.gov/about/news/2022/01/31/hhs-announces-standard-clinical-definition-for-opioid-withdrawal-in-infants.html> [hereinafter “HHS Standard”]; Shahla Jilani, et al., *Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate*, 243 J. PEDIATRICS 33 (Dec. 20, 2021), [https://www.jpeds.com/article/S0022-3476\(21\)01227-0/fulltext#tbl3](https://www.jpeds.com/article/S0022-3476(21)01227-0/fulltext#tbl3); Kathryn Dee L. MacMillan, et al., *Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome, A Systematic Review and Meta-analysis*, 172 JAMA PEDIATR. 345 (2018); Matthew R. Grossman, et al., *An Initiative to Improve the Quality of Care of Infants with Neonatal Abstinence Syndrome*, PEDIATRICS (2017); Ronald R. Abrahams, et al., *Rooming-in compared with standard care for newborns of mothers using methadone or heroin*, 53 CAN. FAM. PHYSICIAN 1722 (2007).

187 See NYS CAPTA CARA *Information & Resources*, <https://health.ny.gov/prevention/captacara/index.htm> (last visited May 16, 2021); see also American College of Obstetricians and Gynecologists, *Substance Use Disorder in Pregnancy*, <https://www.acog.org/advocacy/policy-priorities/substance-use-disorder-in-pregnancy#:~:text=Routine%20urine%20drug%20screening%20is,Factor%20in%20determining%20family%20separation.> [hereinafter “ACOG Substance Use”].

188 ACOG Substance Use, *supra* note 187.

189 MINN. STAT. 260E.32 (2021).

190 See Sanford Policy Bemidji Medical Center, *Suspected Drug Abuse During Pregnancy*, available at https://www.mnhospitals.org/Portals/0/Documents/patientsafety/NAS/Sanford_SubstanceAbusePolicy.pdf (last visited Apr. 28, 2022).

191 See Max Jordan Nguemeni Tiako, et al., The

Government’s Involvement in Prenatal Drug Testing May be Toxic, 26 MATERNAL CHILD HEALTH J. 761 (2022).

192 See Guttmacher Institute, *supra* note 59. For example, “24 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes” and “25 states including the District of Columbia require health care professionals to report suspected prenatal drug use, and 8 states [including Kentucky, Minnesota and Rhode Island] require them to test for prenatal drug exposure if they suspect drug use.”). *Id.* See also National Advocates for Pregnant Women, *Understanding CAPTA and State Obligations* (Oct. 2020), <https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2020/11/2020-revision-CAPTA-requirements-for-states-10-29-20-1-1.pdf>.

193 Margaret H. Lloyd, et al., The Policy to Practice Gap: Factors Associated with Practitioner Knowledge of CAPTA 2010 Mandates for Identifying and Intervening in Cases of Prenatal Alcohol and Drug Exposure, 99 J. CONTEMP. SOC. SERVS., 23 (2018).

194 *Id.*

195 See, e.g., Dep’t of Health and Mental Hygiene and NYC Admin. for Children’s Services, *Reporting and Planning Requirements for Newborns Prenatally Exposed to Substances and Their Caregivers* 1 (Nov. 12, 2020) (“A positive toxicology result for a parent or a newborn, by itself, does not constitute reasonable suspicion of child abuse or maltreatment, and thus does not necessitate a report to the [Statewide Central Register for Child Abuse and Maltreatment].”).

196 Substance Abuse & Mental Health Servs. Admin., *Clinical Drug Testing in Primary Care* 9 (2012), <https://store.samhsa.gov/system/files/sma12-4668.pdf>.

197 U.S. Dep’t of Justice, Drugs, Crime, and the Justice System: A National Report from the Bureau of Justice Statistics 119 (1992); see also Susan Boyd, Gendered drug policy: Mother risk and the regulation of mothering in Canada, 68 INT’L J. DRUG POL’Y 109 (2019) (“Drug use in and of itself does not equal risk, nor is it the only factor that shapes family life — neoliberal social and economic policies also reproduce social inequality and other social ills (like drug laws, homelessness and inadequate wages and social benefits) that make parenting difficult for families.”).

198 American Psychological Association, *Pregnant and Postpartum Adolescent Girls and Women with Substance-Related Disorders* (Mar. 2020), <https://www.apa.org/pi/women/resources/pregnancy-substance-disorders.pdf>.

199 American College of Obstetricians and Gynecologists, *Position Statement, Opposition to Criminalization of Individuals During Pregnancy and Postpartum Period*, [https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period#:~:text=ACOG%20believes%20that%20it%20is,the%20postpartum%20period%20\(11\).](https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period#:~:text=ACOG%20believes%20that%20it%20is,the%20postpartum%20period%20(11).); see also American College of Obstetricians and Gynecologists, Comm. Opinion No. 473, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (Jan. 2011, reaffirmed 2014) (“Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody

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of her children, or loss of housing The use of the legal system to address perinatal alcohol and substance abuse is inappropriate In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions.”).

200 See CDC, *Treatment for Opioid Use Disorder Before, During, and After Pregnancy*, <https://www.cdc.gov/pregnancy/opioids/treatment.html>.

201 ACOG Substance Use, *supra* note 187.

202 See National Center on Substance Abuse and Child Welfare, *Drug Testing for Parents Involved in Child Welfare: Three Key Practice Points*, available at <https://ncsacw.acf.hhs.gov/files/drug-testing-brief-2-508.pdf> (last visited May 16, 2022).

203 New York State Office of Children and Family Services, *Child Protective Services Manual* 255-56 (2019).

204 See HHS Standard, *supra* note 186; Jilani *supra* note 186.

205 Nineteen states have either created or funded drug treatment programs specifically targeted to pregnant women, and seventeen states and the District of Columbia provide pregnant women with priority access to state-funded drug treatment programs. See Gutmacher Institute, *supra* note 59.

206 See Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, HEALTH & JUSTICE (2015), <https://healthandjusticejournal.biomedcentral.com/track/pdf/10.1186/s40352-015-0015-5.pdf> (“[I]n Tennessee, women charged with substance use during pregnancy may be allowed to use evidence of finding and attending treatment as an affirmative defense. However, pregnant women seeking substance use treatment may find that there are no suitable treatment programs available. . . . Journalists from “America Tonight” contacted every treatment program listed on the Tennessee Department of Health and Human Services website that claimed to treat pregnant women and found five clinics that would allow pregnant women to enroll in their program and accepted Medicaid. Two of the programs were full, leaving fewer than 50 beds available.”).

207 Sara Goydarzi, *Separating Families May Cause Lifelong Health Damage*, Scientific American (June 2018), <https://www.scientificamerican.com/article/separating-families-maycause-lifelong-health-damage/%20> (noting that “[t]he younger you are when you’re exposed to stress . . . , the more likely you will have negative health outcomes caused by dysregulation of stress response.”); see also Doyle, *supra* note 184 (finding higher delinquency rates, higher teen birth rates, and lower earnings among children removed to foster care as compared to similarly situated children who remained at home).

208 See, e.g., MacMillan, *supra* note 186; Grossman, *supra* note 186; Abrahams, *supra* note 186.

209 Lane Strathearn, et al., Does Breastfeeding Protect Against Substantiated Child Abuse and Neglect? A 15 Year Cohort Study, 123 PEDIATRICS 483 (2009).

210 *Id.*

211 Harp, *supra* note 17.

212 *Id.*

213 Kim, *supra* note 183.

214 Children’s Bureau, Bulletin for Professionals, *Child Welfare Practice to Address Racial Disproportionality and Disparity* (April 2021), https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf.

215 Harp, *supra* note 17.

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216 American Medical Association, *Patient-Physician Relationships*, <https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships> (last visited May 16, 2022).

217 For example, in Iowa, Christine Taylor, a pregnant 22-year-old and mother of two, tripped and fell down a flight of stairs in her home. She immediately sought medical care from emergency medical professionals who determined that neither she nor the fetus were harmed. After confiding in hospital staff that she had contemplated an abortion earlier in her pregnancy, the staff reported her to the police. Police arrested her for attempted feticide shortly after she left the hospital. See MICHELLE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* 86-87 (2020). In April 2022, Lizelle Herrera, a 26-year-old resident of the Rio Grande Valley in southern Texas, was arrested and charged with murder for allegedly having a self-induced abortion. Although the local district attorney dropped the charges against her shortly after her arrest, someone at the hospital where Herrera sought care had first reported her to the sheriff's office. See Cecilia Nowell, *The Long, Scary History of Doctors Reporting Pregnant People to the Cops* (Apr. 15, 2022) <https://www.motherjones.com/crime-justice/2022/04/self-induced-abortion-herrera-texas-murder-hospital/>.

218 See Caroline Kitchener, *The Texas abortion ban has a medical exception. But some doctors worry it's too narrow to use* (Oct. 22, 2021), <https://www.thelily.com/the-texas-abortion-ban-has-a-medical-exception-but-some-doctors-worry-its-too-narrow-to-use/>.

219 American Medical Association, *Principles of Medical Ethics, Chapter 1, 1.1.2 Patient-Physician Relationships*, <https://www.ama-assn.org/system/files/code-of-medical-ethics-chapter-1.pdf>.

220 Nowell, *supra* note 217.

221 *Id.*

222 ACOG Policy Statement, *supra* note 75; See also If/When/How, *Making abortion a crime (again): how extreme prosecutors attempt to punish people for abortions in the U.S.* (2019), <https://www.ifwhenhow.org/resources/making-abortion-a-crime-again/>; ACOG Opinion No. 473, *supra* note 52.

223 American Psychological Association, *Pregnant and Postpartum Adolescent Girls and Women with Substance-Related Disorders* (Mar. 2020), <https://www.apa.org/pi/women/resources/pregnancy-substance-disorders.pdf>.

224 Racial disparities in pregnancy outcomes are well-documented. Black pregnant women are nearly four times more likely to die from pregnancy-related complications than are white women and Black infants are more than twice as likely as white infants to die in their first year of life. Midwives Alliance, et al., *Racial Disparities in Birth Outcomes and Racial Discrimination as an Independent Risk Factor Affecting Maternal, Infant, and Child Health*, <https://mana.org/healthcare-policy/racial-disparities-in-birth-outcomes#:~:text=Despite%20efforts%20to%20improve%20racial,complications%20than%20are%20white%20women> (last visited May 16, 2022). See also Jason Williams, *Our System Criminalizes Black Pregnancy. As a District Attorney, I Refuse to Prosecute These Cases*, Time Magazine (May 12, 2021), <https://time.com/6049587/pregnancy-criminalization/> (“When people of color

and people with low income are denied access to basic forms of health care, including prenatal and maternal care, as a consequence of prejudice, and when they're arrested, charged and prosecuted for decisions that were made before, during or after pregnancy, it extends injustice in waves that have a ripple effect throughout families, neighborhoods and communities.”); Vanessa B. Sheppard, et al., *Providing health care to low-income women: a matter of trust*, 21 FAMILY PRACTICE 484, 489 (2004) (noting that “[m]any poor and underserved women face barriers to quality care and lack continuity in relationships with physicians,” which contributes to feelings of mistrust towards health care providers).

225 See, e.g., New York State Dep't of Health, *NYS CAPTA CARA Information & Resources*, <https://health.ny.gov/prevention/captacara/index.htm> (last visited May 16, 2022) (explaining that ACOG does “not recommend routine toxicology testing during pregnancy and delivery, or for the newborn”; that a hospital need not collect data on newborns who have positive toxicology screens in the absence of symptoms of substance withdrawal or a diagnosis of Neonatal Abstinence Syndrome or Fetal Alcohol Spectrum Disorder, and even then that the hospital need only collect aggregate de-identified data; and that “substance use alone . . . is not evidence of child maltreatment” and need not be reported to state agencies); New York City Dep't of Health, *Reporting and Planning Requirements for Newborns Prenatally Exposed to Substances and Their Caregivers*, (Nov. 12, 2020), https://www1.nyc.gov/assets/acs/pdf/child_welfare/2020/PositiveToxicology.pdf (“If a medical provider or other mandated reporter learns . . . that the newborn may have been exposed to substances in utero, but the newborn does not show physiological signs of that exposure, the [Child Abuse Prevention and Treatment Act] does not apply A positive toxicology result for a parent or a newborn, by itself, does not constitute reasonable suspicion of child abuse or maltreatment, and thus does not necessitate a report to the [Statewide Central Register of Child Abuse and Maltreatment (“SCR”)] . . . Similarly, a maternal history of past drug use or disclosure of current drug use is not sufficient, by itself, to warrant a report to the SCR.”).

226 *Id.*

227 As of May 1, 2022, 25 states and the District of Columbia require health care professionals to report suspected prenatal drug use, and 8 states require them to test for prenatal drug exposure if they suspect drug use. Guttmacher Institute, *supra* note 59.

228 See also Leticia Miranda, et al., *How States Handle Drug Use During Pregnancy*, ProPublica (Sept. 30, 2015) <https://projects.propublica.org/graphics/maternity-drug-policies-by-state>.

229 See Movement for Family Power, “Whatever They Do, I’m Her Comfort, I’m Her Protector”: How the Foster System Has Become Ground Zero for the U.S. Drug War 19 (June 2020); Joseph J. Doyle, Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 AM. ECON. REV. 1583 (2007) (finding higher delinquency rates, higher teen birth rates, and lower earnings among children removed to foster care as compared to similarly situated children who remained at home).

230 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Pub. L. No. 104-191, 110 Stat. 1938 (1996).

231 National Advocates for Pregnant Women,

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Testimony of National Advocates for Pregnant Women to the Senate Judiciary Committee of the Ohio Senate in Opposition to SB.216 (Feb. 10, 2022), <https://www.nationaladvocatesforpregnantwomen.org/testimony-of-national-advocates-for-pregnant-women-to-the-senate-judiciary-committee-of-the-ohio-senate-in-opposition-to-sb-216/>; see also ACOG Policy Statement, *supra* note 75; ACOG Opinion No. 473, *supra* note 52 (“Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing The use of the legal system to address perinatal alcohol and substance abuse is inappropriate In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions.”).

232 ACOG Opinion No. 711, *supra* note 134.

233 U.S. Dep’t of Health & Human Servs., *HHS Announces a Standard Clinical Definition for Opioid Withdrawal in Infants* (Jan. 31, 2022), <https://www.hhs.gov/about/news/2022/01/31/hhs-announces-standard-clinical-definition-for-opioid-withdrawal-in-infants.html>; Shahla Jilani et al., *Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate*, 243 J. PEDIATRICS 33 (Dec. 20, 2021), [https://www.jpeds.com/article/S0022-3476\(21\)01227-0/fulltext#tbl3](https://www.jpeds.com/article/S0022-3476(21)01227-0/fulltext#tbl3).

234 ACOG Opinion No. 711, *supra* note 134.

235 See, e.g., Anne Branigan, *A hospital reported two new moms for testing positive for drugs. They had eaten poppy seeds, a lawsuit says*, Washington Post (Dec. 22, 2021), <https://www.thelily.com/a-hospital-reported-two-new-moms-for-testing-positive-for-drugs-they-had-eaten-poppo-seeds-a-lawsuit-says/>.

236 Karen E. Moeller, et al., *Urine Drug Screening: Practical Guide for Clinicians*, 83 MAYO CLIN. PROC. 66 (2008) (noting that the U.S. Department of Health and Human Services adjusted its threshold to 2,000ng/mL “to help eliminate false-positive results eg, poppy seeds causing positive opium results”); Troy Anderson, *False Positives Are Common in Drug Tests on New Moms*, L.A. Daily News (June 28, 2008), <https://www.dailynews.com/2008/06/29/false-positives-are-common-in-drug-tests-on-new-moms/#:~:text=On%20average%2C%20the%20study%20found,marijuana%20resulted%20in%20false%20positives>

237 American College of Obstetricians and Gynecologists, Comm. on Ethics, Comm. Opinion 633, *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice* (June 2015, reaffirmed 2021), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/06/alcohol-abuse-and-other-substance-use-disorders-ethical-issues-in-obstetric-and-gynecologic-practice> [hereinafter “ACOG Opinion No. 633”]. ACOG relies on an ethical rationale for clinical recommendations and guidelines related to substance abuse disorder: pillars of (1) beneficence, (2) non-maleficence, (3) justice, and (4) respect for autonomy. *Id.*

238 Matthew Grossman et al., *A Novel Approach to Assessing Infants with Neonatal Abstinence Syndrome*, 8 HOSP. PEDS. 1 (2018); Ronald R. Abrahams et al., *An Evaluation of Rooming-In Among Substance-exposed Newborns in British Columbia*, 32 J. OBSTET. GYNECOL. CAN. 866 (2010); Tolulope Saiki et al.,

Neonatal Abstinence Syndrome - Postnatal Ward Versus Neonatal Unit Management, 169 EUR. J. PEDS. 95 (2010); Gabrielle K. Welle-Strand et al., *Breastfeeding Reduces the Need for Withdrawal Treatment in Opioid-Exposed Infants*, 102 FOUNDATION ACTA PAEDIATRICA 1060 (2013); Alison Knopf, Best—and least costly—treatment for NAS is mother-infant bond, *Alcoholism & Drug Abuse Weekly* (June 12, 2017).

239 ACOG Opinion No. 711, *supra* note 134.

240 ACOG Opinion No. 633, *supra* note 237.

241 ACOG Opinion No. 711, *supra* note 134.

242 See *Birth Rights*, *supra* note 174, at 12–21.

243 See ACOG Opinion No. 711, *supra* note 134 (stating that testing should be performed only with the patient’s consent and in compliance with state laws).

244 *Id.*

245 See *Ferguson v. Charleston*, 532 U.S. 67 (2001).

246 Hayley Fox, *Weed and Pregnancy: How Cannabis Laws Are Hurting Mothers* (Nov. 17, 2018), <https://www.rollingstone.com/culture/culture-features/weed-pregnancy-mother-family-marijuana-cannabis-755697/>.

247 *Id.*

248 *Id.*

249 *Id.*

250 American College of Obstetricians & Gynecologists, Comm. on Ethics, Comm. Opinion 664, *Refusal of Medically Recommended Treatment During Pregnancy* (June 2016, reaffirmed 2019), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy> [hereinafter “ACOG Opinion No. 664”] (“Obstetrician–gynecologists are discouraged in the strongest possible terms from the use of duress, manipulation, coercion, physical force, or threats, including threats to involve the courts or child protective services, to motivate women toward a specific clinical decision.”).

251 ACOG Opinion No. 473, *supra* note 52.

252 ACOG Opinion No. 711, *supra* note 134.

253 ACOG Opinion No. 633, *supra* note 237.

254 ACOG Policy Statement, *supra* note 75.

255 Boone, *supra* note 20.

256 ACOG Opinion No. 711, *supra* note 134. A study conducted by the National Institute of Health found that most women were averse to having drug but not alcohol use identified and were mistrustful of providers’ often inconspicuous efforts to discover drug use. Women expected psychological, social, and legal consequences from being identified, including feelings of maternal failure, judgment by providers, and reports to Child Protective Services. Women did not trust providers to protect them from these consequences. Rather, they took steps to protect themselves. They avoided and emotionally disengaged from prenatal care, attempted to stop using substances that could be detected by urine tests prior to prenatal care visits, and shared strategies within social networks for getting the benefits of

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- prenatal care while avoiding its negative consequences. See Sarah C. M. Roberts & Amani Nuru-Jeter, *Women's perspectives on screening for alcohol and drug use in prenatal care*, 20 WOMEN'S HEALTH ISSUES 193 (2010).
- 257 See Dorothy E. Roberts & Lisa Sangoi, *Black Families Matter: How the Child Welfare System Punishes Poor Families of Color*, The Appeal (Mar. 26, 2018) <https://theappeal.org/black-families-matter-how-the-child-welfare-system-punishes-poor-families-of-color-33ad20e2882e/>; Dorothy E. Roberts, *The Racial Geography of Child Welfare: Toward a New Research Paradigm* 87 CHILD WELFARE 125 (2008); Stephanie L. Rivau et al., *The Intersection of Race, Poverty and Risk: Understanding the Decision to Provide Services to Clients and to Remove Children*, 87 CHILD WELFARE 151 (2008); Wendy G. Lane et al., *Racial Differences in the Evaluation of Pediatric Fractures for Physical Abuse*, 288 JAMA 1603 (2002).
- 258 See Itiel Dror, et al., *Cognitive bias in forensic pathology decisions*, 66 J. FORENSIC SCIENCES 1751 (2021).
- 259 American College of Gynecologists and Obstetricians, *Obstetric Care Consensus No. 10, Management of Stillbirth* (March 2020), <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2020/03/management-of-stillbirth#:~:text=However%2C%20the%20suggested%20requirement%20is,at%2020%20weeks%20of%20gestation.>
- 260 See Ahmed, *supra* note 164.
- 261 Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, ProPublica (Sept. 23, 2015), <https://www.propublica.org/article/when-the-womb-is-a-crime-scene>.
- 262 CDC, *Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting 20* (2003 Revision), available at https://www.cdc.gov/nchs/data/misc/hb_me.pdf (last visited May 18, 2022) [hereinafter "Medical Examiners' Handbook"].
- 263 See Corrie B. Miller & Tricia Wright, *Investigating Mechanisms of Stillbirth in Setting of Prenatal Substance Use*, 8 ACAD. FORENSIC PATHOL. 865 (2018); Tricia Wright et al., *Methamphetamines and Pregnancy Outcomes*, 9 J. ADDICT. MED. 111 (2015); Mishka Terplan et al., *The Effects of Cocaine and Amphetamine Use During Pregnancy on the Newborn: Myth versus Reality*, 30 J. ADDICT. DIS. 1 (2011).
- 264 See Ciara A. Torres et al., *Totality of the Evidence Suggests Prenatal Cannabis Exposure Does Not Lead to Cognitive Impairments: A Systematic and Critical Review*, FRONT. PSYCHOL. (2020); Rachel Levinson-Castiel, et al., *Neonatal abstinence syndrome after in utero exposure to selective serotonin reuptake inhibitors in term infants*, 160 JAMA PEDIATRICS 173 (2006); Deborah A. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 28 JAMA 285 (2001); Joanne P. Brady, et al., *Risk and Reality: The Implications of Prenatal Exposure to Alcohol and Other Drugs*, THE EDUCATION DEVELOPMENT CENTER (1996).
- 265 See Tim F. Oberlander, et al., *Pharmacologic factors associated with transient neonatal symptoms following prenatal psychotropic medication exposure*, 65 J. CLIN. PSYCHIATRY 230 (2004); Kari Laine, et al., *Effects of exposure to selective serotonin reuptake inhibitors during pregnancy on serotonergic symptoms in newborns and cord blood monoamine and prolactin concentrations*, 60 JAMA PSYCHIATRY 720 (2003).
- 266 See Katherine DeJong, et al., *Alcohol Use in Pregnancy*, 62 CLIN. OBSTET. GYNECOL. 142 (2020).
- 267 See Xiaoping Weng, et al., *Maternal caffeine consumption during pregnancy and the risk of miscarriage: a prospective cohort study*, 198 AM. J. OBSTET. GYNECOL. 279 (2008).
- 268 U.S. Dep't of Justice, *Drugs, Crime, and the Justice System: A National Report from the Bureau of Justice Statistics* 119 (1992); see also U.S. Dep't of Health & Human Servs., *HHS Announces a Standard Clinical Definition for Opioid Withdrawal in Infants* (Jan. 31, 2022), <https://www.hhs.gov/about/news/2022/01/31/hhs-announces-standard-clinical-definition-for-opioid-withdrawal-in-infants.html> ("A diagnosis of NAS [neonatal abstinence syndrome] or NOWS [neonatal opioid withdrawal syndrome] does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.").
- 269 See *Medical Examiners' Handbook*, *supra* note 262.
- 270 *Id.* at 12-13.
- 271 Dan Simon, *Minimizing Error and Bias in Death Investigations*, 49 SETON L. REV. 255, 265 (2019).
- 272 See *id.* at 273.
- 273 Ira P. Robbins, *A Deadly Pair: Conflicts of Interest Between Death Investigators and Prosecutors*, 79 OHIO STATE L.J. 901, 912 (2018).
- 274 NAT'L RESEARCH COUNCIL, *STRENGTHENING FORENSIC SCIENCE IN THE UNITED STATES: A PATH FORWARD* 185 (Nat'l Acads. Press 2009), <https://www.ncjrs.gov/pdffiles1/nij/grants/228091.pdf> [hereinafter "NRC Report"].
- 275 Robbins, *supra* note 273.
- 276 PEKKA SAUKKO & BERNARD KNIGHT, *KNIGHT'S FORENSIC PATHOLOGY* 449 (CRC Press, 4th ed. 2016).
- 277 See Letter from Gregory J. Davis, et al. to Hon. Judge Timothy McCrone (Feb. 24, 2020) (on file with NAPW) (a letter from over 45 forensic pathologists stating that the lung float test "is not a scientifically reliable test or indicator of live birth").
- 278 Ahmed, *supra* note 164 at 1126-27.
- 279 Marta C. Cohen & Irene Scheimberg, *Forensic Aspects of Perinatal Deaths*, 8 ACAD. FORENSIC PATHOL. 452 (2018).
- 280 See Ahmed, *supra* note 164 at 1127-31 (discussing the use of the "lung float test" to convict Purvi Patel). Purvi Patel was sentenced to 20 years in prison for feticide and neglect of a dependent after purchasing and taking mifepristone and misoprostol to terminate her pregnancy and experiencing a stillbirth. The pathologist who testified for the defense said the fetus was at 23 or 24 weeks gestation and its lungs weren't developed enough to breathe. The pathologist for the prosecution, on the other hand, used the "lung float test" to determine that the fetus was born alive, despite acknowledging himself that the test is unreliable. See Emily Bazelon, *Purvi Patel Could Be Just the Beginning*, New York Times (Apr. 1, 2015), <https://www.nytimes.com/2015/04/01/magazine/purvi-patel-could-be-just-the-beginning.html>.

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- 281 NRC Report, *supra* note 274 at 186.
- 282 Centers for Disease Control and Prevention, *What is stillbirth?* (2020), <https://www.cdc.gov/ncbddd/stillbirth/facts.html> (last visited May 8, 2022).
- 283 JONATHAN S. WIGGLESWORTH & DON B. SINGER, *Textbook of fetal and perinatal pathology* (1991) (quoting Lester Adelson, *The Pathology of Homicide: A Vade Mecum for Pathologist, Prosecutor, and Defense Counsel* (1974)).
- 284 NRC Report, *supra* note 274 at 8, n. 8.
- 285 See Simon, *supra* note 271; Itiel E. Dror, et al., Contextual information renders experts vulnerable to making erroneous identifications, 158 *FORENSIC SCIENCE INT'L* 74, 77 (2006); Paul C. Giannelli, *Wrongful Convictions and Forensic Science: The Need to Regulate Crime Labs*, 86 *N.C. L. REV.* 164 (2006).
- 286 *State v. Tyler*, 867 N.W.2d 136, 145 (Iowa 2015).
- 287 *Id.* at 148.
- 288 *Id.*
- 289 *Id.* at 146-47.
- 290 *Id.* at 147.
- 291 *Id.*
- 292 *Id.* at 152. Tyler's conviction was eventually overturned by the Iowa Supreme Court, holding that the district court abused its discretion in allowing the medical examiner to testify to the cause and manner of death. *Id.* at 144.
- 293 Simon, *supra* note 271.
- 294 *Id.* at 271.
- 295 National Institute on Child Health and Human Development, *What are the risk factors for stillbirth?*, <https://www.nichd.nih.gov/health/topics/stillbirth/topicinfo/risk> (last visited May 8, 2022).
- 296 NHS Choices, *Stillbirth - Causes*, <https://www.nhs.uk/conditions/stillbirth/causes/> (last visited May 8, 2022).
- 297 See *A Woman's Rights*, *N.Y. Times* (Dec. 28, 2018), <https://www.nytimes.com/interactive/2018/12/28/opinion/pregnancy-women-pro-life-abortion.html>.

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298 See Kathryn Dee L. MacMillian et al., *Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome: A Systemic Review and Meta-analysis*, 172 JAMA PEDIATR., 345 (2018) (concluding that rooming-in with families significantly reduces need for medication and longer hospital stays for infants with neonatal abstinence syndrome).

299 Shannon Gwin Mitchell et al., *Incarceration and Opioid Withdrawal: The Experiences of Methadone Patients and Out-of-Treatment Heroin Users*, 41(2) J. PSYCHOACTIVE DRUGS, 145 (2009).

300 See, e.g., Reproductive Health Equity Act, 2022 COLO. SESS. LAWS (2022) (to be codified in COLO. REV. STAT. §§ 25-6-401-406) [hereinafter “Colorado Reproductive Health Act”] (codifying fundamental reproductive healthcare rights and prohibiting public entities from prosecuting or punishing pregnant persons for acting or failing to act in specific ways with respect to any impact on pregnancy outcomes); Reproductive Health Act, 775 ILL. COMP. STAT. 55 (2019) (codifying the fundamental right of individuals to make autonomous decisions about one’s own reproductive health and restricting the ability of the state to deny, interfere with, or discriminate against such fundamental rights); Act of March 7, 2022, WA. SESS. LAWS 441 (2022) (to be codified in REV. CODE WA. § 9.02) (codifying that the state cannot penalize, prosecute or take otherwise adverse action against an individual based on their pregnancy outcomes).

301 See National Conference of State Legis., *State Laws on Fetal Homicide and Penalty-enhancement for Crimes Against Pregnant Women* (May 1, 2018), <https://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx>.

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(describing the case of an Alabama woman charged with manslaughter for pregnancy loss after being shot in the abdomen, on the grounds that she provoked the fight that led to her shooting).

303 See ACLU Maine, *Iowa Police Almost Prosecute Woman For Her Accidental Fall During Pregnancy... Seriously* (Feb. 11, 2010), <https://www.aclumaine.org/en/news/iowa-police-almost-prosecute-woman-her-accidental-fall-during-pregnancyseriously> (describing the case of an Iowa woman jailed on suspicion of feticide after falling down the stairs and going to emergency room, where attending nurse reported her to law enforcement); see also Amie Newman, *Pregnant? Don’t Fall Down the Stairs*, Rewire News Group (Feb. 15, 2010), <https://www.usatoday.com/story/news/nation/2013/08/02/woman-freed-after-plea-agreement-in-babys-death/2614301/>.

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305 See Paltrow, *supra* note 4 at 307-08 (describing the case of a Wisconsin woman who was reported to state authorities by hospital staff after seeking help for her opiate addiction while pregnant and was subsequently

detained in a psychiatric ward without prenatal care for nearly a month); see also Tamar Lewin, *Mother Cleared of Passing Drug to Babies*, N.Y. Times (Jul. 24, 1992), <https://www.nytimes.com/1992/07/24/news/mother-cleared-of-passing-drug-to-babies.html> (describing the case of a Florida woman convicted of distribution of drugs to a minor for “passing drugs” to her infant through the umbilical cord); *Johnson v. State*, 602 So. 2d 1288, 1290 (Fla. 1992) (reversing conviction).

306 See, e.g., Diana Penner, *Woman freed after plea agreement in baby’s death*, Indianapolis Star (Aug. 2, 2013) <https://www.usatoday.com/story/news/nation/2013/08/02/woman-freed-after-plea-agreement-in-babys-death/2614301/> (discussing an Indiana woman charged with murder and feticide after attempting suicide by poison and suffering a subsequent pregnancy loss); Jason Foster, *Woman faces charge of killing unborn child during August suicide attempt*, The Herald (Feb. 21, 2009), <https://www.heraldonline.com/news/local/article12250463.html> (discussing a South Carolina woman charged with homicide after jumping out of a window).

307 See, e.g., MO. REV. STAT. § 1.205(4); *State v. K.L.*, No. 03CR113048 (Cir. Ct. Chariton County Dec. 13, 2004); *State v. Lohnstein*, No. 0611-CR08757, Opp. to Mot. to Dismiss (Cir. Ct. St. Charles County Oct. 17, 2007); *State v. Pinder*, (Mo. Cir Ct. Pulaski County Nov. 22, 1991).

308 See, e.g., Penner *supra* note 306 (charges of murder and attempted feticide against Indiana woman who attempted suicide by rat poison dropped only after she spent 89 days in jail and pled guilty to criminal recklessness); *McKnight v. State*, 661 S.E.2d 354, 358 n.10 (S.C. 2008) (reversing homicide by child abuse conviction of South Carolina woman who suffered a stillbirth and, having already served eight out of her twelve-year sentence and not wanting a retrial to result in even more time, pled guilty to manslaughter); Linda Thomson, *Mother is charged in stillbirth of a twin*, Deseret News (Mar. 12, 2004), <https://www.deseret.com/2004/3/12/19817144/mother-is-charged-in-stillbirth-of-a-twin> (discussing a Utah woman who was charged with first-degree murder for delaying a cesarean surgery and pled guilty to child endangerment and third degree felony for prenatal cocaine use, after spending more than two months in jail); Paltrow, *supra* note 4 at 308-09 (discussing a Louisiana woman who was incarcerated for second-degree murder after experiencing a miscarriage from taking a prescribed contraceptive, and who was released only after pleading guilty to improper disposal of human remains).

309 Paltrow, *supra* note 4 at 326-331.

310 See Theresa Morris & Joan H. Robinson, *Forced and Coerced Cesarean Sections in the United States*, 16 CONTEXTS, 24, 34 (2017) (citing multiple appeals of cases where CPS terminated parental rights based on maternal refusal to consent to cesarean surgery); Alexa Richardson, *The Use of Child Protective Services and Court Orders to Enforce Medical Compliance in the Labor and Delivery Room: How Threats of Legal Action Limit Reproductive Choice*, HARVARD J. L. & GENDER (2018), <https://harvardjlg.com/2018/11/the-use-of-child-protective-services-and-court-orders-to-enforce-medical-compliance-in-the-labor-and-delivery-room-how-threats-of-legal-action-limit-reproductive-choice/>.

311 *Compare* H. 221, 192nd Gen. Ct., Reg. Sess. (Mass. 2021) (removing mandated reporting for infants with physical dependence on drugs while remaining CAPTA-

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compliant) with S.B. No. 216, 134th Gen. Assemb., Reg. Sess. (Ohio 2021) (including substance-exposed infants in definition of “abused child,” mandating drug testing wherever reports of child abuse based on infant substance exposure are received, mandating child removal in instances of confirmed infant substance exposure, and setting up significant barriers for reunification).

312 See Laura J. Faherty et al., Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome, *JAMA* (2019), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2755304>.

313 ACOG Committee Opinion, No. 473 *supra* note 52.

314 American Medical Association, Policy Statement, H-420.962, *Perinatal Addition – Issues in Care and Prevention* (1992, reaffirmed 2019), <https://policysearch.ama-assn.org/policyfinder/detail/pregnant?uri=%2FAMADoc%2FHOD.xml-o-3705.xml>.

315 National Perinatal Association, Position Statement, *Perinatal Substance Use*, (Sep. 2017), https://www.nationalperinatal.org/_files/ugd/209d80_6c125977cd764f67933962492fd13b97.pdf.

316 As witnessed in action in Tennessee, following passage of the state’s Fetal Assault Law. SisterReach et al., *Tennessee’s Fetal Assault Law: Understanding its impact on marginalized women* (2017), https://www.sisterreach.org/uploads/1/3/3/2/133261658/full_fetal_assault_rpt_1.pdf (finding that pregnant patients delayed or avoided prenatal care altogether, and an increase in the occurrence of neonatal abstinence syndrome).

317 Boone, *supra* note 20.

318 Lloyd, et al., The Policy to Practice Gap: Factors Associated with Practitioner Knowledge of CAPTA 2010 Mandates for Identifying and Intervening in Cases of Prenatal Alcohol and Drug Exposure, 99 *J. CONTEMP. SOC. SERVS.*, 23 (2018).

319 For example, the New York Department of Health has clarified that the federal guidelines only require de-identified notification and has created a separate pathway by which to make such notifications distinct from reporting suspected child abuse and neglect cases. New York State, Department of Health, *NYS CAPTA CARA Information & Resources*, <https://health.ny.gov/prevention/captacara/index.htm> (last visited May 16, 2022). Additionally, the New York Department of Health instructs that maternal substance use, alone, does not constitute abuse and neglect. *Id.*

320 Lloyd, et al., *supra* note 318.

321 New York State, Department of Health, *supra* note 319.

322 42 U.S.C. § 5106a(b)(2)(B)(iii).

323 CHILD. BUREAU, U.S. DEP’T OF HEALTH AND HUM. SERVICES, *Plans of Safe Care for Infants With Prenatal Substance Exposure and Their Families*, Child Welfare Information Gateway (2020), <https://www.childwelfare.gov/pubPDFs/safecare.pdf>.

324 For a state-by-state review of mandatory reporting statutes and related penalties, see Ariane Frosh, *Mandatory Reporting: A Guide for Practitioners*, ELEPHANT CIRCLE (Sep. 1, 2020), available at <https://static1.squarespace.com/static/57126eff60b5e92c3a226a53/t/>

[5f84b886d7a3130e832fa7e7/1602533514502/Mandatory+Reporter+Laws+by+State.pdf](https://static1.squarespace.com/static/57126eff60b5e92c3a226a53/t/5f84b886d7a3130e832fa7e7/1602533514502/Mandatory+Reporter+Laws+by+State.pdf).

325 See, e.g., ARIZ. REV. STAT. §8-846(D)(1)(g), §8-201(25)(c); KY. REV. STAT. §625.090(1)(a)(4); TEX. FAM. CODE §161.001(b)(1)(R). As of May 1, 2022, 24 states consider substance use by pregnant persons child abuse and 25 states mandate the reporting of suspected prenatal drug use. See Gutmacher Institute *supra* note 59. The National Perinatal Association has released a position statement explicitly warning against treating drug dependency amongst pregnant persons “as a deficiency in parenting that warrants child welfare intervention.” National Perinatal Association, *supra* note 315. American College of Obstetricians and Gynecologists (“ACOG”) also opposes use of drug tests as indicators of neglect. ACOG Opinion No. 633, *supra* note 237.

326 Joseph J. Doyle, Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 *AM. ECON. REV.* 1583 (2007) (finding higher delinquency rates, higher teen birth rates, and lower earnings among children removed to foster care as compared to similarly situated children who remained at home).

327 Kristina Rosinsky & Dana Connelly, *Child Welfare Financing SFY 2014: A Survey of Federal, State, and Local Expenditures*, CHILD TRENDS 11 (Dec. 2016), <https://www.childtrends.org/wp-content/uploads/2016/10/2016-53ChildWelfareFinancingSFY2014-1.pdf>. See also Lisa DeMatteis-Lepore & Ruth White, *Supportive Housing: An Effective Child Welfare Intervention*, CW360 30 (Spring 2017), https://www.casew.org/wp-content/uploads/2017/04/CW360_Spring2017_WEB508.pdf

328 See, for example, two New York cases of poppy seed consumption yielding false positive drug test results for pregnant women who were subsequently barred from breastfeeding, reported to CPS, and subjected to invasive searches of their homes. Johan Sheridan, *New York hospital reports moms after poppy seeds yield positive drug tests*, News 10 (Dec. 20, 2021), [https://www.news10.com/news/ny-news/new-york-hospital-reports-moms-to-cps-after-poppy-seeds-yield-positive-drug-tests/#:~:text=New%20York%20hospital%20reports%20moms%20after%20poppy%20seeds%20yield%20positive%20drug%20tests&text=MIDDLETOWN%2C%20N.Y.,drug%20tested%20while%20giving%20birth](https://www.news10.com/news/ny-news/new-york-hospital-reports-moms-to-cps-after-poppy-seeds-yield-positive-drug-tests/#:~:text=New%20York%20hospital%20reports%20moms%20after%20poppy%20seeds%20yield%20positive%20drug%20tests&text=MIDDLETOWN%2C%20N.Y.,drug%20tested%20while%20giving%20birth.). See also Manny Ramos, *Poppy seeds caused positive drug test before she gave birth, woman says – but hospital wouldn’t listen*, Chicago Sun Times (Feb. 3, 2022), <https://chicago.suntimes.com/news/2022/2/3/22916550/poppy-seeds-easter-cake-positive-drug-test-pregnant-woman-st-alexius-hospital-aclu-complaint-dcfs> (describing similar case of poppy seed consumption and positive drug test in Illinois).

329 See *A Woman’s Rights, Part 4: Slandering the Unborn*, N.Y. Times (Dec. 28, 2018), <https://www.nytimes.com/interactive/2018/12/28/opinion/crack-babies-racism.html>; Kristina B. Wolff, *Panic in the ER: Maternal Drug Use, the Right to Bodily Integrity, Privacy, and Informed Consent*, 39 *POL. & POL’Y*, 679 (2011).

330 See e.g., CENTERS FOR DISEASE CONTROL AND PREVENTION, *Treatment for Opioid Use Disorder Before, During, and After Pregnancy* (Jul. 21, 2021), <https://www.cdc.gov/pregnancy/opioids/treatment.html> (discussing medication-assisted treatment for opioid use disorder in pregnant women)

331 Kristina Rosinsky & Dana Connelly, *Child Welfare*

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332 Colorado's Reproductive Health Equity Act, for example, codifies fundamental reproductive healthcare rights and prohibits public entities from prosecuting or punishing pregnant women for acting or failing to act in specific ways with respect to any impact on pregnancy outcomes. Colorado Reproductive Health Act, *supra* note 300.

333 Criminal punishment has been imposed even when a pregnancy has resulted in a healthy baby. Between 1973 and 2015, 45 states have prosecuted women for drug use while pregnant, even where no pregnancy loss occurred. Leticia Miranda et al., *How States Handle Drug Use During Pregnancy*, ProPublica (Sep. 30, 2015), <https://projects.propublica.org/graphics/maternity-drug-policies-by-state>.

Importantly, carving out an exemption for prescription use in statutes which criminalize prenatal substance is not sufficient to protect these patients' rights. See Amy Yurkanin, *Alabama mom faces felony for filling doctor's prescription while pregnant*, Advance Local (Jun. 21, 2021), <https://www.al.com/news/2021/06/alabama-mom-faces-jail-for-filling-doctors-prescription-while-pregnant.html> (describing how Alabama prosecutors circumvented the prescription exemption in the case of Kim Blalock by charging her with prescription fraud for renewing a valid prescription).

334 In fact, detention tends to lead to more deaths ultimately. While incarcerated, many drug-dependent people experience reduced tolerance but upon release, return to levels of similar use to what they used before incarceration, which increases their risk of overdose and death. One study found that nearly 15 percent of all former prisoner deaths from 1999-2009 were related to opioids. National Institute on Drug Abuse, *Criminal Justice Drug Facts*, available at <https://nida.nih.gov/publications/drugfacts/criminal-justice> (last visited May 5, 2022).

335 Erik Eckholm, *Case Explores Rights of Fetus Versus Mother*, N.Y. Times (Oct. 23, 2013) (describing case of Wisconsin woman forced into a treatment center on the threat of incarceration and citing such programs in Minnesota and South Dakota as well) (<https://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html>). See also Movement for Family Power, *"Whatever They Do, I'm Her Comfort, I'm Her Protector": How the Foster System Has Become Ground Zero for the U.S. Drug War* 7 (June 2020) (highlighting the 2014 case of a Wisconsin woman who refused inpatient treatment and was sent to jail and kept in solitary confinement, notably without prenatal care).

336 See Guttmacher Institute *supra* note 59.

337 See, for example, the case a Florida woman who went to the hospital for IV fluids during a midwife-assisted birth. Doctors obtained a court order that forced her back to the hospital, completed a trial in the operating room, and legally compelled her to submit to cesarean surgery. Morris, *supra* note 310. A 2003 study of maternal-fetal medicine directors at 42 hospitals revealed 9 cases of doctors obtaining court orders to force treatment on non-consenting pregnant women. Molly Redden, *New York hospital's secret policy led to woman being given C-section against her will*, THE GUARDIAN (Oct. 5, 2017), <https://www.theguardian.com/us-news/2017/oct/05/new-york-staten-island-university-hospital-c-section-ethics-medicine>.

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338 See Glenn Osborne, *Couple charged in death of stillborn child*, UNITED PRESS INTERNATIONAL: ARCHIVES (May 7, 1982), <https://www.upi.com/Archives/1982/05/07/Couple-charged-in-death-of-stillborn-child/4018389592000/>

(Kentucky couple who refused cesarean surgery); Linda Thomson, *Rowland accepts plea bargain in twin's death*, DESERT NEWS (Apr. 8, 2004, 6:46 PM), <https://www.deseret.com/2004/4/8/19821876/rowland-accepts-plea-bargain-in-twin-s-death> (Utah woman charged with murder for delaying cesarean surgery).

339 See *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994); *In re A.C.*, 573 A.2d 1235 (D.C. 1990).

340 See Morris, *supra* note 310 (describing the trend of lower courts to rule against pregnant persons and the trend of appellate courts to rule in favor of them).

341 See, e.g., Redden, *supra* note 337 (discussing the case of Rinat Dray's forced cesarean surgery at Northwell's Staten Island University Hospital (SIUH), whose policy allowed doctors to override a pregnant woman's decision to refuse certain surgeries and procedures on the grounds of "reasonable possibility of significant benefit" to the fetus).

342 ACOG Policy Statement *supra* note 75; American Medical Association, Policy Statement, H-420.969, *Legal Interventions During Pregnancy*, (1990, reaffirmed 2018), <https://policysearch.ama-assn.org/policyfinder/detail/pregnant?uri=%2FAMADoc%2FHOD.xml-o-3712.xml>.

343 NAPW, *Thousands Seek End to Forced Cesareans in NY and Justice for Rinat Dray* (Jul. 11, 2019), <https://www.nationaladvocatesforpregnantwomen.org/thousands-seek-end-to-forced-cesareans-in-ny-and-justice-for-rinat-dray/>.

344 See, e.g., S.B.1029, Reg. Sess. (N.Y. 2019), <https://legislation.nysenate.gov/pdf/bills/2019/S1029A>.

345 See, e.g., S.B.4821, Reg. Sess. (N.Y. 2021), <https://legislation.nysenate.gov/pdf/bills/2021/S4821A>.

346 Caroline Kitchener, *Missouri lawmaker seeks to stop residents from obtaining abortions out of state*, Washington Post (Mar. 8, 2022), <https://www.washingtonpost.com/politics/2022/03/08/missouri-abortion-ban-texas-supreme-court/>. See also Kentucky's Humanity in Healthcare Act, which includes a ban on the mailing of abortion medication into Kentucky. *Kentucky abortion law remains blocked; federal judge to issue to new order*, WLKY (May 2, 2022), <https://www.wlky.com/article/controversial-kentucky-abortion-law-still-blocked/39879809#>.

347 See, e.g., David S. Cohen et al., *States Want to Ban Abortions Beyond Their Borders. Here's What Pro-Choice States Can Do.*, N.Y. TIMES, (Mar. 13, 2022), <https://www.nytimes.com/2022/03/13/opinion/missouri-abortion-roe-v-wade.html>.

348 See, e.g., An Act Concerning the Provision of Protections for Persons Receiving and Providing Reproductive Health Care Services in the State and Access to Reproductive Health Care Services in the State, CO.NN. PUB. ACTS No. 22-19 (May 5, 2022), <https://www.cga.ct.gov/2022/act/pa/pdf/2022PA-00019-R00HB-05414-PA.pdf>.

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