

# Helping Women Helping Children: Drug Policy and Future Generations

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We are born into families, and the first society we belong to, one that fits or misfits us for later ones, is the small society of parents (or some sort of child-attendants) and of children. (Baier 1987, 55)

**A** DRUG POLICY DEVELOPED FOR WOMEN MUST TAKE into account the implications of their drug use, not only for themselves as autonomous adults, but also for their biological and social roles as procreators and caregivers. Only women gestate. Furthermore, caregiving has been and continues to be the overwhelming responsibility of women. Although men may also be procreators and caregivers, these roles are not culturally perceived as significant aspects of their lives. Unfortunately, because drug policy discussions have historically focused on the behaviors and needs of male addicts, the individual and social significance of procreative and caregiving roles has been ignored.

A standard approach to analyzing social issues, including drug regulation, is to frame the problem in terms of sensible accommodation between rights-based liberalism emphasizing individual autonomy and choice, on the one hand, and communitarianism, which stresses group interests, on the other. Policy debates concerning drug abuse reflect this framework, with options arrayed along a continuum defined by two

mutually exclusive policy positions: legalization—the general elimination of legal restrictions on possession and sale of drugs—versus vigorous enforcement of criminal laws.

This framework is not useful to a discussion of women's substance abuse because it does not adequately account for the significance of procreative and caregiving roles. Decisions to reproduce and caregiving activities involve establishing and maintaining relationships with special others, especially offspring. A libertarian focus on individual autonomy and choice, therefore, fails to capture important features of women's drug use, such as the harm it may bring to others in these relationships. For example, debating whether to legalize the use and possession of drugs fails to grapple with the significant fact that the fetus in utero is harmed by legal as well as illegal substances. Similarly, vigorous enforcement of criminal laws aimed at preventing individuals from using illegal drugs undoubtedly penalizes the user. Yet, such enforcement is not likely to prevent harm to fetuses or children. Moreover, because fetuses and children are physically and psychologically closely linked with their mother, punishing her may often adversely affect them as well.

The social response to the complex problem of women's drug abuse has been primarily legal, highly punitive in nature, and targeted at pregnant women. This response has taken account of the fact that a woman's drug use has implications for her reproductive role. Unfortunately, however, the response assumes that the interests of the pregnant woman and the fetus are necessarily in conflict. Thus, two dominant perceptions have emerged: the deviant and irresponsible woman and the vulnerable fetus.

The use of addictive substances or participation by pregnant women in activities that risk harming the fetuses contradicts prevailing social norms and expectations about motherhood. Although in the past pregnant women have used alcohol or illegal substances like heroin that interfere with fetal development, women's use of crack, a highly addictive and concentrated form of cocaine, has created and shaped contemporary popular images of substance-abusing pregnant women. The conduct of women addicted to crack is dramatically different from maternal behavior associated with other addictive substances. They often have multiple pregnancies and give birth to infants who have been exposed to crack, frequently just prior to delivery. They seem to exhibit no interest in their infants, often abandoning them in the hospitals where they delivered.

This perception of women who use illegal drugs, particularly crack, as irresponsible mothers is reinforced by the illegal character of their activities. Thus, it becomes easier to condemn their conduct as morally blameworthy. In addition, the profile of women who use illegal addictive substances is consistent with the public perception of addicts as being members of minority groups and predominantly lower class, a perception that has proved influential in gaining public acceptance of punitive drug policies.

The depiction of women who use addictive substances as deviant, irresponsible, and morally blameworthy stands in stark contrast to the perception of the fetus, which is perceived as innocent and especially vulnerable to the pregnant woman's activities, thus requiring protection. As a result, the maternal-fetal relationship is perceived as being an adversarial one. Although the needs of pregnant addicts have been largely neglected by society, it is not surprising, therefore, that when there is active social response to a pregnant woman's drug use, it is characterized primarily as punitive, with the rationalization that such measures are required to protect the fetus or newborn.

Arguments in favor of, or in opposition to, punitive approaches share a common methodological approach when analyzing the policy issues raised by women's substance abuse. Although these arguments vary in their assumptions about fetal status and their justifications for state intervention, they all proceed on the premise that the matter at issue is essentially maternal autonomy versus state intervention. One set of arguments, particularly when grounded in the assumption that fetuses are persons or potential human beings, sees the issue as one of competing individual interests—woman versus fetus—that must be resolved in favor of one interest. They assume that maternal interests and fetal interests can be equated and are necessarily adversarial. The arguments differ only in terms of which interest should have priority. If state intervention is warranted, it is because the fetus, never the mother, needs the state's protection.

A second set of arguments, especially those that do not accord the fetus equal status with the woman, views the issue as one of maternal autonomy versus costs to the community. For example, the state may have an interest in constraining maternal autonomy to reduce the costs of taking care of humans born with disabilities. Alternatively, the unintended effects of taking punitive measures against women, such as discouraging pregnant women from seeking prenatal care, may be so costly

that state intervention is contraindicated. These arguments focus attention only on women, not on third parties and social institutions, and ask whether certain acts are properly within the realm of maternal autonomy.

A more compelling analytical structure for developing drug policies for women would make different assumptions about the nature of the relationship that exists between mother and fetus, parent and child. This approach would assume that humans do not exist in self-interested isolation from others. In particular, we rely on parents to make decisions that will be in the best interest of their offspring. Much of this belief stems from our personal knowledge of the nature of interactions in intimate interpersonal relationships, such as those that exist between parents and children. The reality of family life and the sacrifice and attention to important others that it demands are not easily reconciled with a philosophy that judges human activities to be driven solely by self-interest.

Unlike the underlying perceptions driving current drug policies, this alternative framework is not predicated on an adversarial relationship between the mother and her fetus or child. Rather, it assumes that maternal-fetal and mother-child relationships can only be understood in terms of interactions where the needs of one define the needs of both. This framework permits recognition of the fact that often what adversely affects a parent also harms a fetus or child. The obverse is also true: what helps women become more confident, integrated persons nurtures their children's growth and development. This framework also does not presume that maternal choices will be irresponsible and lead to higher social costs.

Although this focus on a woman's relationship with her fetus or child does not necessarily preclude punitive or coercive responses to the problem of women's substance abuse, it nonetheless broadens the range of strategies to be considered in designing drug policy for women. Moreover, it does raise significant questions about the effectiveness of punitive and coercive strategies. Finally, it suggests that nonpunitive and noncoercive strategies emphasizing education, treatment, and removal of conditions that lead women to abuse drugs in the first place offer the greatest long-term prospect of sparing women, their offspring, and their families the harm that flows from mothers' abuse of legal and illegal psychoactive drugs.

## The Scope and Nature of Women's Drug Use

The most important lesson to draw from the medical and social data about maternal substance abuse is that addiction to both *legal* and *illegal* substances and a woman's entire lifestyle have serious implications, not only for a woman's health and well-being, but also for the health and well-being of her offspring. Maternal substance abuse during pregnancy by almost any measure is a source of significant infant morbidity and mortality that presents serious concerns for our society. Moreover, the policy implications of maternal substance abuse cannot be fully understood by focusing merely on the harms it causes to fetuses and newborns. Policy discussions must also address the implications of maternal substance abuse for children and future generations. Finally, to prevent harm rather than be satisfied with repairing damage already done, drug policy for women must focus on the underlying causes of substance abuse by women.

Women's substance abuse is a problem of serious social dimensions whose impact potentially falls heaviest on poor and minority women. Although there are indications that *illicit* drug use of all kinds is declining (Kandel 1991), the number of women of childbearing age who abuse legal and illegal drugs remains high. A recent estimate is that five million women of childbearing age (ages 15 to 44) currently use illicit drugs, including one million who use cocaine and over three million who use marijuana (U.S. Congress 1990, 4). In addition, approximately six million American women are alcoholics or alcohol abusers. Although women's *illegal* drug usage is associated in the public mind with women of color and poor women, data confirming this association are not available. There are data indicating that African Americans are overrepresented in morbidity and mortality linked with illicit drug use (Kandel 1991). Over time, poor and minority women may indeed constitute the majority of women who abuse *illicit* drugs in ways that put them at great social and medical risk.

The social implications of women's substance abuse cannot be defined solely in terms of the effects of their addictive behavior. Women substance abusers must often cope with economic, health, and psychiatric problems that may be both the cause and the result of their addiction (Daghestani 1988; Regan, Ehrlich, and Finnegan 1987; Regier

et al. 1990). Many substance-abusing women had chemically addicted parents. Often they were physically and sexually abused as children and, as a result, are prone to depression and low self-esteem. Female addicts often live with men who batter them and/or men who also abuse drugs. Typically, they do not have marketable skills. As a result, many turn to prostitution to support their drug habit. Women involved in intravenous drug use and/or prostitution have a high risk of contracting the human immunodeficiency virus (HIV), and, if infected, are capable of transmitting the infection to their sexual partners and fetuses. The severity of these economic, health, and psychiatric problems makes it difficult for women substance abusers to parent in ways that society deems responsible without social assistance. Yet, support of any kind is typically unavailable.

Without support and treatment, women substance abusers who become pregnant pose serious threats to fetal well-being. One estimate is that 375,000 babies born per year have been exposed to illicit substances of all kinds in utero, including cocaine (Chasnoff 1989; *Medical World News* 1990). In addition, abuse of legal substances has potentially severe repercussions for fetal development. For example, the adverse effects of alcohol on fetuses have been known for many years (Abel 1973, 1990; Jones et al. 1973; Weiner and Morse 1988). A female drug user's lifestyle also puts her fetus at risk of HIV infection. There were 2,116 reported cases of pediatric acquired immune deficiency syndrome (AIDS) in children under age 13 as of February 1990. In 80 percent of these reported cases, AIDS was attributed to maternal transmission of the virus. Of these cases of maternal transmission, 90 percent of the babies' mothers either used intravenous drugs or had heterosexual partners who were intravenous drug users (U.S. Congress 1990, 7).

Although it is clear that many legal and illegal substances are potentially harmful to fetuses, the precise causal relationship between the ingested substance and resulting harm to offspring is difficult to discern, especially when the amount and timing of drug ingestion are unknown. There are relatively few clinical studies of pregnant drug users (Daghestani 1988). Even when such studies exist, outcomes are difficult to assess because of polydrug use and other factors in the pregnant woman user's environment that influence fetal development (American College of Obstetricians and Gynecologists 1990). These factors include poor nutrition, lack of prenatal care, maternal psychopathology, and a drug-seeking lifestyle (Keith, MacGregor, and Sciarra 1988). Our inabil-

ity to differentiate and weigh the relative effects of various factors on fetal development suggests that a broad range of policy approaches may be required to address adequately the problem of maternal substance abuse.

Children who live with substance-abusing parents are also at risk of physical and emotional harm (Chasnoff 1988; Deren 1986; Hassett 1985; Rosenbaum 1979). Although addicted parents do not necessarily abuse their children, many substance-abusing parents have impaired parenting skills because of their troubled childhoods and their drug-seeking lifestyles. As a result, substance abuse is frequently noted in cases of child abuse and neglect (Black and Mayer 1980; Burns and Burns 1988; Egan 1990; Mayer and Black 1977). Most children live with or are cared for by women. As a consequence, if children come into contact with a substance-abusing parent, it is likely to be their mothers. Although children, unlike fetuses, can be removed from their parents' custody if they are being abused, removal does not guarantee that the child will be protected from harm. Foster care is not realistically a vast improvement over life with an addicted parent, given the current inadequacies of our foster care system.

Being parented is also the primary preparation for becoming a parent. Patterns of dysfunctional parenting seen in substance-abusing families are thus passed from generation to generation (Burns and Burns 1988). The result is an ongoing cycle of abuse and neglect leading to depression and self-degradation that, in turn, puts individuals at risk both for substance abuse as a form of self-medication and of becoming another inadequate, hurtful parent (Regan, Ehrlich, and Finnegan 1987).

Although the number of women who use addictive substances is substantial, there are comparatively few programs that treat women, and the available slots are severely limited. Even female substance abusers who have access to some economic and social supports have had difficulty gaining access to effective treatment. Obviously, women who do not have employment that provides health care benefits or access to health care by other means are especially disadvantaged. Historically, drug treatment programs have been oriented to the needs of the male addict. As a result, even if a woman gains access to a drug treatment program, she cannot be assured that such programs will meet her needs (Chavkin 1990).

The problem of access and appropriately designed drug treatment programs for women is further accentuated when a substance abuser be-

comes pregnant. She encounters even greater obstacles to getting treatment. For example, of 78 drug treatment programs surveyed in New York City, 54 percent excluded all pregnant women; 67 percent would not accept pregnant women on Medicaid; and 87 percent did not accept pregnant crack-addicted women on Medicaid (Chavkin 1990; McNulty 1987-88). In addition, drug treatment programs for pregnant women, when they do exist, are not well integrated into other programs furnishing health services to them (Dans et al. 1990; National Academy Press 1988).

Women addicts, therefore, face multiple obstacles—medical, social, and economic—in trying to overcome their addiction and related lifestyle problems. Obviously, if women substance abusers are unsuccessful in controlling their addiction or changing their lifestyles, their ability to be productive members of society and to parent effectively is severely compromised.

### The Social Response to Women's Substance Abuse: Focused on Pregnancy and Punitive in Character

What social response there has been to the problems posed by drug use among pregnant women has been largely punitive in nature, taking the form of criminal prosecutions or coerced treatment. More recently, there have been several proposals to limit the reproductive options of pregnant women who use drugs (see section below, "Limiting Women's Reproductive Options"). Conceivably, reliance on punitive approaches could be explained by the belief that *using* drugs is immoral as well as illegal. However, male users and female users who are not pregnant are being prosecuted for possessing or selling illicit drugs, not for using them. Something more seems to be at work in these prosecutions of pregnant women.

The conclusion is inescapable that these prosecutions are connected with the status of pregnancy (Paltrow, Goetz, and Shende 1990). This focus on pregnancy has been fostered by developments in science and medicine that have increased knowledge about uterine life and a simultaneous desire to protect the fetus from life-threatening or permanent injury. Concern about protecting fetal health, coupled with the legacy of the abortion debate, which has stressed an adversarial view of the



maternal-fetal relationship, has led to reliance on punitive and coercive strategies to alter maternal behavior.

### *Vulnerable Fetuses and Preventing Harm*

As a result of rapid developments in science and medicine, the fetus has emerged as a discrete entity from its heretofore hidden and inaccessible existence in the womb. These scientific and medical advances have helped to blur the distinction between fetuses and children because they make it possible to visualize and interact with the fetus to some extent throughout all phases of fetal development (Callahan 1986). In medicine, this outpouring of knowledge and information about the fetus has led to the recognition of the fetus as a second patient. In both criminal and civil law, fetal interests have increasingly come to be recognized as separate and distinct from those of mothers (McNulty 1987-88).

The emergence of the fetus as a discrete entity has been accompanied by rapidly accumulating information about its growth and development, which has revealed that almost everything a pregnant woman experiences—what she eats, what she drinks, her health status—can adversely affect fetal well-being. It is not surprising, therefore, that efforts would be initiated to protect the fetus from preventable injuries caused by maternal conduct.

The public's virtually exclusive preoccupation with hazards to fetuses associated with maternal conduct has served to minimize the fact that many risks to the fetus, such as fetal exposure to the rubella virus, are not of maternal origin. Other risks typically described as being maternally imposed are actually created by other parties. For example, risks to a fetus as a result of a pregnant woman working in a dangerous workplace could more appropriately be described as failure of the employer to provide a safe work environment.<sup>1</sup> A frustrated commentator asks, "How have we come to see women as the major threat to the health of newborns, and the womb as the most dangerous place a child will ever inhabit?" (Pollitt 1990, 409). The answer is linked to a view of pregnancy that assumes that the self-defined interests of pregnant women are at times in conflict with the well-being of fetuses. This assumption is a legacy of the abortion debates.

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<sup>1</sup> *International Union v. Johnson Controls, Inc.* 1991. *Supreme Court Reporter* 111:1196-1217.

*An Adversarial View of Pregnancy:  
The Legacy of the Abortion Debate*

Although the eugenics movement was concerned about who should procreate, abortion was the first significant moral and policy issue to arise out of pregnancy itself. The question of whether a pregnancy could be terminated was highly influenced by the legal context in which the matter was often discussed. The question was typically framed (although it need not have been) in terms of the woman's right to choose to terminate her pregnancy versus the fetus's right to live. As a consequence, pregnancy has been widely understood in terms of either the woman being a container for the fetus or the fetus being a part of a woman's body, which she was entitled to control. Thus, the abortion debate pitted woman against fetus and assumed that their relationship was inherently adversarial in nature. In this context, new knowledge about hazards to fetal well-being easily led to preoccupation with maternal conduct as a source of harm. This perspective, in turn, led to social concerns that a woman's self-defined interests might conflict with fetal interests.

When this adversarial perspective is applied to the situation where a mother has decided to carry her fetus to term, it frames the issue of maternal conduct in terms of whether a woman has the right to act in ways that carry risks of harm to a fetus. Because a fetus who will be carried to term more closely resembles a child, a woman who acts in disregard of potential risks to that fetus seems selfish and uncaring. In addition, a fetus injured in utero will have to bear the burden of injury throughout its life. Thus, fetal injuries resulting from maternal behavior are similar to other intentionally or negligently inflicted injuries that, when performed by others, are capable of legal redress. Injuries caused by maternal conduct that are preventable with little cost to her are particularly troublesome. As a result, once a woman intends to carry the fetus to term, its claim to be free from injury is likely to prevail. Although women's interests in their own health and well-being will not be completely ignored, there is a higher probability that they will be given short shrift.

Many individuals, especially women, are reluctant to move away from arguments about the maternal-fetal relationship that rest on autonomy and rights-based strategies. Alternative approaches that assume women have obligations to their fetuses are reminiscent of earlier definitions of

women's roles and responsibilities that served as ways of subjugating women to male domination (Okin 1989). Rights-based strategies were the means that women successfully employed to free themselves from this oppressed condition. Women particularly fear adoption of a view of pregnancy that undermines gains in their right to exercise autonomous reproductive choices.

Although rights-based arguments played a critical role in furthering the interests of women in the context of abortion, reliance on them in other reproductive contexts is questionable (Wikler 1986). Traditionally, pregnant women have been expected to and have, in fact, done everything possible to promote the well-being of fetuses they intended to carry to term (American Medical Association 1990). At a time when women remained in the home and little was known about the fetus, these requirements were not particularly onerous. With new knowledge about the fetus, however, the demands on pregnant women have become increasingly substantial and burdensome. Even so, women usually do meet these expectations. When women fail to meet social expectations about promoting fetal well-being, they are met with hostility rather than understanding. Such women are perceived as foes of their fetuses.

The consequence of using a conceptual framework that rests on an adversarial understanding of pregnancy is to risk penalizing women for being pregnant. By holding women solely responsible for pregnancy outcomes, the adversarial framework overburdens and isolates them while permitting men and the state to ignore their responsibilities to women, fetuses, and children. Consequently, arguments framed in terms of maternal choice and noninterference from others, on the one hand, and protection of fetuses from harm, on the other, are both likely to lead to state intervention in matters of reproduction to protect the fetus in ways that are detrimental to women.

### *"Deviant" Moms: Enforcing Maternal Responsibility During Pregnancy*

Interventions designed to prevent harm to fetuses by altering maternal behavior to conform with social expectations of pregnant women have employed punitive and coercive approaches. These measures, particularly in the drug context, are either initiated too late to prevent harm or

are of doubtful efficacy and are not demonstrably better than efforts based on voluntary treatment.

Attempts to alter maternal behavior to prevent harm to fetuses are not unknown in medical settings. In those environments, health care administrators and their institutions have petitioned courts to compel a pregnant woman to submit to bodily intrusion in order to prevent harm to their fetuses. Most of these early legal cases involved a woman's objection to a cesarean section or a blood transfusion. With the notable exception of the decision in *In re A.C.*,<sup>2</sup> most courts have ordered women to comply with medical advice to prevent harm to their fetuses. This judicial willingness to intervene and override maternal autonomy is viewed by some as a significant change in the prevailing moral and constitutional approach to reproduction that has emphasized maternal autonomy, choice, and privacy (Bayer 1990). Thus, in light of these precedents, concerned parties, especially prosecutors, looked to the courts for solutions to the problem of maternal drug abuse.

Pregnant women who abuse illegal substances, however, have presented more complicated problems for courts. Unlike cases involving coerced cesareans and transfusions, prosecutions for maternal substance abuse have typically been initiated after the baby has been born, so judicial intervention has been too late to prevent or mitigate harm at the fetal stage. Even incarcerating the woman during pregnancy may not prevent harm to the fetus. The fetus may already have been exposed to drugs before the woman encounters the criminal justice system. Moreover, because drugs are available in prisons, incarceration may not provide a drug-free environment. Worse, prisons rarely offer services such as the special diet, exercise facilities, and medical care that pregnant women require (Barry 1989; Churchville 1988).

Because incarceration is not likely to prevent harm to existing fetuses, prosecutions of women after the birth of a child exposed to drugs in utero have been initiated in the belief that criminal sanctions will deter other pregnant women from using drugs. It is doubtful, however, whether general deterrence can be achieved in these circumstances (McGinnis 1990). Female addicts do not necessarily realize they are pregnant in the early stages of pregnancy; therefore, they could not

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<sup>2</sup> *In re A.C.* (1990). *Atlantic Rep.*, 2nd series 573:1235-69. U.S. Ct. of Appeals, D.C. Circuit.

know that they are harming their fetuses through substance abuse. Even if she knows that she is pregnant, a female addict may not be aware that psychoactive substances may harm her fetus. Moreover, these prosecutions of pregnant women seem to many to be unduly harsh in view of the fact that a pregnant addict's conduct is not truly voluntary. As a result, there has been increased advocacy of mandatory drug treatment as a means of altering maternal behavior during pregnancy.

Requiring pregnant substance abusers to go into drug treatment is appealing to many. If effective, mandated drug treatment seemingly solves many of the medical and social problems associated with women's drug addiction. The woman stops harming herself; thus, state intervention takes the form of rehabilitation rather than punishment. The woman does not continue to physically harm the fetus, and perhaps she will be a better parent. Ideally, then, if we could get all women substance abusers of childbearing age into treatment, we would go a long way toward resolving problems generated by women's drug use.

Mandatory treatment strategies fall into two broad categories (see Gostin, this issue, page 561). First, treatment may be required as a result of involvement with the judicial system. Such involvement ranges from conviction for a criminal offense unrelated to drug use to civil child abuse proceedings, in which retention of child custody is conditioned upon enrollment in a treatment program. If one assumes that the treatment offered is effective, that it is permissible under the Constitution, and that the woman has committed some breach of criminal or civil law independent of drug use itself, thereby permitting the state to take some action against the individual, I have no principled objection to this approach. Rehabilitation is an appropriate goal for redressing wrongs in this society. In addition, mandatory treatment is preferable to incarceration without treatment for redress of wrongs in which substance abuse is implicated.

Second, treatment may be mandated through involuntary civil commitment procedures. Typically, civil commitment is used to isolate and treat individuals with mental health problems who are a danger to themselves or others. Civil commitment could be used generally with substance users by considering substance abuse as analogous to mental health problems. A more recent approach calls for pregnancy-specific commitment statutes. For example, the Minnesota Omnibus Crime Bill of 1989 contains a provision entitled "Prenatal Exposure to Certain Con-

trolled Substances," which creates a special exception to civil commitment procedures for pregnant substance abusers.<sup>3</sup> Under this provision a pregnant woman who habitually and excessively uses certain controlled substances and refuses or fails treatment can be determined to be chemically dependent and subject to involuntary commitment. (Normally, only substance abuse that renders an individual incapable of self-management or a danger to self or others is sufficient to justify involuntary commitment [Renshaw 1990, 143].)

Although there is evidence to indicate that coercion does not compromise the effectiveness of drug treatment (see Gostin, this issue), we cannot confidently assume that research findings on its long-term effectiveness with male inmates and parolees is applicable to women drug users, much less pregnant substance abusers (National Academy Press 1990, 198-9). We do know that women addicts, especially those who bear and rear children, have special needs. We do not have sufficient knowledge about what treatment is effective in meeting these needs. Although there is evidence to indicate that costs associated with fetal cocaine exposure are of sufficient magnitude to make education and treatment programs for pregnant women cost effective (Phibbs, Bateman, and Schwartz 1991), we do not have any information about the costs and benefits of alternative forms of treatment for women. It seems premature, therefore, to mandate drug treatment for female substance abusers, much less those who are pregnant.

Even if we assume that mandatory treatment works for women, problems remain. Although mandatory treatment is often viewed as an alternative to the punitive nature of the criminal justice system, in fact, it merely substitutes another form of coercion that also has punitive effects. Therefore, involuntary civil commitment may be as inappropriate as more explicitly punitive strategies. The Minnesota statute is a good illustration of this problem. Although it specifically avoids criminal prosecution and mandates that pregnant substance abusers receive drug treatment, health care professionals report that pregnant substance abusers are avoiding prenatal care and hospital delivery—precisely the same effect seen in states using criminal prosecution (Nyhus Johnson 1990, 522).

Although many argue that mandatory treatment interferes with a woman's autonomy, the real problem with mandatory treatment is that

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<sup>3</sup> 1989 Minn. Laws, ch. 290, Art. 5.

it carries with it the same assumptions of deviant mom and vulnerable fetus that underlie more explicitly punitive approaches. It assumes that maternal responsibility must be mandated. However, the time, care, and attention that fetuses and children need in order to grow and thrive cannot be coerced. Therefore, these parenting practices are exceedingly difficult for the state to enforce and cannot be easily provided by other means such as foster care. Similarly, the time and effort needed to succeed in drug treatment are difficult for the state to enforce except through the criminal justice system. There is some reason to believe that pregnant women are uniquely motivated to enter treatment voluntarily out of concern for their offspring (Chavkin 1991). Consequently, voluntary treatment programs for pregnant women should be tried before resorting to more punitive and coercive measures. Unfortunately, the Minnesota statute requiring drug treatment for pregnant women did not allocate sufficient funds to treat voluntary patients, let alone women involuntarily committed (Nyhus Johnson 1990, 523). The problem of underfunding is not unique to Minnesota, however. In addition, most voluntary drug treatment facilities use a 90-day program that is probably inadequate to treat addiction, which is a disease that can never be cured, only managed with the help of long-term treatment and lifelong support systems.

Whether directive counseling in some form by health professionals should be employed to get women into treatment is a more difficult problem to resolve. (The decision presumes that drug treatment is available and offered in an effective manner.) There is no reason to consider this strategy if the women involved are not pregnant. Indeed, it would be unfair to single women out on the assumption that they might become pregnant. Men also need access to treatment, especially if they are caregivers. When women are pregnant, however, and they intend to carry their fetuses to term, persuasion for purposes of getting women to agree to treatment seems permissible as long as the pregnant woman clearly understands that the final decision about entry into treatment is hers. More directive forms of counseling are justified under these circumstances because the fetus that will be carried to term is at risk of harm and the woman's health is also imperiled. Moreover, the effects of her addiction on her ability to assess her situation, which do not justify mandatory treatment, cannot be totally ignored. Finally, pressure exerted by the family or employer to enter treatment in a health care situation is of the sort that is viewed as permissible because the ultimate decision remains with the pregnant woman.

### *Limiting Women's Reproductive Options*

Although the rhetoric of social and legal discussions centers on the role of punitive and coercive strategies in protecting children, the reality may be that these social responses are directed at keeping some women from reproducing. For example, in Ohio legislation has been introduced that would mandate sterilization of women unable to overcome their addiction (Berrien 1990). The 1990 approval of Norplant® (a long-term implantable contraceptive) by the Food and Drug Administration has already led to a spate of proposals to use it to reduce the number of childbirths to teenagers, women on welfare, and female drug abusers (Egan 1990; Lev 1991; *Philadelphia Inquirer* 1990).

My belief that such strategies are designed to prevent specific groups of women from procreating receives partial support from the popular association between drug abuse and a user population that is poor and composed of minorities. In addition, poor and minority women have been disproportionately prosecuted for illegal substance abuse when compared with the known incidence of illicit drug use by women of all races and classes. In a survey by the American Civil Liberties Union of criminal prosecutions, 80 percent involved women of color (Paltrow, Goetz, and Shende 1990). Indeed, one study indicates that black women who are substance abusers are ten times more likely to be reported to the authorities than white women (Chasnoff, Landress, and Barrett 1990). Finally, we have a history in this country of coercing reproductive choices of minority women. For example, poor and minority women are disproportionately forced into having cesarean sections (Kolder, Gallagher, and Parsons 1987).

Coercing reproductive decisions—whether to delay or prevent conception—as the primary solution to women's drug abuse squarely poses the question of what motivation really underlies the punitive approaches we have taken in current drug policies for women. For some people, drug-abusing women should not be permitted to parent because they will expose future children to serious physical and psychological harm. Preventing or delaying reproduction is, therefore, an especially effective way of preventing future child abuse (Coyle 1989). For other people, drug-abusing women do not deserve to be parents. Their past conduct is so egregious that they merit severe sanctions. Whatever label or motivation we attach to strategies that prevent or delay reproduction, the potential for unfairly burdening minority groups and the poor is so high



that they must be resisted. Preventing or delaying reproduction also contradicts fundamental values of reproductive freedom. Nevertheless, there are frightening historical precedents suggesting that these values can be ignored in times of acute social crisis, such as the current "drug epidemic."

Although the prevailing liberal view in this society has been that individuals should have freedom of choice in reproductive matters (Bayer 1990), a darker reality has always hovered over the exercise of reproductive options by some individuals and groups. The belief that some individuals should not be permitted to be parents lies deep in our culture. This belief first received widespread social and legal support through the eugenics movement early in this century. Although historically eugenics focused primarily on preventing the transmission of deleterious genes, concern about parental competence—an expanded notion of unfitness—was always implicit. These concerns justified coerced sterilization of immigrants, the poor, and the institutionalized in the early decades of this century. These sterilizations were sanctioned by the U.S. Supreme Court in *Buck v. Bell*,<sup>4</sup> a case whose reasoning has been undermined, but never overruled. Even as late as the 1970s, poor and minority women believed to be unfit for parental responsibilities were being coerced into accepting sterilizations under the threat that their welfare benefits would be withdrawn.<sup>5</sup>

Contemporary concern about parental competence grows, in part, out of legitimate distress about the conditions in which children live and the physical, emotional, and cognitive problems that they may suffer as a result of parental inadequacies. There is an added fear that the state will have to bear the costs of rearing children whose parents are unable, for economic or other reasons, to carry out their responsibilities. This legitimate concern is also accompanied by a persistent, pervasive, and highly discriminatory preference for homogeneity in parenting styles.

African-American women have been a special target of these historical and contemporary concerns about parental competence (Roberts 1991). Stereotypes of African Americans as likely to prefer welfare to work, to be more violent, lazier, and less intelligent are pervasive and enduring (*Washington Post* 1991). In addition, drugs, violence, and

<sup>4</sup> *Buck v. Bell* (1927). *U.S. Reports* 274:200–8.

<sup>5</sup> *Relf v. Weinberger* (1977). *Federal Reports*, 2nd series, 565:722–7. U.S. Ct. of Appeals, D.C. Circuit.

perinatal transmission of HIV infection are associated in the public mind with the African-American community (Garcia 1990). All of these factors reinforce the popular view that African Americans are not competent parents. Consequently, it takes only a small leap to arrive at the view that drug-abusing women, like women on welfare and women who are HIV infected, should be encouraged, perhaps coerced, into forgoing reproduction in order to spare their potential children and the state the harms and costs resulting from their conduct.

The fact that certain women continue to reproduce despite the knowledge that their substance abuse during pregnancy places their offspring at risk of potentially very serious deficits is a source of legitimate concern for all. The legitimacy of this concern, however, cannot alone justify limiting the rights of individuals to reproduce. Control over the body and its reproductive aspects are essential ingredients in the development of individual self-identity as well as fundamental constitutional rights and cannot lightly be ignored.<sup>6</sup> Moreover, enduring unfairness and injustice in this society growing out of race, class, and gender bias call for caution in pursuing policies that single out certain groups of individuals for repressive reproductive strategies. Less drastic alternatives to accomplishing the goal of improving children's lives and reducing the necessity for public support should be pursued before giving the state the power to decide who can or cannot reproduce or even to determine the timing of reproduction.

It is not only direct governmental control over reproductive choices that must be avoided. Social welfare policies and programs can also meaningfully restrict the reproductive options that individuals realistically can exercise (King, forthcoming). For example, offering money to impoverished women on condition that they use a long-term contraceptive may have the same discriminatory effect as passing a law that requires sterilization or long-term contraceptive use. Although such arrangements retain the veneer of voluntariness, the fact is that they require women to choose between unacceptable alternatives—remaining in need or relinquishing reproductive freedom—solely because they are poor.

On the other hand, a woman's addiction to drugs does compromise her ability to make well-thought-out choices. This fact, coupled with

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<sup>6</sup> *Skinner v. State*. 1941. *Pacific Rep.*, 2nd series 115:123 (Oklahoma). *Roe v. Wade*. 1973. *U.S. Reports* 410:113.

the harm that drug abuse brings to her and her children, suggests that in some circumstances directive counseling about reproductive options, emphasizing delayed reproduction, is warranted. John Arras advocates a form of counseling that lies between directive and nondirective approaches. He argues that HIV-infected women should be counseled in a manner that “clarif[ies] the client’s values and expand[s] her awareness of the moral dimensions of her choices through respectful exchanges” (Arras 1990, 374). In principle, I agree with his view, because I am not convinced that counseling is ever value free, and because I do not think that mere recital of the possible consequences of a woman’s drug addiction for her fetus provides her with enough information to make an informed judgment. Seeing the effects of drugs on infants in a nursery caring for addicted babies may facilitate understanding of those consequences in a way that mere verbal disclosure cannot. Therefore, as I understand Arras’s model, it might, at least theoretically, enhance choice rather than impose predetermined outcomes.

Nonetheless, I remain profoundly skeptical about whether even this modified form of directive counseling can be conducted in a manner that realistically permits women to select any reproductive alternative, particularly outcomes we are trying to discourage. I am also convinced that this type of counseling would disproportionately target poor and minority women who, after all, receive most of their care from public sources where our concern about the social cost of their decisions is highest. Again the present-day realities of class, race, gender, and ethnic discrimination urge caution before adopting such a strategy. Less drastic infringements on long-valued rights of reproductive freedom and autonomy should be tried before we resort to these very stringent policies. Otherwise modern reproductive policies will be indistinguishable in their *effect* from their eugenic forebears.

As long as society persists in viewing the maternal–fetal relationship as adversarial, however, punitive and coercive strategies in response to maternal substance abuse are inevitable. Furthermore, punitive and coercive approaches will remain easy to justify as long as we view mothers who are substance abusers as deviant and their fetuses as primarily vulnerable to maternally inflicted injuries. This adversarial view of the maternal–fetal relationship, however, is not inevitable or preordained. In fact, it is antithetical to our own experiences as pregnant women and parents. In addition, adversarial approaches, based as they are on conflicting rights-based arguments, fail to capture the complexity of the

maternal–fetal relationship. To develop truly effective drug policies for women, then, we need to begin with a different, more realistic view of the maternal–fetal relationship.

### In the Body, of the Body: A Reformed Understanding of Pregnancy

A rights-based approach that pits woman against fetus fails to capture the essential biological and emotional reality of pregnancy. The fetus is in the woman's body and part of the woman's body (Purdy 1990, 273). It is simultaneously self and not-self. Most fundamentally, however, the maternal–fetal relationship is an interconnected and interactive *unit*.

In one sense the fetus and woman are one. The fetus exists in a body that shelters it, so their interests are the same. The fetus's continued existence is totally dependent, in a very unique way, on the body of the pregnant woman. Both the fetus and the woman are vulnerable to those forces that impact on the woman's body. It is also clear that, to the extent the woman's body is treated well, both the woman and the fetus benefit. In another important sense, however, the pregnant woman and the fetus are separate. A single act that may not harm the mother, such as exposure to rubella, may hurt the fetus. Alternatively, the fetus may have a developmental problem that needs surgical correction in utero, which of necessity requires the mother to subject herself to risks that will not benefit her personally.

Because of fetuses' total dependence, pregnant women must take enormous care to shield them from many potential sources of harm. At times mothers must choose not simply between their own self-interest and fetal interests. There are circumstances when other individuals' needs must also be weighed into the mother's decision, and these may also diverge from fetal interests. For example, a woman may have to work in order to support her existing children, but she may also be advised that several months of bed rest toward the end of her pregnancy are necessary to prevent harm to her fetus. As the primary decision-maker for the maternal–fetal unit, and often indeed for the family unit, the pregnant woman may make a decision that results in harm to the fetus. This decision may be self-interested, or it may reflect a careful weighing and balancing of the needs of all. To view the woman's deci-

sion as solely adversarial to fetal interests misses the complexity of the interactions involved in the maternal–fetal unit.

Adversarial rights-based analytical frameworks work best when characterizing the duties and obligations that flow from relationships between strangers. These approaches are incapable of capturing “the continual rendering of services, kindnesses, attentions, and concerns beyond what is obligatory between persons whose lives are intimately and enduringly connected” (O’Neill and Ruddick 1979, 7). As Buchanan notes, “Members of an intimate relationship are seen as elements of an affectively integrated whole, who promote each other’s good spontaneously out of love or direct concern, rather than from instrumental calculations of self-interest” (1982, 36). When an intimate relationship is also one in which there is a dependent member, the inadequacy of rights-based frameworks is even more glaring. Surely women have rights of privacy and bodily integrity. Yet, the autonomy argument does not seem compelling in discussing a woman’s gestational and caretaking roles because harm to her frequently results in simultaneously harming her fetus. Alternatively, although an assertion of fetal rights may result in protecting the fetus from maternal harm, it does little to promote fetal well-being in the sense of ensuring that the mother receives access to social resources needed by the fetus for normal development.

In short, treating a fetus as though it were in fact the equal of the woman, using “rights” terminology as a means of establishing its claims to protection or care, tells us nothing about what should be the moral relationship between the pregnant woman and the fetus (Baier 1987, 53). For effective family policy, including drug policy for women, we need to understand terms such as duty, responsibility, and obligation in ways that do not presume that the individuals in a relationship act primarily in self-interested ways. We also need to take special note that individuals in many important intimate relationships do not have equal power in those relationships. Understanding the maternal–fetal relationship as an intimate interactive unit, in which there is a severe discrepancy in power, better helps us define the nature of the moral relationship that exists between the pregnant woman and the fetus. Using this redefinition of the maternal–fetal relationship offers drug policy makers a more realistic and morally supportable basis for developing drug policy for women.

It is generally agreed that parents have moral obligations to their chil-

dren that are derived from their decision to reproduce (Arras 1990; Buchanan 1982; O'Neill and Ruddick 1979). Extension of these obligations to the prenatal period in light of the information that we now possess about the uterine environment seems warranted once there has been a decision to continue pregnancy. Indeed, once a woman decides to carry a fetus to term, it is useful to think of the maternal-fetal relationship as analogous to the parent-child relationship (American Medical Association 1990).

The scope of the moral obligation that parents owe children, however, is not well defined (Blustein 1979). Although it is generally accepted that parents do have obligations of care and support and may not physically abuse or neglect their children, it is not clear how far parents are required to go in sacrificing their own interests for the sake of their children. As Blustein points out, "Child rearers cannot be completely defined by their role as child rearers. . . . If child rearers perceive the raising of their children as an overwhelming burden which makes it impossible to pursue these other desires and interests, child-rearing becomes intolerable. . . . Hence children too have an interest in their rearers being free to pursue other desires and interests" (Blustein 1979, 118-19). Moreover, the fact that philosophers have failed to focus on justifications for promoting another's good in the context of intimate relationships compounds our problem in analyzing moral responsibilities when we move from adult friendships and parent-child relationships to maternal-fetal relationships. Pregnancy, after all, is a unique condition in which two entities are physically joined. As a result, fundamental questions about moral responsibilities raised in the context of pregnancy have no obvious answers.

First, if we assume that decisions to procreate carry obligations to dependent others, the question that arises is whether circumstances in the lives of potential procreators morally require them not to reproduce or at least to delay reproduction. John Arras, for example, has taken an important and courageous step in exploring this issue (although I do not entirely agree with his reasoning) in the context of HIV-infected women and concludes that the risk of transmitting HIV infection is a "good reason," although not in every case a compelling reason, for not procreating (Arras 1990). If there is a moral obligation to refrain from or to delay procreation, would that obligation also justify, if not morally require, abortion in some circumstances?

A second fundamental question concerns the scope of the pregnant

woman's obligation to promote the good of the fetus. How should we think about a woman's use of legal or illegal drugs during pregnancy? Is the pregnant woman inflicting harm on the fetus? Viewed in this way, the pregnant woman might have an obligation of nonmaleficence: to refrain from inflicting harm. Alternatively, would it make more sense to think of the pregnant woman's use of drugs as a failure to benefit another? From this perspective the pregnant woman's obligation is somewhat less obligatory because she is not acting, but rather failing to act in relation to another (Beauchamp and Childress 1989, 120-7). To be sure, whether we view the pregnant woman's actions as inflicting harm or as failing to promote the good of the fetus, the fetus will suffer the same harm. However, the way we define the scope of the pregnant woman's obligation has implications for how we morally regard her conduct and for the policies we develop in response to it.

The lack of attention given special intimate relationships by philosophers, especially relationships that are unequal in power, is reason to urge caution in statements about moral responsibility in specific circumstances like pregnancy. However, our lack of consensus on the scope of a pregnant woman's moral obligation to her fetus is not sufficient reason to reject the idea of moral obligation altogether. Certainly, great sensitivity would be required in developing models of responsibility and obligations to fetuses, but there are a number of philosophical and cultural values that we could rely on in this process. Fetuses are regarded as only potential persons in this society. As a consequence, a woman's moral obligation to her fetus should not be greater than it is to her child (Murray 1987; Purdy 1990). Because men are also parents, there would be some constraint on any undue tendency to burden women. There is no moral requirement that parents of either sex sacrifice their lives or health interests for their children after birth. In her role as parent, a woman should not be required to do so for the sake of the fetus. Under truly exceptional circumstances, we might expect her to subordinate her health interests to those of her fetus.

Defining the maternal-fetal relationship in terms of an interactive unit is a vast improvement over the adversarial model because it more closely approximates our experience of pregnancy and relationships with special intimate others. Significantly, this approach assumes that women will try to promote the well-being of their offspring and encourages policy makers to consider a broader array of concerns, such as the needs of all intimate others for whom a woman is responsible. Finally, there is a

basis for urging, in some circumstances, that women have moral obligations to fetuses that have not been met. However, this conceptual shift does not of itself resolve the problem of the appropriate relationship between this unit and society. Focus on the unit as an integrated whole does not necessarily preclude punitive or coercive strategies to require or strongly encourage women or parents to act in ways to promote the well-being of dependent others, although I consider all such efforts to be very unwise. Such a focus, however, does expand the scope of strategies we ought to review in making drug policy for women, and it makes more compelling a range of strategies that employ softer means of achieving the same goals of helping fetuses, children, and mothers.

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