

Under the Influence: Policy Approaches to Substance Abuse During Pregnancy

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Abstract

This paper explores policy approaches to the issue of substance abuse during pregnancy and argues that current policy approaches inadequately address the issue, pose a threat to reproductive rights, and attempt to regulate motherhood, especially among women deemed “unworthy”—largely poor women and women of color. The paper then proposes a public health policy framework better suited to approaching the issue of substance abuse during pregnancy and explores the implications of such policies for social workers.

1988: In Washington, D.C., thirty-year-old Brenda Vaughn, a pregnant African American, pleads guilty to forging 700 dollars worth of checks. The prosecutor agrees to probation. Judge Peter H. Wolf mandates a drug test, which results positive for cocaine. Although Vaughn is not charged with drug-related crimes, Judge Wolf decides, “I’m going to keep her locked up until the baby is born because she’d tested positive for cocaine when she came before me. . . . She’s apparently an addictive personality, and I’ll be darned if I’m going to have a baby born that way” (Roberts, 1997, p. 161).

1989: Florida prosecutors charge twenty-three-year-old Jennifer Clarise Johnson, a crack-addicted African American, with two counts of delivering a controlled substance to a minor after her children tested positive for cocaine at birth. Although Florida drug laws did not apply to fetuses, the prosecution argued that Johnson had passed cocaine metabolites from her body into the body of the infants after their births before the umbilical cords were cut (Roberts, 1991).

1992: In South Carolina, after a baby’s urine shows traces of cocaine, his twenty-eight-year-old African American mother Cornelia Whitner is charged with criminal child neglect; she pleads guilty and asks to be placed in a residential drug treatment facility. Judge Frank Epps declines her request and sentences her to an eight-year prison term, saying, “Why not just take a pistol and put it in your mouth and blow your head off?” (Roberts, 1997, p. 150).

Such punitive responses to women who abuse substances during pregnancy abounded during the late-1980s and early-1990s. In fact, between 1985 and 1995, more than 200 pregnant women or new mothers in over twenty states were arrested and charged with crimes related to substance use during pregnancy (Paltrow, 1999)—

and more than 80 percent of them were Black or Latina (Kershner & Paltrow, 2001). Few disagree that drug use during pregnancy can pose substantial risks to both the pregnant woman and the fetus. However, policymakers and advocates debate how best to approach the issue; part of the controversy certainly centers on the fact that the issue touches on such hot-button topics as drug policy and abortion.

States have enacted a variety of policies to target substance abuse during pregnancy: criminal prosecutions, mandated reporting laws, child welfare statutes, civil commitment, and drug treatment initiatives. This paper argues that the current policy approaches are inadequate, a threat to reproductive rights, and designed to regulate motherhood—especially placing poor women and women of color “under the influence” and deeming them “unworthy” of motherhood. The paper will then propose a feminist public health policy framework better suited to approaching the issue of substance abuse during pregnancy.

Under the Influence: The Regulation of Motherhood

The policy approaches to substance abuse during pregnancy that will be discussed in further detail below all seek, in one way or another, to keep women “under the influence” and to ensure government regulation of motherhood. Historically, under patriarchy, motherhood has been compulsory for women in the United States; Roberts (1995) argues that our society exerts “structural and ideological pressures upon women to become mothers” (p. 229)—but that not *all* women are pressured in this way. While procreation by white women has been encouraged and viewed as desirable, motherhood among Black women has been devalued and discouraged (Roberts, 1995, p. 229). Solinger (2001) concurs with Roberts, further noting that undergirding rhetoric about motherhood is the assumption that motherhood is a class privilege—that there are women who “deserve” to be mothers (White women from upper- and middle-class backgrounds), and there are women who do not (poor Black women).

This devaluation of Black motherhood has been fueled by the media and public opinion about crack cocaine. Roberts (1997) notes that the impetus for pursuing criminal convictions of women for substance use during pregnancy started in the 1980s, with the boom of

crack cocaine—a drug predominately confined to the inner-city (read: Black and low-income). The media frenzy about the “crack epidemic” and the pathetic figure of the “crack baby” established a climate in which crack-using women were painted as “the exact opposite of a mother: promiscuous, uncaring, and self-indulgent” (Roberts, 1997, p. 156). For Black women, among whom motherhood is already viewed as undesirable, the pregnant crack user became “the latest embodiment of the bad *Black* mother. The monstrous crack-smoking mother was added to the iconography of depraved Black maternity, alongside the matriarch and the welfare queen. Crack gave society one more reason to curb Black women’s fertility” (Roberts, 1997, p.157).

Further placing women “under the influence” are the social expectations about women’s responsibilities: Campbell (1999) notes that in addition to biological reproduction, “women are [also] responsible for the activities of social reproduction, normalization, and the transmission of . . . cultural values, attitudes, and beliefs” (p. 901). Women, Campbell (2000) argues, “embody a collision between normative expectations of how citizens should conduct themselves as citizens and how women should behave as women. What is at stake in drug policy debates and outcomes is the reiteration of women’s responsibility for social reproduction and the nature of women’s economic, social, and political autonomy” (p. 4). Thus, the collision of expectations about women’s role in social reproduction with the continued devaluation of motherhood among poor Black women constrains women’s autonomy—especially already vulnerable and marginalized women—and maintains them “under the influence” of governmental and societal regulations and severe sanctions for substance use during pregnancy.

Criminal Law

While no state has specifically criminalized drug use during pregnancy, prosecutors have utilized a variety of laws already on the books to charge women with crimes ranging from possession of a controlled substance to criminal child abuse and neglect, delivery of drugs to a minor, corruption of a minor, and manslaughter (Figdor & Kaser, 1998; Dailard & Nash, 2000). South Carolina is at the forefront of the movement to criminalize prenatal substance abuse, prosecuting over 40 women since 1989, more than any other state (Roberts, 1997). With the exception of Carolina Whitner’s conviction in South Carolina, all other criminal convictions obtained through reinterpretation of existing state laws have eventually been overturned on appeal—though it is important to note that not all women have appealed their convictions, so many are serving sentences (Dailard & Nash,

2000). State Supreme Courts have determined that expansion of existing criminal statutes went beyond the legislatures’ original intents and that the meaning of words in state law was not to be reinterpreted—the word “child” in state statutes, for example, does not include fetuses, nor does the phrase “delivery of a controlled substance” include drug transmission through “umbilical circulation” (Harris & Paltrow, 2003, p. 1697). State Supreme Courts have also overturned convictions on the grounds that some of the prosecutions violated subjects’ constitutional rights to privacy and to due process—in other words, the prosecuted pregnant woman could not reasonably foresee the way the state was going to apply the law (Dailard & Nash, 2000).

In addition to state Supreme Court arguments against the criminal prosecution of women for substance use during pregnancy, there are several other cogent critiques of this approach. First, many argue that charging women with these crimes opens a veritable Pandora’s Box: if harm to a viable fetus caused by substance use constitutes a crime, then myriad activities could be considered crimes committed against viable fetuses. Will failure to take folic acid, failure to eat adequately, failure to follow doctors’ orders for bed-rest, or failure to obtain prenatal care also be criminalized? What about taking fertility-enhancing drugs that often lead to premature birth, low birth weight, and multiple births—all of which put fetuses at risk? Indeed, in his dissent to the Whitner decision, South Carolina Supreme Court Justice J. Moore ominously noted, “The impact of today’s decision is to render a pregnant woman criminally liable for myriad acts which the legislature has not seen fit to criminalize” (Figdor & Kaeser, 1998, p. 5).

Secondly, critics argue that prosecutions of women have focused largely on women who use illegal drugs during pregnancy, even though the impact of prenatal exposure to cigarettes and alcohol—*legal* substances—is often far more devastating; alcohol, not cocaine or heroin or other illicit substances, is the leading cause of mental retardation, meaning that this approach is far too limited in its scope to truly and effectively address the issue of maternal substance abuse (Paltrow, Cohen, & Carey, 2000).

Third, South Carolina offers a chilling example of the unintended consequences of criminally prosecuting women for substance use during pregnancy: the South Carolina Association of Alcoholism and Drug Abuse Counselors reports that after the state increased criminal prosecutions of pregnant women, drug treatment programs in the state experienced as much as an 80 percent decline in admissions of pregnant women (Dailard & Nash, 2000). South Carolina’s infant mortality rates increased for the first time in over a decade in 1997—the

year after the state Supreme Court upheld Carolina Whitner’s conviction—and by 1999, the state was seeing a 20 percent increase in abandoned babies (Paltrow, Cohen, & Carey, 2000). While it is difficult to directly connect infant mortality and abandonment rates with punitive responses to substance abuse during pregnancy, many critics argue that there is, at least, a correlation.

Fourth, punitive policies in South Carolina, simply put, do not do what they purport to do. The rhetoric behind the laws is one of “protecting future citizens” or “saving at-risk babies.” In fact, according to Charlie Condon, Attorney General for the state of South Carolina at the time of Carolina Whitner’s conviction, the prosecution had garnered “a landmark decision for protecting children” (Associated Press, 1996, p. A1) in the state. However, South Carolina actually does very little to “protect children”: the state ranks forty-second in a recent analysis of the well-being of children, including such measures as child poverty, the percentage of teens who drop out of high school, the percentage of two-year-olds who are immunized, infant mortality, and incidence of prenatal care (Jos, Perlmutter, & Marshall, 2003). Additionally, as will be discussed in greater detail below, prosecutions of women for crimes against fetuses, and attempts to enact new laws aimed at prenatal substance use, may well pose a grave threat to *Roe v. Wade*.

Critics of criminal prosecution note its racist application: over 80 percent of women convicted for substance use during pregnancy were Black or Latina (Kershner & Paltrow, 2001). In South Carolina, all but one woman convicted was poor and Black (Dailard & Nash, 2000)—the other was poor and White. Roberts (1997) notes, “Poor women, who are disproportionately Black, are in closer contact with government agencies, and their drug use is therefore more likely to be detected” (p. 172). It seems that certain women are prosecuted for *becoming* mothers, not for substance abuse; women could avoid such prosecution by terminating their pregnancy. Roberts (1997) concludes, “The prosecutions are better understood as a way of punishing Black women for having babies rather than as a way of protecting Black fetuses” (p. 154).

Mandated Reporting

Related to criminal law approaches to substance use during pregnancy are mandated reporting initiatives. Health care professionals in several states are mandated by law to report prenatal drug exposure to the appropriate authorities—in some states, these reports are used as evidence in criminal proceedings, while in other states, such reports are utilized in civil child welfare proceedings

(Dailard & Nash, 2000). Arizona, Illinois, Iowa, Massachusetts, Michigan, Minnesota, and Utah all require reporting to child protective services following a positive drug screen (Dailard & Nash, 2000); California, on the other hand, has determined that a positive toxicology screen is not sufficient reason to file a report with child protective services—the positive toxicology screen must be coupled with health care personnel concerns about the child’s physical condition as well as parental and environmental risk factors in the home (Lester, Andreozzi, & Appiah, 2004). Ten states require doctors to report positive tests for prenatal substance exposure to law enforcement officials, while nearly two-thirds of all states require reporting of positive tests to the Department of Health (Jos, Perlmutter & Marshall, 2003).

Again, however, many significant concerns arise when considering this approach to the issue of substance abuse during pregnancy. For example, physicians argue that such expectations violate the confidential nature of the doctor-patient relationship. Mandatory reporting laws essentially make physicians agents of the state, thus increasing the likelihood that patients will submit incomplete medical histories, jeopardizing the physician’s diagnostic and treatment abilities; knowledge of mandatory reporting requirements might also deter pregnant women to forego prenatal care altogether to avoid criminal prosecution or risk the loss of custody of a child (Anello, 1995).

Furthermore, concerns arise about which women and infants get tested for substances and are then subject to mandatory reporting requirements. Again, the regulation and monitoring of poor women of color far exceeds the regulation and monitoring of White women or women of more privileged socioeconomic status. For example, researchers in Florida found that while White and African American women used illegal drugs at comparable rates in the state, African American women were *ten times more likely* to be reported for child abuse related to substance use during pregnancy (Paltrow, Cohen, & Carey, 2000). In South Carolina, one large hospital mandated testing of all infants born in the hospital, save for those born to mothers who had private insurance and used the hospital’s private obstetrical/gynecological services (Figdor & Kaeser, 1998). Some physicians fail to detect substance abuse in pregnant women because of flawed assumptions about which socioeconomic and ethnic groups are at risk, thus failing to identify drug-affected newborns or substance-abusing pregnant women who do not match their preconceptions (Anello, 1995).

An additional critique of mandated reporting requirements centers on the gendered nature of testing and reporting. Many argue that universal screenings are the best way to reduce the number of infants born

exposed to substances, suggesting that universal screenings mean that all children will be identified and offered the support and services that they need in order to grow up safely and healthfully. However, these attempts to universalize testing are *extremely* limited in their scope. While they purport to test all women, regardless of race, income and insurance status, the screening is not, in fact universal: “simply put, ‘universal’ testing proposals do not reveal drug use by potential fathers or address the role that men play in women’s substance abuse problems” (Paltrow, Cohen, & Carey, 2000, p. 7). To truly keep children safe, much broader interventions and assessments are absolutely necessary.

Civil Child Welfare Statutes

While some mandatory reporting laws require sharing information with law enforcement officials, most involve reports to child protection authorities. As such, many states have amended their civil child welfare statutes to address the issue of substance abuse during pregnancy and children born substance-exposed. Overall, the purpose of civil child welfare laws is to “protect children from future harm, not to punish parents for past wrongdoing” (Paltrow, Cohen, & Carey, 2000, p. 4). In spite of the statutes’ purported purposes, though, some states’ laws are considerably more punitive than others’: states like Florida, Illinois, and South Carolina automatically define a child born exposed to drugs as abused or neglected; in these states, evidence of prenatal substance exposure offers grounds for automatic removal of the infant from the mother’s custody, and is also a factor in determining whether or not to terminate parental rights (Dailard & Nash, 2000). In other states, such as New Jersey, Connecticut, and New York, statutes are somewhat less penalizing, mandating that substance abuse alone is not grounds for custody loss or termination of parental rights; the substance abuse must be coupled with parental failure to provide adequate care in order to be considered as a factor in loss of custody or termination of parental rights (Dailard & Nash, 2000).

It is undeniable that some newborns exposed prenatally to some substances do, indeed, suffer adverse consequences, including prematurity and low birth rate in the short-term, and possible cognitive delays in the longer-term, and that some infants born exposed to drugs are, indeed, abused and/or neglected, or are at great risk of *being* abused or neglected in the care of their parent(s). However, it is nearly impossible to separate prenatal impacts on a child from postnatal impacts on a child. Research suggests that *poverty*, not drug exposure, has a more dramatic impact on child well-being: “the cocaine-exposed child was stereotyped as being neurologically

crippled—trembling in a corner and irreparably damaged. But this is not the case. And furthermore, the inner-city child who has had no drug exposure at all is doing no better than the child labeled a ‘crack baby’” (Paltrow, Cohen, & Carey, 2000, p. 1).

Automatically removing a substance-exposed child from its parents, then, does not address the factors that pose the greatest risk to child safety and well-being: women who abuse drugs are often poor, homeless, undernourished, physically abused, and sick without access to adequate medical care, and researchers absolutely cannot determine which “of this array of hazards actually caused the terrible outcomes they originally attributed” to prenatal substance exposure (Roberts, 1997, p. 158). Additionally, child welfare statutes that call for immediate removal of a child born substance-exposed presume that out-of-home placement will assure the healthy and safety of the child, which is simply not the case: multiple studies suggest that placement in the foster care system can also be devastating for a child’s development and well-being (Evans, 1997).

Furthermore, current application of child welfare statutes to address the issue of substance abuse during pregnancy is often based on several other faulty assumptions. First are incorrect assumptions about the nature of addiction. Drug use is often viewed as a moral failing and as an individual woman’s personal choice (Campbell, 2000); child welfare statutes assume that women who use drugs could simply stop. The logic of such statutes holds that a woman’s failure to stop drug use during pregnancy indicates her disregard for her future child’s well-being. However, the California Medical Association notes, “Prenatal substance abuse by an addicted mother does *not* reflect willful maltreatment of a fetus, nor is it necessarily evidence that the mother will abuse her child after birth” (As cited in Paltrow, Cohen, & Carey, 2000, p. 5); the American Medical Association supports this argument, stating, “It is clear that addiction is not simply the product of a failure of individual willpower. Instead [substance] dependency is the product of complex heredity and environmental factors. It is properly viewed as a disease” (As cited in Paltrow, Cohen, & Carey, 2000, p. 4). In other words, addicted women, in many cases, do not intentionally get pregnant, nor does addiction simply stop when a woman becomes pregnant.

A second assumption involves the idea that a woman who uses drugs during her pregnancy will be unable to care for her child once born. Certainly, it would be naïve to assume that all addicted parents have the capacity to provide adequate care to their children—just as it would be naïve to assume that all parents who do *not* use drugs will automatically provide adequate care to their children. However, in a comprehensive review of lit-

erature on the subject, Boyd (1999) found that overall, when controlling for such factors as poverty, there are few statistically significant differences between the parenting practices of addicted and non-addicted mothers, meaning that utilizing child welfare statutes to remove children from the custody of their mothers after prenatal substance exposure may be an ineffective and incomplete means of addressing the issue.

Civil Commitment

According to federal laws, commitment requires “clear and convincing evidence that an individual is mentally ill and a danger to self or others” (Dailard & Nash, 2000). Efforts to commit drug-using women assume that a woman is a danger to another person—the fetus. A 1997 Wisconsin law defines a fetus “as a human being from the time of fertilization to the time of birth” (Figdor & Kaeser, 1998, p. 4). A pregnant woman suspected of substance abuse can be taken into custody—against her will—if authorities identify “substantial risk that the physical health of the unborn child, and of the child who will be born, will be seriously affected or endangered” (Figdor & Kaeser, 1998, p. 4). Minnesota and South Dakota admit pregnant women for inpatient treatment for as long as the duration of a pregnancy (Dailard & Nash, 2000).

Again, concerns abound. First, many worry that knowledge of commitment policies deters women from seeking prenatal care or substance abuse treatment, or prevents them from giving complete histories to physicians. Civil commitment initiatives disproportionately impact poor Black women, subjecting them to more monitoring and regulation. Second, critics note lack of adequate medical and prenatal care in residential treatment facilities and hospitals and continued availability of illicit substances in jails and prisons (Anello, 1995). Third, critics believe that these policies seem to prioritize “fetal rights” over maternal rights. Lester, Andreozzi, and Appiah (2004) explain, “By involuntarily committing the mother as a mode of protecting the [yet unborn] infant, the court is . . . putting the needs and the health of the child over those of the mother” (p. 14).

Drug Treatment Initiatives

Twenty-five states have opted to address the issue of substance abuse during pregnancy by way of drug treatment initiatives. A few states have created treatment programs designed especially for pregnant women, while most other states taking this approach have responded to the dearth of treatment slots available to pregnant women by offering pregnant women priority

access to general treatment programs or passed laws prohibiting discrimination against pregnant women seeking drug treatment, including methadone treatment (Paltrow & Carey, 2000). Anello (1995) notes several reasons why such initiatives are important: historically, the drug abuse treatment system has been male-oriented, meaning that many residential treatment programs did not admit women due to inability to meet women’s needs, failure to recognize that women have substance abuse treatment needs, and concerns about liability—especially as related to treating pregnant women.

While drug treatment initiatives are the most humane of the policy approaches to the issue of substance abuse during pregnancy, they remain an incomplete and inadequate response: they only address the issue after substance abuse during pregnancy has already been identified, offering little by way of preventative education or by way of ensuring the health, safety, and well-being of mothers and children in their postnatal environments. Furthermore, in spite of states’ best efforts, access to treatment programs is still far too limited. According to government estimates, drug treatment is only available to one-third of all United States residents who need it—for pregnant women and women with children who have specialized treatment needs, this figure may be even lower (Drug Policy Alliance, 2000). In fact, Kershner and Paltrow (2001) estimate that around 675,000 pregnant women need drug and alcohol treatment services in this country per year, but fewer than 11 percent of them will actually receive it.

Thus, treatment programs specifically designed to meet the needs of pregnant and parenting women are far too difficult to access. Also, standard drug treatment programs may not adequately meet the needs of pregnant and parenting women. Comprehensive, adequate programs would need to offer, among other services: prenatal care, child care, and medical care for women, any children currently in their care, and their newborn infants (Lester, Andreozzi, & Appiah, 2004). Research also suggests that female drug-users are more likely than their male counterparts to have significant co-morbidities, including domestic violence, childhood histories of trauma and abuse, and unaddressed mental health needs (Paltrow & Carey, 2000; Lester, Andreozzi, & Appiah, 2004), meaning that adequate treatment programs would need to be prepared to address much more than merely substance abuse. Indeed, one study of drug-addicted women found 74 percent reporting childhood sexual abuse; another study noted that 70 percent of pregnant women who admitted to using drugs during pregnancy also reported current domestic violence (Center for Reproductive Rights, 2000). In addition, federal policies threaten statewide drug treatment initiatives. Carey

(1998) notes that 1996 welfare reform laws made individuals with drug convictions ineligible for funding from Temporary Assistance to Needy Families (TANF) and also ineligible for food stamps; alcohol and drug treatment programs, especially ones residential in nature, have often utilized welfare funds and food stamps to assist in paying for their services—no plan is in place to help offset these prospective losses.

Threats to Reproductive Rights and the Complexities of “Choice”

In defining the fetus as a viable person under South Carolina state law, thus upholding the Whitner conviction, the South Carolina Supreme Court is certainly challenging *Roe v. Wade* and the right to legally access abortion. The Wisconsin statute allowing for the civil commitment of pregnant women due to concerns about substance abuse explicitly defines “an unborn child as a human being from the time of fertilization to the time of birth” (Figdor & Kaeser, 1998, p. 4)—this law, too, could undermine a woman’s right to have an abortion. Anello (1995) explores the development of statutes like those in South Carolina and Wisconsin, noting that historically, a pregnant woman and the fetus were viewed as a “single organic unit” (p. 1), with the fetus not having any needs or status separate from that of the pregnant woman. Today, Anello (1995) explains, “a growing segment of society has come to see the fetus as the ‘tiniest citizen’ and imbuing it with certain rights and needs” (p. 1). Roberts (1997) concurs, explaining, “As the antiabortion movement portrayed the fetus as a separate person and the medical profession treated the fetus as an independent patient, the fetus acquired more and more legal rights of its own, often against the pregnant woman carrying it” (p. 154). The antiabortion movement has seized the issue of substance abuse during pregnancy and appears to be utilizing it to further its goal of “incrementalism—the gradual chipping away of abortion rights” (Figdor & Kaeser, 1998, p. 5). Policies about substance abuse during pregnancy seem to be little more than a means to an end for “fetal rights”/antiabortion activists, offering a convenient means to justify increasing limitations on women’s rights.

Conversely, Roberts (1991) highlights this other side of the “choice” issue: current policy approaches to substance use during pregnancy offer many women little “choice” but to *have* an abortion. Roberts (1991) explains that

when a drug-addicted woman becomes pregnant, she has only one realistic avenue to escape criminal charges [or other sanctions, including involuntary civil commitment or loss of custody of her child]: abortion. Thus,

she is penalized for choosing to have the baby rather than having an abortion. In this way, the state’s punitive action may coerce women to have abortions. . . . Thus, it is the *choice of carrying a pregnancy to term* that is being penalized (p. 1445).

This highlights the complex issue of “choice” as it relates to motherhood and reproductive rights. This especially holds true for the lower-income Black women who have been targeted for government interventions aimed at substance abuse during pregnancy: motherhood among poor Black women is already devalued and discouraged by society; poor Black women who “choose” motherhood are thus punished for their decisions (Solinger, 2001; Roberts, 1991).

The Proposed Framework: A Public Health Approach

Society has a vested interest in ensuring the birth of healthy infants, but to date, no state has enacted a coherent and comprehensive public health approach to ensure healthy pregnancies and birth outcomes—including preventing and minimizing the impact of prenatal substance exposure (Jacobson, Zellman, & Fair, 2003). Current approaches to substance abuse during pregnancy are inadequate, casting the issue as a moralistic failure or a poor “choice” made by depraved women, particularly demonizing poor women of color, and failing to ensure healthy birth outcomes—these approaches have obviously been unsuccessful. Substance abuse during pregnancy must be recast as a significant public health concern in order for the issue to be adequately and humanely addressed.

A public health model is the best policy approach to substance use during pregnancy for several reasons. First, the harm caused to infants by prenatal substance exposure is almost entirely preventable. Current approaches do not acknowledge this fact, and do very little by way of preventing or minimizing impact—they offer mainly post-fact interventions that are often overly punitive in nature. A public health approach focuses significant efforts on prevention and early interventions, shown to dramatically reduce a pregnant woman’s substance use and provide better birth outcomes (Adams & Young, 1999; Mullen, 1999; Jacobson, Zellman, & Fair, 2003). Second, a public health model helps balance the autonomy and integrity of individual pregnant women—regardless of race or socioeconomic background—with the societal interest in ensuring the birth of healthy infants. Jacobson, Zellman, and Fair (2003) argue that such an approach emphasizes policies that will improve

both maternal *and* fetal health outcomes, as well as improving the postnatal environment for women and their children. Finally, a public health model broadens the scope of policy, taking into account the wide array of threats to fetal and maternal health—not just the use of illegal substances during pregnancy. This approach also broadens the scope of responsibility for child well-being, placing expectations not just on individual women, but also on men/fathers and on society and government at-large.

Griffiths, Jewell, and Donnelly (2005) identify three overlapping basic domains of public health: health improvement, health protection, and health service delivery and quality. The health improvement domain encompasses the prevention and education efforts needed to reduce prenatal substance exposure. It “covers key aspects of activity to reduce inequalities. . . involves engagement with structural determinants such as housing and employment, as well as working with individuals and their families within communities to improve health. . . through adopting healthier lifestyles” (Griffiths, Jewell, & Donnelly, 2005, p. 910). Health improvement efforts must involve public education and outreach to decrease the emphasis on the impact illegal substances, like cocaine and heroin, have during pregnancy, and increase recognition that *many* substances—including alcohol and tobacco—and *many* circumstances—including poverty, domestic violence and lack of access to prenatal care—can impact birth outcomes. Rather than defining the problem of unhealthy newborns narrowly, as a problem of individual behavior, especially the individual behavior of poor women of color, health improvement efforts seek to define the problem of unhealthy newborns much more broadly and to ensure that everyone understands and has a stake in improving the multifaceted elements that contribute to healthy pregnancies.

A public health approach also broadens the scope of the response to include fathers. Current policy approaches place social and legal responsibility for prenatal wellbeing on pregnant women. However, “the complex roles that men play as present or absent fathers, lovers, spouse batterers, enablers, and co-participants in drug abuse must be factored into policy if robust and durable solutions to prenatal substance exposure are to be found” (Jacobson, Zellman, & Fair, 2003, p. 485). Thus, men/fathers, in addition to women/mothers, must be engaged in efforts to prevent prenatal substance exposure.

Furthermore, the health improvement domain seeks to impact the many “structural determinants” that impact birth outcomes rather than merely focusing on prenatal substance exposure or “bad choices” made by depraved individuals (who are, in society’s eyes, predom-

inately low-income women of color). Campbell (2000) argues, “Pregnant addicts represent a call for social responsibility and policies of social justice” (p. 139)—policies of social justice demand an eradication of ignorance, poverty, disease, and inequality through such social rights as universal healthcare, uniform access to contraception and abortion, childcare, anti-violence initiatives, safe housing, and a living wage. If we as a country are interested in ensuring that healthy children are born, we *must* provide the material conditions necessary for that to be a reality.

The second domain of public health, health protection, provides a framework for humane responses when health improvement efforts are unsuccessful, and threats to healthy birth outcomes by way of maternal substance abuse are identified. Health protection efforts call for early detection and early intervention; research suggests that early detection of substance use during pregnancy and early intervention with women using substances while pregnant can reduce the nature and amount of substance used (Anello, 1995). By identifying maternal substance abuse early, a public health model provides for interventions that seek to change the circumstances under which fetuses are exposed to substances, both legal and illegal, which has demonstrated a significant impact on birth outcome. Research has uncovered differences in the impact of maternal alcohol abuse based on maternal socioeconomic status. In one study, mothers

drank at the same rate, [but] the children born to low-income women had a 70.9 percent rate of fetal alcohol syndrome, compared to a 4.5 percent rate for those of upper-income women. The main reason for this disparity was the pregnant women’s nutrition: while the wealthier women ate a regular, balanced diet, the poorer women had sporadic, unhealthy meals. (Roberts, 1997, p. 158)

A public health approach to the issue of substance use during pregnancy, then, must incorporate the following elements in its health protection efforts. First, it must include a referral to treatment facilities and cover the cost of treatment for those unable to pay. Treatment facilities that meet the unique needs of pregnant and parenting women must be established, readily available, and adequately funded in order to minimize negative outcomes attributable to prenatal substance exposure. These treatment programs, in order to optimize success, must be community-based; they must rely “less on professionals from outside the community and more on strengthening the capacity of communities themselves to deal with problems of addiction. Successful programs should be

based on the community needs and utilize naturally occurring social networks” (Jos, Perlmutter, & Marshall, 2003, p. 345). A second important element of an adequate public health approach is that pregnant women are not to be subjected to arrest, commitment, incarceration, confinement, or some form of detention due to prenatal behavior (Paltrow, Cohen, & Carey, 2000). Mothers’ rights and fetal rights are not to be pitted against one another. Third, after a child is born substance-exposed, positive toxicologies are only to be used for medical intervention and not for criminal prosecution or child welfare involvement without additional information and substantiated concerns about parental unfitness.

The third domain of public health, health service delivery and quality, includes “engagement in service delivery, promoting clinically effective practice particularly through promoting evidence-based care, supporting clinical governance, planning and prioritizing services and engaging in appropriate research, audit, and evaluation” (Griffiths, Jewell, & Donnelly, 2005, p. 910). Here, the ways in which the domains of public health overlap with one another is quite clear, as service delivery issues are impacted by health protection issues such as poverty and education level. There are major disparities in access to adequate prevention and treatment services which absolutely must be addressed; institutions of healthcare, prevention, and treatment *must* foster trusting relationships with the communities they are seeking to serve. This component includes constant self-evaluation to ensure that public health services are being administered fairly, humanely, and without perpetuating class and race bias, and that they are, indeed, being administered effectively—in other words, public health policies must be evaluated to assure that they are, indeed, meeting the outcome of improving pregnancy and birth outcomes.

The success of a public health framework to approach the issue of substance abuse during pregnancy depends, in part, on feminist activism. Gomez (1997) offers several important strategies for feminist activists. She suggests that activists must recast the issue of prenatal drug exposure as a women’s health problem with the potential to impact *all* women. She explains, “Part of the strategy to medicalize rather than criminalize prenatal drug exposure . . . [depends on] recasting it as a more generic women’s problem rather than as one limited to the subset of women presumably more apt to be viewed as having criminal propensities” (Gomez, 1997, p. 122). Roberts (2000) rightly notes that indeed, this *is*, in fact, a “generic women’s problem” because of the threats punitive policies make to all women’s reproductive rights.

In reshaping substance use during pregnancy as a public health issue, then, cross-racial coalitions become incredibly important. While poor Black women have

overwhelmingly been targeted by punitive policy approaches, Daniels (1996) notes that their prosecutions have set legal, political, and social precedents that will impact all women—including White women of more privileged socioeconomic status. She charges women with more privilege and power in society to take initiative: “The disproportionate privilege of some women, rather than hopelessly dividing rich from poor or White women from women of color, can be used to defend the rights of all women” (Daniels, 1996, p. 134, as cited in Roberts, 2000, pp. 1365-1366).

Implications for Social Workers

Current policies related to substance use during pregnancy have a disproportionate impact of on poor women of color; this is of serious concern to social workers, for whom integrity, social justice, and the dignity and worth of all people are some of the values on which our profession is based. It is important for social workers, then, to take an active role in advocating for and with the women impacted by punitive policies to not only strike down convictions already handed down and refuse to allow the enforcement of punitive policies, but also to enact public health policies aimed at substance abuse during pregnancy that are more just, compassionate, and humane.

Furthermore, the issue of substance use during pregnancy suggests several research- and training-related implications for social workers. Social workers will need to explore the effectiveness of treatment and intervention programs for pregnant and parenting women with addiction problems, as well as the most effective methods of prevention, screening, and education. This research must explore the nature of addiction in women, including such factors as the co-occurrence of physical and sexual abuse, the failure of this country’s public health system to engage women, the gendered expectations about women’s behaviors and roles, and impact of racism and poverty on women’s addictions. This research would assist in making treatment more effective for pregnant women with addiction problems, and also in helping to eliminate the barriers to treatment that pregnant and parenting women often face. In terms of training needs, social workers will need training in and around the application of the public health model, so that they apply it in a well-informed and compassionate way, expressing genuine concern and regard for the well-being of women before, during, and after pregnancy.

Conclusion

Keeping women who use substances during

pregnancy—especially already-marginalized poor women of color—“under the influence” through criminal interventions, mandated reporting laws, child welfare statutes, civil commitment, and drug treatment initiatives, does not accomplish the goal of promoting the health and well-being of children. To reach this goal, we must take a different approach, one based on the tenets of a public health model. Paltrow, Cohen, and Carey (2000) explain,

Such a new approach would draw on the best of our developing knowledge about the dynamics of addiction, the abuse many

women experience, the intersection of racism and poverty, the shortcomings of our public health system, and the ways in which women’s reproductive choices are stigmatized and second-guessed by a culture still confined by gender stereotypes (p. i).

Such a new approach would allow women more autonomy in their lives, leaving them under their *own* influence, not simply for the sake of promoting healthy pregnancies, but out of concern for the women—all women—themselves.

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