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DENYING THE DYAD: HOW CRIMINALIZING PREGNANT DRUG USE HARMS THE BABY, TAXPAYERS AND VULNERABLE WOMEN

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DENYING THE DYAD: HOW CRIMINALIZING PREGNANT DRUG USE HARMS THE BABY, TAXPAYERS AND VULNERABLE WOMEN

MELISSA BALLENGEE ALEXANDER*

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INTRODUCTION

“These ladies are the worst of the worst. . . .”¹ Or, at least so said the sponsor of the nation’s first criminal law expressly authorizing prosecution of women for assault based on illegal drug use during pregnancy.² Admittedly, there is intuitive appeal to throwing a pregnant woman who uses drugs in jail. The images of a baby detoxing can be heart-wrenching, and the idea of a mother who would harm her baby for a “high” is abhorrent.³ On the surface, these cases typify good versus evil.

However, medical experts who have studied pregnant drug use uniformly oppose criminalization.⁴ They describe drug addiction as a

1. H.R. 1295, Gen. Assemb., Reg. Sess. (Tenn. Apr. 9, 2014, 5:14:32) (statement of Rep. Terri Lynn Weaver), *available at* http://tnga.granicus.com/MediaPlayer.php?view_id=200&clip_id=9325 [hereinafter Statement of Representative Weaver].

2. *Id.*; GUTTMACHER INST., STATE POLICIES IN BRIEF: SUBSTANCE ABUSE DURING PREGNANCY (Aug. 10, 2015) [hereinafter STATE POLICIES] (only Tennessee specifically criminalizes drug use during pregnancy), *available at* http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf.

3. Tony Gonzalez & Shelley DuBois, *Born Hurting: Tennessee’s Struggle with Addicted Mothers and Their Babies*, TENNESSEAN, June 15, 2014, *available at* <http://www.tennessean.com/story/news/investigations/2014/06/13/drug-dependent-babies-challenge-doctors-politicians/10112813/> (“No one who hears it ever forgets the sound. When newborn babies begin to withdraw from powerful drugs, they shriek at a high, telltale pitch . . . they convulse, projectile vomit or writhe . . . [they] are [] heart-wrenching . . .”).

4. U.N. Secretary-General, Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Note of the Secretary-General, (Aug. 3, 2011) [hereinafter *Special Rapporteur Position*] (discussing that criminal sanctions violate the right to health), *available at* <http://daccess-ods.un.org/TMP/1752555.96637726.html>; Brief for American Public Health Association et al. as Amici Curiae Supporting Petitioners at ii, *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (No. 99-936), 2000 WL 33599645 [hereinafter Health Expert’s Amicus]; American Academy of Pediatrics, Committee on Substance Abuse, *Drug-Exposed Infants*, 86 PEDIATRICS, 639, 641 (1990) [hereinafter *AAP Position*] (criminal sanctions are “unjustifiable”); American Medical Association, Board of Trustees, *Legal Interventions During Pregnancy:*

disease that requires treatment.⁵ Where others see blame, medical experts point to a complicated confluence of genetic, environmental, and structural factors that make certain individuals uniquely vulnerable to drug use.⁶ With regard to pregnant women, physicians emphasize the interconnectedness of mother and baby and warn that criminalizing pregnant drug use is far more likely to deter prenatal care than to deter drug use.⁷ The narrative of good versus evil must be rewritten to reflect empirical evidence that disease and structural violence play a significant, often understated, role in pregnant drug use.

Nonetheless, it is indisputable that there is a growing epidemic of narcotic drug use among pregnant women. Nationwide, the incidence of Neonatal Abstinence Syndrome (NAS)—a clinical diagnosis of drug withdrawal syndrome in a baby commonly caused by exposure to narcotic drugs in utero—nearly tripled from 2000 to 2009.⁸ The incidence of NAS then doubled again from 2009 to 2012.⁹

Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663, 2667 (1990) [hereinafter *AMA Position*]; American Congress of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, 473 ACOG (Jan. 2011), <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co473.pdf> [hereinafter *ACOG Substance Abuse Opinion*].

5. Health Expert's Amicus, *supra* note 4, at ii; *AAP Position*, *supra* note 4, at 640–41; *ACOG Substance Abuse Opinion*, *supra* note 4.

6. *ACOG Substance Abuse Opinion*, *supra* note 4 (“Addiction is a chronic, relapsing biological and behavioral disorder with genetic components.”); By some estimates, more than eighty percent of addicted women have at least one chemically dependent parent. Karen Heller, *One Doctor's Crusade Twenty Years Ago, Loretta Finnegan First Became Aware of the Agony Faced by Addict Mothers and Their Babies And She Set Out to Do Something About It*, PHILADELPHIA INQUIRER, Nov. 19, 1989, at 1, available at http://articles.philly.com/1989-11-19/news/26136759_1_drug-users-addict-mothers-cocaine-users.

7. *AAP Position*, *supra* note 4, at 641; *AMA Position*, *supra* note 4, at 2667; *ACOG Substance Abuse Opinion*, *supra* note 4.

8. Stephen W. Patrick et al., *Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000–2009*, 307 JAMA 1934, 1937 (2012) [hereinafter *Associated Health Care Expenditures*] (incidence of NAS nationwide nearly tripled from 2000 to 2009).

9. Stephen W. Patrick et al., *Increasing Incidence and Geographic Distribution of Neonatal Abstinence Syndrome: United States 2009 to 2012*, 35 J. PERINATOLOGY 650, 653 (2015) [hereinafter *Geographic Distribution of NAS*] (incidence of NAS nationwide nearly doubled from 2009 to 2012); see also Veeral N. Toila et al., *Increasing Incidence of the Neonatal Abstinence Syndrome in U.S. Neonatal ICUs* 372:2 NEW. ENG. J. MED. 2118, 2118 (2015) (“From 2004 through 2013, the rate of NICU admissions for the neonatal abstinence syndrome increased from 7 cases per

As a result, prosecutors are increasingly demanding further criminalization of pregnant drug use.¹⁰

Yet, experts report that the NAS epidemic appears to be primarily driven by a nationwide increase in prescription drug use.¹¹ To be successful and reverse the tide of NAS births, legal reform must focus on preventing prescription drug abuse among all population groups, as well as increasing access to education, birth control, and drug treatment.¹² Although popular, criminalization will not stem the rise in NAS births.

In 2014, Tennessee passed the nation's first criminal law expressly authorizing prosecutors to charge women with assault based on illegal drug use during pregnancy.¹³ Since then, five other states have proposed virtually identical legislation.¹⁴ Even without

1000 admissions to 27 cases per 1000 admissions.”).

10. See, e.g., Dave Boucher & Tony Gonzalez, *Prosecutors Argue Law Helps Drug-Addicted Moms*, TENNESSEAN, Apr. 14, 2015, at 9A. In a statewide survey in Tennessee, seventeen district attorneys supported criminalization, only seven opposed it. *Id.*

11. Stephen W. Patrick et al., *Prescription Opioid Epidemic and Infant Outcomes*, 135 PEDIATRICS 843, 846 (2015) [hereinafter *Infant Outcomes*] (noting the temporal correlation between rise in prescription drug use and NAS births and finding that “65% of infants with NAS were exposed to legally obtained [opioid pain relievers] in pregnancy”); see also *Geographic Distribution of NAS*, *supra* note 9, at 653 (“The rapid rise in NAS parallels the increase in [opioid pain reliever] use in the United States, suggesting that preventing opioid overuse and misuse, especially before pregnancy, may prevent NAS.”); Toila et al., *supra* note 9, at 2122 (noting that the “rising incidence of the neonatal abstinence syndrome is due in part to increasing opioid use among pregnant women”).

12. *Infant Outcomes*, *supra* note 11, at 848 (“Public health efforts should focus on limiting inappropriate [opioid pain relievers]”); see also Health Expert’s Amicus, *supra* note 4, at ii (opining that pregnant drug users need treatment, not jail); *AAP Position*, *supra* note 4, at 640–41 (pregnant drug users need treatment, not jail); Sarah H. Heil et al., *Unintended Pregnancy in Opioid-Abusing Women*, 40 J. SUBSTANCE ABUSE TREATMENT 199, 200 (2011) (reporting that eighty-six percent of women who abuse opioids report that their pregnancy is unplanned); *ACOG Substance Abuse Opinion*, *supra* note 4 (opining that pregnant drug users need treatment, not jail); *Neonatal Abstinence Syndrome Among TennCare Enrollees Provisional 2012 Data*, TENNCARE (Oct. 22, 2013), <http://www.tn.gov/assets/entities/tenncare/attachments/TennCareNASData2012.pdf> [hereinafter *TennCare Enrollees Provisional 2012 Data*] (reporting that eighty-two percent of women prescribed narcotics are not on contraceptives).

13. TENN. CODE ANN. § 39-13-107 (2014); STATE POLICIES, *supra* note 2, at 1 (noting that only Tennessee expressly criminalizes drug use during pregnancy).

14. Hayley Fox, *Pregnant Drug Users Face Criminal Prosecution, But Doctors Say That’s a Mistake*, TAKE PART (Apr. 1, 2015), <http://www.takepart.com/article/2015/04/01/pregnant-jail-time-drug> (explaining that Tennessee’s law has already lead

such a law, states around the country criminally prosecute women for drug use during pregnancy pursuant to child endangerment, feticide, and other statutes that do not expressly apply to in utero exposure to drugs.¹⁵ However, few indictments under other states' generic statutes have resulted in convictions that withstood appeal;¹⁶ therefore, the implications of Tennessee's express law could be profound. The goal of this article is to convince other states to avoid mimicking the express criminalization of pregnant drug use that Tennessee adopted and to encourage lawmakers in Tennessee to

to "copycat bills" in Arkansas, Oklahoma, Mississippi, and North Carolina); Emily Lane, *Should Women Who Use Drugs While Pregnant Be Charged for Harm to Child?*, TIMES-PICAYUNE (May 5, 2015), http://blog.nola.com/politics/print.html?entry=/2015/05/pregnant_women_drugs_louisiana.html (explaining that Tennessee's law served as a model for a bill introduced in the Louisiana legislature); see also Sydney Lupkin, *Why Some Doctors Object to Tennessee Law That Criminalizes Drug Use During Pregnancy*, ABC NEWS (July 14, 2014), <http://abcnews.go.com/Health/doctors-object-tennessee-law-criminalizes-drug-pregnancy/story?id=24557525> (quoting Lynn Paltrow, executive director of the National Advocates for Pregnant Women, that "[v]irtually every state has considered" some form of criminalization).

15. See, e.g., *State v. Buckhalter*, 119 So. 3d 1015, 1018 (Miss. 2013) (upholding dismissal of indictment for manslaughter based on pregnant drug use but noting the possibility of prosecution for feticide or unlawful abortion); *State v. Allen*, No. DC 14-62 & 14-27 (Mont. Dist. Ct. 2014) (charging a woman with criminal endangerment after testing positive for illegal drugs in her first trimester; the charges were ultimately dismissed).

16. See, e.g., *Ferguson v. Charleston*, 532 U.S. 67, 221 (2001) (holding that a hospital policy regarding involuntary drug testing of pregnant women for use in criminal conviction violates the Fourth Amendment); *State v. Aiwohi*, 123 P.3d 1210, 1223 (Haw. 2005) (holding that definition of "person" in a manslaughter statute did not include a fetus, after mom's prenatal drug use caused newborn's death); *Commonwealth v. Welch*, 864 S.W.2d 280, 285 (Ky. 1993) (holding that criminal child abuse does not extend to mother's use of drugs while pregnant); *State v. Martinez*, 137 P.3d 1195, 1198 (N.M. Ct. App. 2006) (holding that the ordinary meaning of "child" in a child abuse statute did not include fetus in case where mother used cocaine during pregnancy); *State v. Gray*, 584 N.E.2d 710, 711 (Ohio 1992) (holding that criminal child endangerment does not apply to a fetus). *But see Hicks v. State*, 153 So.3d 53, 54 (Ala. 2014) (interpreting "child" in a criminal chemical-endangerment statute to include unborn); *Whitner v. State*, 492 S.E.2d 777, 778 (S.C. 1997) (interpreting "person" in a criminal statute to include viable fetus).

allow their law to lapse automatically.¹⁷ Absent further legislative action, Tennessee's law will cease to be effective on July 1, 2016.¹⁸

This article analyzes how Tennessee's unprecedented law is flawed and describes why even a more carefully crafted law criminalizing pregnant drug use would be bad public policy because such laws ignore the interconnectedness between mother and baby as well as addiction's unique challenges as a medical disease. Section I provides background information on NAS and traces the intertwined histories of fetal rights, personhood, and assault liability. Section II illustrates how Tennessee's law is poorly targeted, ignoring the overwhelming majority of NAS births—two-thirds of which are associated with prescription drugs.¹⁹ This section then outlines the illusory nature of the affirmative defense for drug treatment and the injustice of the law as applied to women who have repeatedly sought treatment, only to be turned away because treatment was unavailable or unaffordable.²⁰ It explains how the law, influenced by the fetal protection and personhood movements,

17. If sunset proves impossible, at minimum, this article seeks to provide clear guidance for a narrower law that (1) expands the affirmative defense to protect all who seek treatment, regardless of availability and timing; (2) no longer bases assault against pregnant women on undefined unlawful acts; and (3) no longer applies pre-viability.

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

19. See *Drug Dependent Newborns (Neonatal Abstinence Syndrome) Surveillance Summary For the Week of July 26–August 1, 2015*, TENN. DEPT OF HEALTH (Aug. 6, 2015), http://tn.gov/assets/entities/health/attachments/NASsummary_Week_3015.pdf [hereinafter *2015 Year-To-Date TN NAS Summary*] (seventy-five percent of NAS births had at least one prescribed substance linked to NAS); Angela Miller, *Neonatal Abstinence Syndrome Surveillance Annual Report Summary for 2014*, TENN. DEPT OF HEALTH, http://tn.gov/assets/entities/health/attachments/NAS_Annual_report_2014_FINAL.pdf (last visited Nov. 7, 2015) [hereinafter *2014 TN NAS Summary*] (sixty-nine percent of at least one prescribed substance linked to NAS); *Drug Dependent Newborns (Neonatal Abstinence Syndrome) December Update*, TENN. DEPT OF HEALTH (Dec. 28, 2013), http://health.state.tn.us/MCH/PDFs/NAS/NAS_Update_1213.pdf [hereinafter *2013 TN NAS Summary*] (noting that sixty-three percent of NAS births had at least one prescribed substance linked to NAS).

20. See Sanya Dosani, *Should Pregnant Women Addicted to Drugs Face Criminal Charges?*, AL JAZEERA (Sept. 4, 2014), <http://america.aljazeera.com/topics/topic/issue/Addiction.html?page=2> (reporting and criticizing the lack of treatment availability); Rosa Goldensohn & Rachael Levy, *The State Where Giving Birth Can Be Criminal*, NATION, Dec. 10, 2014, at 25 (reporting and criticizing the lack of treatment availability); Gonzalez & DuBois, *supra* note 3 (“Addiction treatment is extremely limited and costly—and nearly nonexistent for pregnant women.”); Cherisse A. Scott, *Pregnancy Bill Makes Bad Situations Worse*, TENNESSEAN, Apr. 14, 2014, at 13A (reporting and criticizing the lack of treatment availability).

rests on the legal fiction that a pregnant woman and her fetus are separate and independent persons. In reality, a mother and her fetus is a dyad, thoroughly intertwined. By failing to appreciate the interconnected nature of this relationship, the law undervalues shared interests, especially the degree to which threatening and punishing a mother intrinsically threatens and punishes her baby. The thirty-seven other states that have fetal protection laws may also be at risk of undervaluing the shared interests of this relationship.²¹ Section II closes by focusing on potential harm lurking in the sweeping, under-reported provision of the new law that criminalizes *any* unlawful act by a pregnant woman that injures her fetus.²²

In Section III, the article shifts to a more general critique of any law criminalizing pregnant drug use. Using Tennessee as a case study, this section illustrates how criminalizing pregnant women's drug use fails to effectively accomplish five objectives of criminal law—to restore, incapacitate, rehabilitate, deter, or punish. Such laws ignore the impact of prescription drugs, the intertwined relationship between mother and baby, and drug addiction's unique challenges as a medical disease. In doing so, criminalization incentivizes abortion, deters prenatal care, wastes taxpayer money, and undermines the health and well-being of the baby.

I. BACKGROUND AND HISTORY

A. *Defining the Problem: Rising Drug Use and NAS*

Neonatal Abstinence Syndrome (NAS) is a clinical diagnosis of drug withdrawal syndrome in a newborn exposed to drugs in utero.²³ NAS results from a mother using prescription and/or illegal drugs during pregnancy.²⁴ Narcotics and benzodiazepines commonly cause

21. See Erik Eckholm, *Specialists Join Call for Veto of Drug Bill*, N.Y. TIMES, Apr. 14, 2014, at A12 (stating thirty-seven other states have assault statutes that define a potential victim to include a fetus); *Fetal Homicide Laws*, NAT'L CONF. ST. LEG. <http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx> (last visited Nov. 7, 2015) [hereinafter *Fetal Homicide Laws*] (“[A]t least 38 states have fetal homicide laws.”).

22. See TENN. CODE ANN. § 39-13-107(c)(1) (2014).

23. *Neonatal Abstinence Syndrome (NAS) Frequently Asked Questions*, TENN. DEPT' HEALTH, https://health.state.tn.us/MCH/PDFs/NAS/NAS_FAQ.pdf (last visited Nov. 7, 2015) [hereinafter *NAS FAQs*]; see also *TennCare Enrollees Provisional 2012 Data*, *supra* note 12, at 1 n. 2. NAS statistics typically exclude fetal alcohol syndrome, harm caused to a newborn by in utero exposure to alcohol. *Id.*

24. See *NAS FAQs*, *supra* note 23 (excluding fetal alcohol syndrome from data);

NAS;²⁵ however, not all babies exposed to narcotics or benzodiazepines in utero appear to suffer from NAS or other obvious harm.²⁶

NAS has a wide array of symptoms including low birth-weight, gastrointestinal problems—like feeding intolerance, diarrhea, or vomiting—and central nervous system problems—such as seizures, tremors, or hyperactivity.²⁷ The symptoms and treatment for NAS vary based on the type, amount, and duration of drug use.²⁸ Importantly, however, experts have concluded that “[u]nlike neonatal exposure to maternal alcohol and tobacco use, there have been no reported long term effects of maternal opioid use on the developing child.”²⁹ In fact, Dr. Loretta P. Finnegan, whose Finnegan scoring system is often used to diagnose and rate NAS, describes NAS as an unfortunate but relatively minor health problem.³⁰

see also *Associated Health Care Expenditures*, *supra* note 8, at 1934; *Infant Outcomes*, *supra* note 11, at 650.

25. *NAS FAQs*, *supra* note 23. Benzodiazepines are a class of psychoactive drugs commonly used to treat anxiety (e.g. Xanax), insomnia, or seizures. *Use of Psychiatric Medications During Pregnancy and Lactation*, 111 ACOG PRACTICE BULLETIN 4, at 1002, 1009 (April 2008).

26. *FAQ [sic] Regarding Public Chapter 820 (PC 820) and Other Requirements Related to Neonatal Abstinence Syndrome (NAS) in Tennessee*, TENN. DEP’T HEALTH 1, http://health.state.tn.us/MCH/PDFs/NAS/NAS%20FAQs_63014L.pdf (last revised June 24, 2014) [hereinafter *NAS Law Guidance*]. “Not all cases of exposure will lead to withdrawal syndrome.” *Id.* In fact, as few as 55% of neonates with in utero opioid exposure may develop NAS; conversely, other estimates suggest as many as 94% will. Mark L. Hudek, *Neonatal Drug Withdrawal*, 129 PEDIATRICS 540, 541 (2012).

27. *Associated Health Care Expenditures*, *supra* note 8, at 1934; *Infant Outcomes*, *supra* note 11, at 650; *NAS FAQs*, *supra* note 23.

28. *NAS FAQs*, *supra* note 23.

29. American Congress of Obstetricians and Gynecologists, *GOVERNMENT AFFAIRS, Toolkit on State Legislation: Pregnant Women & Prescription Drug Abuse, Dependence and Addiction*, ACOG, at 2, available at <http://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf> (last visited Nov. 7, 2015) [hereinafter *ACOG NAS Toolkit*] (also stating that, “Longitudinal studies over 5 to 10 years have shown that children who experienced NAS as infants do not exhibit signs of physical or cognitive impairment as they mature.”); see also Suzanne Wong, Alice Ordean & Meldon Kahan, *Substance Use in Pregnancy*, 114 INT’L J. GYNECOLOGY & OBSTETRICS 190, 194, 196–97 (2011) (finding that there is no definitive evidence that NAS causes long-term health consequences).

30. Goldensohn & Levy, *supra* note 20, at 28 (“NAS is really a very minor medical condition, in contrast to what can happen to a baby, both physically and psychologically, if the mother is not in treatment.”) (quoting Dr. Lorette Finnegan).

Moreover, many other conditions can produce the same symptoms.³¹ Accordingly, health care professionals typically diagnose NAS based on a mother's history of drug use, evidence of exposure—drug testing of a newborn's urine, hair, or meconium—and a standard scoring system.³² Diagnosis remains imperfect and an area in which experts have called for improvement.³³

Yet, treating a newborn with NAS tends to cost significantly more than treating a non-NAS newborn. While this disparity may decrease as more evidence-based approaches replace overtreatment of NAS,³⁴ in 2012, treating NAS births nationwide increased health care charges by approximately \$1.5 billion.³⁵ In Tennessee in 2012, the average newborn with NAS required \$62,324 in health care charges, compared to \$8,359 for the average live birth.³⁶

Nationwide, the incidence of NAS has grown nearly fivefold since 2000 while the incidence of antepartum opiate use grew by a slightly larger factor over the same period.³⁷ In Tennessee, the statistics are even more alarming. Since 2000, Tennessee has seen a more than

31. Wong, Ordean, & Kahan, *supra* note 29, at 192. Poor birth outcomes also correlate strongly to maternal poverty, poor nutrition, inadequate prenatal care, domestic violence, and extensive pre-pregnancy drug use. Linda C. Fentiman, *Pursuing the Perfect Mother: Why America's Criminalization of Maternal Substance Abuse is Not the Answer—A Comparative Analysis*, 15 MICH. J. GENDER & L. 389, 397 (2009); see Lynn Paltrow & Katherine Jack, *Pregnant Women, Junk Science, and Zealous Defense*, 34 CHAMPION 30, 32 (2010).

32. *NAS Law Guidance*, *supra* note 26, at 1; see also Wong, Ordean, & Kahan, *supra* note 29, at 196.

33. Wong, Ordean, & Kahan, *supra* note 29, at 192–93 (stating that urine drug screenings detect only recent drug use, and hair and meconium samples, while detecting intrauterine use in the second or third trimester, is costly and, perhaps more importantly, has a “propensity for false positive results”).

34. Interestingly, some of the higher cost of NAS births appears to stem from overtreatment, not consistent with evidence-based approaches. *ACOG NAS Toolkit*, *supra* note 29, at 2–3. “Treatment is not necessary for every infant exposed to opioids,” and many of these infants are unnecessarily given pharmacological treatment or placed in the NICU, despite evidence that such treatment does not achieve optimal outcomes. *Id.* Moreover, it is important to bear in mind that the prematurity, low birth weight and other NAS symptoms that increase cost also occur in babies who were not exposed to drugs in utero.

35. *Geographic Distribution of NAS*, *supra* note 9, at 652–54 (stating that NAS births add approximately \$1.5 billion each year in health care charges; in 2012, the nationwide mean hospital charges for a NAS birth reached \$66,700, substantially higher than non-NAS births).

36. *TennCare Enrollees Provisional 2012 Data*, *supra* note 12.

37. *Geographic Distribution of NAS*, *supra* note 9, at 653 (“The incidence of NAS in the United States . . . has grown nearly fivefold since 2000.”).

tenfold increase in the number of babies born with NAS.³⁸ Among babies on TennCare,³⁹ in just four years, the incidence of NAS almost tripled, rising from 5.3 cases of NAS per 1,000 live births in 2008 to 14.6 cases of NAS per 1,000 live births in 2012; this trend appears to be continuing.⁴⁰ In fact, Tennessee is on pace for the fourteenth year in a row of increased NAS births.⁴¹

Beginning January 1, 2013, Tennessee became the first state in the country to require health care providers to report all NAS cases to the Department of Health.⁴² Health care providers reported 855 NAS cases in Tennessee in 2013⁴³ and 973 cases in 2014.⁴⁴ However, the Department of Health does not require health care providers to

38. *NAS FAQs*, *supra* note 23; *Neonatal Abstinence Syndrome (NAS): Background Information*, TENN. DEPT' HEALTH, <http://tn.gov/health/topic/nas> [hereinafter *NAS Background*].

39. TennCare is Tennessee's Medicaid managed care program that provides healthcare for low-income pregnant women and their children. *TennCare Medicaid*, TENNCARE DIV. OF HEALTH CARE FIN. & ADMIN., <https://www.tn.gov/tenncare/article/tenncare-medicaid> (last visited Nov. 7, 2015). Eligibility requires income below 195% of the federal poverty line. *Major Medicaid Eligibility Categories in Tennessee*, TENNCARE DIV. OF HEALTH CARE FIN. & ADMIN., <https://www.tn.gov/tenncare/article/categories> (under "Pregnant Women") (last visited Nov. 7, 2015).

40. *TennCare Enrollees Provisional 2012 Data*, *supra* note 12. It is worth noting, however, that troubling identification and testing bias appears likely. Women with family incomes of less than \$20,000 per year were more than twice as likely as women with incomes over \$75,000 to report use of illegal drugs. *See* SHARON L. LARSON ET AL., DEPT. OF HEALTH AND HUMAN SERVICES, WORKER SUBSTANCE USE AND WORKPLACE POLICIES AND PROGRAMS 15 (2007) (13.2% at \$20,000 or lower v. 6.0% at \$75,000 or higher). However, this differential in self-reported illegal drug use would only explain a small fraction of the third-party reported incidence of NAS births among TennCare enrollees.

41. Tony Gonzalez, *On Pregnant Drug Use, Lawmakers Whiff on Data*, TENNESSEAN, Apr. 11, 2015, at 5A ("Tennessee is on pace for the 14th year in a row of more drug-dependent births."); *see also* *NAS FAQs*, *supra* note 23; *2013 TN NAS Summary*, *supra* note 19; *NAS Background*, *supra* note 38; *2014 TN NAS Summary*, *supra* note 19; *2015 Year-To-Date TN NAS Summary*, *supra* note 19.

42. Letter from John J. Dreyzehner, Comm'r of Tenn. Dep't of Health to a Colleague (Nov. 29, 2012), *available at* http://tn.gov/assets/entities/health/attachments/DreyzehnerLetterNASReportable_112912.pdf [hereinafter *Commissioner's Letter*]. Until 2013, Tennessee "rel[ied] upon hospital discharge data to collect information on NAS incidence." *Id.* In particular, data collectors typically relied upon the presence of the ICD-9 code 779.5. *See, e.g., TennCare Enrollees Provisional 2012 Data*, *supra* note 12. In seeking mandatory reporting, the Tennessee Department of Health hoped to eliminate the delay in reporting and collecting more disaggregated data. *See Commissioner's Letter*, *supra* note 42.

43. *2013 TN NAS Summary*, *supra* note 19.

44. *2014 TN NAS Summary*, *supra* note 19.

report NAS births to law enforcement nor does the Department of Health provide NAS case reports to law enforcement as a matter of course.⁴⁵

B. Intertwined Histories: Fetal Rights and Assault Liability

Like many states grappling with skyrocketing NAS births, Tennessee has tried myriad legal approaches to decrease pregnant drug use. Addressing pregnant drug use is complicated, both legally and morally. On the one hand, maternal drug use can harm a fetus or embryo, and states have both a right and a duty to take reasonable steps to protect a potential life from such harm. On the other hand, a pregnant woman also has rights and should be treated as an end in herself (not as a means). She can have a legitimate need for Xanax, Hydrocodone, or other drugs that can cause NAS. Further, even when maternal drug use is not medically indicated, most experts agree that drug addiction is in large part, if not entirely, a medical disease.⁴⁶ In addition, not all maternal drug use appears to injure a baby and not all maternal drug users suffer from addiction.⁴⁷ Under these circumstances, adopting laws that properly balance prevention, treatment, deterrence, punishment, autonomy, and privacy is a complex and challenging task.

The history of Tennessee's assault law over the last thirty years reflects the sort of ambivalence that combatting pregnant drug use invokes. Initially, under Tennessee law, assault required harm to "another person," a term that was not expressly define by the legislature.⁴⁸ This version of the law likely would not have supported criminal liability against a pregnant woman for drug use that harmed her fetus. The Tennessee Supreme Court does not appear to have construed the term "another person" in the context of the assault law. However, the majority of state courts that have interpreted criminal laws that only apply if a "person" or "child" is

45. See *NAS Law Guidance*, *supra* note 26, at 1–2. Any provider who knows of or reasonably suspects child abuse or neglect, however, is already required by other law to make a report to Department of Children's Services, which in turn investigates and decides whether or not to involve law enforcement. *Id.*

46. See *Robinson v. California*, 370 U.S. 661, 667 n.8 (1962) (stating that "persons addicted to narcotics are diseased and proper subjects for [medical] treatment") (quoting *Linder v. United States*, 268 U.S. 5, 18 (1925) (internal quotation marks omitted)); see also *Health Expert's Amicus*, *supra* note 4, at ii (stating that substance abuse is a treatable disease).

47. *NAS Law Guidance*, *supra* note 26.

48. See, e.g., *Casey v. State*, 491 S.W.2d 90, 93 (Tenn. 1972) (defining elements of assault).

harmed have interpreted them as excluding harm to the unborn.⁴⁹ Most courts reason that criminal laws should be strictly construed, as a matter of due process of law and the need to provide notice of what conduct is forbidden. These courts hold that the ordinary meaning of “person” or “child” assumes live birth, absent express language to the contrary.⁵⁰ Moreover, utilizing this reasoning, the Tennessee Court of Criminal Appeals has repeatedly held that criminal child abuse, neglect, and endangerment laws that require harm to a “child” do not allow liability for in utero injury caused by pregnant drug use.⁵¹ Accordingly, Tennessee’s initial assault law would not likely have been construed as allowing liability based on pregnant drug use.

In 1989, this changed. As part of the “fetal rights” or “personhood” movement, Tennessee, like many states, amended its criminal statutes to recognize an unborn fetus as a person.⁵² Such laws were passed at least partly in response to the United States Supreme Court’s decision in *Roe v. Wade*, in which the Court held that the term “person” in the U.S. Constitution does not include the

49. See, e.g., *State v. Aiwohi*, 123 P.3d 1210, 1223 (Haw. 2005) (holding that definition of “person” in manslaughter statute did not include a fetus in a case where mother’s prenatal drug use caused newborn’s death); *Commonwealth v. Welch*, 864 S.W.2d 280, 285 (Ky. 1993) (holding that criminal child abuse does not extend to a mother’s use of drugs while pregnant); *State v. Martinez*, 137 P.3d 1195, 1197 (N.M. Ct. App. 2006) (holding that ordinary meaning of “child” in child abuse statute did not include fetus in case where mother used cocaine during pregnancy); *State v. Gray*, 584 N.E.2d 710, 711 (Ohio 1992) (holding that criminal child endangerment does not apply to fetus). *But see Hicks v. State*, 153 So.3d 53, 54 (Ala. 2014) (interpreting “child” in criminal chemical-endangerment statute to include unborn); *Whitner v. State*, 492 S.E.2d 777, 778 (S.C. 1997) (interpreting “person” in criminal statute to include viable fetus).

50. See, e.g., *Aiwohi*, 123 P.3d at 1223–24.

51. *State v. Hudson*, No. M2006-01051-CCA-R9-CO, 2007 WL 1836840, at *1–2 (Tenn. Crim. App. June 27, 2007) (dismissing criminal child abuse and neglect indictment based on mother’s prenatal cocaine use, reasoning that the ordinary meaning of “child” does not include a fetus and that penal statutes are strictly construed against the state); *Richards v. State*, No. E2004-02326-CCA-R3-PC, E2004-02327-CCA-R3-PC, 2005 WL 2138244, at *1 (Tenn. Crim. App. Sept. 2, 2005) (granting post-conviction relief for two mothers who pled guilty to attempted aggravated child abuse after their infants had positive drug screens at birth because the women were not advised that they could be guilty of child abuse based on using drugs during pregnancy); see also *Tenn. Op. Att’y Gen. No. 13-01* (Feb. 1, 2013) (advising that a “mother’s drug use . . . does not qualify as criminal child abuse, neglect, or endangerment . . . because the applicable statutes do not encompass actions committed against a fetus”).

52. TENN. CODE ANN. § 39-13-107 (1989).

unborn.⁵³ In deciding *Roe*, the Supreme Court relied in part on the fact that most states did not recognize fetal rights in tort and criminal law.⁵⁴ Consequently, in the aftermath of *Roe*, many states passed “fetal rights” legislation. Today, a majority of the states punish feticide and allow recovery for the wrongful death of a fetus.⁵⁵

In 1989, as a part of this trend, Tennessee—like thirty-seven other states—enacted a fetal protection assault law.⁵⁶ Recognizing the “personhood” of a viable fetus, Tennessee amended its assault statute to expressly define “another person” to include a *viable* fetus.⁵⁷ While the amendment targeted third parties, the statute’s broad language would have also likely allowed criminal liability against a pregnant woman whose illegal drug use caused in utero harm to a viable fetus, assuming that the prosecution could prove that her acts were at least reckless.⁵⁸ The statute did not, however, expressly address a pregnant woman’s actions with regard to her

53. *Roe v. Wade*, 410 U.S. 113, 158 (1973); see Saru Matambanadzo, *Embodying Vulnerability: A Feminist Theory of the Person*, 20 DUKE J. GENDER L. & POL’Y 45, at 57 (exploring the link between *Roe v. Wade* and the fetal personhood movement).

54. *Id.*

55. JANET L. DOLGIN & LOIS L. SHEPHERD, *BIOETHICS AND THE LAW* 135 (3d ed. 2013); *Fetal Homicide Laws*, *supra* note 21, at 1 (“[A]t least 38 states have fetal homicide laws.”).

56. Eckholm, *supra* note 21 (stating thirty-seven other states have assault statutes that define a potential victim to include a fetus); *Fetal Homicide Laws*, *supra* note 21, at 1 (“[A]t least 38 states have fetal homicide laws.”).

57. TENN. CODE ANN. § 39-13-107 (1989). “Viability” is a vague standard assessing the potential for fetal survivability and lacks firm definition. Tara Culp-Ressler, *Some 22-Week Old Fetuses Can Now Survive Outside the Womb. How Will This Affect The Abortion Debate?* THINKPROGRESS (May 7, 2015), at 2. Many people use 24 weeks gestation as a shorthand for viability. *Id.* However, what likelihood of survival constitutes “viability” remains a subject of debate, and medical advances make viability a moving target. *Id.* at 2–3. Further, “viability” can vary from individual to individual depending on different biological and technological factors. *Id.* Tennessee’s assault statute referred to possible victims as “another person,” “individuals,” or “another.” TENN. CODE ANN. § 39-13-107 (1989). This article refers only to “another person” for clarity, but the same legal analysis applies to the other terms.

58. TENN. CODE ANN. § 39-13-107 (1989); *State v. Condry*, No. E2013-01209-CCA-R3-CD, 2014 WL 1912349, at *2 (Tenn. Crim. App. May 13, 2014) (holding that Tenn. Code Ann. § 39-13-107 (Supp. 2012) did not apply retroactively to render pregnant drug use that harmed baby in utero non-criminal, affirming conviction against mother for aggravated assault); Tenn. Op. Att’y Gen. No. 08-114 (May 21, 2008) (concluding that a mother could be criminally liable for assault based on ingestion of an illegal drug that injures her viable fetus in utero, with the requisite showing of causation and culpable mental state).

own fetus.⁵⁹ Accordingly, a pregnant woman may have made plausible, though difficult, arguments that the statute was not intended to apply to her or could not constitutionally apply to her.⁶⁰

Then, in 2011, Tennessee went further, joining twenty-two other states in punishing criminal conduct that causes injury *prior* to viability.⁶¹ Effective July 1, 2011, Tennessee amended its assault statute to allow criminal liability based on injury to a “fetus,” “regardless of viability.”⁶² Still silent on its face in regard to a pregnant woman, this version of Tennessee’s assault statute also could have been interpreted to impose criminal liability on a pregnant woman whose reckless drug use caused in utero harm.⁶³ After the amendment, however, potential criminal liability began much earlier—approximately nine weeks after fertilization when an embryo becomes a “fetus.”⁶⁴ At this early point in the pregnancy, a pregnant woman has a constitutional right to obtain an abortion under current law.⁶⁵ Yet, no Tennessee court appears to have addressed any potential right to privacy issues raised by pre-viability assault liability for conduct while pregnant.⁶⁶

One year later, Tennessee adopted an even more expansive view of “personhood” and fetal protection.⁶⁷ Specifically, Tennessee

59. See TENN. CODE ANN. § 39-13-107 (1989).

60. For example, some courts have focused on the fact that NAS arises from “the *withdrawal* of drugs” after birth “rather than the *absorption* of . . . drugs” in utero to avoid criminal liability against the mother. See, e.g., *Commonwealth v. Welch*, 864 S.W.2d. 280, 282–83 (Ky. 1993).

61. *Fetal Homicide Laws*, *supra* note 21, at 1 (“At least 23 states have fetal homicide laws that apply to the earliest stages of pregnancy (any state of gestation, conception, fertilization or post-fertilization).”) (internal quotation marks omitted).

62. TENN. CODE ANN. § 39-13-107 (Supp. 2011).

63. *Id.*; *Condry*, 2014 WL 1912349, at *2.

64. JAYNE KLOSSNER & NANCY HATFIELD, *INTRODUCTORY MATERNITY & PEDIATRIC NURSING* 103 (Elizabeth Nieginski et al. eds. 2006) (“The fetal stage is from the beginning of the 9th week after fertilization and continues until birth.”).

65. TENN. CODE ANN. § 39-15-201(c) (2014) (exempting abortion from criminal liability pre-viability when statutory requirements are satisfied); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 876 (1992) (holding that a state may regulate abortion pre-viability, as long as the regulation does not pose an “undue burden”); see also *Planned Parenthood of Middle Tenn. v. Sundquist*, 38 S.W.3d 1, 4 (Tenn. 2000) (recognizing a woman’s right to obtain an abortion) (abrogated in part with regard to interpretation of the Tennessee Constitution by a November 2014 amendment to the Tennessee Constitution).

66. While this article does not focus on potential constitutional concerns, holding a pregnant woman to heightened standards of conduct from conception onward arguably raises serious autonomy and right to privacy issues.

67. TENN. CODE ANN. § 39-13-107 (Supp. 2012). In fact, “fetal protection”

amended its assault statute to allow criminal liability based on injury to “another person,” defined as an “embryo or fetus at any stage of gestation.”⁶⁸ While there is some debate regarding whether implantation of an egg is required in order to be considered an “embryo,” this definition of “another person” arguably moves potential criminal liability to a point as early as conception.⁶⁹ At the same time, however, Tennessee also expressly exempted a pregnant woman from assault liability based on any act or omission that injured her own embryo or fetus.⁷⁰ Therefore, a pregnant woman no longer faced potential assault liability for personal drug use. This reprieve proved to be short-lived.

II. LAW EXPRESSLY AUTHORIZES PROSECUTING PREGNANT DRUG USERS FOR ASSAULT

In a controversial bill, effective April 28, 2014, Tennessee again amended its criminal assault statute, this time to expressly authorize prosecution of a pregnant woman based on illegal drug use or any other unlawful act or omission that harms her embryo or fetus.⁷¹ Specifically, Tenn. Code Ann. §39-13-107 now provides:

(a) For the purposes of this part, “another,” “individuals,” and “another person” include a human embryo or fetus at any stage of gestation in utero, when any such term refers to the victim of any act made criminal by this part.

(b) Nothing in this section shall be construed to amend the provisions of § 39-15-201, or §§ 39-15-203–39-15-205 and 39-15-207.

becomes a misnomer, as Tennessee and several other states apply legal protection to an embryo that is not yet a fetus.

68. *Id.*; 2012 Tenn. Pub. Acts ch. 1006, §§ 3–4.

69. Compare MERRIAM-WEBSTER'S DICTIONARY (2014), available at <http://www.merriam-webster.com/dictionary/embryo> (last visited Dec. 15, 2015) (defining an embryo “from the time of *implantation* to the end of the eighth week after conception”) (emphasis added), with BLACK'S LAW DICTIONARY (10th ed. 2014) (defining an embryo “from *conception* until the development of organs (i.e., until about the eighth week of pregnancy)”) (emphasis added).

70. 2012 Tenn. Pub. Acts ch. 1006, §§ 3–4 (codified as amended at TENN. CODE ANN. 39-13-107 (2015)) (exempting from criminal liability “any act or omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant”); see TENN. CODE ANN. § 39-13-107(c) (2013); Tenn. Att’y Gen. Op. No. 13-01 (February 1, 2013) (abrogating Tenn. Att’y Gen. Op. No. 08-114 (May 21, 2008)).

71. Legislators also proposed a similar bill to amend the homicide statute, Tenn. Code Ann. § 39-13-214, to allow felony prosecution of pregnant women for drug use that causes the death of a fetus or embryo, but that bill was not adopted.

(c)

(1) Nothing in subsection (a) shall apply to any lawful act or lawful omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant, or to any lawful medical or surgical procedure to which a pregnant woman consents, performed by a health care professional who is licensed to perform such procedure.

(2) Notwithstanding subdivision (c)(1), nothing in this section shall preclude prosecution of a woman for assault under § 39-13-101 for the illegal use of a narcotic drug, as defined in § 39-17-402, while pregnant, if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant.

(3) It is an affirmative defense to a prosecution permitted by subdivision (c)(2) that the woman actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program, regardless of whether the child was born addicted to or harmed by the narcotic drug.

Tennessee's amended law immediately drew attention nationally, even globally, and received almost unanimous criticism for further criminalizing pregnant drug use.⁷² A scholarly analysis of this statute reveals that the law rests on a fundamentally flawed understanding of the relationship between mother and baby. Moreover, the law is poorly designed because it ignores prescription drug use—the primary driver of NAS births—and offers only an illusory affirmative defense that does not provide any meaningful opportunity for women to obtain drug treatment. Further, the amended law criminalizes undefined, unlawful acts.

A. Personhood, Abortion, and Criminal Liability for Assault Imposed On a Pregnant Woman at "Any Stage of Gestation"

Tennessee's amended assault statute is fatally flawed because it rests on the legal fiction of fetal personhood. Specifically, the law defines "another person" to include an "embryo or fetus at any stage of gestation."⁷³ This definition of "person" reflects the reverence

72. See, e.g., Lindsay Beyerstein, *Bad Medicine in Tennessee for Pregnant and Drug-Addicted Women*, AL JAZEERA (Sept. 30, 2014), <http://america.aljazeera.com/articles/2014/9/30/tennessee-new-lawsb1391.html>; Deborah Coughlin, *Pregnant Women Addicted to Alcohol Need Help, Not Criminal Sanctions; Another Voice*, INDEPENDENT, Nov. 6, 2014, at 36; Eckholm, *supra* note 21.

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

many feel for an embryo.⁷⁴ While this definition may be appropriate for harms inflicted by a third party, it raises much more complicated issues when a pregnant woman is charged based on the potential effect of her actions on an embryo that is a part of her person.⁷⁵ After all, despite the merits of legally recognizing the value of even embryonic life, embryonic personhood is a fiction. It is factually false because an embryo exists only as part of the woman who carries it.⁷⁶

A legal framework that treats as separate and independent a pregnant woman and her embryo—a dyad that factually is thoroughly intertwined—distorts the relationship in ways that are both harmful and unjust.⁷⁷ It undervalues and attempts to rewrite the natural, beautiful, miraculous oneness of a pregnant woman and her embryo.⁷⁸ It immorally treats a pregnant woman as a vessel—a means to an end rather than an end.⁷⁹ It creates an adversarial

74. This article takes no position on the interesting and difficult moral question of when a zygote, embryo, or fetus becomes a “person” in the full rights-bearing sense. On a personal, experiential note, I loved my son deeply from the time I learned I was expecting. On a policy basis, however, the view of personhood ultimately expressed by the Tennessee legislature in its assault statute, if applied consistently, would prohibit common, in vitro fertilization practices, embryonic stem cell research, and possibly intra-uterine devices in ways that do not resonate with many Americans.

75. Interestingly, the “at any stage of gestation” language in Tennessee’s statute parallels language in the federal Unborn Victims of Violence Act that criminalizes certain conduct causing harm to the unborn at “any stage of development.” 18 U.S.C. § 1841 (2012). However, the federal act expressly exempts a woman with regard to her own unborn child. *Id.*

76. See American Congress of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Maternal Decision Making, Ethics, and the Law*, ACOG (Nov. 2005), <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co321.pdf>? [hereinafter *ACOG Ethics Opinion*].

77. *Id.*

78. While pregnant, there is only a “we.” Rene Descartes’ well known *cogito ergo sum*, “I think, therefore I am,” thought exercise, applied personally, reflects this intertwined oneness with simplicity. Normally, I crave red meat daily. While pregnant, I cannot stand the thought of red meat. The “I” that thinks while expecting is different than my normal “I.” Pregnancy temporarily alters sense of self; while pregnant there is only a “we.”

79. See IMMANUEL KANT, *GROUNDWORK OF THE METAPHYSICS OF MORALS* § 4:412 (Mary Gregor ed. & trans., Cambridge Univ. Press 1998); April L. Cherry, *Shifting Focus from Retribution to Social Justice: An Alternative Vision for the Treatment of Pregnant Women Who Harm Their Fetuses*, 28 J. L. & HEALTH 6, 50–52 (2015); *ACOG Ethics Opinion*, *supra* note 76. Legislation that approaches an embryo as a separate and independent legal being from its mother, and uses this legal fiction to criminally charge a pregnant woman for her conduct during pregnancy calls to mind Margaret Atwood’s novel about a dystopian monotheocracy, *THE HANDMAID’S*

relationship, when in reality a mother and her infant's interests are almost always interrelated.⁸⁰

Moreover, as written, Tennessee's statute allows assault charges to be brought against a pregnant woman at the very earliest embryo stage when she still has a constitutional right to obtain an abortion.⁸¹ As discussed in greater detail below, this creates a perverse and seemingly unacceptable incentive for a pregnant woman who has used drugs to obtain an abortion pre-viability.⁸² Tennessee's broad definition of "person" also raises the very real possibility of charging a woman who does not know that she is pregnant with assault for conduct that would not be "reckless" with regard to injuring a third party who is not in utero. While largely beyond the scope of this article, such a framework raises difficult concerns regarding autonomy, equal protection, fairness, and due process.⁸³

Because Tennessee's statute rests on the fiction of fetal personhood while ignoring the interconnected relationship between mother and baby, both in utero and during the baby's first years, the law is practically and morally flawed.⁸⁴

TALE, in which the main character, Offred, laments, "We are two-legged wombs, that's all: sacred vessels, ambulatory chalices." MARGARET ATWOOD, *THE HANDMAID'S TALE* 136 (Houghton Mifflin 1986).

80. *ACOG Ethics Opinion*, *supra* note 76.

81. *See, e.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. at 833, 870 (1992).

82. This problem would be ameliorated by returning to the 1989 definition of "another person" in Section 107(a), which only applied to a viable fetus. TENN. CODE ANN. § 39-13-107(a) (1989). Some concern regarding the incentive to abort would remain, however, because pregnant drug users may be aware of the statute and potential criminal liability but not that liability was limited to after viability. The incentive to abort would also remain troubling because some pregnant drug users may abort pre-viability out of concern that they will be unable to stop using drugs after viability.

83. *See, e.g.*, Tiffany Lyttle, *Stop the Injustice: A Protest against the Unconstitutional Punishment of Pregnant Drug-Addicted Women*, 9 N.Y.U. J. LEGIS. & PUB. POL'Y 781, 783 (2006); John E.B. Myers, *A Limited Role for the Legal System in Responding to Maternal Substance Abuse During Pregnancy*, 5 NOTRE DAME J.L. ETHICS & PUB. POL'Y 747, 761 (1991) (stating that prosecuting mothers for drug use affects their right to procreative privacy).

84. April Cherry, commenting on an article by Seema Mohapatra, has an interesting discussion of why we should focus on the health and welfare of the pregnant woman for her own sake rather than as a means to ensure better fetal health. Cherry, *supra* note 79, at 50; *see* Seema Mohapatra, *Unshackling Addiction: A Public Health Approach to Drug Use During Pregnancy*, 26 WISC. J.L. GENDER & SOC'Y 241, 253 (2011). I agree that a pregnant woman ought to be treated as an end

B. Ignoring the Primary Driver of Increasing NAS Births

Tennessee's law is also poorly targeted for its stated purpose. Legislators claim that criminalizing pregnant drug use is necessary to respond to a rising epidemic of NAS births. However, the explosion of NAS births in Tennessee—as is also the case in Kentucky, Alabama, Mississippi, Maine, New Hampshire, West Virginia, and Florida—appears to be driven by prescription drug use.⁸⁵ Statistics show that approximately two-thirds of NAS births in Tennessee are linked to at least one legally prescribed drug.⁸⁶ Almost half of NAS births in Tennessee are due *exclusively* to legally prescribed drugs.⁸⁷

in herself, that states should take a public health approach, and that rhetoric matters. Nonetheless, because a primary goal of this article is to influence open-minded legislators primarily concerned with protecting the unborn, the article often and necessarily focuses on how treatment of a pregnant woman impacts her baby. Such a focus is not intended to rob the pregnant woman of her instrumentality, but rather to illustrate that the relationship between mother and baby are interrelated to such an extent that the policy approach should be the same with either focus.

85. *Associated Health Care Expenditures*, *supra* note 8, at 1937 (noting temporal correlation between rise in prescription drug use and NAS births); *see also Geographic Distribution of NAS*, *supra* note 9, at 653 (“The rapid rise in NAS parallels the increase in [opioid pain reliever] use in the United States, suggesting that preventing opioid overuse and misuse, especially before pregnancy, may prevent NAS.”); Toila et al., *supra* note 9, at 2119 (noting the rising incidence of NAS due to increasing opioid use among pregnant women).

86. *Infant Outcomes*, *supra* note 11, at 846 (“65% of infants with NAS were exposed to legally obtained [opioid pain relievers] in pregnancy.”); *2013 TN NAS Summary*, *supra* note 19 (sixty-three percent of NAS births had at least one prescribed substance linked to NAS); *2014 TN NAS Summary*, *supra* note 19, at 14 (sixty-nine percent of NAS births had at least one prescribed substance linked to NAS); *2015 Year-To-Date TN NAS Summary*, *supra* note 19 (seventy-five percent NAS births had at least one prescribed substance linked to NAS).

When at least one legally prescribed drug could have caused the NAS, but the pregnant woman also used another “diverted” or “illicit” substance during pregnancy, it may be unclear whether legal or illegal drug use caused NAS. If a pregnant woman has access to robust legal representation, with sufficient resources to hire a compelling expert, the law should not result in liability in these cases. After all, prosecutors bear the burden of proof that the newborn's harm is “a result of” the mother's illegal narcotic use while pregnant. This burden should be difficult to meet when a health care provider prescribed the mother at least one substance that causes NAS. Assuming a pregnant woman who has taken a legally prescribed drug linked to NAS will typically not face liability, only roughly 1/3 of pregnant women who deliver babies diagnosed with NAS remain vulnerable to criminal liability under the new law.

87. *2013 TN NAS Summary*, *supra* note 19 (reporting that 42.3% were only

Likely, the impact of legally prescribed drugs on NAS births is even greater than one-half to two-thirds of all NAS births. Many women become addicted to legally prescribed drugs first and later switch to heroin or another illicit substance that is cheaper and easier to obtain.⁸⁸ If this switch occurs prior to pregnancy, the NAS birth would not be listed as attributable to legally prescribed drugs, despite the fact that the legally prescribed drugs caused the underlying addiction.⁸⁹

Yet, the amended assault statute only authorizes charges if a woman uses an *illegal* “narcotic” while pregnant and thereby harms her baby.⁹⁰ It does not criminalize the use of legal drugs that might injure a baby, such as alcohol, tobacco, or prescription drugs.⁹¹ Because the statute ignores the leading cause of the burgeoning NAS

using prescribed substances); *2014 TN NAS Summary*, *supra* note 19, at 16 (reporting that 46.6% were only using prescribed substances); *2015 Year-To-Date TN NAS Summary*, *supra* note 19 (reporting that 41.3% were only using prescribed substances).

88. Todd Barnes, *Report: TN's Uninsured, Pill Scripts Linked to Heroin Abuse*, TENNESSEAN, July 15, 2015, at 5A (many drug users first become addicted to legally prescribed narcotics and only later switch to illegal drugs like heroin because heroin is cheaper and easier to obtain) (citing 2015 report from the Center for Disease Control and Prevention). Experts estimate that seventy-five percent of heroin users first became addicted to prescription drugs. *Id.*

89. It is unclear the extent to which the rampant prescription drug use in Tennessee begins with the patient innocently being prescribed a drug to treat a legitimate medical problem, from which the patient is simply unable to wean herself. In some instances, even the initial legally prescribed drug may stem from less innocent behavior whereby the patient intentionally seeks the drug primarily for a high. Either way, Tennessee’s amended statute does absolutely nothing to curtail the legally prescribed drug use driving the increase in NAS births.

90. See TENN. CODE ANN. § 39-13-107(c)(2) (2014). “Narcotic” is defined by reference to TENN. CODE ANN. § 39-17-402 and appears to include opiate and cocaine based drugs but not marijuana or methamphetamine. TENN. CODE ANN. § 39-17-402 (2010). While Tennessee legislators introduced bills in 2015 that would expand the assault statute to include methamphetamine, HB 1340 and SB 586, to date such expansion has not passed. H.B. 1340, 109th Gen. Assemb. (Tenn. 2015); S.B. 586, 109th Gen. Assemb. (Tenn. 2015).

91. TENN. CODE ANN. § 39-13-107(c)(1)–(2). However, Section 107(c)(1), which is broader than Section (c)(2), may still provide a basis for prosecution of an under-age pregnant woman whose alcohol or tobacco use harms her baby since such act is not “lawful.” *Id.*; see TENN. CODE ANN. § 39-17-1505 (2014) (unlawful for person under age 18 to possess, purchase or accept tobacco); TENN. CODE ANN. § 57-3-412(3)(A)–(C) (2014) (stating that it is unlawful for person under age 21 to possess or consume alcohol). Health experts typically categorize neonatal harm caused by alcohol (fetal alcohol syndrome) or tobacco separately from NAS. See, e.g., *TennCare Enrollees Provisional 2012 Data*, *supra* note 12.

crisis—legally prescribed prescription drugs—it cannot and will not reverse the incidence of NAS births.⁹²

Criminalizing pregnant drug use is bad public policy for the reasons discussed below; therefore, the narrower the law the better. However, Tennessee’s law is poorly targeted if the goal is to reduce NAS births. The law does nothing to address the primary cause of NAS births—prescription drugs—and the high rate of unintended

92. Even in the remaining third of NAS births, prosecutors may find it difficult to criminally convict a pregnant woman whose drug use causes in utero harm. First, to the extent these cases involve illegal drugs that are not narcotics, like marijuana or methamphetamine, Section 107(c)(2) does not authorize liability. TENN. CODE ANN. § 39-13-107(c)(2) (2014); TENN. CODE ANN. § 39-17-402(17) (2014) (defining “narcotic”).

Second, to the extent a woman reasonably does not know that she is pregnant, the statute probably does not provide for liability. Assault is a specific intent offense, requiring prosecutors to prove that a mother “intentionally, knowingly or recklessly” caused bodily injury. TENN. CODE ANN. § 39-13-101(a)(1) (2014). Under Tennessee law, a woman acts recklessly when she “consciously disregards a substantial and unjustifiable risk that the circumstances exist or the result will occur.” TENN. CODE ANN. § 39-11-302(c) (2014). “The risk must be of such a nature and degree that its disregard constitutes a gross deviation from the standard of care that an ordinary person would exercise . . .” *Id.* Sometimes a risk is not imminent or substantial enough to make consciously disregarding it a “reckless” act. A woman who reasonably does not know she is pregnant when she uses drugs does not consciously disregard a substantial and unjustifiable risk of harm to her fetus or embryo. In this regard, a drug user who reasonably does not know she is pregnant is different from a defendant who does not know her driving under the influence will cause an accident, as personal drug use does not endanger another unless one is pregnant.

Third, to the extent that many of the remaining cases involve “diverted” narcotics, prosecutors may be unable to prove the required intent. While use of illicit drugs may often meet the recklessness requirement, the case is much less clear for diverted narcotics. A pregnant woman who takes a prescription drug without a valid prescription may do so because she lacks the ability to visit a physician. After all, ninety-three percent of reported NAS cases in Tennessee [could not find data to support this figure], and seventy-eight percent nationwide involve a woman who lives in poverty, and many are uninsured. *Associated Health Care Expenditures*, *supra* note 8, at 1936. For these women, self-medicating may be the only financially feasible health care. Moreover, these women may, somewhat understandably, believe that the diverted drugs are safe—especially if they have previously been prescribed them. A pregnant woman who suffers anxiety and takes Xanax to manage her condition cannot be prosecuted if she can afford to visit a physician. Perhaps then, a poor, pregnant woman with the same medical condition who treats the condition with the same drug does not “consciously disregard” a “substantial and unjustifiable” risk. *See* TENN. CODE ANN. § 39-11-302(c) (2014). So, while troubling for the reasons outlined below, Tennessee’s law is circumscribed by the limitation to illegal narcotics and by the evidentiary difficulty of establishing causation and intent.

pregnancy in connection with prescription drug use.⁹³ It also does nothing to increase the availability of drug treatment, which is essential to effectively combat the remaining NAS births.⁹⁴

C. The Illusory Affirmative Defense Fails to Account for Lack of Available, Affordable, and Appropriate Treatment

1. The Affirmative Defense Should Protect Women Who Seek Treatment, Not Only Those Able to Obtain It

Without expressly acknowledging that the law is poorly targeted to address the vast majority of NAS births, the sponsors of Tennessee's new law claim that the law targets "the worst of the worst."⁹⁵ The pregnant women desperately seeking drug treatment, then still being prosecuted pursuant to the law, belie this assertion. Under Tenn. Code Ann. §39-13-107(c)(3), if a pregnant woman can establish that she is enrolled in an addiction recovery program

93. *Infant Outcomes*, *supra* note 11, at 848 ("Public health efforts should focus on limiting inappropriate [opioid pain relievers] . . ."); *see also* Heil, *supra* note 12, at 200 (noting that eighty-six percent of women who abuse opioids report that their pregnancy is unplanned); *TennCare Enrollees Provisional 2012 Data*, *supra* note 12 (noting that eighty-two percent of women prescribed narcotics are not on contraceptives). In separate legislation, Tennessee has taken some positive steps to address the prescription drug crisis. In particular, the Tennessee Prescription Safety Act of 2012 now requires prescribers to report narcotic prescriptions and to check the statewide Controlled Substance Monitoring Database before writing an opioid prescription in most cases. TENN. CODE ANN. § 53-10-302 (2012). Similarly, Tennessee has established dispensing limits on many narcotics, limiting patients to a 30-day supply. TENN. CODE ANN. § 53-11-308(e) (2014). Further, the legislature recently passed the 2015 Opioid Abuse Reduction Act, requiring the Department of Mental Health and Substance Abuse to convene a working group on the problem of opioid abuse. *See* H.B. 0403, 109th Gen. Assemb. (Tenn. 2015); S.B. 0570, 109th Gen. Assemb. (Tenn. 2015). Moreover, the governor's "Prescription for Success," if fully implemented, would positively impact public health. The difficulty, of course, is that the Prescription for Success is not fully funded, and the legislative initiatives, while promising, do not go far enough. Tom Wilemon, *Tennessee Fails to Up Ante for Drug Treatment*, TENNESSEAN, Nov. 27, 2014, available at <http://www.tennessee.com/story/news/health/2014/11/27/tennessee-fails-ante-drug-treatment/70111366/> (despite announcing Prescription for Success, new budget contains no additional money for addiction treatment and less funds for support services).

94. Health Expert's Amicus, *supra* note 4, at 6–8 (opining that pregnant drug users need treatment, not jail); AAP Position, *supra* note 4, at 640–41 (opining that pregnant drug users need treatment, not jail); ACOG Ethics Opinion, *supra* note 76, at 6–8 (opining that pregnant drug users need treatment, not jail).

95. Statement of Representative Weaver, *supra* note 1.

before her child was born, remained in the program after delivery, and successfully completed the program, she has a valid affirmative defense.⁹⁶ However, this defense does not protect a pregnant woman who seeks treatment but is unable to receive treatment due to a lack of available, affordable, or appropriate treatment options.

Addiction treatment options for pregnant women are extremely limited, costly, and nearly non-existent.⁹⁷ Like in many states, “only 2 of Tennessee’s 177 addiction treatment facilities provide prenatal care on site and allow older children to stay with their mothers.”⁹⁸ Only 19 provide any addiction care for a pregnant woman, and only 5 of these accept TennCare.⁹⁹ Moreover, the distance between a woman seeking treating and a treatment facility, even when the treatment is otherwise available and affordable, often proves an insurmountable obstacle. In September 2014, there were fewer than 50 beds available to treat poor pregnant drug users statewide—an embarrassing shortfall relative to the almost 1,000 pregnant women who gave birth to a baby diagnosed with NAS that year.¹⁰⁰

Perhaps, nothing captures the lack of available, affordable drug treatment as well as the experience of one pregnant woman seeking help:

96. TENN. CODE ANN. § 39-13-107(c)(3) (2014).

97. *AAP Position*, *supra* note 4, at 640–41 (noting that the demand for treatment “far exceeds supply”); Gonzalez, *supra* note 41 (stating that since passage of the law, “little [has been] done to expand addiction treatment services”); Gonzalez & DuBois, *supra* note 20 (“Addiction treatment is extremely limited and costly—and nearly nonexistent for pregnant women.”); *see also* SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEP’T OF HEALTH AND HUMAN SERVICES, RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 7 (2014) [hereinafter *National Drug Survey*] (reporting that in 2013 alone, 316,000 Americans tried and failed to obtain substance abuse treatment, most commonly due to lack of insurance coverage and affordability); Christopher M. Jones, et al., *National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment*, 105 AM. J. PUB. HEALTH, vol. 8 e55, e55 (“Significant gaps between treatment need and capacity exist at the state and national levels.”).

98. Scott, *supra* note 20.

99. *Id.*; Goldensohn & Levy, *supra* note 20, at 26 (noting that only 5 treatment centers accept TennCare).

100. Dosani, *supra* note 20 (reporting fewer than 50 beds in Tennessee are available to treat pregnant drug users); Goldensohn & Levy, *supra* note 20, at 26 (reporting fewer than 50 beds in Tennessee are available to treat pregnant drug users); 2014 *TN NAS Summary*, *supra* note 19 (reporting 973 NAS births in Tennessee in 2014).

For months, she and her mother tried every clinic and hospital they could find—about thirty by the time [Carmen] Wolf was due. “We had numbers and places written horizontally and diagonally across papers every which way,” Wolf recalled. “Everything is unorganized, because we were in such a hurry to get help.” Almost all of the centers told her no flat out, citing liability issues. . . . Only one center would take her in, but she would have to pay [\$3,000 up front] first.¹⁰¹

In fact, several of the women who have been charged under the new law report that they sought treatment during pregnancy but were turned away *repeatedly* by facilities that did not accept pregnant women, did not accept TennCare or that were full.¹⁰² Clearly, these women seeking treatment are not “the worst of the worst,”¹⁰³ yet the law ensnares them.

At the very least, the law’s affirmative defense should be expanded to protect pregnant women that *seek* treatment, not only those that successfully obtain it.¹⁰⁴ Given the fact that the demand for treatment greatly exceeds the supply of suitable treatment options,¹⁰⁵ there is no reasonable basis upon which to punish a woman who seeks help. Such an approach serves no deterrent purpose (as the woman cannot control the treatment options available to her), and it is manifestly unfair to punish a woman for the state’s lack of available, affordable, and appropriate treatment.

2. The Affirmative Defense Should Protect Women Who Complete Treatment, Even If They Enroll After Giving Birth

The affirmative defense’s unrealistic timing further compounds the lack of adequate supply, unaffordability, and other barriers to

101. Goldensohn & Levy, *supra* note 20, at 26 (quoting Carmen Wolf regarding her experience in Tennessee seeking drug treatment while pregnant in 2014).

102. *Id.* (reporting Brittany Hudson and Jamillah Fall separately being turned away from multiple treatment centers and Carmen Wolf seeking treatment at thirty centers without success).

103. Statement of Representative Weaver, *supra* note 1, at 5:14:32 (exhibiting the contrast between the intent of Tennessee’s law and its actual effect).

104. This result could be accomplished by amending TENN. CODE ANN. § 39-13-107(c)(3) (2014) to read: “It is an affirmative defense to a prosecution permitted by subdivision (c)(2) that the woman actively sought enrollment in an addiction recovery program before the child was born, regardless of whether the child was born addicted to or harmed by the narcotic drug.”

105. *AAP Position*, *supra* note 4, at 640–41 (stating that demand for voluntary drug treatment far exceeds supply).

treatment. The defense only applies if a pregnant woman finds and enrolls in treatment *prior* to birth.¹⁰⁶ For pregnant women using drugs, the time between discovering the pregnancy and delivery is usually less than six months—often much less.¹⁰⁷ In most cases, this provides insufficient time to find and begin treatment before birth.¹⁰⁸ Thus, the affirmative defense is illusory, allowing legislators and voters to believe that any woman willing to accept treatment can avoid criminal charges, while such treatment is generally unavailable, especially within the timeframe required by the statute.

Moreover, several of the women charged under the statute to date were only charged *after* birth, at which time it is already too late to avoid a penalty by obtaining drug treatment.¹⁰⁹ If the goal of

106. TENN. CODE ANN. § 39-13-107(c)(3) (2014).

107. Heil, *supra* note 12, at 200. Eighty-six percent of women who abuse opioids report that their pregnancy is unplanned. *Id.* Unplanned pregnancies tend to be discovered later in the pregnancy, and this problem is often worse when a woman is using drugs. Drug use may disrupt her menstrual cycle or otherwise mask the pregnancy, leaving little time to find and arrange for treatment. See Linda C. Fentiman, *Rethinking Addiction: Drugs, Deterrence, and the Neuroscience Revolution*, 14 U. PA. J.L. & SOC. CHANGE 233, 255–56 (2011).

108. See Fentiman, *supra* note 107, at 258 (“[T]he need for treatment is immediate, yet historically, many women have had difficulty in obtaining a ‘slot’ in any treatment program . . .”). Ironically, one legislator argued in favor of the law, recognizing the lack of available, affordable treatment, as a way to provide a pregnant woman access to drug court programs and thereby affordable treatment. See S.B. 1391, 108th Gen. Assemb., Reg. Sess. (Tenn. Mar. 31, 2014, 46:07) (statement of Sen. Reginald Tate), available at http://tnga.granicus.com/MediaPlayer.php?view_id=269&clip_iid=9225&meta_id=174300. Needless to say, there are more helpful ways to provide access to affordable drug treatment than through criminal liability. In fact, in addition to expanding access to affordable treatment, in order to curtail NAS births, states also need to greatly improve communication regarding existing services. Tennessee already is one of eleven states that gives pregnant women priority access to all treatment programs that accept them. STATE POLICIES, *supra* note 2, at 2.

109. Goldensohn & Levy, *supra* note 20, at 26–27 (describing instances of post-delivery arrest). In addition to being unrealistically short, the affirmative defense’s timing also fails to provide an incentive for treatment once a woman knows she will face liability. See TENN. CODE ANN. § 39-13-107(c)(3) (2014). Some studies suggest that as few as fifty-five percent of neonates with in utero narcotic exposure may develop NAS. Hudek, *supra* note 26, at 541; see also *NAS Law Guidance*, *supra* note 26, at 1 (“Not all cases of exposure will lead to withdrawal syndrome.”). So, a woman may not know if she faces liability until *after* birth. As drafted, once a baby is born with NAS, it is too late to avoid penalty by seeking drug treatment, even though successful treatment after birth has a materially positive impact on the baby and the mother. See TENN. CODE ANN. § 39-13-107(c)(3) (2014); see also *AMA Position*, *supra* note 4, at 2669 (indicating that treatment “facilitates a more emotionally positive

the statute is to couple the “carrot” of preferential placement for pregnant women in drug treatment programs with the “stick” of jail time if a woman refuses treatment, the “stick” should only apply after the woman has had an opportunity to receive treatment and refused. The law’s affirmative defense should be expanded to protect a woman who is willing to complete treatment once it is offered to her, even if that opportunity arises for the first time after birth.¹¹⁰

As drafted, the illusory affirmative defense perpetuates the myth that pregnant drug users are being offered help and refusing it. In reality, even without the threat of assault charges, the demand for drug treatment among pregnant women greatly exceeds the supply of available drug treatment.¹¹¹ The problem is often not pregnant drug users’ lack of desire to obtain help, but rather the existence of available, affordable treatment. As long as the demand for treatment continues to exceed the supply of available treatment, there is absolutely no way that criminalizing pregnant drug use will increase the number of pregnant women receiving drug treatment or decrease the number of NAS births. At a minimum, the affirmative defense should be amended to protect any woman who accepts available treatment.¹¹²

D. An Underreported Amendment Creates Broad, Undefined Liability

While the further criminalization of illegal narcotic use has received most of the attention, the amended language of Tenn. Code

relationship after birth”). By limiting the “carrot” contained in the affirmative defense to a pregnant woman “actively enrolled” in drug treatment *before* delivery, the law provides no incentive for treatment by the time a woman knows she faces liability.

110. This result could be accomplished by amending TENN. CODE ANN. § 39-13-107(c)(3) to read: “It is an affirmative defense to a prosecution permitted by subdivision (c)(2) that the woman successfully completed an addiction recovery program, regardless of whether the child was born addicted to or harmed by the narcotic drug. Any woman charged under subdivision (c)(2) must be offered affordable placement in an addiction recovery program, with the opportunity to satisfy this affirmative defense.”

111. Scott, *supra* note 20 (“Only two of Tennessee’s 177 addiction treatment facilities provide prenatal care on site . . . and only 19 provide any addiction care for pregnant women.”).

112. While a significant improvement that would increase the statute’s fairness—even a robust affirmative defense as proposed in the footnote above—would not cure many of criminalization’s ills. See *ACOG Substance Abuse Opinion*, *supra* note 4, at 2 (stating that “use of the legal system to address” NAS is simply “inappropriate”).

Ann. §39-13-107(c)(1) is also troubling. The broad, undefined language of this section could be used to prosecute a pregnant woman for *any* act or omission that harms her embryo or fetus, unless such act or omission is “lawful.”¹¹³ One of the arguments against criminalizing illegal drug use by pregnant women is and has always been the “slippery slope.”¹¹⁴ The concern is that if the state criminalizes pregnant drug use, it might also eventually criminalize pregnant smoking, exercising too much, or even the failure to eat and sleep as recommended. Section Tenn. Code Ann. §39-13-107(c)(1) raises the very real specter of abusive prosecution of pregnant women for a wide range of conduct.¹¹⁵

When Tennessee first amended its assault statute to expressly include an “embryo or fetus at any stage of gestation,” it carved out an exception for pregnant women with regard to their own embryo or fetus.¹¹⁶ After the 2014 amendment, however, a prosecutor may charge a pregnant woman with assault based on any reckless act or omission that harms her embryo or fetus, unless the act or omission is “lawful.”¹¹⁷ The addition of the word “lawful” dramatically narrows the exemption.

While at first blush requiring pregnant women to behave “lawfully” may not seem draconian, the possibility of a woman being called into court to defend her behavior when she miscarries or delivers a baby with a fetal abnormality is both real and troubling.¹¹⁸

113. TENN. CODE ANN. § 39-13-107(c)(1) (2014).

114. *See, e.g., Commonwealth v. Welch*, 864 S.W.2d. 280, 283 (Ky. 1993) (expressing concern regarding the slippery slope of charging a pregnant woman).

115. TENN. CODE ANN. § 39-13-107(c)(1) (2014). In fact, Section 107(c)(1) arguably provides a basis for prosecution of an under-age pregnant woman whose alcohol or tobacco use harms her baby since such act is not “lawful.” *See* TENN. CODE ANN. § 39-17-1505 (2014) (unlawful for person under age eighteen to possess, purchase or accept tobacco); TENN. CODE ANN. § 57-3-412(3)(A)-(C) (2013) (unlawful for any person under age twenty-one to possess or consume alcohol).

116. TENN. CODE ANN. § 39-13-107 (a), (c) (Supp. 2012); 2012 Tenn. Pub. Acts 1006, §§ 2, 4–5.

117. TENN. CODE ANN. § 39-13-107(c)(1) (2014) (“Nothing in subsection (a) shall apply to any *lawful* act or *lawful* omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant . . .”) (emphasis added).

118. The broad scope of section 107(c)(1) may also create an internal inconsistency—a “lesser” illegal drug like marijuana could pose a *greater* risk of criminal liability than the illegal narcotics the statute targets. *See* TENN. CODE ANN. § 39-17-415 (2014) (classifying marijuana as a Schedule VI controlled substance). After all, unlike section 107(c)(2), a pregnant woman charged under section 107(c)(1) has no affirmative defense. TENN. CODE ANN. § 39-13-107(c)(3) (2014). Because marijuana use is less likely to harm a baby in utero, it is hard to imagine a compelling rationale for treating a pregnant woman who uses marijuana more

Speeding, failing to wear a seat belt, and texting while driving, while quite common, are not “lawful.” If such conduct contributes to a car accident in which an embryo or fetus is harmed, the pregnant woman could be charged with assault.¹¹⁹ While liability for assault should be limited by the specific intent requirement, the trauma of facing prosecution may not be.¹²⁰

Moreover, any such prosecutions reinforce the already damaging notion that a woman is at fault if her baby is not perfect. Pregnancy is an incredible gift but also a long, trying, and stressful time for many. A pregnant woman should not be held to unrealistic standards of conduct that threaten to turn relatively minor infractions into criminal assault. Broad laws criminalizing undefined conduct, like Tenn. Code Ann. §39-13-107(c)(1), unfairly burden a pregnant woman and leave far too much discretion to prosecutors.¹²¹ The language of the statute should be returned to its pre-2014 amendment form.¹²²

harshly than a pregnant woman who uses cocaine or heroin. *See AAP Position, supra* note 4, at 639 (stating that withdrawal from marijuana “does not appear to result in as severe a syndrome of abstinence as withdraw from narcotics”); Peter A. Fried, *The Consequences of Marijuana Use During Pregnancy: A Review of the Human Literature*, 2 J. CANNABIS THERAPEUTICS 85, 99 (2002) (finding no increased risk of NAS after marijuana use); Eran Kozer & Gideon Koren, *Effects of Prenatal Exposure to Marijuana*, 47 CAN. FAM. PHYSICIAN 263, 263 (2001) (finding no increased risk of NAS after marijuana use). Yet, the statute could arguably be interpreted to do so. Of course, this internal inconsistency could be avoided by reading the statute as a whole to exclude liability for non-narcotic illegal drug use (or relying on the legislative history to reach this same result). This is without question the better statutory interpretation. Nonetheless, the tension in the language illustrated by this example remains. Pursuant to section 107(c)(1), undefined, possibly less pernicious conduct by a pregnant woman could result in assault liability with no affirmative defense.

119. *See, e.g.,* Eckholm, *supra* note 21 (reflecting concern that pregnant women could be charged for harm relating to relatively minor driving offenses); Goldensohn & Levy, *supra* note 20, at 28 (reflecting concern that pregnant women could be charged for harm relating to relatively minor driving offenses).

120. *See* Linda C. Fentiman, *In the Name of Fetal Protection: Why American Prosecutors Pursue Pregnant Drug Users (and Other Countries Don't)*, 18 COLUM. J. GENDER & L. 647, 665–68 (2009) (discussing the dangers of prosecutorial discretion with regard to pregnant women).

121. *Id.* at 666–67.

122. Specifically:

(c) Nothing in subsection (a) shall apply to any act or omission by a pregnant woman with respect to an embryo or fetus with which she is pregnant, or to any lawful medical or surgical procedure to which a pregnant woman consents, performed by a health care professional who is

In summary, Tennessee's new law criminalizing illegal narcotic use by pregnant women is inherently flawed because it ignores the scientific and medical facts: the interconnected relationship between mother and baby, the reality that prescription drugs drive the majority of NAS births, as well as the empirical data that in Tennessee the demand for drug treatment for pregnant women already greatly exceeds the available supply.

III. CRIMINALIZING PREGNANT DRUG USE FAILS TO SERVE CRIMINAL LAW OBJECTIVES

Having analyzed the contours of the first law expressly authorizing criminal assault charges against a pregnant woman for drug use, this article now considers how that law and others like it comport with the ends of criminal justice. Criminal law arguably has five objectives: restoration, incapacitation, rehabilitation, deterrence, and punishment.¹²³ Tennessee's new assault statute, in particular, and criminalizing pregnant drug use, in general, fail to satisfy these objectives.

A. *Restoration Fails: The Statute Is Not in the Baby's Best Interest*

Through restoration, criminal law seeks to repair any injury inflicted upon the victim by the offender. In general, the goal of restoration is to return the victim to his or her position prior to injury.¹²⁴ Restoration works effectively in cases where an offender is

licensed to perform such procedure.

TENN. CODE ANN. § 39-13-107(c) (Supp. 2012). Amendment of section 107(c)(1) was unnecessary and inadvisable. Reverting to the pre-2014 amendment form of section 107(c)(1) would not impact the efficacy of section 107(c)(2), as section 107(c)(2) begins "Notwithstanding subdivision (c)(1)." TENN. CODE ANN. § 39-13-107(c)(2) (2014).

123. See, e.g., ELLEN S. PODGOR ET AL., *CRIMINAL LAW: CONCEPTS AND PRACTICE* (2d ed. 2009); John B. Mitchell, *Crimes of Misery and Theories of Punishment*, 15 *NEW. CRIM. L. REV.* 465, 475 (2012). While a growing number of scholars recognize restoration as an important goal of criminal law, the majority likely would not characterize restoration as a traditional objective of criminal law. This article leads with an analysis of restoration nonetheless because sponsors of Tennessee's amended assault law and others pushing further criminalization for pregnant drug use claim to do so in order to protect the baby. The restoration analysis demonstrates that further criminalization is not in the best interest of the baby.

124. See Courtney E. Lollar, *What is Criminal Restitution?*, 100 *IOWA L. REV.* 93, 99 (2014) ("Traditionally, . . . courts used restitution to financially restore a person economically damaged by another's actions, thereby preventing the unintended beneficiary from being unjustly enriched at the aggrieved party's expense.").

able to repay the amount improperly acquired, like fraud or theft,¹²⁵ but it fails in the context of in utero drug exposure. In the case of in utero drug exposure, criminalizing the mother's conduct places the baby in a worse position.¹²⁶ If the goal of criminalizing pregnant drug use is to protect the unborn, as proponents claim, it is important to begin an analysis by considering the likely impact of criminalization on the baby.

1. An Incentive to Abort

First, criminal laws that can be used to prosecute a pregnant woman for behavior during pregnancy create a perverse incentive for women to have an abortion. A woman who aborts her pregnancy in accordance with the law prior to viability faces no liability, while a woman who carries her baby to term after using illegal drugs may be criminally prosecuted.¹²⁷ It is impossible to ignore the cruel irony that Tennessee's assault law places the victims it purports to protect in mortal danger, a far greater harm, by providing an incentive to abort.¹²⁸ Perhaps nothing demonstrates the moral perversion of criminalization quite like considering that a woman who ingests drugs pre-viability *intending to kill* her fetus (with a medically supervised abortifacient) faces no criminal liability, while a woman who takes drugs *without intending to harm* her fetus faces liability for assault.¹²⁹ Given the fact that there is no definitive evidence that

125. *See id.*

126. *See, e.g.,* Meghan Horn, Note, *Mothers Versus Babies: Constitutional and Policy Problems with Prosecutions for Prenatal Maternal Substance Abuse*, 14 WM. & MARY J. WOMEN & L. 635, 652 (2008).

127. Compare TENN. CODE ANN. § 39-15-201(c) (2014) (exempting an abortion performed by a physician with consent through viability), with TENN. CODE ANN. § 39-13-107(c)(1)-(2) (2014) (defining assault to include unlawful acts or omissions taken by a mother that harm her baby in utero).

128. This risk is especially acute given the lack of definitive evidence that NAS causes long-term health consequences. *See* Goldensohn & Levy, *supra* note 20, at 28 (quoting Dr. Loretta Finnegan, an expert on NAS: "NAS is really a very minor medical condition, in contrast to what can happen to a baby, both physically and psychologically, if the mother is not in treatment."); *see also* Wong, Ordean, & Kahan, *supra* note 29, at 376 (noting that there is no definitive evidence NAS causes long-term harm).

129. Abortifacients—drugs that induce a miscarriage—such as RU-486 may be taken legally early in pregnancy. Renée C. Wyser-Pratte, *Protection of RU-486 as Contraception, Emergency Contraception and as an Abortifacient Under the Law of Contraception*, 79 OR. L. REV. 1121, 1121 (2000). A criminal law that only applied *post-viability* would lessen, but not obviate, the incentive to abort.

NAS birth causes any long-term health consequences,¹³⁰ the risk of incentivizing abortion seems wholly unacceptable.¹³¹

Pro-life advocates, in particular, should find Tennessee's law pernicious since it encourages a pregnant drug user who cannot (or will not) successfully complete treatment to opt for abortion.¹³² Pro-choice advocates should be concerned that the law provides a pregnant woman who uses illegal narcotics only a Hobson's choice: she may wish to keep her baby but feel compelled to abort her pregnancy to avoid potential criminal conviction. Such alternatives make a mockery of reproductive "freedom" and "free choice."

During the debate on criminalization of pregnant women's drug use, proponents denied that there would be an incentive to abort a pregnancy, arguing that any woman criminally prosecuted would have used illegal drugs within two days of delivery, too late for an abortion.¹³³ This argument ignores the plain language of the statute, the factual evidence to the contrary, and, perhaps most importantly, the potentially dangerous force of a legal incentive.¹³⁴

First, the plain language of the statute is not limited to illegal drug use in the final days of pregnancy or even in the last trimester.¹³⁵ To the contrary, the statute expressly authorizes prosecution based on harm to the embryo or fetus at "any stage of gestation," including pre-viability when abortion is legal.¹³⁶ Nothing

130. ACOG NAS Toolkit, *supra* note 29, at p. 2 ("There have been no reported long term effects of maternal opioid use on the developing child.").

131. Wong, Ordean, & Kahan, *supra* note 29, at 376.

132. Dosani, *supra* note 20 (reporting anecdotal evidence of pregnant women in Tennessee considering abortion because of the new law).

133. S.B. 1391, 108th Gen. Assemb., S. Judiciary Comm. (Tenn. Mar. 18, 2014, 2:26:12) (statement of D.A. Barry Staubus), available at http://tnga.granicus.com/MediaPlayer.php?view_id=%20269&clip_id=9050&meta_id=168824.

134. In addition, if the statute actually operates this way, the affirmative defense provided in Section 107(c)(3) would be a cruel fiction, as a pregnant woman would lack any meaningful opportunity to obtain treatment in the less than two days remaining prior to birth. See TENN. CODE ANN. § 39-13-107(c)(3) (2014) (requiring women to have "actively enrolled in an addiction recovery program before the child is born" to qualify for the affirmative defense).

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

136. TENN. CODE ANN. § 39-13-107(a) (2014); TENN. CODE ANN. § 39-15-201(c) (2014). On November 4, 2014, Tennessee voters passed a referendum amending the state Constitution to allow legislation restricting abortion. See S.J. Res. 127, 108th Gen. Assemb., Reg. Sess. (Tenn. 2011) (creating ballot referendum to amend TENN. CONST. art. I, § 36). Since that time, legislation has narrowed the right to abortion in Tennessee, but the procedure remains legal. Tim Ghianni, *Tennessee Governor Signs Law Setting 48-Hour Abortion Wait Period*, HUFFINGTON POST (May 18, 2015), http://www.huffingtonpost.com/2015/05/18/tennessee-abortion-wait-p_n_7310058.

prevents a prosecutor from bringing charges against a woman for drug use at any point in her pregnancy.

Second, even if cases often stem from drug use at the end of pregnancy, factually, women can and have been criminally prosecuted in Tennessee and other states for earlier drug use.¹³⁷ Several tests exist that provide evidence for such prosecutions. Urine screens only detect relatively recent drug use, but such screens can be, and often are, done on the mother much earlier in the pregnancy, especially if drug use is suspected.¹³⁸ Similarly, drug testing of newborn hair or meconium can provide evidence of illegal drugs ingested months before delivery.¹³⁹ Moreover, prosecutors can bring charges based on circumstantial evidence, witness testimony, or admissions, without any conclusive drug tests.

Third, the incentive to abort applies whenever a pregnant drug user *believes* that she has only two choices: jail or abortion—without regard to whether or not her assessment is correct. For example, even if affordable treatment is available prior to birth, a woman might opt for an abortion due to a lack of knowledge of the statute's affirmative defense or fear that she will be unable to meet the defense's stringent requirements.¹⁴⁰ This fear of prosecution or fear of failure seems to be particularly acute among the women who are commonly targeted for prosecution, less educated, less affluent women, who are ill at ease with the court system, and often already feel powerless.¹⁴¹ So, even if prosecution only actually occurs in cases

html. Given federal precedent, abortion seems likely to remain legal in Tennessee for the foreseeable future.

137. See, e.g., Whitney Good, *Gatlinburg Mom-to-Be Arrested for Allegedly Taking Drugs While Pregnant*, WATE (Sept. 30, 2014), <http://www.easttntimes.com/News%202014/10012014/gatlinburgwomancharged.htm> (reporting arrest of pregnant woman pursuant to statute in connection with a disturbance call months prior to birth). The statute has already been used to charge a pregnant woman who was not within days of delivery. *Id.* Moreover, in Montana, Casey Gloria Allen was arrested in connection with opiates she took when she was twelve weeks pregnant. See John S. Adams, *Judge Drops Drug Charge Against Pregnant Woman*, USA TODAY, (Sept. 23, 2014), <http://www.usatoday.com/story/news/nation/2014/09/23/judge-drops-drug-charge-against-pregnant-mom/16125379/>.

138. Wong, Ordean, & Kahan, *supra* note 29, at 370 (stating urine drug screenings detect only recent drug use).

139. *Id.* (stating hair and meconium samples at birth can detect intrauterine drug use from the second or third trimester).

140. Notwithstanding Tennessee's Safe Harbor Act, TENN. CODE ANN. § 33-10-104(f) (2014), a pregnant drug user may also abort out of concern that report of her drug use could cause her to lose custody of her older children.

141. See Goldensohn & Levy, *supra* note 20, at 27 (indicating that the nine Tennessee women arrested under the amended statute "represent some of the state's

in which a woman uses illegal drugs shortly before delivery (and all evidence is to the contrary), the troubling incentive to abort remains likely to influence behavior pre-viability.¹⁴²

2. A Dangerous Deterrent to Prenatal, Postpartum, and Newborn Care

Even if a woman does not abort her pregnancy, criminalizing pregnant drug use runs counter to the goal of restoration because it deters a woman from seeking prenatal care. “Research and clinical experience teach that when, as here, the personal risks of seeking medical care are raised to intolerably high levels, it is more likely that prenatal care and patient candor—and not drug use—will be what is deterred, often with tragic health consequences.”¹⁴³ Because criminalizing pregnant drug use deters prenatal care, the American Medical Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists all oppose such legislation.¹⁴⁴ Internationally, the United Nations Special Rapporteur for the Right to Health decries such laws because “criminalization of conduct during pregnancy impedes access to health care goods and services, infringing the right to health.”¹⁴⁵ Once a pregnant woman becomes concerned that medical personnel will report her drug use to the authorities, she has every incentive to misrepresent her drug use or to avoid medical personnel altogether.

poorest areas, and all but one used a public defender”).

142. The practical effects of this incentive to abort likely depend in part on how many pregnant drug users are aware of both their pregnancy and the law (or some perceived version of it) prior to viability. Clinics report pregnant drug users in Tennessee are aware of the law and that “[t]hey know they’re at risk for arrest and prosecution.” See, e.g., Dave Boucher & Tony Gonzalez, *Should Mom Be Charged?*, TENNESSEAN, April 9, 2015, at 9A (quoting Jessica Young, obstetrician at the Obstetrics Drug Dependency Clinic at Vanderbilt University). Nonetheless, it is difficult if not impossible to assess the increased risk of abortion with scientific accuracy.

However, a law that would lead even one pregnant woman to abort her baby is troubling, especially since there is no proof that NAS causes *any* long-term health effects. See Goldensohn & Levy, *supra* note 20, at 28 (quoting Dr. Loretta Finnegan, “NAS is really a very minor medical condition, in contrast to what can happen to a baby, both physically and psychologically, if the mother is not in treatment”); Wong, Ordean, & Kahan, *supra* note 29, at 376 (noting that there is no definitive evidence that NAS causes long-term harm).

143. Health Expert’s Amicus, *supra* note 4, at 6.

144. AAP Position, *supra* note 4, at 641; AMA Position, *supra* note 4, at 2667, 2670; ACOG Substance Abuse Opinion, *supra* note 4, at 2.

145. Special Rapporteur Position, *supra* note 4, at 12.

Factually, this is already happening in Tennessee. Pregnant women are avoiding prenatal care, and worse still, attempting detox and delivery without medical supervision.¹⁴⁶ After birth, some are avoiding newborn care in an attempt to avoid detection of their drug use.¹⁴⁷ Most experts believe that lack of prenatal care poses a greater risk for the unborn baby than a mother's drug use.¹⁴⁸ Likewise, experts believe that attempting to detox without medical supervision (which is often unavailable) poses a greater risk to the baby in utero than continued drug use. Criminalizing drug use creates a dangerous deterrent to the care a baby needs.

3. Because Demand Exceeds Supply, No Net Treatment Benefit

It is theoretically possible, of course, that criminalization could incentivize a pregnant woman to enter treatment prior to birth when such treatment might benefit (or "restore") her unborn baby. Across Tennessee and most of the United States, however, there would still be no net benefit as a result of criminalization. As discussed above, demand for treatment greatly exceeds the supply of available treatment resources. Consequently, there can be no increase in the total number of pregnant women treated until treatment options become more readily available and accessible.¹⁴⁹ Criminalization does nothing to increase the supply of treatment options. As such, any theoretical benefit is illusory. At most, one baby would be restored at the expense of another.

Timing also makes such a benefit unlikely. A baby is often most susceptible to damage from illegal drug use during the first

146. Boucher & Gonzalez, *supra* note 10 ("Laura Berlind, head of Renewal House, an addiction treatment facility in Nashville, said she'd heard stories of women giving birth outside of hospitals to avoid the authorities."); *see also* Dosani, *supra* note 20 (Jessica Lyons, manager of a Tennessee treatment program, "said pregnant women with addictions are already dropping out of treatment, avoiding prenatal checkups and even considering abortion - all in fear of prosecution."); Goldensohn & Levy, *supra* note 20, at 25 (quoting women who attempted to detox without medical supervision, fled the state to deliver, and/or avoided prenatal care after failed attempts to find available drug treatment in Tennessee).

147. *E.g.*, Goldensohn & Levy, *supra* note 20, at 27.

148. *AAP Position*, *supra* note 4, at 641; *AMA Position*, *supra* note 4, at 2667, 2669; *ACOG Substance Abuse Opinion*, *supra* note 4, at 1.

149. *See AAP Position*, *supra* note 4, at 640-41 (finding that demand for treatment "far exceeds supply"); Goldensohn & Levy, *supra* note 20, at 26 (describing the lack of available treatment for poor pregnant women); Gonzalez & Du Bois, *supra* note 20 (stating that, in Tennessee, "[a]ddiction treatment is extremely limited and costly—and nearly nonexistent for pregnant woman."); Scott, *supra* note 20 (decrying lack of available, appropriate treatment).

trimester when women are often unaware that they are pregnant and are least likely to be prosecuted.¹⁵⁰ Moreover, as discussed above, there will seldom be sufficient time between prosecution and birth to find treatment. Further, aside from cases in which treatment might prevent premature delivery, there is little evidence that a pregnant drug user who enters treatment days before delivery provides any benefit to her newborn. Certainly, public health experts weighing any possible benefit to criminalization against the danger of deterring prenatal care have almost uniformly concluded that such laws are more likely to hurt a baby than help.¹⁵¹

4. Undermines the Baby's Family

Criminalizing pregnant drug use also hurts the baby by undermining his or her family. As discussed above, such laws create a fictitious, adversarial relationship between mother and fetus that is contrary to the reality of this interconnected and symbiotic relationship.¹⁵² A pregnant woman and her fetus is a dyad, mutually intertwined and not separate.¹⁵³ Laws that presuppose a two-person model, which does not factually exist, distort the natural oneness of the maternal-fetal dyad and pit a pregnant woman against her unborn baby in harmful ways.¹⁵⁴

In addition, even after birth, the well-being of the mother and baby remain interconnected. To the extent a woman faces jail time as a result of an assault conviction, incarcerating the mother harms her baby.¹⁵⁵ In particular, the resulting separation interferes with

150. Ellen Marrus, *Crack Babies and the Constitution: Ruminations About Addicted Pregnant Women After Ferguson v. City of Charleston*, 47 VILL. L. REV. 299, 319 (2002) ("The medical evidence indicates that drug abuse, similar to alcohol abuse, does the most damage in the first trimester . . .").

151. AAP Position, *supra* note 4, at 641; AMA Position, *supra* note 4, at 2667; ACOG Substance Abuse Opinion, *supra* note 4, at 1. Interestingly, however, after negotiation and compromise, the Tennessee Medical Association did not oppose the state's amended assault law. Sydney Lupkin, *Why Some Doctors Object to Tennessee Law That Criminalizes Drug Use During Pregnancy*, ABC NEWS (July 14, 2014), <http://abcnews.go.com/Health/doctors-object-tennessee-law-criminalizes-drug-pregnancy/story?id=24557525>.

152. ACOG Ethics Opinion, *supra* note 76.

153. *Id.* at 4.

154. *Id.*

155. Michal Gilad & Tal Gat, *U.S. v. My Mommy: Evaluation of Prison Nurseries as a Solution for Children of Incarcerated Women*, 37 N.Y.U. REV. L. & SOC. CHANGE 371, 380 (2013) ("Children are affected by the incarceration of either parent, but they typically experience greater harm when their mother is imprisoned."); Myrna S. Raeder, *A Primer on Gender-Related Issues That Affect Female Offenders*, 20 CRIM.

important maternal-infant bonding.¹⁵⁶ This is problematic because the quality of the mother–infant relationship has a significant influence on a baby’s well-being, development, and adaptation throughout life.¹⁵⁷ In fact, empirical evidence demonstrates that common symptoms of maternal separation include “attachment disorders; aggression and anger; developmental and behavioral problems; sleeping, eating, or attention disorders; delays in educational development and achievement . . . [and] greater likelihood to develop addiction to drugs or alcohol or engage in criminal activity.”¹⁵⁸ Further, if no close relatives of the mother are available to care for her baby, and the state places the baby in foster care in connection with a conviction, foster care may also harm the baby. On average, children in foster homes struggle more with mental illness, academic success, and criminal activity.¹⁵⁹ Laws that criminalize pregnant drug use fail to recognize the intrinsic interconnectedness between a mother and her baby. While a baby is

JUST. 4, 7 (2013) (“It is common knowledge that children of incarcerated parents have greater risk of offending.”).

156. Gilad & Gat, *supra* note 155, at 381; Kayla Johnson, *Maternal-Infant Bonding: A Review of Literature*, 28 INTL. J. CHILDBIRTH EDUC. No. 3, 17, 19 (2013) (finding that postnatal separation has negative outcomes on the mother-infant bonding process that can affect the child’s cognitive and socio-emotional development, physical health, and personal relationships).

157. Johnson, *supra* note 156, at 21 (stating that the quality of the maternal-infant relationship has a significant influence on infant well-being, development, and adaptation throughout life).

158. Gilad & Gat, *supra* note 155, at 381 (“Empirical evidence shows that the separation of an infant from her mother during the first year drastically impairs her ability to sympathize or show concern for others. Additional common symptoms of maternal separation are attachment disorders; aggression and anger; developmental and behavioral problems; sleeping, eating, or attention disorders; delays in educational development and achievement; excessive hostile behaviors toward peers; problems with social adaptation; greater likelihood to develop addiction to drugs or alcohol or engage in criminal activity; and manifestation of sexually promiscuous behavior.” (footnotes omitted)).

159. See, e.g., Joseph J. Doyle, Jr., *Child Protection and Adult Crime: Using Investigator Assignment to Estimate Causal Effects of Foster Care*, 116 J. POL. ECON. 746, 748, 762 (2008) (noting that in marginal cases, children seem to do better with their birth parents); Beth Troutman, *Effects of Foster Care Placement on Young Children’s Mental Health: Risks and Opportunities*, IOWA CONSORTIUM FOR MENTAL HEALTH 1–2 (2011), <http://www.healthcare.uiowa.edu/icmh/archives/documents/Effectsoffostercareplacementonyoungchildren.pdf> (finding that infants who lack a steady caretaker during the first year or so of life have issues creating attachment bonds, damaging their mental and emotional well-being, and hindering development).

in utero and for the first few years after birth, it is impossible to punish a mother without also punishing her baby.

5. Imposes Economic Hardship on the Baby

Unfortunately, criminalizing pregnant drug use also has the practical effect of placing both mother and baby in a worse position financially. So, not only is there no “restoration,” but criminal liability actually has the opposite economic impact. It causes an additional economic injury to the baby. Restoration fails in this context because the baby’s economic well-being is intrinsically bound to the mother’s economic well-being. A mother who is in jail or prison is unable to provide care or economic support for her baby, and a conviction will have long-term economic effects. Specifically, studies estimate that being an ex-offender lowers employment rates by between 0.3% to 0.9%.¹⁶⁰ Conviction for a violent crime also impacts future earnings and has an immediate fiscal impact on the family due to lost wages, court costs, and probation costs. Accordingly, the practical effect of criminalizing pregnant drug use is that the baby has fewer available economic resources. Restoration is an impossibility in this context.¹⁶¹

In summary, because saddling a pregnant woman with a violent criminal conviction, or even threatening to do so, places the baby in a far worse position, Tennessee’s amended assault statute is contrary to the goal of restoration.

B. Incapacitation is Unnecessary and Harms the Baby

Likewise, criminalizing pregnant drug use fails to provide meaningful incapacitation. Through incapacitation, criminal law seeks to keep criminals away from society so that the public is

160. JOHN SCHMITT & KRIS WARNER, EX-OFFENDERS AND THE LABOR MARKET 14 (2010), available at <http://www.cepr.net/documents/publications/ex-offenders-2010-11.pdf>.

161. Theoretically, of course, if a wealthy woman were criminally prosecuted for pregnant drug use, a judge could order the woman to pay restitution into a trust for her newborn. Practically, however, restoration will almost certainly never occur. In 2012, ninety-three percent of NAS births in Tennessee involved a woman so poor that she qualified for state assistance. *TennCare Enrollees Provisional 2012 Data*, *supra* note 12, at 2. Even for the remaining seven percent, most likely cannot afford to pay restitution without a negative impact on the resources otherwise available to the baby. Moreover, it would be virtually impossible for the state to prevent a more affluent woman from simply providing fewer resources to the child growing up to offset any restitution payment.

protected from their misconduct.¹⁶² In the case of a pregnant woman who uses drugs, the mother is usually only a direct danger to her baby in utero.¹⁶³ Separation during the pregnancy is, of course, physically impossible. After the baby's birth, separation for *prior* drug use is no longer necessary for the baby's protection and, in fact, can cause additional harm to the baby.¹⁶⁴ Generally, separating a mother and her baby interferes with maternal-infant bonding and thus causes harm to the baby.¹⁶⁵ To the extent that separation after birth is in the best interest of the baby, there are ample civil remedies to achieve this result. In most situations, not only is incapacitation after birth unnecessary, it is also impossible without causing further harm to the baby.¹⁶⁶

C. Rehabilitation Requires Treatment, Not Jail

Criminalization also fails from a rehabilitation perspective. The goal of rehabilitation is to reform an offender.¹⁶⁷ Numerous studies have concluded that treatment is more effective than jail at decreasing drug use, as well as other criminal recidivism.¹⁶⁸

162. PODGOR, *supra* note 123, at 5.

163. Some mothers' drug use interferes with parenting so much that the mother remains a danger to her infant even after birth. As Tennessee has recognized by passage of the Safe Harbor Act, however, this is not generally the case. See TENN. CODE ANN. § 33-10-104(f) (2014).

164. C. Antoinette Clarke, *Fins, Pins, Chips, & Chins: A Reasoned Approach to the Problem of Drug Use During Pregnancy*, 29 SETON HALL L. REV. 634, 658-59 (1998) ("Unlike children who are physically or emotionally abused by their parents, whose abuse stops when the parent is removed from the home, the harm inflicted on drug-exposed babies ceases when the baby is born."). Many women who use drugs during pregnancy are capable of providing appropriate homes for their babies after birth, and often, foster care is a worse alternative.

165. Gilad & Gat, *supra* note 155, at 380; Johnson, *supra* note 156, at 19.

166. See, e.g., Gilad & Gat, *supra* note 155, at 372; Johnson, *supra* note 156, at 20 (stating that postnatal separation has negative effects on the mother-infant bonding process that can "affect the child's cognitive and socio-emotional development, . . . physical health and personal relationships"); Raeder, *supra* note 155, at 7.

167. PODGOR, *supra* note 123, at 5.

168. See STEVE AOS, ET AL., THE COMPARATIVE COSTS AND BENEFITS OF PROGRAMS TO REDUCE CRIME 23-26 (2001) (concluding that, generally, drug treatment lowers criminal recidivism rates); THE NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE AT COLUM. UNIV., SHOVELING UP II: THE IMPACT OF SUBSTANCE ABUSE ON FEDERAL, STATE AND LOCAL BUDGETS 45 (2009) [hereinafter BUDGETARY IMPACT] (scientific evidence confirms efficacy of science-based interventions); Richard Elliott et al., *Harm Reduction, HIV/AIDS, and the Human Rights Challenge*

Similarly, treatment is more effective than punishment at returning a person to economic independence.

For taxpayers, it is important to understand that treatment also offers enormous cost-saving potential as opposed to punishment. Treatment costs less than a third of what incarceration costs.¹⁶⁹ Several economic analyses comparing criminal prosecution to treatment have concluded that “[s]ubstance abuse treatment is more cost-effective than prison or other punitive measures.”¹⁷⁰ One study found that “[e]very dollar spent on drug treatment in the community is estimated to return \$18.52 in benefits to society.”¹⁷¹ Other studies have estimated the return on every treatment dollar at closer to \$7.¹⁷² Studies have consistently shown, however, that treatment pays off. In contrast, for every dollar spent on enforcement, society receives only half of that value—\$0.52 in benefit.¹⁷³ Criminalization is fiscally irresponsible; this waste of tax-payer dollars should stop.¹⁷⁴

Just as analyses of restoration and incapacitation demonstrate that criminalizing pregnant drug use is not in the best interest of a baby, an analysis of rehabilitation shows that criminalization is ineffective rehabilitation and improperly squanders tax dollars.

to *Global Drug Control Policy*, 8 HEALTH AND HUMAN RIGHTS 104, 116–17 (2005); Barry M. Lester et al., *Substance Use During Pregnancy: Time for Policy to Catch Up with Research*, 1:5 HARM REDUCTION J. 16, 21 (Apr. 2004).

169. Scott, *supra* note 20 (noting that treatment costs less than a third as much as incarceration).

170. JUSTICE POLICY INST., SUBSTANCE ABUSE TREATMENT AND PUBLIC SAFETY 2 (2008) [hereinafter SUBSTANCE ABUSE AND SAFETY].

171. *Id.*

172. NAT’L INST. OF DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 13 (3d ed. 2012) (“According to several conservative estimates, every dollar invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.”); Rydell, C.P. & Everingham, S.S., *Controlling Cocaine*, Prepared for the Office of National Drug Control Policy and the United States Army (RAND Corp., 1994), at xvi (estimating that every dollar spent on treatment returns \$7.46 through reduced crime and increased productivity).

173. Rydell, *supra* note 172.

174. See JEFFREY A. MIRON & KATHERINE WALDOCK, CATO INST., THE BUDGETARY IMPACT OF ENDING DRUG PROHIBITION 2, 51 (2010); BUDGETARY IMPACT, at 2 (estimating legalization of drugs would save \$41.3 billion dollars per year in government expenditure and also generate \$46.7 billion dollars in new tax revenues).

D. Criminalization Will Deter Prenatal Care, Not Drug Use

Perhaps the central fallacy of criminalization, however, is the argument that it serves as a deterrent to pregnant drug use. Certainly, there is no empirical evidence that criminalizing pregnant drug use reduces NAS births.¹⁷⁵ To the contrary, NAS births in Tennessee have continued to increase since the state criminalized pregnant drug use.¹⁷⁶ In fact, at least one legislator has candidly admitted that “[w]hatever we’re trying isn’t working.”¹⁷⁷

Logically, criminalizing pregnant drug use cannot yield a deterrent effect until the supply of drug treatment increases dramatically. Experts overwhelmingly agree that an addict lacks control over her addiction and is generally powerless to stop using without treatment—regardless of the consequences.¹⁷⁸ Criminalization does nothing to increase the amount of available services so that a pregnant woman can receive treatment.¹⁷⁹ Because demand for treatment greatly exceeds the supply of treatment options, even if criminalization increases the demand for treatment (by offering a stronger incentive to obtain treatment), it will still fail to increase the number of pregnant women actually being treated.¹⁸⁰ Put differently, the number of pregnant women who stop using drugs is currently limited by the *supply* of available treatment, not

175. Fentiman, *supra* note 107, at 261. Nationally and internationally, what little evidence does exist on deterrence suggests that a harm reduction approach would do more to decrease drug use than criminalization. Elliott, *supra* note 168; Lester et al., *supra* note 168, at 16, 30.

176. Compare 2013 TN NAS Summary, *supra* note 19 (reporting 855 NAS births in 2013), 2014 TN NAS Summary, *supra* note 19 (reporting 973 NAS births), and 2015 Year-To-Date TN NAS Summary, *supra* note 19 (reporting 550 NAS births through Aug. 1, 2015), with *Drug Dependent Newborns (Neonatal Abstinence Syndrome): Surveillance Summary for the Week of April 20–26, 2014*, TENN. DEP’T HEALTH (Feb. 20, 2015), http://health.state.tn.us/MCH/PDFs/NAS/NASsummary_Week_1714.pdf [hereinafter 2014 TN NAS Summary At Law Passage] (reporting the number of NAS births for 2014 as of the date the new assault law became effective).

177. Gonzalez, *supra* note 41, at 5A (quoting Sen. Todd Gardenhire, R-Chattanooga); see also Boucher & Gonzalez, *supra* note 10, at 9A (“Treatment facilities and advocates say the law isn’t working.”).

178. Health Expert’s Amicus, *supra* note 4, at 12–13; AAP Position, *supra* note 4, at 640–41; ACOG Ethics Opinion, *supra* note 76, at 7; see also Clarke, *supra* note 164, at 659; Fentiman, *supra* note 107, at 266–67.

179. TENN. CODE ANN. § 39-13-107(c)(2) (2014); Gonzalez, *supra* note 41, at 5A (noting that Tennessee has done little to expand treatment services since criminalization); Scott, *supra* note 20.

180. Dosani, *supra* note 20; Goldensohn & Levy, *supra* note 20, at 25; Gonzalez & DuBois, *supra* note 20, at 15A; Scott, *supra* note 20.

by the number of pregnant women willing to enter treatment. Until the supply of available treatment exceeds the demand for treatment, increasing the incentive to obtain treatment cannot and will not result in more pregnant women receiving treatment and/or fewer NAS births.¹⁸¹

Further, to the extent that a pregnant woman has control over her drug use and a criminal conviction would be sufficient to deter her, drug use is already criminal (independent of the amended assault law).¹⁸² A pregnant woman also already faces the possibility of losing custody of her baby and any prior children. As such, there is no cogent reason to conclude that threatening a pregnant drug user with an assault charge will provide any additional deterrent effect.¹⁸³ To the extent that evidence to date demonstrates anything about this complicated, multifaceted problem, it is that criminalization is not an effective deterrent to drug use by pregnant women.

181. Moreover, to the extent criminalization leads to efforts to detox without medical supervision, unintended consequences may follow. Abrupt discontinuation of opioids “can result in preterm labor, fetal distress, or fetal demise.” American Congress of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Opioid Abuse, Dependence, and Addiction in Pregnancy*, ACOG Op. No. 524 (May 2012) (reaffirmed 2014). Detoxing without supervision is likely to be more dangerous to the health of an unborn baby than the mother’s continued drug use (because NAS appears to be a treatable, relatively short-term problem when compared to miscarriage). *Cf.* Goldensohn & Levy, *supra* note 20, at 28 (quoting Dr. Loretta Finnegan, an expert on NAS: “NAS is really a very minor medical condition, in contrast to what can happen to a baby, both physically and psychologically, if the mother is not in treatment.”); Wong, Ordean, & Kahan, *supra* note 29, at 376 (noting that there is no definitive evidence NAS causes long-term harm). Accordingly, if criminalization increases the incentive to stop using drugs, without making treatment available, the unintended consequence could be fetal trauma or even death during unsupervised detox.

182. Approximately forty-five percent of women using illegal drugs stop once they learn they are pregnant. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 23 (2013) (finding that, in 2012, the rate of illegal drug use among pregnancy aged women nationwide was 10.7% but that rate decreased to 5.9% among pregnant women).

183. Drug users are particularly unlikely to be more deterred by a marginal increase in the potential severity of punishment. *See* Fentiman, *supra* note 107, at 261–62.

E. Punishment is Unwarranted and Counterproductive

Criminalization also cannot be justified as retribution or punishment. Retribution seeks to ensure that someone who breaks the law gets the punishment that he or she deserves.¹⁸⁴ When it comes to pregnant drug use, moral culpability is complicated in ways that impact the appropriateness of blame and punishment.¹⁸⁵ First, according to medical experts, addiction is a disease; a pregnant woman who is an addict will generally be unable to stop on her own.¹⁸⁶ In Tennessee, as in many states, affordable, accessible drug treatment is often unavailable for poor, pregnant women.¹⁸⁷ The disadvantaged pregnant women who are seeking treatment and are being turned away do not deserve to be punished; they deserve to be helped, especially since many became addicts by using legal prescription drugs.

Second, many external factors appear to play a significant role in making certain women particularly vulnerable to pregnant drug use. For example, genetics play a role in drug use and addiction, as do domestic violence and mental illness.¹⁸⁸ In fact, in one study, two-thirds of patients in substance abuse treatment reported being physically or sexually abused as children.¹⁸⁹ Moreover, pregnant women who are prescribed opioids are almost twice as likely to suffer from depression and almost three times as likely to suffer from an anxiety disorder as other women.¹⁹⁰ Similarly, having a parent that used drugs appears to increase the risk of drug use.¹⁹¹

184. PODGOR, *supra* note 123, at 5.

185. See LYNN P. FREEDMAN, PERSPECTIVES ON HEALTH AND HUMAN RIGHTS 527, 530, 535 (Sofia Gruskin et al. eds., 2005).

186. Health Expert's Amicus, *supra* note 4, at 6–8; AAP Position, *supra* note 4, at 640–41; ACOG Substance Abuse Opinion, *supra* note 4.

187. AAP Position, *supra* note 4, at 640–41 (noting that demand for treatment “far exceeds supply”); Dosani, *supra* note 20 (reporting grossly inadequate availability of drug treatment for pregnant women); Goldensohn & Levy, *supra* note 20, at 25 (reporting grossly inadequate availability of drug treatment for pregnant women); Gonzalez & DuBois, *supra* note 20 (“Addiction treatment is extremely limited and costly—and nearly nonexistent for pregnant women.”); National Drug Survey, *supra* note 97, at 7 (in 2013, 316,000 Americans tried and failed to obtain substance abuse treatment, most commonly due to a lack of insurance coverage and affordability); Scott, *supra* note 20.

188. ACOG Substance Abuse Opinion, *supra* note 4 (“Addiction is a chronic, relapsing biological and behavioral disorder with genetic components.”).

189. Magnitude, NAT'L INST. ON DRUG ABUSE, <https://archives.drugabuse.gov/about/welcome/aboutdrugabuse/magnitude/> (last visited Nov. 8, 2015).

190. Infant Outcomes, *supra* note 11, at 844.

191. By some estimates, more than eighty percent of addicted women have at

Perhaps nothing highlights the role of external factors in pregnant drug use as well as the significant geographic variability of such use. The rate of NAS births is not uniform. Tennessee suffers from a much higher rate of NAS births than the national average, and within Tennessee, the rate of NAS births varies dramatically. In the Sullivan Region of eastern Tennessee, in both 2013 and 2014, approximately 50 per 1,000 live births were diagnosed with NAS—more than 20 times the annual rate in the Jackson Region of western Tennessee.¹⁹² In 2012, 76% of women who gave birth to a baby diagnosed with NAS in Tennessee resided in eastern Tennessee.¹⁹³ These statistics are startling. Eastern Tennessee moms are not bad mothers; they do not love their children less. Traditional narratives of good and evil and the accompanying notion of just punishment must be rewritten to acknowledge the multiple, complicated external risk factors that contribute to pregnant drug use.

Temporal variation also highlights the role of external influences. There has been a dramatic increase in NAS births over the last decade, both nationally and in Tennessee.¹⁹⁴ The temporal impact is perhaps most pronounced, however, in Kentucky. In Kentucky, NAS births soared 48% in a single year (from 955 NAS births in 2013 to 1,409 NAS births in 2014), a fifty-fold increase from 2000 when Kentucky reported only 28 NAS births.¹⁹⁵ The discrepancy in NAS births over time is troubling and underscores the social and environmental forces underlying the current NAS epidemic.

Clearly, the prescribing practices of medical professionals have a major impact on susceptibility. In fact, the rate of NAS births by geography discussed above mirrors a similar regional pattern for prescription drug use and overdoses.¹⁹⁶ It is no surprise that

least one chemically dependent parent. Heller, *supra* note 6.

192. *2013 TN NAS Summary*, *supra* note 19; *2014 TN NAS Summary*, *supra* note 19.

193. *TennCare Enrollees Provisional 2012 Data*, *supra* note 12, at 3–4.

194. *Associated Health Care Expenditures*, *supra* note 8, at 1934, 1937 (reporting that nationwide, NAS births nearly tripled from 2000 to 2009); *NAS FAQs*, *supra* note 23 (noting that in Tennessee, NAS births rose ten times higher over the same period).

195. Laura Ungar, *Born Into Suffering: More Babies Arrive Dependent on Drugs*, USA TODAY (July 8, 2015), <http://www.usatoday.com/story/news/nation/2015/07/08/babies-born-dependent-on-drugs-continue-to-rise/29212565/>.

196. *Geographic Distribution of NAS*, *supra* note 9, at 653; *Infant Outcomes*, *supra* note 11, at 842, 847; Toila et al., *supra* note 9, at 2122; *TennCare Enrollees Provisional 2012 Data*, *supra* note 12, at 3.

Tennessee has the highest rate of NAS births in the nation considering that it also has one of the highest numbers of prescriptions filled per person.¹⁹⁷ Often, physicians prescribe narcotics to a woman, who then becomes addicted and turns in her addiction to diverted or illicit drugs.¹⁹⁸ Experts estimate that three-fourths of heroin users were first addicted to prescription drugs.¹⁹⁹ In order to combat NAS, states will have to take more steps to reform their prescription drug practices and to increase access to contraception, education, and opportunities for drug treatment.²⁰⁰

Poverty also appears to correlate strongly with increased risk of NAS birth.²⁰¹ In Tennessee, from 2008 to 2012, 93% of reported NAS cases arose out of households that qualified for TennCare.²⁰² Nationally, over 80% of newborns diagnosed with NAS relied on state-funded health care.²⁰³ The markedly higher reported incidence

197. HENRY J. KAISER FAMILY FOUND., *RETAIL PRESCRIPTION DRUGS FILLED AT PHARMACIES (ANNUAL PER CAPITA) (2011)* (reporting Tennessee fills 18.7 prescriptions per person compared to a national average of 12.71; Kentucky fills 21.5; and West Virginia fills 21.4 prescriptions per person).

198. See Barnes, *supra* note 88. To make matters worse, eighty-two percent of women prescribed narcotics are not on contraceptives, and eighty-six percent of NAS births were unintended pregnancies. Heil et al., *supra* note 12, at 200; *TennCare Enrollees Provisional 2012 Data*, *supra* note 12, at 6. When doctors prescribe addictive drugs to women without contraception, they are unintentionally feeding the NAS epidemic.

199. See Barnes, *supra* note 88 (citing 2015 report from the Center for Disease Control and Prevention).

200. See *supra* text accompanying note 90 (providing a brief description of some of Tennessee's recent legislative efforts to address the prescription drug epidemic).

201. See *TennCare Enrollees Provisional 2012 Data*, *supra* note 12, at 4 (ninety-four percent involve non-Hispanic whites). In Tennessee, the overwhelming majority of NAS births involve white women. *Id.* Accordingly, one would not expect Tennessee's criminal law to suffer from the racially discriminatory application reported in other states' efforts at criminalizing pregnant drug use. See, e.g., Carla-Michelle Adams, *Criminalization in Shades of Color: Prosecuting Pregnant Drug-Addicted Women*, 20 *CARDOZO J.L. & GENDER* 89, 94, 103–04 (2013); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 *HARV. L. REV.* 1419, 1424, 1432, 1481 (1991). Yet, five of nine arrests reported in the first few months the law was effective in Tennessee involved African American women. Goldensohn & Levy, *supra* note 20, at 25. Given the relatively small percentage of NAS births attributable to African-Americans, these statistics are troubling and this issue merits further tracking.

202. *TennCare Enrollees Provisional 2012 Data*, *supra* note 12, at 2.

203. *Geographic Distribution of NAS*, *supra* note 9, at 653 (from 2009 to 2012, over eighty percent of infants with NAS were enrolled in state Medicaid programs); see also *Associated Health Care Expenditures*, *supra* note 8, at 1936 (from 2000 to 2009, seventy-eight percent of infants with NAS were enrolled in state Medicaid

of NAS among those eligible for state assistance seems to indicate that structural violence plays a role in pregnant drug use, although such statistics may also reflect at least in part a testing, diagnosing and/or reporting bias.²⁰⁴ Poor women are not “worse” mothers than wealthier women, and they do not love their babies less. If policy makers ignore this fundamental truth and blame only the pregnant drug user, without regard for or change to the structures that reinforce such use, states will never stem their NAS epidemic.

The caricature of a pregnant woman using drugs because she is selfish and uncaring withers under evidence of an overwhelming correlation between external factors beyond individual control and a dramatic increase in pregnant drug use. Pregnant drug use cannot be reduced to personal responsibility alone, although such responsibility should not be discounted entirely. Until the prescription drug crisis is remedied²⁰⁵ and there is affordable treatment available for all pregnant women, punitive policies that criminalize pregnant drug use are unjust. Moreover, even if a pregnant woman did “deserve” punishment, it would be manifestly unfair to punish her knowing that such punishment would, as set forth in detail above, also unavoidably punish her already vulnerable baby.

CONCLUSION

In Tennessee, it appears that medical experts have been better forecasters of the impact of criminalizing pregnant drug use than prosecutors. Women report skipping prenatal care, delivering at home, and fleeing the state in an effort to avoid criminal liability.²⁰⁶ Meanwhile, NAS births continue to rise, belying any assertion that the law would serve as an effective deterrent. Several of the women charged under the new law actively sought treatment during

programs).

204. Also concerning, while women with family incomes of less than \$20,000 per year were more than twice as likely as women with incomes over \$75,000 to report use of illegal drugs, this differential would only explain a small fraction of the increase in reported incident of NAS. See SHARON L. LARSON ET AL., DEPT. OF HEALTH AND HUMAN SERVICES, WORKER SUBSTANCE USE AND WORKPLACE POLICIES AND PROGRAMS 15 (2007) (13.2% at \$20,000 or lower v. 6.0% at \$75,000 or higher).

205. Dosani, *supra* note 20; Goldensohn & Levy, *supra* note 20, at 28; Gonzalez & DuBois, *supra* note 20; Scott, *supra* note 20.

206. In the first 6 months of Tennessee’s law, 57 Tennessee women fled the state to deliver a baby with NAS in a neighboring state. Gonzalez & Boucher, *supra* note 142.

pregnancy, only to be *repeatedly* turned away.²⁰⁷ As for one of the women charged, her “boyfriend found her dangling from the clothesline pole in her grandmother’s yard.”²⁰⁸ She simply “couldn’t shake her addiction or the depression that plagued her.”²⁰⁹ Allowing a pregnant woman who uses drugs to be prosecuted for assault is ultimately cruel, counterproductive, harmful to her newborn, and a waste of taxpayer dollars. Tennessee should allow its new assault law to lapse in 2016, and other states should avoid adopting similar statutes that criminalize pregnant drug use.²¹⁰

207. Goldensohn & Levy, *supra* note 20, at 26–27.

208. *Id.* at 25.

209. *Id.*

210. While completely allowing the law to sunset would be ideal, at an absolute minimum, Tennessee should revert to the pre-amendment version of Section 107(c)(1) and amend Section 107(c)(3) to provide:

It is an affirmative defense to a prosecution permitted by subdivision (c)(2) that the woman successfully completed an addiction recovery program, regardless of whether the child was born addicted to or harmed by the narcotic drug. Any woman charged under subdivision (c)(2) must be offered affordable placement in an addiction recovery program, with the opportunity to satisfy this affirmative defense.