



CRIMINALIZING PREGNANCY

POLICING PREGNANT WOMEN WHO USE DRUGS IN THE USA

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Cover photo: CM, pictured in a drug treatment unit at a juvenile detention center in the USA. She is 16 years old and 8 months pregnant.

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CONTENTS

1. EXECUTIVE SUMMARY	7
2. METHODOLOGY	12
3. PREGNANCY CRIMINALIZATION IN THE USA	14
3.1 A PATCHWORK OF LAWS	15
3.2 TYPES OF LAWS THAT CRIMINALIZE PREGNANT WOMEN	17
3.2.1 “FETAL PERSONHOOD” MEASURES	17
3.2.2 “FETAL ASSAULT” LAWS: DEFINING FETUSES AS VICTIMS OF CRIME	17
3.2.3 CRIMINAL CHILD ABUSE LAWS APPLIED TO FETUSES	19
3.2.4 SUBSTANCE USE DURING PREGNANCY AS CHILD ABUSE	19
3.2.5 CIVIL COMMITMENT LAWS	21
3.3 FORCES DRIVING CRIMINALIZATION OF PREGNANCY	22
3.3.1 A HISTORY OF RACIAL DISCRIMINATION IN POLICING REPRODUCTION	22
3.3.2 THE EROSION OF SEXUAL AND REPRODUCTIVE RIGHTS	23
3.3.3 HEALTH DISPARITIES AND DISCRIMINATION IN MATERNAL HEALTHCARE	24
3.3.4 PUNITIVE DRUG CONTROL POLICIES: AN EMPHASIS ON CRIMINAL PUNISHMENT OVER PUBLIC HEALTH	25
4. TENNESSEE “FETAL ASSAULT LAW”	27
4.1 TRACKING THE IMPACT OF THE LAW	28
4.1.1 DISCRIMINATORY APPLICATION OF THE LAW	28
4.2 LACK OF ACCESS TO DRUG TREATMENT	30
4.3 WHEN CRIMINAL JUSTICE AND HEALTHCARE CONVERGE	31
4.4 DETERRENCE FROM PRENATAL CARE	33
4.5 DRUG TESTING IN HEALTHCARE SETTINGS	35
5. ALABAMA “CHEMICAL ENDANGERMENT” LAW	36
5.1 APPLICATION OF THE LAW	37
5.2 WHEN CRIMINAL JUSTICE, CHILD WELFARE AND HEALTHCARE CONVERGE	38
5.3 DRUG TESTING AND ARRESTS	39
5.4 DISCRIMINATORY DRUG TESTING	40

5.5 LACK OF INFORMED CONSENT FOR DRUG TESTING	41
5.6 IMPACT OF THE LAW: FEAR AND CONFUSION	42
5.7 DRUG COURTS: FINES AND FEES	43
5.8 COURT-MANDATED RESIDENTIAL TREATMENT	44
6. CRIMINALIZING PREGNANCY: A VIOLATION OF INTERNATIONAL HUMAN RIGHTS	46
6.1 THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH	49
6.1.1 CRIMINALIZING PREGNANCY DETERS WOMEN'S ACCESS TO HEALTHCARE SERVICES	50
6.1.2 DRUG TESTING WITHOUT INFORMED CONSENT AND COERCIVE TESTING PRACTICES	51
6.2 RIGHT TO PRIVACY	53
6.2.1 CONFIDENTIALITY IN HEALTHCARE CONTEXTS	55
6.3 RIGHT TO A FAIR TRIAL	56
6.4 THE RIGHT TO EQUALITY AND NON-DISCRIMINATION	58
6.4.1 DIRECT DISCRIMINATION	59
6.4.2 INDIRECT DISCRIMINATION	60
6.4.3 EQUAL PROTECTION UNDER LAW	61
6.4.4 IMPACT OF STIGMA AND DISCRIMINATION ON HEALTH	62
6.4.5 THE OBLIGATION TO COMBAT STEREOTYPES BASED ON SEX AND GENDER	62
7. CONCLUSIONS AND RECOMMENDATIONS	65

GLOSSARY

CHILD PROTECTIVE SERVICES (CPS) Child Protective Services refers to state-level agencies that intervene to investigate allegations of child abuse or neglect.¹ In this report, relevant agencies are the Alabama Department of Human Resources (DHR) and Tennessee Department of Human Services (DHS). Child abuse and neglect are defined by federal and state laws, and may be defined in both civil and criminal statutes.

CRIMINALIZATION OF PREGNANCY The process of attaching punishments or penalties to women for actions that are interpreted as harmful to their own pregnancies. This includes laws that punish actions during pregnancy that would not otherwise be made criminal or punishable. It also refers to other laws not specific to pregnancy but which are either applied in a discriminatory way against pregnant women and/or have a disproportionate impact on pregnant women which can in practice work as de facto criminalization.

DRUG COURT Drug courts are specialized court programs that are intended to offer court-supervised treatment for drug dependence. While there is no single model, the principal aim of the programs is to divert people from incarceration into treatment.² Family drug court programs serve families involved with Child Protective Services due to parental drug use.

DRUG DEPENDENCE Drug dependence is a chronic, relapsing disorder involving brain function that may require medical treatment.³ Drug use is not a medical condition and does not necessarily imply dependence.⁴ Some government agencies and physicians cited in this report use the terms “substance abuse” and/or “addiction” interchangeably with the term drug dependence.

FETAL ASSAULT LAW In 38 states, “fetal assault” laws define an embryo or fetus as being the potential victim of a crime. In 23 states, these laws apply from the moment of fertilization. In most states, these laws may be applied to pregnant women with regards to their own pregnancies.

1 See U.S. Department of Health & Human Services, Administration for Children & Families and Children’s Bureau, Child Welfare Information Gateway, www.childwelfare.gov/topics/can/overview/

2 See Fact Sheet: Office of National Drug Control Policy, www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/drug_courts_fact_sheet_5-31-11.pdf

3 Report of the U.N. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255 at para. 7; see Official Records of the Economic and Social Council, 2010, Supplement No. 8 (E/2010/28), p. 47.

4 Report of the U.N. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255 at para. 7; see Official Records of the Economic and Social Council, 2010, Supplement No. 8 (E/2010/28), p. 47.

**MEDICATION-
ASSISTED
TREATMENT**

Medication-Assisted Treatment is the use of medications in combination with behavioral therapies to treat drug dependence including dependence on opioid drugs. Methadone and buprenorphine are examples of opioid maintenance therapies and are generally referred to as opioid maintenance treatment. The World Health Organization recommends opioid maintenance treatment as the recommended treatment for pregnant women with opioid dependence. Opioid drugs include prescription pain medications as well as illegal drugs. The terms Medication-Assisted Treatment, Opioid Maintenance Treatment and Opioid Substitution Treatment are sometimes used interchangeably.

1. EXECUTIVE SUMMARY

“If I had known that you go to the doctor and get a positive drug screen, I would not have gone to the doctor. I’d let nobody know. Especially not the doctor. Especially not the people who say they want to help. I really wanted the help. But now I feel that my help is punishing me. It hurts and it’s scary as hell that I’ve got to walk around carrying this baby and not know if I’m going to get charged.”

Nikki, pregnant woman at a residential drug treatment center in Birmingham, Alabama

Throughout the USA, women become subject to unique forms of regulation when they become pregnant. While pregnant women remain subject to the same laws as anyone else, an additional set of legislation targets pregnant women, particularly those who are marginalized and those who use drugs, based on a belief that they have caused or risked harm to their fetus. Often known as “fetal assault”, “chemical endangerment” or “personhood” laws, these measures have been used to arrest and prosecute women who experience pregnancy complications and conditions such as drug dependence. A patchwork of evolving laws and practices impact women in every region and state.

This is an area of active legislative change and judicial review. In January and February 2017, 17 state legislatures introduced measures like the ones discussed in this report. These proposals come amidst an onslaught of measures designed to limit access to sexual and reproductive healthcare and a presidential administration that has ushered in a backlash against human rights, particularly those related to women’s bodily integrity and sexual and reproductive freedom.

Laws policing pregnant women’s actions and circumstances are collectively referred to as pregnancy criminalization laws throughout this report. The report provides a basic overview of the implications of these laws on women’s human rights and access to pregnancy related healthcare across the USA and focuses on specific criminal laws in two states: Alabama and Tennessee.

TENNESSEE’S “FETAL ASSAULT” LAW

In April 2014, Tennessee amended its “fetal assault” law, becoming the first state to introduce a criminal law explicitly making it a crime to give birth to a child showing symptoms of prenatal exposure to narcotics. Beyond this, any unlawful act or omission a pregnant woman engaged in had the potential to be considered an assault against her own embryo or fetus. About 100 women have been charged under the “fetal assault” law since 2014, mostly in rural eastern Tennessee, an area severely lacking in drug treatment facilities, and in Memphis, a majority African-American city.

Tennessee’s amended “fetal assault” law contained a clause that specified the end date as 1 July 2016. Amnesty International researched the impacts of this law during the two years in which it was in effect and contributed to local advocacy ensuring that this change to the law was not made permanent. State legislators proposed a new bill that would have eliminated the termination date in 2016, but this bill failed. However, the threat to women’s rights is ongoing. In February 2017, Tennessee introduced Senate Bill 1381, containing the same language as the previous law, illustrating that similar legislation may be reenacted.

ALABAMA’S “CHEMICAL ENDANGERMENT” LAW

Alabama’s “chemical endangerment” law was passed in 2006 as a means to protect children from environments where they could be exposed to drugs or controlled substances. However, individual prosecutors and the Alabama Supreme Court have interpreted the law to apply to pregnant women themselves. We spoke to women who were arrested while they were pregnant and one who was handcuffed as she was taking her newborn son home from the hospital. One woman told us she was charged with “chemical endangerment” even though she was unaware she was pregnant and another was planning to get an abortion at the time she was arrested. Advocates and researchers have documented 479 such prosecutions between 2006 and 2015, more than have been documented under any other single law. Of these women, 89% were unable to afford their own lawyers.

NATIONAL CONTEXT OF PREGNANCY CRIMINALIZATION

All of the cases discussed in this report, and the majority that have been documented by researchers and advocates, involve women who were dependent on drugs while pregnant. However, most of the state laws that criminalize pregnant women are not specific to drug use but are more general “fetal assault” laws which include fetuses within the legal definition of a “victim” of assault. Laws identifying fetuses as potential “victims” can have the effect of putting pregnant women’s rights at risk, regardless of the law’s intended purpose. Most “fetal assault” laws do not exempt pregnant women from committing crimes in relation to their own pregnancies. As a result, the laws have been used to prosecute women who miscarried or were believed to have harmed their fetus.

Advocacy groups and scholars have documented cases in which pregnant women have been arrested for otherwise legal activities such as refusing medical interventions including caesarean surgery or even for attempting suicide. For this reason, key legal advocates told Amnesty International that regardless of their intended aim, the laws can have the effect of punishing women for their pregnancy status.

Pregnant women may also receive more severe punishments for crimes if their embryo or fetus is considered to be a legally separate “person.” For example, driving without a seatbelt may be punishable by a small fine, but in one case in Tennessee it was considered felony “reckless endangerment” because a court interpreted a woman’s fetus as a legally separate “person.” The vague and overbroad nature of pregnancy criminalization laws mean that almost any behavior perceived as harmful can be criminalized, inviting discriminatory application against women in marginalized positions.

There is no comprehensive data on the exact number of women who have been charged with a crime related to their pregnancy. State governments do not collect this information, and even identifying these cases is complicated due to the number of different laws that may be applied. Researchers, advocates and investigative reporters told us that since 2005, approximately 500 women have been charged with “chemical endangerment” in Alabama, 100 with “fetal assault” in Tennessee, and over 100 with unlawful conduct or neglect in South Carolina. According to National Advocates for Pregnant Women (NAPW), the leading national advocacy organization working to secure the civil and human rights of pregnant women, hundreds of others across the country have also been charged.

HOW AMNESTY INTERNATIONAL CONDUCTED THE RESEARCH

Over the course of three years, Amnesty International conducted desk-based research to analyze the human rights impacts of laws and policies that criminalize pregnant women. Amnesty organized a series of four meetings with key national legal experts, consulted with a Human Rights and Gender Justice Law Clinic and obtained pro bono assistance from a law firm to analyze a dossier of 84 cases in ten different states.

Amnesty International researchers conducted two field research missions to Alabama and Tennessee from 18-31 January and 22-27 March 2015 and a follow-up visit from 1-3 October 2015. Amnesty maintained ongoing communication with local advocates and conducted additional phone interviews over the course of

2016. Amnesty International conducted 20 individual in-person interviews with women impacted by relevant laws in Alabama and Tennessee and spoke to 34 women in informal focus group settings at two residential drug treatment facilities specifically for pregnant and postpartum women. The research team participated in 20 interviews and meetings with national and local NGOs, 17 interviews and meetings with state and local government officials including police, prosecutors, child welfare, drug court and public health authorities and 19 interviews with healthcare providers and employees at drug treatment facilities. Amnesty International sent a summary of their findings to the Governor of Tennessee and law enforcement officials in Alabama on 25 January 2017 and requested a response. Amnesty had not received a response at the time of publishing this report.

DETERRENCE FROM PRENATAL CARE

While the government officials who promote and interpret pregnancy criminalization laws may be doing so with the intention of promoting maternal and infant health, the laws do not achieve this stated aim. Women in residential drug treatment centers and healthcare providers told Amnesty that the threat of criminal punishment for drug use during pregnancy drives pregnant women away from healthcare, prenatal care and even drug treatment, in violation of their right to health. Healthcare providers told Amnesty International that women were forgoing prenatal care and in some cases attempting to drive to neighboring states to seek medical care or give birth to avoid prosecution. Zac Talbott, a drug treatment advocate in East Tennessee said:

“Everybody that we’ve asked has been fearful of the ‘fetal assault’ law. Three recent referrals to my drug treatment facility have not even sought obstetrical (OB) care. They have avoided OB care because of this law. Remember, a lot of them have past histories where their perception is that the law is not going to be their friend. They understand that there is a law. That if you deliver they are going to take your baby and throw you in jail.”

Rather than promoting healthy pregnancies, Amnesty International found that a criminal justice approach pushes pregnant women who are dependent on drugs to avoid healthcare. In addition to negatively impacting women’s access to healthcare, women who used drugs while pregnant told Amnesty that fear of punishment erodes their trust in healthcare providers. Some women feared coming into contact with the healthcare system because they had previous involvement with the child welfare system and knew they would be tested for drugs during their prenatal appointments or in the hospital at the time of delivery. Others were unaware they were being tested. Amber, a woman at a residential drug treatment center in Birmingham, Alabama told Amnesty International:

“Nope, they didn’t tell me anything about any drug tests or that I was positive for anything until the day it was time for us to leave the hospital and they told me I couldn’t take my babies with me and I’m going to jail.”

Alarming, most of the women we spoke to did not give informed consent for drug testing, interfering with the right to privacy. Some women did not know they were tested until child welfare officials informed them. Child welfare officials explained to Amnesty that prenatal clinics and hospitals call their offices to report positive drug tests. Child welfare officials then investigate and decide whether to open a case and whether to pass their findings on to law enforcement. According to Alabama police, prosecutors and child welfare officials, the process is not uniform and differs based on the priorities of the officials in each county. Information released by prosecutors and legal advocates in Tennessee indicates that some prosecutors were enforcing the law much more aggressively than others.

CRIMINALIZATION IN THE ABSENCE OF DRUG TREATMENT

In the context of public concern over high rates of drug dependence, states are failing to provide access to healthcare services, and instead responding with punishment. The healthcare systems in both Alabama and Tennessee rank in the bottom quartile in terms of access and affordability and they have not taken steps to expand insurance coverage for low-income residents.

Public health experts and healthcare providers described a lack of access to drug treatment facilities for pregnant women and this absence is magnified for those with low incomes and in rural areas. In Alabama, there is only one program that provides specialized, evidence-based treatment for pregnant women and postpartum women with children, accepts everyone regardless of ability to pay and does not have a waiting list.

In Tennessee, the state-funded insurance program for people with low incomes does not cover any of the costs of methadone maintenance treatment, considered a “standard of care” for pregnant women

dependent on opioid drugs. Rather, these expenses must be borne out-of-pocket, at a price of approximately US\$4,500 per year. Healthcare providers and officials told Amnesty International that many women are unable to pay or travel to the closest appropriate drug treatment facility, and left without treatment as a result. Brittany, a woman who was charged under the Tennessee “fetal assault” law, said that after her arrest she tried to get into treatment for three months. She told Amnesty International:

“Nobody would take my insurance. I kept getting decline letters. TennCare [the state insurance] would send me letters saying they would let me go and pay out-of-network [to a doctor outside of the insurance plan], then they could call back and say no. I was kind of thrown away at the wayside.”

DRUG COURT PROGRAMS AND MANDATORY TREATMENT

Almost all of the women Amnesty International spoke to in Alabama were in residential treatment centers mandated by the terms of drug court. Drug courts are intended to offer court-supervised treatment for drug dependence as an alternative to prison for certain drug-related offenses. There is no single model, but these programs typically oversee offenders outside of jail or prison, and maintain legal authority to enforce sanctions. A law enforcement official and a counselor at one of the centers explained that they have a close working relationship. The treatment center will often negotiate with the judge to pick up women directly from jail, and similarly, if a woman violates the terms of the treatment program, law enforcement will take her back. Prosecutors told us that judicial intervention serves as leverage to get women into treatment and rehabilitation which they would not otherwise seek.

Criminal justice advocates criticize the fact that the model allows judges to essentially make medical treatment decisions, such as how long treatment is necessary, and what types of treatment are allowed. Several of the women Amnesty International spoke to raised concerns about the right to a fair trial, such as inadequate legal counsel and a lack of information on their case and how long they would be in treatment through drug court.

DISCRIMINATION AGAINST THOSE MOST IN NEED OF SERVICES

The Convention on the Elimination of All Forms of Discrimination against Women is the foremost human rights treaty that calls for the elimination of all forms of discrimination against women and achievement of gender equality. The Committee on the Elimination of All Forms of Discrimination against Women, the body tasked with interpreting the Convention, has explicitly critiqued governments that criminalize healthcare services that only women need and punish women for accessing such services. It has also repeatedly called on states to prevent gender discrimination in access to healthcare.

Laws that directly criminalize or indirectly discriminate against pregnant women violate the right to equal protection under the law without discrimination. On top of this, these laws tend to be disproportionately enforced against low-income women and women of color - people who are often already facing multiple levels of discrimination and who may already be involved in the criminal justice or child welfare system. The effect is that certain classes of women are at heightened risk of prosecution if they become pregnant. The largest systematic study of these cases, analyzing 413 arrests and forced interventions over the course of 30 years, found that 71% of cases were brought against low-income women who qualified for indigent defense, and 52% of the cases were brought against African-American women.

Based on cases tracked by advocates in Tennessee, about a quarter of arrests occurred in Shelby County, a county that is over half African-American, and yet according to health data, has among the lowest rates of babies born exposed to opioid drugs. Nearly all of the arrested women had low-incomes and qualified for indigent defense. Arrests were also concentrated in East Tennessee, a region that particularly lacks access to scientific evidence-based drug treatment facilities for pregnant women. The challenges of finding treatment and the financial burdens of overcoming an assault charge are particularly acute for women who lack financial resources.

In Alabama, enforcement rates vary widely between counties, with prosecutors holding a large degree of discretion. Child protective service workers, healthcare professionals and women involved in these systems explained that a lack of state oversight intensifies the disparate impact the “chemical endangerment” law has on low-income and marginalized women. Similarly, advocates voiced concern about the potential for discrimination in drug testing practices, which is backed up by scientific studies. Of the women Amnesty International interviewed, almost all came from low income backgrounds and most spoke about personal histories which included trauma or physical and mental health conditions.

CONCLUSIONS AND RECOMMENDATIONS

In the USA, pregnant women lie at the center of a contested battleground over their sexual and reproductive rights and for some, this intersects with a stigmatizing and punitive state response to drug use. However, neither the condition of pregnancy nor one's drug use justify the violation of individuals' human rights. Laws and policies that render women vulnerable to criminalization simply because they have become pregnant have a profound impact on the health and lives of women, their children and their families.

Promoting women's health during pregnancy is a legitimate aim, but using criminal laws to promote public health goals is the wrong approach as it promotes fear and does not encourage healthy pregnancies or expand access to healthcare and other social services. Instead, punitive approaches deter women from seeking healthcare services, have a discriminatory impact on marginalized individuals and effectively criminalize pregnancy for certain classes of women, violating their human rights.

States have an obligation to promote the health and well-being of pregnant women through adequate maternal healthcare, goods and services. Pregnant women who are dependent on drugs need support and access to healthcare including evidence-based drug treatment services, which currently remain largely inaccessible to many.

States must amend or repeal laws that criminalize women for actions in relation to their own pregnancies, including drug use. States should also ensure access to affordable, scientific evidence-based, gender-appropriate drug dependence treatment and sexual and reproductive healthcare services without discrimination. Policy-makers should issue guidelines on drug testing practices to ensure pregnant women are not tested without their knowledge or consent and their autonomy and privacy are respected.

Detailed recommendations are included at the end of this report.

2. METHODOLOGY

In 2015, Amnesty International conducted two field research missions in Alabama and Tennessee from January 18-31 and March 22-27, a follow-up visit from October 1-3 and ongoing research through December 2016. The primary objectives of the missions were to learn more about the experiences of women impacted by pregnancy criminalization laws as well as of the views of healthcare providers and law enforcement officials concerned with this issue. Amnesty International also held meetings with a range of local and national non-governmental organizations.

In addition to extensive desk research, the research team organized a series of meetings with a group of leading legal and medical authorities across the country, consulted with the CUNY Human Rights and Gender Justice Clinic and obtained pro bono assistance from a law firm to compile and analyze a dossier of 84 cases in ten different states.

Amnesty International conducted 20 individual interviews with women impacted by relevant laws in Alabama and Tennessee. These included women charged with criminal offenses such as “chemical endangerment” of a child as well as women in family drug court and drug court programs due to sanctions from the criminal justice and child welfare systems. Amnesty also spoke with 34 women in informal focus group settings at two residential drug treatment programs specifically for pregnant and postpartum women in Alabama and Tennessee.

The research team participated in 20 interviews and meetings with NGOs and advocates around the country including women’s rights, criminal justice, reproductive rights and reproductive justice organizations. Amnesty interviewed a total of 19 healthcare providers, healthcare administrators and public health experts including a labor and delivery nurse, a neonatal intensive care unit nurse, an obstetrician/gynecologist, a neonatologist and drug dependence treatment researchers; seven of these people worked directly in residential drug dependence treatment facilities serving pregnant and postpartum women.

Amnesty interviewed five criminal defense lawyers including public defenders and private attorneys. The research team met a total of 17 government officials including representatives from the Tennessee Department of Mental Health and Substance Abuse, the Alabama Department of Human Resources, two Alabama district attorneys and a sheriff’s department as well as a drug court judge and administrators. Amnesty International did not receive a response to all requests for interviews with lawmakers, prosecutors and other government officials. A brief summary of the findings were sent to public officials in Alabama and Tennessee, and Amnesty invited a response in advance of publication.

Identifying women interviewees impacted by the laws and policies described in this report was challenging. The stigma surrounding drug use and the lack of services and support for women living in poverty and impacted by the child welfare and criminal justice systems meant that many women were hesitant to speak out. Amnesty International located women impacted by these laws and policies by visiting drug court programs and residential drug treatment centers. Most of the interviews were anonymous and Amnesty uses pseudonyms for most interviewees in this report to protect the privacy of those who they spoke with.

Establishing the number of arrests in relation to pregnancy criminalization laws was also challenging as arrests occur under an array of charges and laws in each state. Also, states do not provide comprehensive, publicly available data on “fetal assault” or “chemical endangerment” charges or provide sex-disaggregated data identifying how frequently the laws are applied to men, women and pregnant women. In addition to this, criminal cases rarely go to trial, which limits public documentation, and reports to the child welfare system are protected by confidentiality provisions. Most personal medical information is also covered under federal privacy guidelines.

Throughout this report, Amnesty International refers to “women” in discussing the impact of laws that criminalize actions during pregnancy. Although cisgender women – who were identified as female at birth and who identify as female – make up the majority of experiences with pregnancy criminalization, transgender men and people who identify as neither men nor women may also have the reproductive capacity to become pregnant and are also impacted by pregnancy criminalization laws. Amnesty International did not in the course of this research interview individuals with these gender identities; as a result, this report does not reflect any experience they may have had with pregnancy criminalization laws.

Amnesty International wishes to thank all of the women who shared their experiences and knowledge as well as the healthcare providers and NGOs who shared their expertise and time. Amnesty International is particularly grateful for the assistance of Healthy and Free Tennessee, National Advocates for Pregnant Women, The Vance Center for International Justice, the CUNY Gender Justice and Human Rights Clinic, Ralph Hendrix, Lisa Sherman-Nikolaus and legal experts Michele Goodwin, David Orentlicher, Dorothy Roberts, Kimberly Mutcherson, Khiara Bridges, Song Richardson, Farah Diaz-Tello and Cindy Soohoo.

3. PREGNANCY CRIMINALIZATION IN THE USA



ANNE

Anne, a 36 year-old woman from northern Alabama, was arrested for drug possession and paraphernalia in 2015. At the time, she was homeless and used methamphetamine. Anne had known she was pregnant but was not planning to continue the pregnancy which resulted from sexual assault. Anne's relationship with her husband was not stable and he was also struggling with drug dependence.⁵

Shortly before her arrest, she had an argument with someone over money for the abortion. "Someone saw the argument and took it for domestic violence and called the police. The police saw track marks, asked if they could search my purse. I said no, but they searched anyway. They found drugs and paraphernalia."⁶

Anne was taken to jail and tested for drugs two days later. "They called me out of my cell and told me they were going to drug test. They charged me with 'chemical endangerment' even before they'd done the drug screen. The investigator came and charged me."⁷

"They publicized it everywhere. Fox 6 News, the newspaper, blogs, on Facebook. The District Attorney and Sheriff have a Facebook page dedicated to mug shots. They post the pictures of everyone arrested for 'chemical endangerment'. The picture on the news was awful. Later, when I got to treatment one of the staff members told me they had seen me on the news. It made me feel shameful and embarrassed, and a little angry."⁸

5 Interview, Anne, Treatment Center, Birmingham, AL, 27 January 2015.

6 Interview, Anne, Treatment Center, Birmingham, AL, 27 January 2015.

7 Interview, Anne, Treatment Center, Birmingham, AL, 27 January 2015.

8 Interview, Anne, Treatment Center, Birmingham, AL, 27 January 2015.

3.1 A PATCHWORK OF LAWS

The circumstances that result in criminalization of pregnant women defy simple categorization.⁹ A range of criminal laws, judicial rulings, and legislation addressing child abuse and neglect can be used to criminalize pregnant women. These measures include criminal laws that directly criminalize or otherwise punish certain conduct as well as civil laws that result in sanctions such as removing a child from her mother's custody.

Pregnant women are often unaware of the type of actions during pregnancy that may lead to state sanction, monitoring and punishment in matters relating to pregnancy. There is also often a lack of agreement and understanding what criminal laws sanction and how they should be interpreted and applied by law enforcement, healthcare providers and social workers. Prosecutors have great discretion, thus the enforcement of criminal laws can be uneven across jurisdictions and reflect startling patterns of inequality and discrimination. A drug dependency treatment provider in Tennessee told Amnesty International:

“There’s nothing formulaic about how the law is used. We don’t know. It depends what county they come from. We’re not sure what the state will do.”

Evan Sexton, Clinical Director, Renaissance Recovery Group, Knoxville, TN

PREGNANCY CRIMINALIZATION ACROSS THE USA

- 45 states have documented cases in which pregnancy was a necessary factor leading to attempted and actual deprivations of liberty
- 38 states have “fetal assault” laws which consider fetuses potential victims of crimes
- 18 states consider substance use during pregnancy to be child abuse
- 4 states consider drug use during pregnancy to be grounds for civil commitment or involuntary detention in a treatment facility
- From 2014-2016, 1 state (Tennessee) specifically allowed assault charges to be filed against a woman for any unlawful act with respect to her own embryo or fetus

While pregnancy criminalization laws do not appear to be directly related to abortion, they are closely linked to legislative and judicial attempts to treat fetuses as legally separate persons. The criminalization of pregnant women results from the passage and, at times, overreaching interpretation of a range of laws. These can include laws whose stated rationale is to protect pregnant women from violence, and even laws against “the introduction of a controlled substance into the body of another person.”¹⁰ What unites these laws is that they have been used to criminalize women for their actions in relation to their own pregnancies.

In recent years, state laws have become more explicit, and the number of prosecutions has increased. For example, the National Advocates for Pregnant Women (NAPW) documented 413 arrests, detentions or forced medical interventions (such as caesarean surgery) between 1973 and 2005.¹¹ Since 2006, investigative journalists identified 479 arrests in Alabama alone.¹² In Tennessee, advocates identified approximately 100 of such cases between 2014 and 2016.¹³

9 L. Paltrow & J. Flavin, ‘Arrests of and forced interventions on pregnant women in the United States (1973-2005): The implications for women’s legal status and public health’, *Journal of Health Politics, Policy and Law*, 2013.

10 For examples, see Supreme Court of Arkansas, *Melissa McCann Arms v State of Arkansas* <http://opinions.aoc.arkansas.gov/WebLink8/0/doc/335588/Electronic.aspx>

11 L. Paltrow & J. Flavin, ‘Arrests of and forced interventions on pregnant women in the United States (1973-2005): The implications for women’s legal status and public health’, *Journal of Health Politics, Policy and Law*, 2013.

12 Interview, Nina Martin, Nashville, TN, 2 October 2015, also see: ‘How We Identified Alabama Pregnancy Prosecutions’, www.propublica.org/article/how-we-identified-alabama-pregnancy-prosecutions

13 This number comes from cases identified through Josh Spickler, Executive Director of Just City, a criminal justice organization in Memphis, TN, the results of a survey of Tennessee District Attorneys, and reports from individual District Attorneys published in local news outlets. For more information on these sources, see the chapter on this law.

While there have been some positive changes, such as the expiration of Tennessee’s amendment to its “fetal assault” law, and an amendment to Alabama’s law that exempts the lawful use of prescription drugs,¹⁴ there is also momentum to expand these laws. In 2015, five states proposed bills that would have created new crimes to punish pregnant women.¹⁵



HOW STATES CRIMINALIZE

States’ pregnancy criminalization efforts fall within the context of criminalization of sexuality and reproduction. This occurs directly through criminal laws and policies that target particular sexual and reproductive actions, decisions, and identities and indirectly through selective enforcement of criminal, civil and other policies against particular individuals and groups. The result of this type of criminalization is not only arrests, investigations, prosecutions and punishments, but increased stigmatization and an erosion of trust in and relationships with healthcare and social service providers.

DIRECT CRIMINALIZATION

Governments sometimes criminalize conduct during pregnancy directly through passing and/or implementing criminal laws that explicitly punish specific conduct. For example, Tennessee’s law criminalized women who gave birth to children showing symptoms of narcotic exposure.

INDIRECT CRIMINALIZATION

States also criminalize sexual and reproductive actions, decisions and identities indirectly by enforcing existing general criminal laws disproportionately against pregnant women. For example, Alabama’s “chemical endangerment” law was not specifically written to apply to pregnant women but is used disproportionately against them.

PUNITIVE REGULATION AND CRIMINAL STATUS

Marginalized communities are subject to high levels of policing and drug testing in healthcare settings. Greater interaction with the state can increase the chances that a person will be subject to screening or oversight from the criminal justice or child welfare systems. For example, hospitals serving people with publicly-funded health insurance may decide to test pregnant women for drugs based on suspicion.

CRIMINAL LAW APPROACHES HOLD STRONG POLITICAL CACHET

Politicians and legislators often rely on criminal law to demonstrate “state action” to tackle particular social problems. Criminal law also has a communicative function; a statement that something is not acceptable in a society. However, criminalization can be a relatively superficial and ill-fitting response to certain issues, and may even be counterproductive to the stated goal. Criminalizing drug use during pregnancy does not improve access to healthcare or lead to healthier pregnancies.

14 Alabama Senate Bill 372 Passed 4 May 2016, legiscan.com/AL/text/SB372/2016

15 The bills are: Arkansas HB 1376, Mississippi HB 559, Mississippi HB 610, Mississippi SB 2272, Missouri HB 1284, North Carolina SB297, Oklahoma SB 559. Information on the tracking of these state bills provided by National Advocates for Pregnant Women. Though it did not pass, Alabama introduced HB 408, a bill that would have expanded its ‘chemical endangerment’ law to mandate healthcare providers to report suspicion of drug use during pregnancy to the authorities within two hours; even before drug test results were completed. Alabama House Bill 408. Text of Bill available at legiscan.com/AL/text/HB408/id/1192216/Alabama-2015-HB408-Introduced.pdf

3.2 TYPES OF LAWS THAT CRIMINALIZE PREGNANT WOMEN

3.2.1 “FETAL PERSONHOOD” MEASURES

Increasing punitive regulation of pregnant women in the USA has occurred against the backdrop of an ongoing hostile debate around “fetal personhood” measures, also known as “prenatal personhood” measures. These measures refer to attempts to establish fertilized eggs, embryos and/or fetuses as “legal persons” (separate from pregnant women) with equal rights to others.

Some measures have attempted to secure legal rights for fertilized eggs, embryos and fetuses by defining life as beginning at the moment of fertilization. For example, in early 2017, 18 states introduced personhood measures¹⁶ and in 2016, 15 states introduced measures to ban abortion by establishing fetal personhood, though none of them passed.¹⁷ Others have proposed state constitutional amendments that provide that the term “person” means “every human being from the moment of fertilization, cloning, or the functional equivalent thereof.”¹⁸ This would have the effect of attaching the state constitution’s right to life from the earliest stages of pregnancies, and in some proposals, would have changed the penal law so that abortion would become first-degree murder.¹⁹ While none of these explicit measures to establish “fetal personhood” have passed to date,²⁰ many states have incorporated similar definitions of “person” into state criminal codes in order to include fertilized eggs, embryos or fetuses within the potential victims of violent crime.²¹

These initiatives contravene international human rights standards which confirm that human rights protections do not apply before birth. The history of the development of UN human rights treaties, including the Convention on the Rights of the Child (CRC), and the subsequent interpretation of their right to life provisions by their official interpretative bodies, shows that the right to life treaty provisions only apply after birth.²² While human rights bodies have recognized that states have an interest in promoting healthy pregnancies, this cannot be at the expense of women’s human rights. UN bodies have recognized that prenatal development can be protected through promoting the health and well-being of pregnant women, through adequate maternal healthcare, information and goods and services.²³

3.2.2 “FETAL ASSAULT” LAWS: DEFINING FETUSES AS VICTIMS OF CRIME

Laws in which the “victim” of a crime can include a fetus, generally called “fetal assault,” “fetal homicide” or “fetal protection” laws, exist in 38 states and 23 states apply these laws at any stage of gestation.²⁴ These laws can be vague and broad, sometimes so much so that legal experts argue they transgress US

16 Rewire News Legislative Tracker, <https://rewire.news/legislative-tracker/law-topic/personhood/>

17 Guttmacher Institute, State Policy Updates, Major Developments in Sexual & Reproductive Health, www.guttmacher.org/state-policy

18 See, e.g., Proposed Initiative Measure No. 26 (Mississippi 2011).

19 See Colorado ballot initiative, Amendment 67 (known as the “Brady Amendment”) (2014).

20 Center for Reproductive Rights, ‘Whose Rights to Life? Women’s Rights and Prenatal Protections under Human Rights and Comparative Law’, 2014.

21 See National Conference of State Legislatures for an updated summary of state ‘Fetal Homicide’ Laws.

www.ncsl.org/research/health/fetal-homicide-state-laws.aspx

22 Rhonda Copelon et. al. ‘Human Rights Begin at Birth: International Law and the Claim of Fetal Rights’, in *Reproductive Health Matters* Vol. 13, No. 26, November 2005, pp. 120-129. An argument to the contrary is erroneously built upon Paragraph 9 of the UN Convention on the Rights of the Child Preamble, which provides: “Bearing in mind that, as indicated in the Declaration of the Rights of the Child, ‘the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.’ The history of negotiations by states on the treaty clarify that these safeguards “before birth,” must not affect a woman’s choice to terminate an unwanted pregnancy. As originally drafted, the Preamble did not contain the reference to protection “before as well as after birth,” although this language had been used in the earlier Declaration on the Rights of the Child. The Holy See led a proposal to add this phrase, at the same time as it “stated that the purpose of the amendment was not to preclude the possibility of an abortion” (UN Commission on Human Rights, Question of a Convention on the Rights of a Child: Report of the Working Group, 36th Session, UN Doc. E/CN.4/L/1542 (1980)). Although the words “before or after birth” were accepted, their limited purpose was reinforced by the statement that “the Working Group does not intend to prejudice the interpretation of Article 1 or any other provision of the Convention by States Parties.” UN Commission on Human Rights, Report of the Working Group on a Draft Convention on the Rights of the Child, 45th Session, UN Doc. E/CN.4/1989/48 (1989), p. 10. Also see: Amnesty International, *She is not a criminal: the impact of Ireland’s restrictive abortion laws* (Index: EUR 29/1597/2015).

23 See, for example, Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, 11 August 2000 UN Doc. E/C.12/2000/4, para. 14.14. (CESCR General Comment 14)

24 National Conference of State Legislatures, www.ncsl.org/research/health/fetal-homicide-state-laws.aspx

constitutional standards.²⁵ Tennessee’s law specified that a woman can be prosecuted for any “act” or “omission” deemed unlawful.²⁶ Around the US, women have been charged with crimes under such laws for a range of actions including failing to wear a seatbelt, falling down stairs, attempting suicide and refusing medical interventions.²⁷ Pregnant women are not always aware that what they are doing could be considered a crime. The principle of legality is a foundational requirement contained in almost every international human rights instrument.²⁸ It requires that crimes and punishments be defined by law in a manner that is accessible to the population and that clearly outlines what conduct is criminalized.

While some state laws specifically carve out an exception for women’s actions in relation to their own pregnancies, including “legal abortion,” this exception is not adequate to protect women’s and girls’ health and human rights.²⁹ The definition of what constitutes a “legal” abortion can be quite narrow due to restrictive anti-abortion measures and in several cases, women have been prosecuted for trying to end their own pregnancies with physical means, with medication or to assist others in obtaining an abortion.³⁰

The effect of these laws is to leave marginalized pregnant women and girls increasingly at risk of prosecution for their circumstances, establishing a form of criminal liability that only applies to pregnant women. This creates a barrier to accessing healthcare services and drug treatment.

According to prominent legal scholar Michele Goodwin, medical staff are the primary enforcers of state ‘fetal protection’ laws, with support of police, prosecutors and judges.

“We should be concerned about non-legally-trained medical staff increasingly enforcing fetal protection laws, as thirty-eight states have adopted some form of feticide legislation.”

Michele Goodwin, “Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront”, California Law Review, 2014.



PURVI PATEL: CRIMINALIZATION OF SELF-INDUCED ABORTION

In 2015, Purvi Patel, a South Asian-American woman in Indiana, was sentenced to twenty years of imprisonment after a self-induced medical abortion. Patel's prosecution involved a novel application of Indiana Code § 35-42-1-6 (“the Feticide Statute”) and Indiana Code § 35-46-1-4(b) (“the Child Neglect Statute”) to criminally prosecute Patel for seeking to terminate her pregnancy and for failing to summon medical services immediately following the unexpected emergency delivery.

25 M. Goodwin, ‘Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront’, California Law Review, Vol. 102: Number 4, 2014.

26 Tennessee Code Annotated 39-13-107. Fetus as victim, <https://apps.tn.gov/carat/pdf/tncchild-39-13-107.pdf>

27 For a large selection of cases see L. Paltrow & J. Flavin, ‘Arrests of and forced interventions on pregnant women in the United States (1973-2005): The implications for women’s legal status and public health’, Journal of Health Politics, Policy and Law, 2013; M. Goodwin, Precarious Moorings: Tying Fetal Drug Law Policy to Social Profiling, Rutgers Law Journal, 42: 659; A. Cherry, “The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health”, Columbia Journal of Gender & Law, 147, 2007. For more discussion on suicide also see A. Murphy “A Survey of State Fetal Homicide Laws and Their Potential Applicability to Pregnant Women Who Harm Their Own Fetuses,” Indiana Law Journal, 89:2, 2014.

28 See S Lamb ‘Nullum Crimen, Nulla Poena Sine Lege in International Criminal Law’ in A Cassese & P Gaeta, et al. (eds.) The Rome Statute of the International Criminal Court (2002) 19; Rome Statute of the International Criminal Court, opened for signature 17 July 1998, 2187 U.N.T.S. 90 (entered into force 1 July 2002) Art 22(1); Universal Declaration of Human Rights, adopted 10 December 1948, G.A. Res. 217A (III), UN Doc A/810, Art 11; European Convention for the Protection of Human Rights and Fundamental Freedoms, signed 4 November 1950, 213 U.N.T.S. 222 (entered into force 3 September 1953) Art 7; American Convention on Human Rights, 22 November 1969, O.A.S.T.S. No. 6, O.A.S. Off. Rec. OEA/Serv.L/V/II.23, doc. 21, rev. 6 (entered into force July 18 1978) Art 9; African Charter on Human and Peoples’ Rights, adopted 27 June 1981, O.A.U. Doc CAB/LEG/67/3, rev.5, 21 I.L.M 58 (1982) (entered into force 21 October 1986) Art 7; League of Arab States, Arab Charter on Human Rights, May 22, 2004, reprinted in 12 International Human Rights Rep. 893 (2005) (entered into force March 15, 2008) Art 15.

29 ACLU, What’s Wrong with Fetal Rights? www.aclu.org/whats-wrong-fetal-rights

30 Amnesty International filed an amicus brief in support of a woman in Indiana who was prosecuted for seeking to terminate her own pregnancy under Indiana Code 35-41-1-6 Feticide; See Amicus Brief in Support of Appellant Purvi Patel by International Women’s Human Rights Clinic, Amnesty International, and the Center for Reproductive Rights, <http://advocatesforpregnantwomen.org/Patel%20-%20Intl%20Womens%20HR%20Clinic%20Amicus%20Brief.pdf> ; In Tennessee, Anna Yocca was charged with attempted murder after trying to end her own pregnancy, L. Stack, “Woman Accused of Coat-Hanger Abortion Pleads Guilty to Felony”, 11 January 2017, www.nytimes.com/2017/01/11/us/tennessee-abortion-crime.html, and in Pennsylvania, Jennifer Whalen obtained medication for her daughter www.nytimes.com/2014/09/22/magazine/a-mother-in-jail-for-helping-her-daughter-have-an-abortion.html

In an important precedent, the Court of Appeals of Indiana found that "the legislature did not intend for the feticide statute to apply to illegal abortions or to be used to prosecute women for their own abortions."³¹ As a result, Patel's "feticide" conviction was vacated. Feticide laws should not be interpreted in novel ways to prosecute women for their actions in relation to their own pregnancies. Despite concerns about the lack of sufficient evidence, Patel's "felony neglect of a dependent" conviction was not vacated, although the crime was reclassified with a shorter sentence.³²

3.2.3 CRIMINAL CHILD ABUSE LAWS APPLIED TO FETUSES

Alabama and South Carolina courts have interpreted child abuse laws to apply to fetuses. In 1997, the South Carolina Supreme Court decided in *Whitner v South Carolina* that a "viable" fetus is a "child" within the meaning of the child abuse and endangerment statute.³³ Since this ruling, prosecutors have relied on this interpretation of the word "child" to charge women for their actions during pregnancy. PhD candidate Grace Howard has documented 108 arrests in South Carolina in which women were charged with unlawful conduct toward a minor, unlawful neglect of a minor, or similar charges of child abuse for their actions with regard to their own pregnancies.³⁴

“Since 1996, every third trimester fetus has been considered a child for child protection and criminal law. For a pregnant woman, everything she might do that might potentially be seen as dangerous might set her up for arrest. Every pregnant woman is a walking disaster.”³⁵

Susan Dunn, Attorney, South Carolina

3.2.4 SUBSTANCE USE DURING PREGNANCY AS CHILD ABUSE

Eighteen states consider substance use during pregnancy a form of child abuse under civil child welfare laws.³⁶ Substance use during pregnancy can in some cases result in investigation or loss of custody of the child after birth. In 2014, Wisconsin Child Protective Services investigated 387 allegations of "unborn child abuse," and removed 19 children from their homes after birth.³⁷ These laws operate based on the faulty assumption that a single positive drug test alone may signal "abuse" or "harm."

31 Court of Appeals of Indiana | Opinion 71A04-1504-CR-166 | July 22, 2016, p. 4.

32 Court of Appeals of Indiana | Opinion 71A04-1504-CR-166 | July 22, 2016.

33 *Whitner v State*, 328 S.C. 1, 492 S.E.2d 777 (1997).

34 The arrests spanned 26 counties, and involved a variety of charges, including Unlawful Conduct toward a Minor, Unlawful Neglect of a Minor, Homicide by Child Abuse, Inflicting Great Bodily Injury to a Child, Child Abuse, Cruelty to Children, Involuntary Manslaughter, and Unlawful Exposure of a Child to Methamphetamine. The vast majority of these arrests (93) were made under charges of unlawful conduct or unlawful neglect. All but one case involved allegations of substance use during pregnancy, generally determined by the presence of a single positive drug test. Of the 108 cases, 61 resulted in a guilty plea, 11 were disposed, and one defendant was convicted. 24 cases have not yet been resolved. Sentences ranged dramatically, from the completion of drug court, to several years of probation, to 20 years in prison. Grace Howard, Conference Presentation at Mid-Atlantic Law and Society Association, Oct 10, 2015, John Jay College of Criminal Justice, New York, NY, and Interview with Amnesty International, October 2015, Nashville, Tennessee.

35 Susan Dunn, ACLU of South Carolina, Interview, 2 October 2015.

36 U.S. Department of Health and Human Services, "Parental Drug Use as Child Abuse," State Statutes, available at: www.childwelfare.gov/pubPDFs/drugexposed.pdf

37 Wisconsin Department of Children and Families, Child Abuse and Neglect Annual Reports, <https://dcf.wisconsin.gov/>

THE FEDERAL CHILD ABUSE PREVENTION AND TREATMENT ACT

The Federal Child Abuse Prevention and Treatment Act (CAPTA) requires states that accept federal grant funding to have policies and procedures to notify child protective services agencies of “infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.”³⁸ Though reporting cases of child abuse or neglect to child protective services (CPS) is required, it is up to each state to define what constitutes a “substance-affected infant,” to decide if the infant was in fact “affected” by an illegal substance and if this qualifies as child abuse.³⁹ Most states do not have specific reporting procedures and not all states include drug exposure in their definitions of child abuse and neglect. A total of 18 states have laws defining drug exposure during pregnancy as presumptive evidence of child abuse.⁴⁰ Some localities have chosen to pursue certain conduct more aggressively than others, for example, deciding to remove children solely based on marijuana use, while others do not pursue or ignore these cases altogether.⁴¹ In most states, a CPS worker may use a single positive drug test to make a claim of abuse even without an assessment of the family’s ability to care for a child.⁴² Even in states without such laws defining drug exposure during pregnancy as child abuse, CPS can monitor pregnant women and intervene as soon as a child is born.⁴³

DRUG TESTING

There are no uniform regulations protecting women’s rights in relation to drug testing during pregnancy or at birth. States and each individual hospital and physician may choose to test patients at their own discretion.⁴⁴ If a healthcare worker tests a pregnant woman and finds a positive drug test, this would be reportable to Child Protective Services (CPS) in 18 states.⁴⁵ However, testing on suspicion is only a requirement in four states.⁴⁶ Hospitals may profile certain women for drug testing based on their medical history or on a notification from CPS. Testing is frequently conducted without consent and may result in false positive or negative results which can have a devastating impact on the patient if they result in accusations of child abuse and neglect.⁴⁷

MANDATED REPORTING

Physicians, social workers and nurses are “mandated reporters,” meaning that if they suspect child abuse or neglect they must report it to the state CPS.⁴⁸ However, they do not necessarily need to characterize a positive drug test as evidence of child abuse. The complicated nature of these laws and lack of legal clarity make it easy to mischaracterize the “mandated reporting” function to mean that healthcare providers must test pregnant women and newborns and that a positive drug test must be considered abuse. A child welfare advocate explained to Amnesty International that immunity statutes in each state protect reporters from liability that could result from reporting but not for failing to report, a policy that can incentivize over-reporting.⁴⁹

38 Child Abuse Prevention and Treatment Act as Amended by P.L. 111-320, the CAPTA Reauthorization Act of 2010 p.19; also see U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), ‘Substance-Exposed Infants: State Responses to the Problem’, p. 8 (SAMHSA Substance-Exposed Infants), www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf

39 SAMHSA Substance Exposed Infants, also see U.S. Children’s Bureau, ‘Parental Drug Abuse as Child Abuse’, Child Welfare Information Gateway, www.childwelfare.gov/pubPDFs/drugexposed.pdf

40 Guttmacher Institute, ‘State Policies in Brief: Substance Abuse During Pregnancy’, www.guttmacher.org/statecenter/spibs/spib_SADP.pdf, (Guttmacher Substance Abuse During Pregnancy)

41 Interview, with Alabama DHR worker, anonymous, March 2015.

42 Interview, Susan Dunn, ACLU of South Carolina, 2 October 2015.

43 K. M. Bridges, ‘Pregnancy, Medicaid, State Regulation, and the Production of Unruly Bodies’, *Northwestern Journal of Law & Social Policy*, Vol. 3, Issue 1, Winter 2008; BBC ‘Nine Months in the Bronx - a pregnant woman’s fight to keep her baby’, 16 June 2016, www.bbc.com/news/world-us-canada-36543406

44 Guttmacher Substance Abuse During Pregnancy. 15 states require healthcare workers to report to authorities if they suspect a woman is abusing drugs during pregnancy.

45 Guttmacher Substance Abuse During Pregnancy.

46 Guttmacher Substance Abuse During Pregnancy.

47 American Congress of Obstetricians and Gynecologists, ‘Toolkit on State Legislation: Pregnant Women & Prescription Drug Abuse, Dependence and Addiction’, www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf

48 U.S. Children’s Bureau, ‘Parental Drug Abuse as Child Abuse’, Child Welfare Information Gateway, www.childwelfare.gov/pubPDFs/drugexposed.pdf

49 Interview, Lisa Sangoi, NYU Family Defense Clinic, September 2016.

3.2.5 CIVIL COMMITMENT LAWS

Wisconsin, Minnesota, Oklahoma, North Dakota and South Dakota have civil child protection or public health and safety laws in place that specifically allow the state to detain pregnant women.⁵⁰ The Wisconsin law allows the court to claim “jurisdiction over an unborn child” if a pregnant woman “lacks self-control in the use of alcohol beverages” or controlled substances.”⁵¹

After a visit to the USA in 2016, the UN Working Group on Arbitrary Detention commented on these civil laws, finding, “[t]his form of deprivation of liberty is obviously gendered and discriminatory in its reach and application as pregnancy – combined with the presumption of drug or substance abuse – is the determining factor for involuntary treatment.”⁵²

In July 2013, Alicia Beltran, a 28-year-old woman from Wisconsin⁵³ confided in her doctor that she had struggled with an addiction to prescription painkillers the previous year but had weaned herself from their use with the help of Suboxone, a prescription drug therapy designed for this purpose. Despite the fact that Alicia Beltran was not using drugs, which was confirmed by a drug test, healthcare providers reported her to the Department of Human Services. As a result she was taken from her home and presented in shackles before a court. While Alicia Beltran was denied a lawyer, a legal guardian was appointed to represent her fetus. Beltran was forced into an inpatient drug treatment program for 90 days against her will and lost her job as a result.

In April 2017, a federal court in Wisconsin struck down this law. Represented by National Advocates for Pregnant Women (NAPW), the NYU School of Law Reproductive Justice Clinic, and the Perkins Cole law firm, Tamara Loertscher sued the State of Wisconsin and Taylor County.⁵⁴ After seeking healthcare and testing positive for past drug use, Loertscher was reported for “unborn child abuse,” detained and incarcerated.⁵⁵

The court concluded that the law is vague in violation of the U.S. Constitution's guarantee of due process of law, explaining it “affords neither fair warning as to the conduct it prohibits nor reasonably precise standard for its enforcement.”⁵⁶

“The Wisconsin law takes away from a pregnant woman virtually every right associated with constitutional personhood, from the most basic right to physical liberty to the right to refuse bad medical advice... this kind of dangerous, authoritarian state-action, is exactly what happens when laws give police officers and other state actors the authority to treat fertilized eggs, embryos, and fetuses as if

⁵⁰ Title 63 OK Stat § 63-1-546.5 (2015); Wis. Stat. Ann. § 48.193; Minn. Stat. Ann. § 253B.02(2); S.D. Codified Laws § 34-20A-63; North Dakota Chapter 50-25.1-16; also see National Institutes for Alcohol Abuse and Alcoholism, Alcohol Policy Information System, Pregnancy and Alcohol: Civil Commitment, alcoholpolicy.niaaa.nih.gov/Alcohol_and_Pregnancy_Civil_Commitment.html

⁵¹ See Wisconsin's fetal protection law: <https://docs.legis.wisconsin.gov/statutes/statutes/48/III/133/>

⁵² Working Group on Arbitrary Detention: Preliminary Findings from its visit to the United States of America (11-24 October 2016), www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20746&LangID=E; The Supreme Court of Canada found detention of a pregnant woman dependent on drugs impermissible, see: *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.)*, [1997] 3 S.C.R. 925, <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1562/index.do>

⁵³ See National Advocates for Pregnant Women ‘First Fed Challenge To Pregnant Woman’s Arrest Under “Personhood”-Like Measure’, press Release 2 October 2013; Erik Eckholm, Case Explores Rights of Fetus Versus Mother. *New York Times*, 23 October 2013, www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html

⁵⁴ See National Advocates for Pregnant Women ‘Federal Court Declares Wisconsin “Unborn Child Protection” Law Unconstitutional’, press release 1 May 2017.

⁵⁵ United States District Court for the Western District of Wisconsin *Tamara M. Loertscher v Eloise Anderson, Brad D. Schimel, and Taylor County* Case 3:14-cv-00870-jdp

⁵⁶ United States District Court for the Western District of Wisconsin *Tamara M. Loertscher v Eloise Anderson, Brad D. Schimel, and Taylor County* Case 3:14-cv-00870-jdp

they are already completely separate from the pregnant woman.”⁵⁷

Lynn Paltrow, Executive Director of National Advocates for Pregnant Women

3.3 FORCES DRIVING CRIMINALIZATION OF PREGNANCY

3.3.1 A HISTORY OF RACIAL DISCRIMINATION IN POLICING REPRODUCTION

Criminal prosecutions of women in the USA based on their actions during pregnancy began to increase sharply in the late 1980s, following debates on abortion rights, repressive drug control policies in the so-called “war on drugs” and a political turn toward stigmatizing urban poverty. The American Civil Liberties Union Reproductive Freedom project first documented prosecutions in 1990; by 1992, there were more than 160 prosecutions in 24 states.⁵⁸ About 75% of the prosecutions were brought against women of color, though approximately 75% of the US population was white.⁵⁹

At that time, the media focused on crime in American cities and the perceived “epidemic” of crack cocaine use. While African-Americans use illegal drugs at approximately the same rate as whites, they are ten times more likely to go to prison for drug offenses.⁶⁰ Laws that appear to be race neutral may also disproportionately impact Black communities. For example, at the time, it took 100 times more powder cocaine to trigger the same sentence as the same amount of crack cocaine, a form of the drug that was associated with Blacks in the popular consciousness.⁶¹

Media portrayals of babies born harmed by their mothers’ cocaine use during pregnancy spread quickly despite a lack of scientific evidence of the purported harm. These reports reflected and perpetuated stigma and blamed women, rather than encouraging the state to take responsibility for failures in the healthcare system, including lack of access to healthcare and discrimination in healthcare settings.⁶²

Extensive long-term scientific studies have found that developmental outcomes are related to the complex social environment in which individuals develop and that cocaine exposure does not result in measurable differences in intelligence and other outcomes.⁶³ Poverty is a more powerful influence than exposure to cocaine.⁶⁴ Despite the evidence, sensationalized media accounts alleging women’s callous disregard for the health of their pregnancies caught on in the public imagination and drove early “fetal protection” efforts. The

57 See National Advocates for Pregnant Women ‘First Fed Challenge To Pregnant Woman’s Arrest Under “Pershonhood”-Like Measure’, press Release 2 October 2013.

58 L. Paltrow, *Defending the Rights of Pregnant Addicts*, *Champion*, Aug. 1993, cited in D.E. Roberts, *Unshackling Black Motherhood*, 95 *Mich. L. Rev.* 1996-1997.

59 L. Paltrow, *Defending the Rights of Pregnant Addicts*, *Champion*, Aug. 1993, cited in D.E. Roberts, *Unshackling Black Motherhood*, 95 *Mich. L. Rev.* 1996-1997; US Census Data available at census.gov

60 Human Rights Council, Report of the Working Group of experts on people of African descent, 6 August 2010, A/HRC/15/18; Human Rights Watch, ‘Decades of Disparity: Drug Arrests and Race in the United States’ 2009, www.hrw.org/sites/default/files/reports/us0309web_1.pdf

61 Human Rights Council, Report of the Working Group of experts on people of African descent, 6 August 2010, A/HRC/15/18

62 These early prosecutions have been recognized as part of a long legacy of government policies to control black women’s bodies, reproductive lives and their ability to parent. From the control of black women’s reproductive lives during slavery, to abusive sterilization in the 20th Century, and disproportionate removal of black children from their families, criminalizing pregnancy became part of this broader legacy. See: D. Roberts ‘Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right to Privacy’, *Harvard Law Review* 104:7 May 1991.

63 For example see: LM Betancourt, W. Yang, N.L. Brodsky, PR. Gallagher, E.K. Malmud, J.M. Giannetta, M.J. Farah, & H.

Hurt: Adolescents with and without gestational cocaine exposure: Longitudinal analysis of inhibitory control, memory and receptive language. *Neurotoxicology Teratology* 22(1): 33-46, Jan 2011; L. Betancourt and others, Adolescents with and without Gestational Cocaine Exposure: Longitudinal Analysis of Inhibitory Control, Memory and Receptive Language, *Archives of Pediatric and Adolescent Medicine*, 1997, 151(12): 1237-41.

64 ‘Poverty More Damaging Than Gestational Drug Exposure’, *Neonatology Update*, Children’s Hospital of Pennsylvania, October 2013, www.chop.edu/news/poverty-more-damaging-gestational-drug-exposure

assumption of substance use as an indicator of maternal unfitness has persisted, causing continued stigmatization and overbroad criminal law endeavors.⁶⁵

The sensationalized images of infants born “addicted” to drugs remained in the popular consciousness and in accounts of pregnant women’s drug use. Exaggerated media reports of methamphetamine use in the early 2000s followed a similar pattern, decrying a “scourge” of drug use accompanying the economic struggles of rural white communities.⁶⁶

Recent concern over prescription opiate painkiller abuse has led to new concern over reducing the costs of caring for newborns experiencing opiate withdrawal.⁶⁷ In all of these cases, the most marginalized communities, including poor women, rural women, and women of color, have been targeted and blamed disproportionately.

A study by NAPW identified 413 arrests, detentions and forced interventions on pregnant women between 1973 and 2005.⁶⁸ Of these cases, the vast majority of women were economically disadvantaged, with 71% qualifying for indigent defense. Of the 368 women for whom information on race was available, 59% were women of color, including African-Americans, Hispanic American/Latinas, Native Americans, and Asian/Pacific Islanders. Comprising 52% of the cases, African-American women were particularly overrepresented.

3.3.2 THE EROSION OF SEXUAL AND REPRODUCTIVE RIGHTS

Women’s sexual and reproductive rights have been and continue to be contested terrain in the USA. Each month legislation targeting sexual and reproductive actions and decisions are introduced in states across the country.⁶⁹ In January 2017, a total of 434 provisions impacting sexual and reproductive health were introduced at the state level.⁷⁰ Many of these bills propose restrictions on sexual and reproductive rights that will be harmful for women and maternal health if enacted as law. These provisions include measures to restrict abortion rights, cut funding and availability for family planning services and health insurance coverage for sexual and reproductive healthcare.⁷¹ The result is the erosion of women’s rights to sexual and reproductive health, as well as negative impacts on their broader human rights.⁷²

Each US state is covered by its own criminal code. Prosecutors are charged with enforcing state law and there are few institutional controls from the federal level.⁷³ Local prosecutors have wide discretion regarding which laws to prioritize enforcement and these priorities may be swayed by political concerns, as many prosecutors are elected (as opposed to appointed) in many jurisdictions.⁷⁴ In order to appeal to voters, prosecutors may opt to take stands that are politically popular or expedient.⁷⁵

Laws regulating women’s reproduction include restrictions on access to contraception and abortion services. Such regulations are often premised on patriarchal attitudes towards women, particularly as they relate to childbearing and motherhood, and subject women’s reproductive decisions to an unparalleled level of scrutiny and surveillance.⁷⁶ The notion that women’s health should be protected primarily due to the possibility of pregnancy threatens to conflate women’s health with maternal health and enables imposing discriminatory regulations on women simply because of their reproductive capacity.⁷⁷

65 M. Terplan et al. ‘Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness’, *Substance Abuse: Research and Treatment*, 9(S2), pp. 1-4.

66 G. Howard, ‘The Limits of Pure White: Raced Reproduction in the ‘Methamphetamine’ Crisis’, *Women’s Rights Law Reporter*, 35, 2013.

67 Tennessee Department of Mental Health and Substance Abuse Services, *Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee*, 2015.

68 L. Paltrow & J. Flavin, 2013, ‘Arrests of and forced interventions on pregnant women in the United States (1973-2005): The implications for women’s legal status and public health’, *Journal of Health Politics, Policy and Law*, 2013.

69 See Guttmacher Institute, *State Laws and Policies*, for updates, www.guttmacher.org/state-policy/laws-policies

70 Guttmacher Institute, *State Laws and Policies*, for updates, www.guttmacher.org/state-policy/laws-policies

71 For a summary see: Guttmacher Institute State Center Monthly State Update: Major Developments in 2015, www.guttmacher.org/statecenter/updates/index.html

72 Report of the Working Group on the issue of discrimination against women in law and in practice, on its mission to the United States, 7 June 2016, UN Doc. A/HRC/32/44/Add.2 at para. 28.

73 L. Fentiman, ‘In the Name of Fetal Protection: Why American Prosecutors Pursue Pregnant Drug Users (And Other Countries Don’t)’, *Columbia Journal of Gender and Law* 647, 2009, <http://digitalcommons.pace.edu/lawfaculty/655/>

74 See ‘Justice for All?’, A Project by the Reflective Democracy Campaign on Who Prosecuted in America, <http://wholeads.us/justice/>

75 Interview, Josh Spickler, Public Defender, Memphis, TN, 20 January 2015.

76 See OHCHR, *Gender Stereotypes and Stereotyping and Women’s Rights*, September 2014, www.ohchr.org/Documents/Issues/Women/WRGS/OnePagers/Gender_stereotyping.pdf; R. Cook and S. Cusack, “Gender Stereotyping: Transnational Legal Perspectives”, University of Pennsylvania Press, 2010.

77 See: Miranda Waggoner, ‘Cultivating the Maternal Future: Public Health and the New Pre-Pregnant Self’, *Signs: Journal of Women in Culture and Society* and Miranda Waggoner, ‘Motherhood Preconceived: The Emergence of the Preconception Health and Healthcare Initiative’, *Journal of Health Politics, Policy and Law* 38(2): 345-371, 2013.

3.3.3 HEALTH DISPARITIES AND DISCRIMINATION IN MATERNAL HEALTHCARE

In the USA, women's and girls' access to comprehensive sexual and reproductive healthcare are neither uniform nor guaranteed.⁷⁸ The federal Constitution does not explicitly protect the right to health and there are longstanding political debates regarding the provision of healthcare services. Along those lines, healthcare is available through a patchwork of private and public state coverage that leaves many without adequate access to care.⁷⁹

An individual's ability to access healthcare depends on a number of factors including where they live, state laws and policies and socio-economic status. Access to health insurance, in particular, is often precarious, hinging on one's employment, immigration status, and entitlements (or lack thereof) provided by the city or state, as well as one's health condition. The healthcare systems in Alabama and Tennessee, two of the states Amnesty International focuses on in this report, rank in the bottom quartile in terms of access and affordability.⁸⁰

Income shapes the type of prenatal healthcare women receive due to the way insurance coverage structures the American healthcare system. The protocols for prenatal care can differ based on whether a woman accesses healthcare through private insurance, or through Medicaid, a government-funded and regulated health program for people with low-incomes.⁸¹

Racial disparities are particularly pronounced in terms of access to and quality of maternal healthcare. Black women in the USA are three to four times more likely to die from pregnancy-related causes than white women.⁸² In 2008, the UN Committee on the Elimination of Racial Discrimination recognized pervasive racial disparities in women's sexual and reproductive health and called on the US government to improve women's access to reproductive and sexual healthcare.⁸³

This disparity is driven by multiple and intersecting discrimination, where racial and gender discrimination intersect with poverty, a lack of health insurance and other barriers to healthcare access.⁸⁴ Those most in need are the first to have their rights threatened by measures to cut funding or access to sexual and reproductive healthcare services.

An Amnesty International report from 2010 on the maternal healthcare crisis in the USA catalogued the US government's failures to ensure that all women are able to enjoy the highest attainable standard of health by providing them with the necessary services and information on the basis of equality and non-discrimination.⁸⁵

DRUG TESTING

Women with low incomes are less likely to be in good health when becoming pregnant because of a lack of access to primary healthcare services. These women are also more likely to experience complications during their pregnancies. Pregnancy complications or health issues after birth often bring drug testing which can then serve as the basis for criminal charges and determinations that women are "unfit" to parent their children. In the presence of a positive drug test, poor health may be considered evidence of "harm."⁸⁶

Drug testing is applied selectively, often based on highly discretionary "risk factors."⁸⁷ The discretionary nature of testing reinforces stigma and discrimination and also reflects providers' personal attitudes towards

78 Report of the Working Group on the issue of discrimination against women in law and in practice, on its mission to the United States. June 7 2016 UN Doc. A/HRC/32/44/Add.2 at para. 61 to 74.

79 Report of the Working Group on the issue of discrimination against women in law and in practice, on its mission to the United States. June 7 2016 UN Doc. A/HRC/32/44/Add.2.

80 The Commonwealth Fund Health System Data Center <http://datacenter.commonwealthfund.org/#ind=1/sc=>

81 K. Bridges, "Pregnancy, Medicaid, State Regulation, and the Production of Unruly Bodies," in *Northwestern Journal of Law and Social Policy*, Volume 3, Issue 1.

82 U.S. Centers for Disease Control, *Pregnancy Mortality Surveillance System*,

www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html; Center for Reproductive Rights, *Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Healthcare*, <https://www.reproductiverights.org/document/black-mamas-matter-toolkit-for-advancing-human-right-to-safe-respectful-maternal-health-care>

83 Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States, 72d Sess., para. 33, U.N. Doc. CERD/C/USA/CO/6 (2008).

84 Center for Reproductive Rights, *Reproductive Injustice: Racial and Gender Discrimination in US Health Care*, 2014.

85 Amnesty International USA, *Deadly Delivery: The Maternal Healthcare Crisis in the USA* (Index: AMR: 51/007/2010).

86 Michele Goodwin, 'Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield', Vol 102: Number 4, August 2014.

87 C. Miller, A. Lanham, C. Welsh, S. Ramanadhan & M. Terplan 'Screening, Testing, and Reporting for Drug and Alcohol Use on Labor and Delivery: A Survey of Maryland Birthing Hospitals', *Social Work in Healthcare*, 53:7, 659-669, 2014.

their patients. A study of low-income women who delivered at an urban teaching hospital found that those patients who were single, black, or received prenatal care at the clinic were more likely to be tested.⁸⁸

Scientific studies have found racial disparities in drug testing practices among pregnant women, as well as racial disparities in the adverse consequences of testing positive.⁸⁹ In one large study of over 8,000 women, black women were 1.5 times more likely to be tested for illicit drugs than non-black women, despite similar rates of testing positive.⁹⁰ Another study found that black women testing positive were 10 times more likely to be reported to child protective services.⁹¹

Those receiving care through Medicaid may be screened for drug use more frequently than more wealthy women with private insurance.⁹² The American Congress of Obstetricians and Gynecologists has taken the position that imposing mandatory screening for those within the Medicaid program disproportionately burdens low-income communities and racial minorities.⁹³

3.3.4 PUNITIVE DRUG CONTROL POLICIES: AN EMPHASIS ON CRIMINAL PUNISHMENT OVER PUBLIC HEALTH

For over 50 years, international drug control policies have been based largely on a prohibitionist approach. The international community, concerned about the impact of drugs, has developed an international drug control regime that imposes on states the obligation to ban the non-medical and scientific use of certain substances primarily by way of using the criminal justice system and other crime control policies to eliminate their production, transport, sale and consumption.⁹⁴

Amnesty International and other civil society organizations have for decades documented a wide range of human rights abuses and violations that arise from and/or are facilitated by the implementation of drug control policies and counter-narcotic operations worldwide. Despite the heavy reliance on criminal law, repressive policies and other measures implemented with the aim of prohibition, drug use has not decreased over the years while the associated risks and harms of using drugs have risen.⁹⁵ Drug control policies have markedly different impacts on the lives of different populations. The impacts of punitive drug laws and policies on women, and particularly on pregnant women's health and human rights, are being increasingly recognized by advocates and raised in human rights discussions at the international level.⁹⁶

Harsh criminal justice responses to drug use and dependence can have the effect of blaming individuals for their health status, and can shift attention away from the social determinants of health, and away from states' obligations to protect the right to health. One prominent legal scholar notes:

“By blaming individual women for conduct which is often not freely chosen, government avoids taking responsibility for its continuing failure to meaningfully address the reality that many poor and low income Americans lack access to healthcare or acknowledge the special problems faced by women who are victims of domestic violence, suffering from mental illness, and/or addicted to drugs and alcohol. Effective health policy

88 B.D. Kerker, S.M. Horowitz, J.M. Leventhal, 'Patients' characteristics and providers' attitudes: predictors of screening pregnant women for illicit substance use', *Child Abuse and Neglect*, 28(2):209-233, 2004.

89 H. Kunins and others, 'The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting', *Journal of Women's Health*, March 2007, www.ncbi.nlm.nih.gov/pmc/articles/PMC2859171/; B.D. Kerker, S.M. Horowitz, J.M. Leventhal, 'Patients' characteristics and providers' attitudes: predictors of screening pregnant women for illicit substance use', *Child Abuse and Neglect*, 28(2):209-233, 2004.

90 H. Kunins and others, 'The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting', *Journal of Women's Health*, March 2007, www.ncbi.nlm.nih.gov/pmc/articles/PMC2859171/

91 I.J. Chasoff, H.J. Landress, M.E. Barrett, The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida, *New England Journal of Medicine* 1990; 322:1202; also see D.R. Neuspiel, T.M. Zingman, V.H. Templeton, P. DiStabile, E. Drucker, Custody of cocaine-exposed newborns: Determinants of discharge decisions. *American Journal of Public Health* 1993; 83:1726.

92 For example, the South Carolina Health & Human Services "Screening, Brief Intervention and Referral to Treatment" (SBIRT) program provides doctors with reimbursement to perform standardized screening of pregnant women receiving Medicaid benefits; See K. M. Bridges, "Pregnancy, Medicaid, State Regulation, and the Production of Unruly Bodies," *Northwestern Journal of Law & Social Policy*," Vol. 3, Issue 1, Winter 2008.

93 American Congress of Obstetricians and Gynecologists, "Toolkit on State Legislation: Pregnant Women and Prescription Drug Abuse, Dependence and Addiction", www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf The American Congress of Obstetricians and Gynecologists is a companion organization to the American College of Obstetricians and Gynecologists and focuses on socioeconomic and political activities.

94 The international drug control regime is based on the Single Convention on Narcotic Drugs (1961, and subsequently amended by the Protocol of 1972), the Convention on Psychotropic Substances (1971) and the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

95 United Nations Office on Drugs and Crime, 'World Drug Report 2015', May 2015.

96 See National Advocates for Pregnant Women, 'UNGASS 2016 Women's Declaration', www.ungasswomen2016.com; K. Malinowska-Sempruch and O. Rychkova, *The Impact of Drug Policy on Women*, Open Society Foundations, May 2015.

requires the provision of adequate healthcare services for all, including reproductive healthcare across the life span and targeted services addressing our most vulnerable women and children.”⁹⁷

DRUG COURTS

While women do sometimes serve significant jail or prison sentences for drug use during pregnancy, a large number of these cases are adjudicated in drug treatment courts. These proceedings are not public, and each judge has a large degree of discretion in defining the terms of treatment within the court. This means that oftentimes, “one judge is overseeing the treatment decisions of a lot of very vulnerable women”⁹⁸

Drug courts are intended to offer court-supervised treatment for drug dependence as an alternative to prison for certain drug-related offenses, thus in theory ensuring treatment for people within the criminal justice system and reducing rates of incarceration and overcrowding.⁹⁹ Drug courts are sometimes referred to as a “community corrections” program, meaning that the program oversees offenders outside of jail or prison, but has legal authority to enforce sanctions.¹⁰⁰ The basic assumption of this model is to use the judicial intervention as leverage for treatment and rehabilitation, through which drug dependence is seen as a health issue.¹⁰¹

Drug courts are more common in the US than anywhere else in the world.¹⁰² These courts have been gaining popularity in the USA as a way to address the rising costs of incarceration for drug offenses, an overburdened jail and parole system, as well as an acknowledgment that people in the criminal justice system need treatment for drug dependence. Many counties also use the fines and fees obtained from drug court participants to fund the programs or make money for the department, and proudly present the cost savings as a benefit to taxpayers.¹⁰³

Critics to this model have argued that drug courts often fail to acknowledge relapse as a normal part of an effort to cease the use of drugs, whereby those who “fail” in completing court-supervised treatment are treated as in contempt and sent back to court with a guilty plea already on their record that can result in a harsher sentence than if they had never been in the drug court.¹⁰⁴ Drug courts have also been criticized for mandating medical treatment for any type of drug use, even if just occasional, which is not by itself a medical condition, without properly assessing the level of dependency.¹⁰⁵ In the end, court-supervised treatment takes the form of punishment rather than of therapy.¹⁰⁶

Some advocates believe drug courts may also “widen the net” and capture a population in drug court that might not otherwise enter the criminal justice system.¹⁰⁷ This “net-widening” effect may be particularly relevant for pregnancy crimes, as the number of prosecutions increases, but at the same time, many prosecutors would like to avoid putting pregnant women in jail. The availability of drug court programs may have the effect of enabling prosecutors to penalize larger numbers of women for drug use in pregnancy.

97 L. C. Fentiman ‘The New ‘Fetal Protection’: The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children’, Denver University Law Review Vol. 84:2, 2006.

98 Interview, Josh Spickler, Public Defender, Memphis, TN, 20 January 2015.

99 Joanne Csete and Denise Tomasini-Joshi, ‘Drug Courts: Equivocal evidence on a popular intervention’, Open Society Foundations, 2015.

100 See: National Institute of Justice, www.nij.gov/topics/corrections/community/pages/welcome.aspx

101 M.B. Hoffman, ‘Therapeutic jurisprudence, neo-rehabilitationism, and judicial collectivism: the least dangerous branch becomes most dangerous’, in Fordham Urban Law Journal, New York 2002.

102 Other countries that have established drug courts include the United Kingdom, Australia, Chile, Brazil and Jamaica. For more information about the history and development of drug courts, see D.E. Guzman. Drug courts: Scope and challenges of an alternative to incarceration. International Drug Policy Consortium in collaboration with DeJuSticia. May 2012.

103 Etowah County Community Corrections Website, <http://etowahcorrections.com/3t0wah/>; Gadsden Times, Court Referral Service Defends Location, www.gadsdentimes.com/news/20110413/court-referral-service-defends-location; also Interview with Attorney Brian White; S. Dewan and A. Lehren ‘Alabama Prosecutor Sets the Penalties and Fills the Coffers’ New York Times, 13 December 2016, www.nytimes.com/2016/12/13/us/alabama-prosecutor-valeska-criminal-justice-reform.html

104 E. L. Seigny et. al., ‘Do drug courts reduce the use of incarceration? A meta-analysis’, in Journal of Criminal Justice, December 2013.

105 Joanne Csete et. al., ‘Public Health and international drug policy’, in The Lancet. April, 2016 pp. 1456; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255.

106 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Mission to Azerbaijan, 3 May 2013, UN Doc. A/HRC/23/41/Add.1, para. 55; Committee on Economic, Social and Cultural Rights (12 June 2009), Concluding Observations: Cambodia, UN Doc. E/C.12/KHM/CO/1, para. 33; World Health Organization, ‘Assessment of Compulsory Treatment of People Who Use Drugs in Cambodia, China, Malaysia and Viet Nam’, 2009, p. 3.

107 National Association of Criminal Defense Lawyers, ‘America’s Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform’, September 2009, ; Drug Policy Alliance, ‘Drug Courts Are Not the Answer: Toward a Health-Centered-Approach to Drug Use’, 2011, www.drugpolicy.org/docUploads/Drug_Courts_Are_Not_the_Answer_Final2.pdf

4. TENNESSEE “FETAL ASSAULT LAW”

“In a lot of spheres, addiction is seen as a health issue, as a disease. But now, if you have a woman who is pregnant, all of a sudden she's a criminal.”

Allison Glass, State Director, Healthy and Free Tennessee, October 2015

From July 2014 until July 2016, Tennessee enacted a law specifically authorizing criminal assault charges against women who give birth to a child showing symptoms related to exposure to a narcotic drug if the drug was used illegally during pregnancy. The Tennessee General Assembly enacted Public Chapter 820 (“PC 820”), an amendment that expanded Section 39-13-107 of the Tennessee code,¹⁰⁸ which includes fetuses within the legal definition of a “victim” of assault. This law is commonly known as a “fetal assault” law. The law allowed for a woman to be charged with misdemeanor simple assault 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”, and interpreted by prosecutors to permit charges for any unlawful “act” or “omission”.¹⁰⁹ Notably, this law defines “a human embryo or fetus at any stage of gestation in utero” as the potential victim of an “assaultive offense”.¹¹⁰

The amendment to the “fetal assault” law expired 1 July 2016, after the Tennessee Criminal Justice Subcommittee defeated a bill that would have made the expanded law permanent. While the expansion that specifically criminalized drug use has expired, the “fetal assault” law is still in the Tennessee code, and may be amended again in the next legislative session.

108 Tennessee Code Section 39-13-107 (2015). Fetus as victim.

(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.

(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.

109 Tenn. Code Ann. § 39-13-107(c)(2) (2015).

110 Tenn. Code Ann. § 39-13-107(2) (2015), <https://apps.tn.gov/carat/pdf/tncchild-39-13-107.pdf>; The framing of a fetus as a potential victim of a crime is salient. For example, in November, 2014, a pregnant woman in Greene County in Northeastern Tennessee was charged with “felony reckless endangerment” after being pursued by police after a traffic stop. Such a charge requires interpreting a pregnant woman to be committing an offense against “another person.” See Tennessee Code Annotated § 39-13-103 (2014) Reckless endangerment (a) “A person commits an offense who recklessly engages in conduct that places or may place another person in imminent danger of death or serious bodily injury.”

The NGO Healthy and Free Tennessee organized a coalition of health and drug treatment professionals, reproductive justice organizations and others including Amnesty International to advocate for the expiration of this law. Amnesty international researched this law while it was in place to document the impact on women's human rights.

4.1 TRACKING THE IMPACT OF THE LAW

Amnesty International interviewed a range of attorneys, advocates, healthcare providers, health experts and government officials to learn about the impact of “fetal assault” law throughout the state. One of the primary difficulties raised was that the state did not create a mechanism for tracking the number of arrests.¹¹¹ In addition to difficulties consolidating data, a drug treatment advocate suspected that the government is not dedicating resources into collecting data because attention to the arrests would dissuade women from seeking treatment.¹¹² A physician who treats infants told Amnesty International: “It’s hard to build a therapeutic relationship. The system breeds mistrust.”¹¹³

In April 2015, the state released the results of a survey of District Attorney Generals about prosecutions in each county.¹¹⁴ The survey documented 28 arrests across the state occurring between 24 April 2014, the effective date of the legislation, and 31 December 2014. During this time period, the law was used to initiate prosecutions in ten out of the state’s thirty-one judicial districts, with prosecutions clustered in two different areas of the state; in Shelby County, where the city of Memphis is located, and in counties in East Tennessee.¹¹⁵

After the passage of the law, advocates were immediately concerned that the law would be used disproportionately against low-income women and women of color, as these groups disproportionately lack access to healthcare and therefore experience more pregnancy complications.¹¹⁶

4.1.1 DISCRIMINATORY APPLICATION OF THE LAW

Some prosecutors have pursued cases against pregnant women much more aggressively than others. The law has had a significant impact on the city of Memphis, in Shelby County.

Memphis’ population is about 63% black, compared to 16% throughout the state of Tennessee;¹¹⁷ about 30% of the city’s inhabitants live below the poverty line¹¹⁸ with a persistent high incidence of poverty among people of color.¹¹⁹ These disparities in income and health have been perpetuated through the discriminatory allocation of economic resources.¹²⁰

Shelby County District Attorney Amy Weirich, who drove the law’s passage, told reporters that the intent of the law was to wield a “velvet hammer of justice”¹²¹ to protect children from being born dependent on illegal drugs. However, the law reform simply expanded the criminal code and did not allocate any funding or provisions of any kind to expand drug treatment services or any other services for pregnant women or children.¹²²

A criminal justice organization tracked the cases of 24 women arrested for “fetal assault” and found that nearly all qualified as indigent and were unable to afford their own legal representation.¹²³ During the time

111 Interview, Government official, Tennessee Department of Mental Health and Substance Abuse, March 2015.

112 Zac Talbott, Director of the East and Middle Tennessee Chapter of the National Alliance for Medication Assisted Recovery, 2 October 2015.

113 Stephen Patrick interview, 29 January 2015, Nashville, TN.

114 Survey of District Attorneys prepared by Commissioned Bill Gibbons of the Department of Safety & Homeland Security. This survey is not comprehensive, as only 27 of the 31 district attorneys responded, and it only covers cases initiated for prosecution from the law’s enactment on April 24, 2014 until December 31, 2014.

115 Survey of District Attorneys prepared by Commissioned Bill Gibbons of the Department of Safety & Homeland Security, www.documentcloud.org/documents/1873320-survey-of-district-attorneys-general.html

116 Healthy and Free Tennessee Meeting, Memphis, TN, 19 January 2015.

117 United States Census Bureau, State & County FastFacts, www.census.gov/quickfacts/table/PST045216/00

118 United States Census Bureau, State & County FastFacts, www.census.gov/quickfacts/table/PST045216/00

119 See Population Reference Bureau, “The Social and Economic Isolation of Urban African Americans”, www.prb.org/Publications/Articles/2005/TheSocialandEconomicIsolationofUrbanAfricanAmericans.aspx

120 Healthy Memphis Common Table, Status Report to Advance Health Equity in Clinical Care and Health Outcomes in Memphis and Shelby County, Tennessee, May 2011.

121 M Willard, ‘Lawmakers Consider Jailing Mothers of Babies Born Drug-Addicted’, TN Report, <http://tnreport.com/2013/10/30/legislation-aims-at-combating-epidemic-of-drug-addicted-babies/>

122 Tennessee Code Annotated 39-13-107. Fetus as victim, <https://apps.tn.gov/carat/pdf/tnchild-39-13-107.pdf>

123 Information collected by Josh Spickler, Executive Director, Just City, a criminal justice reform organization in Memphis.

when Amnesty international was investigating the impact of the “fetal assault” law, 13 of these women had already been sentenced to jail time after their initial arrest and more could be incarcerated over the course of “drug court,” the court-supervised treatment program some women are offered.

According to criminal justice reform advocate Josh Spickler:

“Drug Court is hard. Lots of women fail. Of those who have been to jail after their initial arrest, four have gotten sentences of three to six months. This is a massive sentence for a first offense misdemeanor assault... Especially considering, as a man, I could never ever be treated this way for an assault charge in Tennessee. Ever.”¹²⁴

Despite the high rate of arrests, Shelby County and the surrounding areas have the lowest rates of newborns born exposed to drugs in the state.¹²⁵

Based on the Department of Health Surveillance Summaries, between April 2014, when the “fetal assault” law went into effect, and the end of November 2015, there were a total of 53 births of “drug exposed” babies in Shelby County.¹²⁶ Spickler found evidence of 24 arrests during the same time period.¹²⁷ This indicates that women found giving birth to children with positive drug tests in Shelby County had a significant risk of arrest. By contrast, other Health Department regions list hundreds of drug dependent births and few to no arrests.¹²⁸

Cherisse Scott, founder of SisterReach, a reproductive justice organization based in Memphis that advocates on behalf of women and girls of color, poor women, and rural women, told Amnesty International that: “We’re talking about poor women who do not have the resources to navigate the court system and to have the proper representation for themselves.”¹²⁹

Scott had spoken with the first woman arrested in Memphis under the “fetal assault” law. She told Amnesty International that the woman was turned away from detoxification facilities several times due to her pregnancy and tried unsuccessfully to detox on her own. This woman ultimately gave birth in a hospital, left her newborn and went into hiding to evade arrest.¹³⁰ Scott told Amnesty International that without the drug treatment services, counseling, job training, housing and other support needed to help women recover, the law captures a new population of women within the criminal justice system.¹³¹

“We’re talking about poor women who do not have the resources to navigate the court system or child protection services. We’re also talking about women, particularly women of color affected by this law, who were already mothers and have no way of maintaining the life of their families while participating in this punitively driven program. Poor women will not have resources for proper representation. So if you are poor and struggle with addiction in Tennessee, you lose everything with no sound

124 Interview, Josh Spickler, Executive Director, Just City, Nashville, TN, 1 October 2015.

125 In 2014, only 3.8% of such births in Tennessee occurred in Shelby County, and subsequent numbers for 2015 put the percentage even lower, at 2.9%. See Tennessee Department of Health, Drug Dependent Newborns Surveillance Summary for the Week of December 28, 2014 to January 2, 2015, http://tn.gov/assets/entities/health/attachments/NASsummary_Week_5314.pdf

126 NAS Surveillance Summary shows 14 babies at Week 18 of 2014, beginning in on April 27, 2014, and 38 at Week 53, for a total of 24 between the week after PC 820 went into effect until the end of 2014, plus 29 in 2015 at Week 47 ending November 28, 2015.

127 Though “drug dependent newborns” are tracked by the state, the arrests were not.

128 Tennessee Department of Health, Drug Dependent Newborns Surveillance Summary, www.tn.gov/assets/entities/health/attachments/NASsummary_Week_5314.pdf

129 Interview, Cherisse Scott Executive Director and CEO, SisterReach, Memphis, TN, 20 January 2015.

130 Interview, Cherisse Scott Executive Director and CEO, SisterReach, Memphis, TN, 20 January 2015.

131 Interview, Cherisse Scott Executive Director and CEO, SisterReach, Memphis, TN, 20 January 2015.

plan to ever get your life back. That's what this law has done to Tennessee mothers and families.”

Cherisse A. Scott, Founder and CEO, SisterReach, Memphis, TN

4.2 LACK OF ACCESS TO DRUG TREATMENT

East Tennessee reports the highest rates of opioid dependence and infants born exposed to opiates in Tennessee.¹³² However, due to the lack of drug treatment facilities, and in particular, licensed medication-assisted treatment providers, patients must travel long distances to have access to such treatment.¹³³ The challenges of finding treatment and the financial burdens of overcoming an assault charge are particularly acute for women who lack financial resources.

Republican state Senator Mike Bell who represents the 9th District in the eastern part of the state, told the press he was against the law saying: “There’s no treatment facility for these women there, and it would be a substantial drive for a woman caught in one of these situations to go to an approved treatment facility. Looking at the map of the state, there are several areas where this is going to be a problem.”¹³⁴ Bell’s statement acknowledged that lack of access to drug treatment is a problem in parts of the state and in the absence of treatment, criminalization may not be an effective response.

Only two of Tennessee’s 177 drug treatment facilities provide prenatal care on site and allow older children to stay with their mothers, and only 19 provide any care for pregnant women.¹³⁵ The clinical director of a treatment facility in Knoxville, Tennessee, told Amnesty International:

“I’ve been in this field for over 20 years. I’ve always been trying to get people into treatment. It’s not as simple as when someone is willing, they just call and then get in. There’s always going to be a pushback from the insurance. There’s a million ways to get rejected from services.”¹³⁶

The American College of Obstetricians and Gynecologists (ACOG) recommends methadone maintenance treatment as the “standard of care” for pregnant women using opiates.¹³⁷ The US government Substance Abuse and Mental Health Services Administration (SAMHSA) also recommends this treatment to reduce maternal and fetal complications.¹³⁸ However, there are only 12 licensed methadone treatment centers throughout Tennessee. Patients must drive to the centers on a daily basis to receive medication, counseling and other services. In East Tennessee, this can mean “traveling two hours each way every day.”¹³⁹

In addition to the lack of treatment centers, cost for treatment is a significant problem. TennCare, the state-funded insurance program for people on low incomes, does not cover any of the costs of methadone treatment. Rather, these expenses must be borne out-of-pocket, at a price of approximately US\$4,500 per year.¹⁴⁰ Many women are simply unable to pay and left without treatment as a result. Brittany, who was

132 Tennessee Department of Health, Drug Dependent Newborns (Neonatal Abstinence Syndrome) Surveillance Summaries, published weekly, available at <https://tn.gov/health/topic/nas>; Tennessee Department of Mental Health & Substance Abuse Services, see ‘Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee’.

133 Zac Talbott, Director of the East and Middle Tennessee Chapter of the National Alliance for Medication Assisted Recovery, 2 October 2015.

134 K. McDonough, ‘You can’t always trust people to do the right thing: How a law split pro-life GOPers in Tennessee’ Salon, www.salon.com/2014/04/21/you_cant_always_trust_people_to_do_the_right_thing_how_a_law_split_pro_life_gopers_in_tennessee/

135 Interview, Allison Glass, Healthy and Free Tennessee, Memphis, TN, 20 January 2015.

136 Phone Interview, Evan Sexton, Clinical Director, Renaissance Recovery Group, Knoxville, TN, 22 February 2016.

137 American College of Obstetricians and Gynecologists, ‘Committee Opinion: Opioid Abuse, Dependence, and Addiction in Pregnancy’, Number 524, 2012, www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy

138 Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 43.) Chapter 13. Medication-Assisted Treatment for Opioid Addiction During Pregnancy, www.ncbi.nlm.nih.gov/books/NBK64148/

139 Zac Talbott, Director of the East and Middle Tennessee Chapter of the National Alliance for Medication Assisted Recovery, 2 October 2015; Tennessee Department of Mental Health and Substance Abuse, Map of Opioid Treatment Clinics shows only 12 clinics in the state, www.tn.gov/assets/entities/behavioral-health/sa/attachments/Tennessee_Opioid_Treatment_Clinics_Map%2C_locations.pdf

140 Mary-Linden Salter, The Tennessee Association of Alcohol, Drug, and Other Addiction Services (TAADAS) ‘Opportunities to address pregnancy, drug use and the law’, unpublished policy paper, December 2015; according to the National Institute on Drug Abuse, “the average cost for 1 full year of methadone maintenance treatment is approximately \$4,700 per patient”, in National Institute on Drug Abuse, Principles of Drug Addiction Treatment: A Research-Based Guide, www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost

charged under the law, told Amnesty International that after her arrest she tried to get into treatment for three months:

“Nobody would take my insurance. I kept getting decline letters. TennCare would send me letters saying they would let me go and pay out-of-network [to a doctor outside of the insurance plan], then they could call back and say no. I was kind of thrown away at the wayside.”¹⁴¹

Licensed residential detoxification programs are also in short supply; only 11 such programs will accept pregnant women throughout the state. These centers have a total of 117 treatment slots for both men and women available at any one time. The Tennessee Association of Alcohol, Drug, and Other Addiction Services (TAADAS) released data which found that based on an expected rate of opiate use of 5.4%, as many as 4,318 pregnant women could need treatment each year in Tennessee and that the available beds serve less than half of this need.¹⁴²

An official from the Tennessee Department of Mental Health and Substance Abuse agreed and told Amnesty International that: “There’s almost always a waiting list for inpatient residential treatment. Often these women need residential treatment because of co-occurring mental health issues. Trauma is rarely not an issue.”¹⁴³

One of the very few physicians who offer prenatal care to women on medication-assisted treatment told Amnesty International:

“Access is the problem. Patients travel as long as 2-3 hours for their appointments with us. There are few options for these women. Many addiction programs don’t treat pregnant women and don’t take insurance. Our waiting list is long, 6-8 weeks, too long for pregnant women. The need for comprehensive healthcare services is great. Of my patients, 90% have coexisting psychiatric illness and a 98% rate of unintended pregnancy.”¹⁴⁴

A public defender in Knox County told Amnesty International about an incarcerated, pregnant client who is seeking drug treatment:

“The wait was 4-6 months, so she might not be in treatment before the pregnancy is over. Nobody wants a baby born exposed to drugs. Nobody wants to give birth in jail. My client wants to stay clean upon release, but the criminal justice system has no ability to address that.”¹⁴⁵

4.3 WHEN CRIMINAL JUSTICE AND HEALTHCARE CONVERGE

When the criminal justice system attempts to take on a healthcare issue, inaccuracy and stigma can make their way into law.

The terminology of a newborn being “addicted” to drugs, as stated in the law, is considered both stigmatizing and inaccurate by some healthcare experts.¹⁴⁶ A researcher on drug dependence during pregnancy told Amnesty International that: “Babies cannot, by definition, be addicted. They have not had a life course long enough where they would be using a substance in an uncontrollable way.”¹⁴⁷

Defining “harm” is also problematic as the law provides no definition.¹⁴⁸ Beyond this, according to leading medical authorities at the American Congress of Obstetricians and Gynecologists, there is no evidence that opioid exposure itself “is life threatening or results in permanent harm.”¹⁴⁹ Nineteen medical and public

141 Interview, Brittany, March 2015.

142 Mary-Linden Salter, The Tennessee Association of Alcohol, Drug, and Other Addiction Services (TAADAS) ‘Opportunities to address pregnancy, drug use and the law’, unpublished policy paper, December 2015.

143 Interview, government official at the Tennessee Department of Health and Mental Health, Nashville, TN, 30 March 2015.

144 Interview, Obstetrician-Gynecologist Jessica Young, 30 January 2015.

145 Interview, Knox County Public Defender’s Office, March 2015.

146 While newborns may exhibit symptoms of physical withdrawal to a substance, they do not experience “addiction,” (also known as “dependence syndrome” by the World Health Organization (WHO)). According to the WHO’s International Classification of Diseases, “dependence syndrome” includes “physiological, behavioral, and cognitive phenomena in which the use of a substance... takes on a much higher priority for a given individual than other behaviors that once had greater value.” Furthermore, a central descriptive characteristic of the “dependence syndrome” is the desire to take drugs, which involves mental processes of reward, motivation and memory. World Health Organization, ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and diagnostic guidelines, F 10-F19 Mental and behavioural disorders due to psychoactive substance use, p.4, www.who.int/substance_abuse/terminology/ICD10ClinicalDiagnosis.pdf

147 Interview, Healthcare provider for pregnant drug dependent women, 3 October 2015.

148 American Congress of Obstetricians and Gynecologists (ACOG), ‘Toolkit on State Legislation: Pregnant Women & Prescription Drug Abuse, Dependence and Addiction’, www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf

149 American Congress of Obstetricians and Gynecologists (ACOG), ‘Toolkit on State Legislation: Pregnant Women & Prescription Drug Abuse, Dependence and Addiction’, available at www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf

health associations have released policy statements opposing punishment of pregnant women for the sake of public health.¹⁵⁰ The World Health Organization provides detailed guidelines on providing opioid maintenance treatment to pregnant women and newborns.¹⁵¹

Under the “fetal assault” law, women facing charges could avoid conviction if they “actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program...”¹⁵² However, being in treatment does not prevent investigation or arrest and the defendant must find a way to prove that she is in treatment despite the lack of availability and affordability.¹⁵³

Moreover, demonstrating that a woman has “completed” a program is not straightforward as the law fails to define what qualifies as “completion” of treatment. Drug dependence is a chronic, relapsing condition¹⁵⁴ and many forms of treatment are ongoing and must be continued long-term, including methadone maintenance treatment, the current standard of care for pregnant women in the USA.¹⁵⁵ Like treatment for other chronic conditions, the goal of treatment is often ongoing management, not cure.¹⁵⁶

More broadly, physicians and other experts have expressed concern about mixing medical care with criminal justice endeavours as is the case with the Tennessee “fetal assault” law. A criminal justice advocate told Amnesty International:

“We see a conflation of the public health system and the criminal justice system. That’s an observation knowing how drug court operates and how these women are treated.”¹⁵⁷

A physician told Amnesty International that:

“Judges are taking more liberty with medical decisions from the bench. For example, by saying someone has to stop medication maintenance or go to jail. It goes against medical advice. It compromises medical care and decision-making.”¹⁵⁸

A woman with a young child currently living in a residential facility questioned whether criminalization would improve the situation of those who were drug dependent during pregnancy said:

“I just don’t understand how the law makes anything better. If you lose your child and go to jail, you are never going to recover.”¹⁵⁹

The American Congress of Obstetricians and Gynecologists is a companion organization to the American College of Obstetricians and Gynecologists and focuses on socioeconomic and political activities.

150 Statements collected by National Advocates for Pregnant Women,

[http://advocatesforpregnantwomen.org/blog/Medical%20Grps%20Position%20Statements-2014%20\(Updated\).pdf](http://advocatesforpregnantwomen.org/blog/Medical%20Grps%20Position%20Statements-2014%20(Updated).pdf)

151 World Health Organization, Guidelines for the identification and management of substance use disorders in pregnancy, 2014.

152 Tenn. Code Ann. § 39-13-107 (2015).

153 Interview, Tom Castelli, ACLU-TN, Nashville, TN, 30 January 2015.

154 National Institute on Drug Abuse, ‘The Science of Drug Abuse and Addiction: The Basics’, www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics

155 American College of Obstetricians and Gynecologists, ‘Committee Opinion: Opioid Abuse, Dependence, and Addiction in Pregnancy’, Number 524, May 2012, www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy

156 American Congress of Obstetricians and Gynecologists (ACOG), ‘Toolkit on State Legislation: Pregnant Women & Prescription Drug Abuse, Dependence and Addiction’, www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf

157 Interview, Director of Just City Josh Spickler, 20 January 2015.

158 Interview, Obstetrician-Gynecologist Jessica Young, Nashville, TN, 30 January 2015.

159 Interview, woman who had been dependent on drugs while pregnant, Nashville, Tennessee, Focus Group of 8 women, 17 March 2015.

MEDICATION-ASSISTED TREATMENT AND HUMAN RIGHTS PRINCIPLES

While methadone maintenance therapy is recommended as the standard of care for pregnant women dependent on opioids, some drug court judges have decided that medication-assisted treatment is not appropriate for court-supervised therapy.¹⁶⁰ There is also a high level of stigma surrounding medication assisted treatment.¹⁶¹ Opioid replacement therapy is recognized as a crucial drug treatment tool by national and international health authorities, including the World Health Organization (WHO), and denying this treatment option undermines the right to access essential health services.¹⁶² Further, the Special Rapporteur on Torture has said that “denial of opiate substitution treatment” may amount to torture or other ill-treatment.¹⁶³

The WHO, the Joint United Nations Program on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) issued a joint position paper confirming that: “Effective pharmacotherapy treatment of opioid dependence can substantially improve obstetric, perinatal and neonatal outcomes. Opioid substitution maintenance therapy also has an important role in attracting and retaining pregnant women in treatment and ensuring good contact with obstetric and community-based services including primary care. Addressing childcare and family support issues for women continues to be a major gap in the delivery of services for women in most countries.”¹⁶⁴

The WHO recognizes that drug dependence often follows the course of “a relapsing and remitting chronic disease”.¹⁶⁵ UN guidance indicates that people may need to try several kinds of treatment or several episodes of treatment to overcome drug dependence.¹⁶⁶ Opioid dependence is a complex health condition, and more than one treatment option should be available.¹⁶⁷

However, requiring enrolment in a treatment program contradicts these basic understandings of the nature of drug dependence treatment by mandating treatment that is overseen by a judge rather than a healthcare professional and is therefore not necessarily evidence-based. For example, some drug courts may refuse medication-assisted treatment as a treatment option even if it is needed.¹⁶⁸

Critics to this model have argued that drug courts normally fail to acknowledge relapse as a normal part of an effort to cease the use of drugs, such that those who “fail” in completing court-supervised treatment may be sent back to court with a guilty plea that can result in a harsher sentence.¹⁶⁹ A physician who specializes in treating pregnant women with opiate dependence told Amnesty International that such sanctions “make it harder to individualize care. “It’s frustrating from a medical perspective because of a low level of understanding of opioid addiction as a disease and the risk of detox and relapse in the natural course of addiction, and how resource intensive therapy is in terms of resources and support.”¹⁷⁰

Punishing a treatment “failure” violates international guidelines, which call for drug treatment to be voluntary and for patients to be treated with dignity.¹⁷¹

4.4 DETERRENCE FROM PRENATAL CARE

“The problem with the law is that it discourages women from seeking treatment. I’ve seen higher no-show rates for the first appointment. Patients are showing up later in their pregnancies for care. Patients are telling me they

160 J. Csete and H. Catania Methadone treatment providers’ views of drug court policy and practice: a case study of New York State, *Harm Reduction Journal*, 10:35, 2013.

161 H. Matusow, S.L. Dickman, J.D. Rich et al., Medication assisted treatment in U.S. drug courts: results from a nationwide survey of availability, barriers and attitudes. *Journal of Substance Abuse Treatment* 44(5):473-480, 2013. <http://www.harmreductionjournal.com/content/10/1/35>

162 World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, 2009, www.who.int/substance_abuse/activities/treatment_opioid_dependence/en/

163 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, U.N. Doc A/HRC/22/53, para. 73

164 WHO/UNODC/UNAIDS Position paper, ‘Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention’, 2004, p. 26.

165 UN Office on Drugs and Crime and World Health Organization, ‘Principles of Drug Dependence Treatment’, (Discussion paper) Vienna, 2008, p.1, www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-ofDrug-Dependence-Treatment-March08.pdf; WHO, ‘Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence’, 2009, pp. xiv-xvii.

166 WHO ‘Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence’, 2009, pp. xiv-xvii.

167 UN Office on Drugs and Crime and World Health Organization, ‘Principles of Drug Dependence Treatment’ (Discussion paper), Vienna, 2008, www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-ofDrug-Dependence-Treatment-March08.pdf

168 J. Csete, ‘Costs and Benefits of Drug-Related Health Services’, in *Ending the Drug Wars*, Report of the LSE Expert Group on the Economics of Drug Policy, p. 75, May 2014, www.lse.ac.uk/IDEAS/publications/reports/pdf/LSE-IDEAS-DRUGS-REPORT-FINAL-WEB.pdf

are considering delivering out of state. Some women may decide they have to self-detox at home because they don't want it on their record."

Jessica Young, Obstetrician-Gynecologist treating pregnant women with drug dependence in Nashville

Some treatment providers have become vocal advocates speaking out about the impact of the law on the people they serve. Evan Sexton, the Clinical Director of Renaissance Recovery Group in Knoxville, Tennessee, told Amnesty International:

"Everybody that we've asked has been fearful of this law. Three recent referrals to my drug treatment facility have not even sought obstetrical [OB] care. They have avoided OB care because of this law. Remember, a lot of them have past histories where their perception is that the law is not going to be their friend. They understand that there is a law. That if you deliver they are going to take your baby and throw you in jail. In the years I've been doing treatment, this law has got more moving parts than any other situation I can imagine. Everyone has an opinion about what we need to do with those women."¹⁷²

Along similar lines, the administrator of a program at a treatment center in Memphis told Amnesty International:

"Mothers said they were afraid to go to the doctor for routine prenatal visits. We currently have empty beds, but there used to be a waiting list of 90 days."¹⁷³

A woman who had previously lost custody of a child due to her drug use told Amnesty International:

"The threat of jail is like putting a noose around your neck. You're just going to go on the run."¹⁷⁴

Healthcare providers have also found that women from Tennessee are being driven to cross state lines to give birth in other states. The Executive Director of an obstetrics and gynecology clinic specializing in care for women who use drugs in neighboring North Carolina told Amnesty International that about five women from Tennessee have come to her clinic to obtain prenatal care in the last year.¹⁷⁵

Zac Talbott, the Director of the East and Middle Tennessee Chapter of the National Alliance for Medication Assisted Recovery, has spoken with several pregnant women in his capacity as an advocate providing referrals for individuals seeking treatment. He told Amnesty International that:

"The pregnancy criminalization law has struck fear in the hearts of women who have sought treatment, causing undue stress in women who are pregnant. These are women who want to do what's right; what was best for them and for their developing fetus... There was a woman from Cleveland, Tennessee, on the border with Georgia. This woman drove to Georgia while in labor. She did not make it to the hospital in time and gave birth by herself in her car. Another woman, who was using prescription opioids off-label, decided to have an abortion. Fear that a rogue prosecutor could prosecute her was part of the decision."¹⁷⁶

The threat of pregnant women driving to nearby states drew attention from the Tennessee Department of Health. The state agency published additional guidance on reporting NAS cases from border states, altering its NAS reporting portal to allow for reports from hospitals serving counties that border Tennessee.¹⁷⁷

Soon thereafter, North Carolina legislators concerned by pregnant women crossing state lines to give birth in their state and evade punishment, proposed SB 297; a bill to criminalize drug use during pregnancy,

169 E.L. Seigny et. al., 'Do drug courts reduce the use of incarceration?: A meta-analysis', in *Journal of Criminal Justice*, December 2013.

170 Interview, Obstetrician-Gynecologist Jessica Young, Nashville, TN, 30 January 2015.

171 CESCR General Comment 14, WHO 'Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence', 2009, pp. xiv-xvii; Joint Open Letter by the UN Working Group on Arbitrary Detention, the Special Rapporteurs on extrajudicial, summary or arbitrary executions, torture and other cruel, inhuman or degrading treatment or punishment, the right of everyone to the highest attainable standard of mental and physical health, and the Committee on the Rights of the Child, on the occasion of the United Nation General Assembly Special Session on Drugs, New York, 19-21 April 2016, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=19828&LangID=E

UN Office on Drugs and Crime and World Health Organization, *Principles of Drug Dependence Treatment* (Discussion paper), Vienna, 2008, ; p. 10, www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf

172 Phone Interview, Evan Sexton, Clinical Director, Renaissance Recovery Group, Knoxville, TN, 22 February 2016.

173 Interview, Sara Evans, Meharry Rainbow Program, Memphis, TN, 17 March 2015.

174 Interview, Nashville Focus Group with 8 women, 17 March 2015.

175 Interview, Healthcare provider for drug dependent pregnant women, October 2015.

176 Zac Talbott, Director of the East and Middle Tennessee Chapter of the National Alliance for Medication Assisted Recovery, 2 October 2015.

177 Tennessee Department of Health memo to NAS Hospital Contacts From Angela M. Miller, PhD, MSPH, Epidemiologist, Division of Family Health and Wellness, http://tn.gov/assets/entities/health/attachments/NAS_Reporting_Border_States_06.24.2014.pdf

copying exact language from Tennessee's criminal code.¹⁷⁸ Due to mobilization by medical professionals and advocates, this bill did not pass in 2015. Nevertheless, the bill's proposal indicates the reverberating effect of the law.

4.5 DRUG TESTING IN HEALTHCARE SETTINGS

Amnesty International's research indicates that a number of health and human rights concerns arise when drug testing pregnant women. Nurses do not always tell patients whether they are being tested¹⁷⁹, in violation of the principle of informed consent and privacy. Guidelines on screening or testing do not exist at the state or federal level and academic researchers have found that hospitals frequently test without obtaining consent.¹⁸⁰

The American College of Obstetricians and Gynecologists recommends that urine drug testing is only performed with a patient's consent, and that "pregnant women must be informed of the potential ramifications of a positive test result, including any mandatory reporting requirements."¹⁸¹

A Labor and Delivery nurse told Amnesty International that:

"Sometimes, I'll tell them the doctor ordered it, but they don't have a choice. It's at the doctor's discretion. There isn't a policy that I know of... You probably have to get consent, but it's not the practice."¹⁸²

A neonatal intensive care nurse similarly told Amnesty International that she was unsure patients knew about the reporting of their results to child protective services:

"I don't think we told the mothers that we were reporting. Maybe the doctors did but the nurses didn't. I don't even know if they knew it was reported".¹⁸³

This nurse told Amnesty International that when one new mother found out she was being reported for a positive test, she ran away from the hospital. Meanwhile, her newborn required life-saving surgery.¹⁸⁴ The same nurse told us about another new mother who knew she was being reported and then left the hospital.¹⁸⁵

A Labor and Delivery Nurse told Amnesty International that some colleagues were hesitant to screen for drug use because they did not agree with the law, or did not want to be bothered with the administrative requirements that arise with a positive test result.¹⁸⁶ However, an accurate assessment of drug exposure can be medically necessary for providing the best care to a newborn with a health condition.¹⁸⁷ Removing barriers to open and honest communication between doctors and patients ultimately promotes maternal health, and the threat of criminalization stands in the way.

178 Interview with Executive Director of substance abuse treatment program for pregnant and parenting women, also see North Carolina General Assembly Senate Bill 297 'Prenatal Narcotic Drug Use/Criminal Offense', filed 17 March 2015, sponsored by Senators Brent Jackson and Louis Pate,

www.ncga.state.nc.us/Applications/BillLookup/LoadBillDocument.aspx?SessionCode=2015&DocNum=1229&SeqNum=0

179 Interview, Labor and Delivery Nurse, Nashville, TN, 6 September 2015.

180 C. Miller, A. Lanham, C. Welsh, S. Ramanadhan & M. Terplan, 'Screening, Testing, and Reporting for Drug and Alcohol Use on Labor and Delivery: A Survey of Maryland Birthing Hospitals', *Social Work in Health Care*, 53:7, 659-669, 2014.

181 American College of Obstetricians and Gynecologists, "Committee Opinion: Opioid Abuse, Dependence, and Addiction in Pregnancy," Number 524, p. 3, May 2012, www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy

182 Interview, Labor and Delivery Nurse, Nashville, TN, 6 September 2015.

183 Interview, Neonatal Intensive Care Unit Nurse, Nashville, TN, 7 September 2015.

184 Interview, Neonatal Intensive Care Unit Nurse, Nashville, TN, 7 September 2015.

185 Interview, Neonatal Intensive Care Unit Nurse, Nashville, TN, 7 September 2015.

186 Interview, Labor and Delivery Nurse, Nashville, TN, 6 September 2015.

187 Interview, Stephen Patrick, Division of Neonatology, Vanderbilt School of Medicine, Nashville, TN, 29 March 2015.

5. ALABAMA “CHEMICAL ENDANGERMENT” LAW

“In my town, I was worried about going to the doctor because if you test positive [for drugs], bam, you’re slapped with a ‘chemical endangerment’ charge.”

Woman in court-mandated treatment, Birmingham, Alabama, 19 March 2015

Over the past decade, Alabama has enforced a child abuse law aimed at protecting children from environments with controlled substances against pregnant women for drug use during pregnancy. Since 2006, at least 479 women have been charged with the crime of “chemical endangerment” for using a controlled substance while pregnant.¹⁸⁸ Charges are frequently brought after pregnant women or their newborns test positive for illegal drugs, though the law is vaguely written and did not, until 2016, exclude prescription drugs when used as directed. This type of law enforcement can discourage women from seeking healthcare, including vital prenatal care, and increase stigma and fear among those in communities targeted by the law.

Amnesty International learned from women who used drugs while pregnant, that women are frequently tested for drugs without their knowledge or consent, and then sent to jail or diverted through “drug court” programs into residential treatment programs far from their homes.¹⁸⁹ Healthcare providers work closely with law enforcement and child welfare officials during this process, creating the potential for conflicts between the obligation to provide patients with confidential treatment and the obligation to report patient information to the state.¹⁹⁰ Given the vague and overbroad nature of this law, prosecutors have great discretion in determining how to apply the law.

The way in which Alabama’s “Chemical Endangerment” law is applied is not straightforward. It involves the interaction of healthcare providers, multiple government agencies and private drug treatment facilities. Amnesty International interviewed healthcare providers, drug treatment providers, law enforcement officers, child protective services officials and women impacted by the law in order to understand their experiences under this law.

188 Interview, Nina Martin, Nashville, TN, 2 October 2015, also see: ‘How We Identified Alabama Pregnancy Prosecutions’, www.propublica.org/article/how-we-identified-alabama-pregnancy-prosecutions

189 Focus Group with 26 women, Birmingham, AL, 19 March, 2015; interview, Brian White, Defense Lawyer, Decatur, AL, 16 March 2015.

190 See: Physicians for Human Rights and the School of Public Health and Primary Healthcare, University of Cape Town, Health Sciences Faculty. ‘Dual Loyalty & Human Rights: In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms’, 2002.

5.1 APPLICATION OF THE LAW

In 2006, Alabama passed a law making it a crime to expose a child to an “environment” in which they could be exposed to a “controlled substance,” commonly referred to as the “chemical endangerment” law (Alabama Code Section 26-15-3.2).¹⁹¹ At the time, there was great concern about the manufacture and use of methamphetamine drugs in private homes. Under the law, a person commits the crime of “chemical endangerment” when they expose a child to illegal drugs or drug paraphernalia, with penalties ranging from one year in the case of a positive drug test to a maximum of life in prison. However, prosecutors started using this law to charge women who tested positive for drugs while pregnant and delivered newborns with drugs in their systems. This was based on the premise that the term “child” includes a fetus and that the womb was an “environment.” In practice, a law that was passed to protect children from drugs was essentially expanded and reinterpreted by prosecutors to criminalize pregnant women.

In 2013 and 2014, three women appealed their convictions to the Alabama Supreme Court, arguing that the child abuse law did not apply to them for drug use while pregnant.¹⁹² The Court, however, held that the plain meaning of the word “child” included a fetus, whether viable or not, empowering some law enforcement officials to charge pregnant women in their jurisdictions.¹⁹³

Brian White, an attorney who led a challenge to the law, told Amnesty International that the original legislative intent was not to target pregnant women and that “the court’s ideological interpretation was nowhere on the radar.”¹⁹⁴



LAURIE

Laurie, a 23-year old woman in residential drug treatment, was taking anxiety medications prescribed by her obstetrician and she also used the illegal drug methamphetamine once while pregnant. She went for regular obstetrical care and was tested for drugs throughout her pregnancy.

“I was going to an obstetrics clinic at a hospital in Birmingham. That clinic was giving me the prescriptions. The doctor knew I was an addict when I got there. They asked me had you ever had a drug addiction. I said yeah. He took me off my anxiety medication and put me on an opiate. It just made my addiction a whole lot worse. Whole lot worse. I asked him if it was alright to take this while pregnant. He said it was fine. Why I did methamphetamine when was five months pregnant, I have no idea. I don’t know.”

After her son’s birth, a Child Protective Services (CPS) worker from the Department of Human Resources (DHR) told her to take a drug test. The worker told her that according to the “safety plan” established by DHR, she would be able to take her son home as long as another adult was living with her.

Looking forward to caring for her son, Laurie “got the house ready, got the crib ready, everything. I get up to the hospital to pick my son up, and a cop was waiting on me. They let me put my son in the car seat and then handcuffed me in front of my whole entire family, and then charged me with ‘chemical endangerment’ of a child. The hardest thing was my 7-year-old nephew was there and they handcuffed me in front of him. I couldn’t enjoy watching my son go home. They took that moment away from me.”

191 Alabama Code Section 26-15-3.2: Chemical Endangerment of Exposing A Child to an Environment in Which Controlled Substances are Produced or Distributed.

(a) A responsible person commits the crime of chemical endangerment of exposing a child to an environment in which he or she does any of the following:

(1) Knowingly, recklessly, or intentionally causes or permits a child to be exposed to, to ingest or inhale, or to have contact with a controlled substance, chemical substance, or drug paraphernalia as defined in Section 13A-12-260. A violation under this subdivision is a Class C felony.

(2) Violates subdivision (1) and a child suffers serious physical injury by exposure to, ingestion of, inhalation of, or contact with a controlled substance, chemical substance, or drug paraphernalia. A violation under this subdivision is a Class B felony.

(3) Violates subdivision (1) and the exposure, ingestion, inhalation, or contact results in the death of the child. A violation under this subdivision is a Class A felony. Ala. Code § 26-15-3.2 (LexisNexis 2014).

192 See Ex parte Hope Elisabeth Ankrom Petition for Writ of Certiorari, Nos. 1110176, 1110219, 2013 WL.

135748 (Ala. Jan. 11, 2013); Ex parte Sarah Janie Hicks, No. 1110620, 2014 WL 1508698 (Ala. 18 April 2014).

193 See Ex parte Hope Elisabeth Ankrom Petition for Writ of Certiorari, Nos. 1110176, 1110219, 2013 WL.

135748, (Ala. Jan. 11, 2013); Ex parte Sarah Janie Hicks, No. 1110620, 2014 WL 1508698 (Ala. 18 April 2014).

194 Interview, Brian White, Defense Lawyer, Decatur, AL, 16 March 2015.

A month and a half later, “I’m still going through all the ‘chemical endangerment’ charges now. I went to court two times and each time my lawyer did not show up. So they kept putting it off and putting it off. And it just kept putting more stress on my mind because I don’t know what’s going to happen, I don’t know what to do.”

“I’m on drug court for 18 months. Will be hopefully getting my son back, but I’m looking at prison time. I still think I should have gotten an opportunity to go into treatment while I was pregnant. I should have been aware of how it was going to play out. I was unaware. I had no idea about this law.”



AMANDA KIMBROUGH

Amanda Kimbrough, a mother of two from Colbert County, in northwest Alabama, had a history of preterm labor and showed up at the hospital with labor pains at 25 weeks pregnant.¹⁹⁵ After emergency cesarean surgery, her infant was not breathing. The pediatrician told the court that the infant died of “respiratory arrest secondary to prematurity,” but the medical examiner found methamphetamine in his system.¹⁹⁶

Because of the medical examiner’s findings, Kimbrough was ultimately charged and convicted for “chemical endangerment”. The court affirmed during her trial that Alabama’s “chemical endangerment” law may be used to prosecute women for their actions during pregnancy. The ruling empowered prosecutors across the state to bring these cases in larger numbers.

A number of medical experts and human rights organizations filed an amicus brief during Kimbrough’s trial outlining several concerns. Foremost, they outlined that scientific evidence does not support the assumption that prenatal exposure to illicit substances causes “unique, severe, or even inevitable harm.”¹⁹⁷ In fact, the experts and rights groups argued that allowing the “judicial expansion” of the “chemical endangerment” law could endanger maternal and child health through deterring drug-dependent pregnant women from seeking healthcare, carrying pregnancies to term, sharing vital information with healthcare professionals, incarcerating pregnant women, and making women who lawfully take controlled substances subject to arrest.¹⁹⁸

5.2 WHEN CRIMINAL JUSTICE, CHILD WELFARE AND HEALTHCARE CONVERGE

Under Alabama law, drug use in pregnancy is considered a form of child abuse, and medical providers are mandatory reporters, meaning they are required to report positive test results to child welfare authorities.¹⁹⁹ According to Brian White, a lawyer who has represented women charged with “chemical endangerment,” child welfare authorities investigate and may then pass on their findings to law enforcement officials, who may or may not “run with it” and pursue a case.²⁰⁰ In some localities, these actors work very closely together and may even develop policies in conjunction with one another.²⁰¹

Amnesty International interviews with child protective services (CPS) workers, drug treatment providers, healthcare professionals and women involved in these systems in Alabama revealed a lack of oversight

195 Interview, Brian White, Defense Lawyer, Decatur, AL, 16 March 2015.

196 Interview, Brian White, Defense Lawyer, Decatur, AL, 16 March 2015.

197 Brief of Amicus Curiae in Support of Petition of Amanda Helaine Kimbrough in Ex Parte Amanda Helaine Kimbrough in re State of Alabama vs Amanda Helaine Kimbrough no. 11-10219 (2012), p. 28.

198 Brief of Amicus Curiae in Support of Petition of Amanda Helaine Kimbrough in Ex Parte Amanda Helaine Kimbrough in re State of Alabama vs Amanda Helaine Kimbrough no. 11-10219 (2012), p. 28.

199 Alabama Code Section 26-15-3.2: Chemical Endangerment of Exposing A Child to an Environment in Which Controlled Substances are Produced or Distributed; Alabama Code Section 26-14-3: Reporting of Child Abuse or Neglect.

200 Interview, Brian White, Defense Lawyer, Decatur, AL, 16 March 2015.

201 Interview, Department of Human Resources Barry Spear, Public Information Manager and Carolyn Lapsley, Deputy Commissioner of Children and Family Services, 26 January 2015; interview, District Attorney Jimmie Harp, Gadsden, AL, 28 January 2015; interview, District Attorney Steve Marshall, Guntersville, AL, 18 March 2015.

which intensifies the disparate impact the “chemical endangerment” law has on certain groups of women. A Department of Human Resources Official for the State said: “There are 67 counties in Alabama. It varies county to county in how the DA enforces the law. Some are strict, others are not”.²⁰²

A county-level program supervisor agreed: “Every single county is entirely different.”²⁰³ As did a district attorney, who told us: “There are 41 judicial circuits in Alabama, which means 41 separate fiefdoms.”²⁰⁴ State child welfare officials explained that CPS workers must collaborate with law enforcement and can be subpoenaed.²⁰⁵ Some counties go even further. For example, Etowah County publicized their cross-agency pledge of greater co-ordination to prosecute women with “chemical endangerment.”

In another county, a program supervisor for CPS explained that: “The prenatal clinic gives the patient history to the hospital and then they call it in to CPS. I’ve gotten calls from the prenatal clinic if they know there are kids at home. The report just says there’s drug use. There’s no explanation of how or why it is impacting the child. Every single thing we [CPS] receive, we share it with law enforcement. If it’s something really bad, we’ll file a police report on top of that.”²⁰⁶

In addition to punishment for convictions under the “chemical endangerment” law, women may face related sanctions and other punitive monitoring and regulation from CPS. For example, women must adhere to a “safety plan” devised by a case manager and be subjected to repeated and frequent drug tests, classes and other sanctions.²⁰⁷

A pervasive concern among pregnant women was whether or not they would lose custody of their children. One woman told Amnesty International: “If someone took my kids, I’d have no reason to stay clean; I’d have no reason to live”.²⁰⁸

Another woman in treatment said: “They’re holding our children over our heads and they know we’ll just lay down because that’s my child”.²⁰⁹

5.3 DRUG TESTING AND ARRESTS

Charges under Alabama’s “chemical endangerment” law can be filed during pregnancy or at the time of delivery. Amnesty International spoke with five women who were charged with “chemical endangerment” during pregnancy. One woman was arrested at the hospital and in the other cases, the women were initially stopped for a violation while driving, arrested for another crime, such as drug possession or theft, and then tested for pregnancy, drugs, or both, while in jail. The Executive Director of a drug treatment center told Amnesty International that: “Prosecutors charge with everything they can; more charges is more bargaining power.”²¹⁰ One woman, “Dana” found out in jail that she was pregnant after being tested there:

202 Interview, Barry Spear, Public Information Manager and Carolyn Lapsley, Deputy Commissioner of Children and Family Services, Alabama Department of Human Resources, Montgomery, AL, 26 January 2015.

203 Phone Interview, Program Supervisor for Alabama Department of Human Resources, 23 January 2015.

204 Meeting, District Attorney Steve Marshall, Birmingham, AL, 27 September 2014.

205 Interview, Barry Spear, Public Information Manager and Carolyn Lapsley, Deputy Commissioner of Children and Family Services, Alabama Department of Human Resources, Montgomery, AL, 26 January 2015.

206 Phone Interview, Program Supervisor for Alabama Department of Human Resources, 23 January 2015.

207 Interviews at Birmingham Family Drug Court, Birmingham, AL, 22 January 2015; interview, Barry Spear, Public Information Manager and Carolyn Lapsley, Deputy Commissioner of Children and Family Services, Alabama Department of Human Resources, Montgomery, AL, 26 January 2015.

208 Focus Group with 26 women, Birmingham, AL, 19 March, 2015.

209 Focus Group with 26 women, Birmingham, AL, 19 March, 2015.

210 Interview, Chris Retan, Executive Director of Aletheia House, Birmingham, AL, 21 January 2015.



DANA

“They did the pregnancy test about an hour in. The nurse asked questions, like if I had any health problems, checked my weight and gave me a cup to pee in. She did the test there. I didn’t believe her. I was in shock. It all happened at once. I was scared. I felt real bad. She didn’t talk to me about it. I asked for a second test, but she said it was 99% accurate and sent me back to the cell.

Dana further explained that: “The investigator asked if I used drugs. I said yes. I said I wasn’t aware I was pregnant. [The investigator] didn’t believe me. I was really upset. He continued to tell me I was being smart about it, he said they can’t be real tears. He would say things like that. He said he was charging me with ‘chemical endangerment’ of the unborn and he put me back in jail.”²¹¹ As a result of the ‘chemical endangerment charge’, Dana’s bail was raised to US\$10,000, making it “impossible” to pay.²¹²

5.4 DISCRIMINATORY DRUG TESTING

Amnesty International’s interviews with child welfare authorities, medical professionals, and women indicate that drug testing of pregnant women is conducted in a discriminatory manner that targets certain women including those who have low incomes and a history of drug use. Hospitals are reluctant to share their policies and patients are often unaware that they have been tested.²¹³ Some doctors recognize that this type of approach leaves room for bias and discrimination among medical providers. For example, Dr Stephen Patrick, a neonatologist, told Amnesty International that: “If the decision to test is risk-based, we essentially apply our own biases to the situation, which is problematic.”²¹⁴

Some hospitals in Alabama only test women based on what are described as risk factors, such as having no record of receiving prenatal care or disclosing previous drug use. However, “risk-based” assessments can unfairly target poor women, who have less access to healthcare. Women already involved with CPS also face increased surveillance and scrutiny. One child welfare official told Amnesty International that she regularly communicates with hospitals about testing individual patients:

“If we have concerns we can call the hospital and put them on the ‘baby watch list.’ If she comes through [the hospital] she will be checked.”²¹⁵

In order to avoid concerns over discrimination, some hospitals in Alabama have a policy of testing all newborns. If an infant tests positive, mothers are then tested and reported to authorities.

For example, in Marshall County, the District Attorney and hospital decided that there would be blanket testing across the board, and thus all women would walk in “on the same playing field.”²¹⁶ In nearby Etowah County, a law enforcement official told Amnesty International that the situation was the same: “Every time you go for care there’s blanket urine testing.”²¹⁷ Though while everyone is tested in this county, this does not guarantee that every positive test will be reported to law enforcement.²¹⁸

Drug testing and reporting of positive test results to government agencies raises issues related to patient privacy. The UN Special Rapporteur on the Right to Health, an international human rights expert appointed by the UN, has found that compulsory testing is disempowering and a deterrent for individuals who wish to access health services.²¹⁹ The American College of Obstetricians and Gynecologists (ACOG), a prominent professional authority on obstetrical care, takes the position that urine testing should only be administered

211 Interview, Dana, treatment center, Birmingham, AL, 27 January 2015.

212 Interview, Dana, treatment center, Birmingham, AL, 27 January 2015.

213 Interview, Nina Martin, Nashville, TN, 2 October 2015. Also see: N. Martin and A. Yurkanin, How Some Alabama Hospitals Quietly Drug Test New Mothers- Without Their Consent, ProPublica, Sept 30, 2015, www.propublica.org/article/how-some-alabama-hospitals-drug-test-new-mothers-without-their-consent

214 Interview, Stephen Patrick, 29 January 2015, Nashville.

215 Phone Interview, Program Supervisor for Alabama Department of Human Resources, 23 January 2015.

216 Interview, District Attorney Steve Marshall, Guntersville, AL, 18 March 2015.

217 Interview, Chief Deputy Scott Hassell, Gadsden, AL, 18 March 2015.

218 Interview, Chief Deputy Scott Hassell, Gadsden, AL, 18 March 2015.

219 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 August 2009, para 27.

with the woman's consent and the woman must be informed of potential ramifications of a positive test result.²²⁰

5.5 LACK OF INFORMED CONSENT FOR DRUG TESTING

“I didn't know they could test without my knowledge. No one ever told me my rights. They should have asked me”

Interview, Amber, treatment center, Birmingham, AL, 22 January 2015

There are a lack of clear protocols and compliance with patients' rights to informed consent to treatment and testing throughout the USA. In addition to implicating privacy rights, the circumstances around drug testing and whether or not women consent to being tested are particularly relevant as a positive drug test may result in criminal charges and liability.

Hospitals have an ethical obligation to obtain a patient's informed consent before drug testing. Along these lines, most people in the USA are accustomed to signing long, complicated legal forms before medical procedures despite that they may not actually have time to read the forms, or lack the reading comprehension or language skills to be able to understand them.²²¹ According to a study from the US Agency for Healthcare Research and Quality, most patients are unable to recall or do not understand most of the information that is presented to them in the informed consent process.²²² Furthermore, reading the forms may not be entirely feasible if a woman is in labor.

Amnesty International asked a number of medical professionals in different roles, including obstetrician/gynecologists and labor and delivery nurses about the protocols for obtaining informed consent for drug testing. There was a general lack of knowledge about how these decisions are made and whether there is any consistency between hospitals or medical providers. The Director of a community corrections program in Birmingham explained to Amnesty International that:

“If she's tested in the hospital, she might not know. All hospitals have different rules. A lot of it is random. It's not a real system. We're kind of random here. You've got hospitals that report, that support arrests, you've got DAs interested in that, DAs that don't.”²²³

Several healthcare providers told us that the general hospital admissions forms, which cover basic consent to medical services, include drug testing as part of the general consent to receive medical care.²²⁴

There was agreement from law enforcement, child welfare and drug court officials that women did not always know they were being tested. For example, District Attorney Steve Marshall told Amnesty International:

“Did they sign a consent form to be drug tested? No, I don't know.”²²⁵

A Program Supervisor with Child Welfare in Alabama similarly told us that: “The women don't know they are being tested or reported. I think that's terrible... A hospital drug screen may not break everything down. A positive methamphetamine drug screen could be because of sinus medicine. Benzodiazepines could have

220 American College of Obstetricians and Gynecologists, 'Committee Opinion: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist', Number 473, January 2011, www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co473.pdf?dmc=1&ts=20150126T0317044530

221 K.M. Cordasco, 'Obtaining Informed Consent From Patients: Brief Update Review', Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices, Rockville (MD): US Agency for Healthcare Research and Quality, 2013; Evidence Reports/Technology Assessments, Chapter 39, www.ncbi.nlm.nih.gov/books/NBK133402/

222 K.M. Cordasco, 'Obtaining Informed Consent From Patients: Brief Update Review', Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices, Rockville (MD): US Agency for Healthcare Research and Quality, 2013; Evidence Reports/Technology Assessments, Chapter 39, www.ncbi.nlm.nih.gov/books/NBK133402/

223 Interview with the Director of a Community Corrections Program, Birmingham, AL, 23 January 2015.

224 Interview, pediatrician, Huntsville, AL, 28 January 2015; Interview, nurse, Huntsville, AL, 28 January 2015.

225 Interview with Steve Marshall, Marshall County District Attorney, 18 March 2015.

been given to her by the hospital. A mom could also have a prescription for something. I think this happens often.”²²⁶

Along these lines, a defense lawyer told Amnesty International that he could not imagine anyone would voluntarily submit for a drug test. “It’s skewed to younger people, those who are less savvy and don’t have the knowledge they can say no.”²²⁷

Investigative journalist Nina Martin sought to investigate drug testing practices in Alabama by submitting a questionnaire to the 49 hospitals that have maternity wards. After repeated requests, 42 hospitals declined to answer, three provided only partial information.²²⁸ The sample of admissions forms obtained through the investigation listed vague boilerplate language asking for consent to “diagnostic procedures,” “usual and customary medical/emergency treatment,” and “other... care considered advisable or necessary by the physician.”²²⁹ Rarely is drug testing specifically mentioned despite the fact that detailed rules are spelled out for far more mundane policies, such as the number of visitors allowed.²³⁰

Amnesty International’s interviews with women in treatment facilities further revealed that many women did not know that they were being tested.

Amber, who had given birth to twins and had lost custody of her older children due to drug use said:

“Nope, they didn’t tell me anything about any drug tests or that I was positive for anything until the day it was time for us to leave the hospital and they told me I couldn’t take my babies with me and I’m going to jail. A DHR worker came and said you know you were positive for marijuana and cocaine and you’re not going to take your babies home.”²³¹

Laurie said:

“No, the doctor never once told me that they were testing me. They knew I was dirty. They were doing blood tests on me. I didn’t know I had failed a drug test every time I went until after I had the baby.”²³²

The widespread practice of drug testing women without informed consent has major human rights implications, particularly with regard to the rights to health and privacy. The ability to make decisions regarding individual healthcare is central to the enjoyment of these rights. The right to health, in particular, includes the right to “control one’s health and body” and the right to be free from “non-consensual medical treatment.”²³³

5.6 IMPACT OF THE LAW: FEAR AND CONFUSION

“Criminalization is often referred to by its proponents as a ‘velvet hammer’ approach to getting pregnant women to seek help for issues with substance use. But you don’t provide healthcare with a hammer. There is a growing understanding that there is a maternal health crisis in the USA, but it’s not something we can arrest our way out of.”

Farah Diaz-Tello, Human Rights Attorney, New York, January 2017

226 Phone Interview, Program Supervisor for Alabama Department of Human Resources, 23 January 2015.

227 Interview, Brian White, Defense Lawyer, Decatur, AL, 16 March 2015.

228 N. Martin and A. Yurkanin, ‘How Some Alabama Hospitals Quietly Drug Test New Mothers- Without Their Consent’, 30 September 2015, www.propublica.org/article/how-some-alabama-hospitals-drug-test-new-mothers-without-their-consent

229 N. Martin and A. Yurkanin, ‘How Some Alabama Hospitals Quietly Drug Test New Mothers- Without Their Consent’, 30 September 2015.

230 Interview, Nina Martin, Nashville, TN, 2 October 2015.

231 Interview, Amber, treatment center, Birmingham, AL, 22 January 2015.

232 Interview, Laurie, treatment center, Birmingham, AL, 19 March 2015.

233 CESCR General Comment 14, para. 8.

While some prosecutors in Alabama make a point to publicize their tough stance on drug use during pregnancy, the goal is not necessarily to place women in jail, but instead, in one District Attorney's opinion, "compulsory rehabilitation,"²³⁴ meaning that the criminal justice system is using its tools to push women into drug treatment. Another District Attorney described the law as a "hammer over your head" that ensures some leverage.²³⁵ Similarly, Marchetta Shawl, an employee with the Marshall County Court Referral Services, told Amnesty International that: "Without it [drug use while pregnant] being a crime you have no way to make them do what you want."²³⁶

Amnesty International's interviews with women impacted by the "chemical endangerment" law indicate that the law instills fear in women, but this fear may not necessarily promote practices improving their health or the health of their pregnancies. Fear can either disincentive care, or for those who do not know about the law, have no impact at all.

Those going through times of crisis are in need of healthcare and other services and the law does nothing to address this. Another woman in residential treatment told Amnesty International:

"I'd not heard or thought about the law – it's not something I think of. When I lost my husband, mentally I lost my mind. I was unaware of things going on around me, much less myself."²³⁷

Amnesty International's interviews with pregnant women in Alabama indicated that while many women did not have an in-depth understanding of the specifics of the law, they were still fearful. This fear impacted encounters with medical professionals. A 29-year-old black woman escaping an abusive relationship and struggling with depression said:

"This law is in the news and I'm scared as hell because I was a drug addict. I'm scared because I don't know nothing about 'chemical endangerment' and it's not right that those of us who get help are going to get charged... I feel like they're after me. I'm just worried. It makes me scared because you can't really trust what they're really saying. If you're pregnant and you go to rehab you can still get charged and they can take your baby. Women are coming back from the hospital here and they don't have their babies. So why seek help if you're going to get a charge? Back in the day women didn't have ultrasounds and that stuff. That's the way I would do it now. I wouldn't go to the doctor."²³⁸

5.7 DRUG COURTS: FINES AND FEES

Drug Courts are a specialized kind of court program that typically offers supervised treatment for drug dependence. The aim of these programs is to divert people who are drug-dependent from incarceration into treatment.²³⁹ Family drug court programs are for families involved with Child Protective Services due to parental drug use. For example, a woman charged with "chemical endangerment" might receive an offer to get out of jail on bond if she enrolls in a residential treatment program and is able to adhere to the terms of the program.

A 24 year-old woman in treatment in Alabama raised concern with this model, telling Amnesty International: "You have to pay a whole bunch of money and before you ever get sentenced or charged with anything, you're already pretty much guilty, because you have to do their system. Even when you go to court, if you're proven innocent, you don't get any kind of money back or anything."²⁴⁰

Some advocates are critical of the "drug court" model, finding that it shifts costs onto low-income people. For example, attorney Brian White told Amnesty International:

"They're funding the criminal justice system on the backs of poor people. The fire department doesn't bill, but the criminal justice system works this way. Pre-trial intervention program sticks it to the offenders to pay for the system. It takes food out of children's mouths. First the house, now the car, now the money goes to the DA instead of family stability."²⁴¹

234 Interview, District Attorney Jimmie Harp, Gadsden, AL, 28 January 2015.

235 Interview, District Attorney Steve Marshall, Guntersville, AL, 18 March 2015.

236 Interview, Marchetta Shawl, Marshall County Court Referral Service, Guntersville, AL, 20 March 2015.

237 Interview, Anne, treatment center, Birmingham, AL, 27 January 2015.

238 Interview, Nikki, treatment center, Birmingham, AL, 19 March 2015.

239 See Fact Sheet: Office of National Drug Control Policy, www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/drug_courts_fact_sheet_5-31-11.pdf

240 Interview, Kate, treatment center, Birmingham, AL, January 2015.

241 Interview, Brian White, Defense Lawyer, Decatur, AL, 16 March 2015.

The Executive Director of an organization serving women in prison explained that the drug court approach is appealing to some policy-makers seeking to address Alabama's over-burdened criminal justice system.²⁴² Once arrested for "chemical endangerment," county jails are quick to remove pregnant women from their charge. Chief Deputy of Detention, Scott Hassell, explained to Amnesty International that "as a prison administrator, the last thing I want is a pregnant female in jail."²⁴³

According to interviews Amnesty International conducted with two women who had been released in 2014 from Alabama's Tutwiler Prison for Women, conditions in detention are dangerous and healthcare is poor.²⁴⁴ At the time of these interviews, the Tutwiler Prison for Women was under federal investigation for violence and sexual abuse. In May 2015, the state of Alabama reached a settlement to protect prisoners from staff sexual abuse and violence.²⁴⁵ A woman who was recently released from Tutwiler told Amnesty International:

"There are drugs in the jail system... it makes no sense to charge a pregnant woman and throw her in jail where there are drugs everywhere."²⁴⁶

5.8 COURT-MANDATED RESIDENTIAL TREATMENT

Promoted as an alternative to prison, women charged with "chemical endangerment" in some counties in Alabama are sent to a residential treatment facility in Birmingham. This facility actively promotes its services, and even has a community outreach specialist, who is in close contact with the law enforcement officials in a number of counties.²⁴⁷ Chris Retan, Executive Director of Aletheia House, explained to Amnesty International that the outreach specialist's job is "to go to the judge and pick people up."²⁴⁸ Aletheia House has thrived and expanded its provision of drug treatment through the use of Medicaid reimbursements for services.²⁴⁹ Retan further explained: "If there's a strong residential facility then the judge will say 'come and get them'."²⁵⁰

Amnesty International visited two treatment centers in Birmingham and a transitional home in Montgomery. Women told Amnesty that the quality of residential treatment centers varied considerably.²⁵¹ Some women believed that treatment, whether court-mandated or not, had saved their lives and they were thankful.²⁵² Others found the environment repressive. For example, one woman in treatment told Amnesty International:

"I want to go exercise, to the doctor, to the library. I'm not allowed to leave yet. It could be six months. We get ten-minute cigarette breaks. We can only go outside for 30 minutes at lunch. Not many people from the outside come in. I feel cooped up. I sit in the TV room bored. Not sure what I can do for work now that I have this felony."²⁵³ In several of the residential drug treatment facilities that Amnesty International visited, the treatment centers maintained a close relationship with law enforcement. If a woman fails to return for treatment after a visit to her family, the center contacts the county sheriff, and the woman is promptly arrested.²⁵⁴ Along these lines, the involvement of law enforcement in the drug treatment process created a sense of fear for some women.

Dora, a woman in a residential drug treatment center, shared her perspective with Amnesty International.

"Clients shouldn't feel threatened about getting kicked out. The fear is so deep, there has to be a process together to not get back to that place."²⁵⁵

In individual interviews, some women told Amnesty International that they felt like their lives were on hold and in limbo while they were away from their homes and families, with little contact with their community's

242 Interview, Executive Director of an organization serving women in prison, 26 January 2015.

243 Interview, Chief Deputy Scott Hassell, Gadsden, AL, 18 March 2015.

244 Interviews with two women who were recently released to a "halfway house" in Montgomery, Alabama. One woman developed diabetes while incarcerated, and though her health records indicated this, she was not informed, 26 January 2015.

245 'Justice Department Reaches Landmark Settlement with Alabama to Protect Prisoners at Julia Tutwiler Prison for Women from Harm Due to Staff Sexual Abuse and Sexual Harassment', www.justice.gov/opa/pr/justice-department-reaches-landmark-settlement-alabama-protect-prisoners-julia-tutwiler

246 Interview, Woman recently released from Tutwiler Prison, 26 January 2015.

247 Interview, Emuni Sanderson, Aletheia House, Birmingham, AL, 21 January 2015.

248 Interview, Chris Retan, Executive Director of Aletheia House, Birmingham, AL, 21 January 2015.

249 Interview, Chris Retan, Executive Director of Aletheia House, Birmingham, AL, 21 January 2015.

250 Interview, Chris Retan, Executive Director of Aletheia House, Birmingham, AL, 21 January 2015.

251 Interview, Executive Director of a program for women involved in the criminal justice system, Montgomery, AL, 26 January 2015;

Interview, Dora, treatment center, Birmingham, AL, 23 January 2015.

252 Interview, Laurie, treatment center, Birmingham, AL, 19 March 2015; Interview, Sam, treatment center, Birmingham, AL, 19 March 2015.

253 Interview with Dora, treatment center, Birmingham, AL, 23 January 2015.

254 Interview with Life Skills Instructor, treatment center, Birmingham, AL, 27 January 2015.

255 Dora, treatment center, Birmingham, AL, 23 January 2015.

drug court or lawyer. The lack of information about their cases and lack of legal aid exacerbated women's sense of unease and uncertainty. Some women were unable to contact their court-appointed lawyers, who have large caseloads and few resources and were sometimes unaware of the details of their case.

A pregnant woman in treatment said:

“My lawyer doesn’t know who I am. He knows where he’s going to make his money. Why spend a lot of time on me?”²⁵⁶

²⁵⁶ Interview, Anne, treatment center, Birmingham, AL, 27 January 2015.

6. CRIMINALIZING PREGNANCY: A VIOLATION OF INTERNATIONAL HUMAN RIGHTS

Laws that criminalize pregnant women's drug use and other conduct during pregnancy can violate a range of human rights including the rights to the highest attainable standard of health, privacy, freedom from discrimination and equal protection before the law as well as fair trial rights. States have an obligation to respect, protect and fulfil the full range of human rights for all people, including pregnant women. These obligations apply to both states' law and policy-making, criminal and civil law enforcement and provision of services, including health and social services.

The US government has signed and ratified two relevant international human rights treaties: the International Covenant on Civil and Political Rights (ICCPR) and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). This means the US government is bound to comply with international legal obligations under these treaties. The government has also signed but not ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the American Convention on Human Rights,²⁵⁷ thus requiring it to refrain from acts that would defeat the object and purpose of these treaties.²⁵⁸ The obligations and protections provided under these international human rights instruments apply to the country as a whole, meaning that individual state law and policy-making may not be used as a justification for the US government's lack of compliance with its international legal obligations under the treaties.²⁵⁹ The authorities have a duty under international human rights law to protect human rights from abuse by non-state actors, which includes companies such as private healthcare providers.²⁶⁰

The USA voted in favour of the Universal Declaration of Human Rights,²⁶¹ the cornerstone of the international human rights system which was adopted in 1948 and which sets out fundamental principles of

257 UN General Assembly, Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979 (entered into force 3 September 1981); UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966 (entered into force 3 January 1976); American Convention on Human Rights, 22 November 1969, O.A.S.T.S. No. 36, O.A.S. Off. Rec. OEA/Ser.LV/II.23, doc. 21, rev. 6 (entered into force 18 July 1978).

258 See Article 18, Vienna Convention on the Law of Treaties.

259 Article 27, Vienna Convention on the Law of Treaties.

260 See for example: Human Rights Committee, General Comment No. 31 (The Nature of the General Legal Obligation Imposed on States Parties to the Covenant), UN Doc CCPR/C/21/Rev.1/Add.13, 26 May 2004, para 8; Committee on Economic, Social and Cultural Rights, General Comment 12: The right to adequate food (Article 11), UN Doc E/C.12/1999/5, 12 May 1999, para. 15.

261 Universal Declaration of Human Rights, UNGA Res 217 A(III), UN Doc. A/RES/3/217/A, 10 December 1948.

international law.²⁶² The US is a party to the Charter of the Organization of American States (OAS).²⁶³ The states that were members of the OAS in 1948 adopted the American Declaration of the Rights and Duties of Man. The Inter-American Court of Human Rights has stated that the American Declaration authoritatively interprets the human rights provisions of the OAS Charter.²⁶⁴

This section analyses the extent to which each of the above-referenced human rights is affected by laws, policies and practices that criminalize pregnancy in the USA with a particular focus on Alabama's "chemical endangerment" law and Tennessee's "fetal assault" law. The analysis draws on recommendations by international human rights bodies and experts. These bodies and experts are increasingly focusing on the human rights impact of criminalizing pregnancy and specifically punishing women for actions taken during pregnancy, in one case recommending that states move towards decriminalization of conduct during pregnancy and prioritizing the health and human rights of women.²⁶⁵

262 In 1963, the UN General Assembly declared that every State 'shall fully and faithfully observe the provisions of... the Universal Declaration of Human Rights ...' Resolution 1904 (XVIII) (20 November 1963) art 11 (adopted without a vote). In 1968, States unanimously agreed that the UDHR 'states a common understanding of the peoples of the world concerning the inalienable and inviolable rights of all members of the human family and constitutes an obligation for the members of the international community'. See 'Proclamation of Teheran', Final Act of the International Conference on Human Rights UN Doc A/Conf.32/41, para. 2. The International Court of Justice has stated that the UDHR sets out 'fundamental principles', see the case of United States Diplomatic and Consular Staff in Tehran [1980] ICJ Rep 3, para. 91.

263 Organization of American States (OAS), Charter of the Organization of American States, 30 April 1948, Chapter XV, Article 106, The Inter-American Commission on Human Rights, Chapter XXII, Article 145, Transitory Provisions.

264 'Interpretation of the American Declaration of the Rights and Duties of Man Within the Framework of Article 64 of the American Convention on Human Rights', Advisory Opinion OC-10/89 of 14 July 1989, para. 43.

265 Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health, U.N. General Assembly, 66th Sess., 3 August 2011, A/66/254; Office of the High Commissioner on Human Rights, 'Study on the impact of the world drug problem on the enjoyment of human rights', 4 September 2015, UN Doc. A/HRC/30/65.

HUMAN RIGHTS DO NOT APPLY PRENATALLY

“Fetal assault” laws and other punitive regulation of pregnant women have been passed in the context of ongoing debates around “prenatal personhood” measures – efforts to establish fertilized eggs, embryos and/or fetuses as “legal persons” (separate from pregnant women) with equal rights to others.

However, international and regional human rights treaty provisions protecting the right to life, and the official bodies that interpret articles protecting life and other human rights guarantees, do not extend such protections prenatally.²⁶⁶ No international human rights body has ever recognized a fetus as a subject of protection under the right to life under Article 6 (1) of the International Covenant on Civil and Political Rights (ICCPR) or other provisions of international human rights treaties, including the Convention on the Rights of the Child.²⁶⁷ The negotiating history of the ICCPR further negates the proposition that the protection of the right to life, in Article 6(1), applies before birth.²⁶⁸

The UN Human Rights Committee has criticized a State Party’s Constitution which grants the right to life of the “unborn” on an equal footing with a pregnant woman’s right to life.²⁶⁹ Human rights bodies have refrained from stating that right to life protections apply prenatally as these would inevitably lead to conflicts between a pregnant woman or girl and her fetus. A position such as this would not only undermine the rights of the woman in the context of access to abortion, but also in other maternal health and general healthcare services required.²⁷⁰ For example, this reasoning has been used as a justification to override a woman’s refusal to consent to a caesarean section.²⁷¹

UN human rights bodies have recognized that prenatal development can be protected by promoting the health and well-being of pregnant women, through adequate maternal healthcare, information and goods and services.²⁷² Expanding access to healthcare and particularly drug treatment services to pregnant women would promote progress towards this goal.

According to international human rights standards, states have an obligation to take measures to ensure that the life and health of the woman or girl take priority over the protection of her fetus.²⁷³

266 R. Copelon et. al., ‘Human Rights Begin at Birth: International Law and the Claim of Fetal Rights’, in *Reproductive Health Matters* Vol. 13, No. 26, November 2005, pp. 120-129; While Article 4 of the Inter-American Convention on Human Rights states that the right to life “shall be protected by law and, in general, from the moment of conception,” the Inter-American Court on Human Rights has established that any interest states may have in protecting the right to life should be “gradual and incremental,” and cannot be absolute. The Court further confirmed that an embryo is not a person under the Inter-American Convention. See Inter-American Court of Human Rights, *Artavia Murillo et al. (“In Vitro Fertilization”) v Costa Rica*, Preliminary objections, Merits, Reparations and Costs, Judgment, Inter-American Court of Human Rights, Nov. 28, 2012, para. 264 (ban on IVF violated the rights to privacy, family and equality before the law); Also see Inter-American Commission on Human Rights, *Baby Boy (case 2141)*, Resolution 23/81, 6 March 1981, 25/OEA/ser.L./II.54, Doc. 9 Rev.1. 267 R. Copelon et. al., ‘Human Rights Begin at Birth: International Law and the Claim of Fetal Rights’, in *Reproductive Health Matters* Vol. 13, No. 26, November 2005, p. 122. Copelon explains that an argument to the contrary is erroneously built upon Paragraph 9 of the UN Convention on the Rights of the Child Preamble, which provides: “Bearing in mind that, as indicated in the Declaration of the Rights of the Child, ‘the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.’” The history of negotiations by states on the treaty clarify that these safeguards “before birth,” must not affect a woman’s choice to terminate an unwanted pregnancy. As originally drafted, the Preamble did not contain the reference to protection “before as well as after birth,” although this language had been used in the earlier Declaration on the Rights of the Child. The Holy See led a proposal to add this phrase, at the same time as it “stated that the purpose of the amendment was not to preclude the possibility of an abortion” (UN Commission on Human Rights, Question of a Convention on the Rights of a Child: Report of the Working Group, 36th Session, UN Doc. E/CN.4/L/1542 (1980)). Although the words “before or after birth” were accepted, their limited purpose was reinforced by the statement that “the Working Group does not intend to prejudice the interpretation of Article 1 or any other provision of the Convention by States Parties.” UN Commission on Human Rights, Report of the Working Group on a Draft Convention on the Rights of the Child, 45th Session, UN Doc. E/CN.4/1989/48 (1989), p. 10.

268 The history of the negotiations on the Covenant indicates that an amendment was proposed and rejected that stated: “the right to life is inherent in the human person from the moment of conception, this right shall be protected by law.” UN GAOR Annex, 12th Session, Agenda Item 33, at 96, UN Doc. A/C.3/L.654; UN GAOR, 12th Session, Agenda Item 33, at 113, A/3764, 1957. The Commission ultimately voted to adopt Article 6, which has no reference to conception, by a vote of 55 to nil, with 17 abstentions.

269 Human Rights Committee, Concluding observations on Ireland, UN Doc. CCPR/C/IRL/CO/4, para. 9; Human Rights Committee, *Amanda Mellet v Ireland*. UN Doc. CCPR/C/116/D/2324/2013, 17 November 2016.

270 For example, see evidence presented in Amnesty International, *She is not a criminal: the impact of Ireland’s restrictive abortion laws* (Index: EUR 29/1597/2015).

271 For example, *Laura L. Pemberton et al. v Tallahassee Memorial Regional Medical Center, Inc.* 66 Federal Supplement, 2d 1247, 1249 (N.D. Fla. 1999).

272 See for example, Committee on Economic, Social and Cultural Rights, General Comment 14 (The right to the highest attainable standard of health), 11 August 2000, UN Doc. E/C.12/2000/4, para. 14; CEDAW Article 12; CEDAW General Recommendation 24 on Women and Health, UN Doc. A/54/38/Rev.1, 1999, para. 31(c).

273 *L.C. vs Peru* (UN Committee on the Elimination of Discrimination against Women) UN Doc. CEDAW/C/50/D/22/2009, 3 November 2011; Committee on the Elimination of Discrimination against Women, Concluding Observations on Hungary, 2013, CEDAW/C/HUN/CO/7-8, 1 March 2013, para. 30.

6.1 THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

When pregnant women are threatened with criminal punishment when seeking healthcare services, when they are tested for drugs without their informed consent, when they lack access to drug treatment and when their healthcare providers share information with law enforcement to punish them, as opposed to providing essential care, then these actions constitute potential violations of their right to the highest attainable standard of health.

As a signatory to two international human rights treaties that specifically protect women's right to health – the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) – the US government (including at both national and local level) is obliged to refrain from any actions that would defeat the object and purpose of these treaties. This includes compliance with the core obligations of the treaty, such as non-retrogression and discrimination. In this context the official monitoring body of the ICESCR, the UN Committee on Economic, Social and Cultural Rights ("CESCR Committee") has made clear that, as with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. "If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the state party's maximum available resources."²⁷⁴

The CESCR Committee has confirmed that States must ensure that all healthcare facilities, goods and services are available, accessible, acceptable and of good quality.²⁷⁵ Ensuring reproductive healthcare is one of the core obligations set out under the right to health and states must ensure access to health facilities, goods and services on a non-discriminatory basis.²⁷⁶ Moreover, the Committee has affirmed that the right to health extends to the underlying determinants of health – socio-economic factors that have bearing on individuals' health status.²⁷⁷ The Committee has also highlighted the requirements of accessibility, acceptability and quality as well as gender responsiveness for reproductive healthcare services.²⁷⁸

The US has also signed and ratified the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) and therefore is legally obliged to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, in the enjoyment of all rights including the right to public health and medical care.²⁷⁹

Racial and gender discrimination underlie sharp disparities in maternal mortality, access to contraception, prenatal care and adequate labor and delivery services.²⁸⁰ As such, the US government is obliged to promptly address these persistent health disparities. The UN Committee on the Elimination of Racial Discrimination (CERD Committee) has called upon the US government to improve access to healthcare by "eliminating the obstacles that currently prevent or limit access to adequate health care, such as lack of health insurance, unequal distribution of health-care resources".²⁸¹

The US has also signed and ratified the ICCPR, which protects the right to life. The Human Rights Committee has recognized that this right needs to be interpreted in a wide sense.²⁸² For example, the

274 CESCR General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12), E/C.12/2000/4, 11 August 2000, para 32. (CESCR General Comment 14)

275 CESCR General Comment 14, para. 12.

276 CESCR General Comment 14, para. 44 (a) and para. 43 (a).

277 CESCR General Comment 14, para. 11.

278 CESCR General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/22, 2 May 2016, Para. 27. "Seemingly neutral laws, policies and practices can perpetuate the already existing gender inequalities and discrimination against women. Substantive equality requires that the laws, policies and practices do not maintain, but rather alleviate, the inherent disadvantage that women experience in exercising their right to sexual and reproductive health. Gender-based stereotypes, assumptions and expectations of women as men's subordinates and of women's role as only caregivers and mothers in particular, are obstacles to substantive gender equality including the equal right to sexual and reproductive health and need to be modified or eliminated, as does men's role only as heads of the household and breadwinners. At the same time special measures, both temporary and permanent, are necessary to accelerate de facto equality of women and to protect maternity".

279 International Convention on the Elimination of All Forms of Racial Discrimination, Article 5(e)(iv), entry into force 4 January 1969 (CERD).

280 Amnesty International USA, *Deadly Delivery: The Maternal Health Care Crisis in the USA* (Index: AMR: 51/007/2010); Center for Reproductive Rights, "Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care," www.reproductiverights.org/document/reproductive-injustice-racial-and-gender-discrimination-in-us-health-care

281 CERD Concluding observations to the USA 2008, UN Doc. CERD/C/USA/CO/6, 8 May 2008, para. 32.

282 Human Rights Committee, *Judge v. Canada*, Communication No. 829/1998, para. 10.5; see also, Human Rights Committee, General Comment 6, Article 6 (Right to life), para. 1: "It is a right which should not be interpreted narrowly".

Committee, recognizing the strong link between the rights to life and health based on the principles of indivisibility and interdependence of rights, considers it desirable for states to take positive measures to reduce infant mortality, increase life expectancy and eliminate malnutrition and epidemics.²⁸³

With respect to the core obligation not to discriminate, the UN CEDAW committee has affirmed that states should take all appropriate measures to eliminate discrimination against women in the field of healthcare, and to ensure women-appropriate services in connection with pregnancy and the postnatal period.²⁸⁴ The Committee has also noted that special attention should be given to the health needs of women belonging to marginalized groups, taking into account the manner in which social factors can determine health status.²⁸⁵

The UN Working Group on discrimination against women stressed: “The obligation to respect, protect and fulfil women’s right to equal access to healthcare services and to eliminate all forms of discrimination against women with regard to their health and safety is violated by neglecting women’s health needs, failing to make gender-sensitive health interventions, depriving women of autonomous decision-making capacity and criminalizing or denying them access to health services that only women require.”²⁸⁶

The American Declaration of the Rights and Duties of Man, which explicitly recognizes the right to health and the right to protection of mothers states: “All women, during pregnancy and the nursing period... have the right to special protection, care and aid.”²⁸⁷ Similarly, the Universal Declaration of Human Rights states: “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including... medical care and necessary social services... motherhood and childhood are entitled to special care and assistance.”²⁸⁸

6.1.1 CRIMINALIZING PREGNANCY DETERS WOMEN’S ACCESS TO HEALTHCARE SERVICES

In the USA, pregnant women who use drugs lie at the center of a political battleground over their sexual and reproductive health and rights that intersects with a stigmatizing and punitive drug control regime. However, neither the condition of pregnancy nor drug use justify the violation of individuals’ human rights.

Despite the purported health-related aims of laws specifically penalizing pregnant women’s drug use, professional health associations and human rights experts have uniformly dismissed such legislation as damaging to public health and human rights. The UN Special Rapporteur on the Right to the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (“Special Rapporteur on the Right to Health”) has confirmed that criminalization of various forms of conduct during pregnancy such as drug use impedes access to healthcare goods and services, infringing the right to health of pregnant women. The threat of criminal laws around pregnancy have a chilling effect on women and create barriers to seeking care while eroding trust in healthcare providers. The Special Rapporteur has explicitly called for states to suspend the application of “existing criminal laws to various forms of conduct during pregnancy.”²⁸⁹ Laws that criminalize conduct during pregnancy are a disproportionate response and an ineffective deterrent to drug use. They are also discriminatory, as the UN Working Group on the issue of discrimination against women in law and in practice has highlighted: “the use in some countries of custodial or punitive rather than educative measures to prevent injury to the fetus as result of drug or alcohol consumption by addicted pregnant women is another manifestation of gender discrimination.”²⁹⁰

Criminal laws can violate the right to health when they discourage or prevent individuals from obtaining medical care and from freely making their own healthcare decisions. In this context, the UN Special Rapporteur on the Right to Health – an independent human rights expert appointed by the UN Human Rights Council – has further criticized criminal laws relating to sexual and reproductive health, perinatal HIV

283 Human Rights Committee, General Comment 6, Article 6 (Right to life), para. 5.

284 UN Committee on the Elimination of Discrimination against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 4 May 1999, UN Doc. A/54/38 Part 1, para. 31 (c)-9(f).

285 Committee on the Elimination of Discrimination against Women, *Alyne da Silva Pimentel v Brazil*, Communication No. 17/2008, August 10, 2011, UN Doc. CEDAW/C/49/D/17/2008, para. 3.2.

286 Report of the Working Group on the issue of discrimination against women in law and practice, 8 April 2016, UN Doc. A/HRC/32/44, para. 14.

287 American Declaration on the Rights and Duties of Man, 1948, Article 7.

288 Universal Declaration of Human Rights, Article 25.

289 These restrictions can “violate the right to health by infringing human dignity by restricting the freedoms to which individuals are entitled under the right to health, particularly in respect of decision-making and bodily integrity. The application of such laws as a means to achieving certain public health outcomes is often ineffective and disproportionate.” See Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health, U.N. General Assembly, 66th Sess., 3 August 2011, UN Doc. A/66/254, para. 65 (n).

290 Report of the Working Group on the issue of discrimination against women in law and practice, 8 April 2016, UN Doc. A/HRC/32/44, para. 39.

transmission and drug use during pregnancy.²⁹¹ The Special Rapporteur has confirmed that where a barrier to individual healthcare decision-making and access to healthcare is “created by a criminal law or other legal restriction, it is the obligation of the State to remove it.”²⁹²

Rather than criminalizing pregnant women’s drug use, states can more effectively protect fetuses from harm through other available approaches that respect human rights and promote healthy pregnancies. Pregnancy criminalization laws such as Tennessee’s “fetal assault” law and Alabama’s “chemical endangerment” law are vague and overbroad, rendering women at risk of penalization as soon as they become pregnant. The vague language and inconsistent application of pregnancy criminalization laws create an atmosphere of uncertainty that deters women from trusting their healthcare providers and seeking healthcare.

In the end, taking a right-to-health-approach to states’ laws, policies and practices around pregnancy could ensure that the need for drug treatment is not a reason for bringing women into criminal justice systems. Criminal justice systems should never be relied on as a primary path for healthcare treatment and support.

6.1.2 DRUG TESTING WITHOUT INFORMED CONSENT AND COERCIVE TESTING PRACTICES

According to the World Health Organization (WHO) guidelines, drug treatment should not be compulsory and should only be undertaken with informed consent.²⁹³ Informed consent to medical treatment is an essential component of the right to health. The concept is grounded in the ethical principle of patient autonomy²⁹⁴ and human rights.²⁹⁵ Informed consent is the ability to make a voluntary and sufficiently informed decision, which protects the right of the patient to be involved in medical decision-making, and it assigns duties and obligations to health-care providers.²⁹⁶

Informed consent requires that information must be provided voluntarily, without coercion, undue influence or misrepresentation. It mandates disclosure of the benefits, risks and alternatives associated with any offered medical procedure or treatment.²⁹⁷ Special attention should be paid to marginalized groups to ensure that the requirements of informed consent are met.²⁹⁸ The UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“Special Rapporteur on Torture”) has highlighted that informed consent is a critical element of voluntary counselling, testing and treatment, particularly for marginalized groups.²⁹⁹

In the context of reproductive healthcare, the Inter-American Commission on Human Rights, the official body of independent experts elected by members of the Organization of American States to monitor human rights performance, has emphasized the need for states to ensure that women make decisions about their reproductive health free from discrimination, and that women give their informed consent for medical treatment.³⁰⁰ The CEDAW Committee has also stressed the right to full and informed consent of women in their reproductive life decisions.³⁰¹ Free and informed decision-making and consent requirements also apply to drug testing and treatment, as these obligations apply to all medical procedures.

291 Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health, U.N. General Assembly, 66th Sess., 3 August 2011, UN Doc. A/66/254.

292 Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health, U.N. General Assembly, 66th Sess., 3 August 2011, UN Doc. A/66/254, summary para.

293 World Health Organization, ‘Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence’, 2009, p. 9, 15.

294 T.L. Beauchamp, J.F. Childress, ‘Principles of Biomedical Ethics’, 5th ed. Oxford: Oxford University Press, 2001.

295 N.R. Madhava Menon, ‘Medical ethics and healthcare - issues and perspectives’, Karnataka Medical Journal 71:2-9, 2000.

296 Report of the Special Rapporteur on Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 August 2009, UN Doc. A/64/272 para. 9.

297 Report of the Special Rapporteur on Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 August 2009, UN Doc. A/64/272 at para. 15.

298 Report on the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, UN Doc A/HRC/22/53 2013, para. 38.

299 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, UN Doc. A/HRC/22/53, para. 38.

300 Inter-American Commission on Human Rights, ‘Access to information on reproductive health from a human rights perspective’, 2011, para 61.

301 Committee on the Elimination of Discrimination against Women, *AS v Hungary*, Communication No. 4/2004, 29 August 2006, UN Doc. CEDAW/C/36/D/4/2004, paras. 11.2-11.4; CEDAW General Recommendation No. 24: Women and Health (Article 12), 5 February 5 1999, para. 22: ‘Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women’s rights to informed consent and dignity’.

Alarming, not only did the majority of the women interviewed for this report not give informed consent for drug testing in the context of maternity care, but many did not even know they were being tested. This violates pregnant women's right to health as well as their right to privacy (see "Right to Privacy" for further discussion). The UN Special Rapporteur on Torture has noted that subjecting people to "treatment or testing without their consent may constitute a violation of the right to physical integrity."³⁰² The Special Rapporteur has made clear that "drug dependence should be treated like any other health-care condition,"³⁰³ thus requiring medical providers to abide by clear "informed consent" requirements around treatment and drug testing.

Beyond informed consent, human rights violations can occur in situations of compulsory testing. The UN Special Rapporteur on the Right to Health has confirmed that compulsory testing must not be used as a means to police private behavior and any limitations must be carefully justified by public health necessity and implemented with participation, transparency and accountability.³⁰⁴ For example, temporary measures can be justified in exceptional circumstances, such as to prevent pandemic influenza, but personal drug use does not meet this threshold.³⁰⁵

While states have a legitimate interest in promoting maternal health, efforts should be made to ensure that this aim actually underlies their laws, policies and practices around pregnancy and that they comply with human rights standards. As documented throughout this report, however, drug testing is a compulsory component of and effectively a condition to accessing prenatal healthcare for many women in the US. Additionally, those who had disclosed their drug use to a healthcare provider were more likely to be flagged for testing and those who had cases with CPS were often tested. These practices raise significant human rights concerns including potential violations of the right to health.

Amnesty International's research further confirmed that coerced testing is also a frequent occurrence for those in "drug court" or other similar diversion programs. Not only is drug testing generally required to avoid more severe sanctions, but the decision to enter treatment is also coerced, as it is a means to avoid incarceration or other punishment. While compulsory treatment may be touted by prosecutors and judges as a less severe "alternative" punishment compared to serving jail time, such sanctions cannot be imposed without considering the impact of compulsory testing on the rights to health and privacy. As noted by the UN Special Rapporteur on the Right to Health:

"Treating persons who use drugs as criminals is counterproductive from a right to health perspective. States should change legislation that supports criminalization based on non-consensual testing. Any routine drug or alcohol testing should be consensual to encourage appropriate conditions of counselling and treatment, and implemented in a non-discriminatory, transparent and inclusive way. Testing and treatment protocols should treat drug dependence like any other health-care condition."³⁰⁶

302 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 14 January 2009, UN Doc. A/HRC/10/44, para. 71.

303 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 14 January 2009, UN Doc. A/HRC/10/44, para. 72.

304 Report of the Special Rapporteur on Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 August 2009, A/64/272 para. 32.

305 Report of the Special Rapporteur on Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 August 2009, A/64/272 para. 32; See L.O. Gostin, 'Public Health Strategies for Pandemic Influenza: Ethics and the Law', *Journal of the American Medical Association*, vol. 295, issue 14, 2006, pp. 1700-1704.

306 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/64/272, August 10, 2009, para. 90.

IMPACT OF DRUG POLICIES ON HUMAN RIGHTS

The human rights dimensions of drug control policies are increasingly being considered by international human rights experts.³⁰⁷ In 2015, the Office of the High Commissioner for Human Rights (OHCHR) released its first ever study on the impact of the world drug problem on the enjoyment of human rights.³⁰⁸ The report raises concern about the criminalization of drug use during pregnancy, pointing out that in addition to criminal penalties, women may also face losing custody of their children without justification as to the necessity of such intervention in order to prevent harm to children or to demonstrate that doing so is in the best interest of the child, and detention during pregnancy³⁰⁹; all of which are penalties used in the United States.

The OHCHR has also released statements³¹⁰ highlighting the harms of criminalization on the human rights of people who use drugs, particularly noting the impact of criminalization on access to healthcare services:

“Criminalization of drug use is also a key impediment to the right to health. In States that criminalize drugs, users may avoid reaching out for health care or essential, sometimes lifesaving, information. They may legitimately fear that seeking help would end up resulting either in arrest or in treatment against their will.”³¹¹

The Special Rapporteur on the right to the highest attainable standard of health has underlined this point, explaining that police crackdowns and other interventions associated with criminalization drive marginalized populations away from areas where they receive health and harm reduction services including medication-assisted treatment.³¹²

The right to the highest attainable standard of health seeks to “ensure access to quality health facilities, goods and services without discrimination, including on the grounds of physical or mental disability, or health status.”³¹³ “As such, an individual’s use of drugs cannot constitute grounds for curtailing her/his rights, irrespective of whether she or he has a recognized dependence syndrome or whether the applicable drug control regime allows for imprisonment or other sanctions.”³¹⁴

Several other human rights mechanisms and UN agencies have recommended that states consider the decriminalization of certain drug-related conduct, in particular drug use and possession for personal consumption, as a means of protecting public health and human rights.³¹⁵ The WHO and UNAIDS have recommended decriminalizing drug use as a means of removing barriers to essential health services. “Without protective policies and efforts to decriminalize the behaviour of key populations, barrier to essential health services will remain.”³¹⁶

As the former UN High Commissioner for Human Rights has observed:

“Too often, drug users suffer discrimination, are forced to accept treatment, marginalized and often harmed by approaches which over-emphasize criminalization and punishment while under-emphasizing harm reduction and respect for human rights.”³¹⁷

6.2 RIGHT TO PRIVACY

To respect privacy and confidentiality, health facilities must be respectful of medical ethics, sensitive to gender and designed to improve the health status of those concerned. Article 17(1) of the ICCPR specifically

307 Nevanathem Pillay, United Nations High Commissioner for Human Rights, ‘High Commissioner calls for focus on human rights and harm reduction in international drug policy’, 10 March 2009,

www.ohchr.org/documents/Press/HC_human_rights_and_harm_reduction_drug_policy.pdf

Statement by Mr. Zeid Ra’ad Al Hussein, United Nations High Commissioner for Human Rights at the United Nations Work on the World Drug Problem, New York, 20 November 2015,

www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16791&LangID=E#sthash.gDhwrjeB.pCkgrbqV.dpuf

308 Office of the High Commissioner for Human Rights, ‘Study on the impact of the world drug problem on the enjoyment of human rights’, 4 September 2015, UN Doc. A/HRC/30/65.

309 Office of the High Commissioner for Human Rights, ‘Study on the impact of the world drug problem on the enjoyment of human rights’, 4 September 2015, UN Doc. A/HRC/30/65, para. 53.

310 Nevanathem Pillay, United Nations High Commissioner for Human Rights, ‘High Commissioner calls for focus on human rights and harm reduction in international drug policy’, 10 March 2009,

www.ohchr.org/documents/Press/HC_human_rights_and_harm_reduction_drug_policy.pdf

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www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16791&LangID=E#sthash.gDhwrjeB.pCkgrbqV.dpuf

311 Statement by Mr. Zeid Ra’ad Al Hussein, United Nations High Commissioner for Human Rights at the United Nations Work on the World Drug Problem, New York, 20 November 2015,

www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16791&LangID=E#sthash.gDhwrjeB.pCkgrbqV.dpuf

recognizes the right to privacy stating that: “No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence.”³¹⁸ The UN Committee on Economic, Social and Cultural Rights has also emphasized the need to respect privacy and confidentiality in healthcare settings as part of the right to health under the ICESCR,³¹⁹ as does the non-binding international expert declaration, the World Medical Association (WMA) Declaration on the Rights of the Patient.³²⁰

Limitations on individuals’ human rights, including interference with regard to the right to privacy, may only be permitted if it is necessary and proportionate to a legitimate aim.³²¹ While a state’s aim to promote maternal and newborn health is legitimate, punishing pregnant women for actual or suspected drug use is not a proportionate response or necessary to meet those aims. The right to found a family and to be free from unlawful interference in family life as protected by Article 23 of ICCPR is also at stake as criminal justice approaches can fracture families and separate children from their parents or caregivers without necessarily demonstrating that doing so is in the best interest of the child.

The Tennessee and Alabama laws reviewed in this report are neither proportionate nor necessary. There are other more effective means that states can undertake to support pregnant women, such as providing high quality, comprehensive sexual and reproductive healthcare services, drug dependence treatment, health education and social support. As such, it is not necessary, and is in fact counter-productive for the government to resort to punishing pregnant women. This type of punitive and disproportionate legal approach can lead to incarceration, family disruption and imposition of longstanding criminal records, which will severely impact women’s ability to earn a livelihood and maintain housing down the line – all of which can be counterproductive in terms of promoting health and reducing harm and drug use.³²²

Beyond the fact that criminal drug laws can implicate pregnant women’s right to privacy, specific measures used to enforce such laws and policies can further result in privacy rights violations in healthcare contexts. As referenced earlier, both conducting drug tests and sharing the results of those tests and/or one’s drug history with law enforcement without informed consent violates the right to privacy.

The right to confidentiality of medical records is firmly grounded in the right to privacy, as contained in Article 17 of the ICCPR. While this treaty does not specifically address confidentiality of medical records, the Human Rights Committee has confirmed in its General Comment 16 that “[e]ffective measures have to be taken by States to ensure that information concerning a person’s private life does not reach the hands of persons who are not authorized by law to receive, process and use it, and is never used for purposes incompatible with the Covenant.”³²³ While drug test results conducted in Tennessee and Alabama might be shared with law enforcement in accordance with law or policy, this type of interference with the right to privacy is disproportionate. In other words, human rights safeguards remain regardless of whether a state has passed a law which allows a positive drug test to be used as evidence of a crime. Using positive drug

312 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, U.N. Doc. A/65/255, para. 27.

313 Committee on Economic, Social and Cultural Rights, General Comment 14, UN Doc. E/C.12/2000/4, paras 18 and 19 in Report of the U.N. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255 para. 8.

314 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, U.N. Doc. A/65/255, para. 8.

315 Office of the High Commissioner on Human Rights, ‘Study on the impact of the world drug problem on the enjoyment of human rights’, 4 September 2015, UN Doc. A/HRC/30/65 at para. 28, 29, 30; UNAIDS, ‘The Gap Report’, 2014, Joint United Nations Programme on HIV/AIDS, Geneva, p. 183, www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport/

World Health Organization, ‘Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations’, Geneva, 2014, p. 91; UNDP, ‘Addressing the Development Dimensions of Drug Policy’, 2015, p. 34; UN Women, ‘A gender perspective on the impact of drug use, the drug trade and drug control regime’, July 2014, www.unodc.org/documents/ungass2016/Contributions/UN/Gender_and_Drugs_-_UN_Women_Policy_Brief.pdf

316 World Health Organization, ‘Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations’, 2016, p. 86.

317 Nevanathem Pillay, United Nations High Commissioner for Human Rights, ‘High Commissioner calls for focus on human rights and harm reduction in international drug policy’, 10 March 2009, www.ohchr.org/documents/Press/HC_human_rights_and_harm_reduction_drug_policy.pdf

318 International Covenant on Civil and Political Rights (ICCPR), Art. 17(1) (‘No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation’); Convention on the Rights of the Child, Art. 16(1), Convention on the Rights of Persons with Disabilities (CRPD), Art. 22.

319 ICESCR, Art. 12, CESCR General Comment 14, UN Doc. E/C.12/2000/4, para. 12.

320 World Medical Association, Declaration on the Rights of the Patient. Principle 7.

321 Human Rights Committee, *M.G. v Germany*, Communication No. 1482/2006, UN Doc. CCPR/C/93/D/1482/2006, 2 September 2008, para. 10.1; European Court of Human Rights, *S. and Marper v the United Kingdom*, Applications nos. 30562/04 and 30566/04, para. 101; European Court of Human Rights, *Szuluk v the United Kingdom*, Application no. 36936/05, para. 45; European Court of Human Rights, *Leander v Sweden*, Application no. 9248/81, para. 58.

322 See, for example, Human Rights Watch, *In Harm’s Way*, 2013, www.hrw.org/reports/2013/12/11/harms-way K. Malinowska-Sempruch and O. Rychkova, ‘The Impact of Drug Policy on Women’, Open Society Foundations, May 2015, www.opensocietyfoundations.org/reports/impact-drug-policy-women

323 UN Committee on Civil and Political Rights, General Comment 16. The right to respect of privacy, family, home and correspondence, and protection of honour and reputation (art. 17); CESCR General Comment 14 para 12(b).

tests, particularly compulsory drug tests taken without patients' informed consent, to potentially launch investigations which may result in incarceration and coerced treatment, constitute disproportionate interference with the right to privacy. Such limitations on the right to privacy can only be justified as temporary measures in exceptional circumstances and with participation, transparency, and accountability.³²⁴ Additionally, drug test disclosure cannot be discriminatory and/or result in discrimination.³²⁵

Beyond privacy rights-related concerns, mandatory reporting requirements can also impose a “dual loyalty” or “simultaneous obligation to a patient and a third party”³²⁶ (including law enforcement and/or social service providers) on healthcare providers. “Dual loyalty poses particular challenges for health professionals throughout the world as the subordination of the patient’s interests to state or other purposes risks violating the patient’s human rights.”³²⁷ While doctors owe “complete loyalty” to patients according to the World Medical Association’s International Code of Medical Ethics,³²⁸ in practice, additional obligations are imposed on medical providers by family members, employers, insurance companies and state governments, which often conflict with their loyalty to patients.³²⁹ In one noteworthy case, the US Supreme Court found that a South Carolina state hospital’s performance of drug tests to obtain evidence of a patient’s drug use for law enforcement purposes was unconstitutional.³³⁰ Healthcare professionals often lack clear guidance on how to evaluate situations where dual loyalty may violate a person’s human rights and how to implement appropriate responses that respect human rights.³³¹

6.2.1 CONFIDENTIALITY IN HEALTHCARE CONTEXTS

Privacy and specifically medical confidentiality are key components of the right to health. The UN CESCR Committee has confirmed that: “All health facilities, goods and services must be... designed to respect confidentiality.”³³² However, in 18 states in the USA, healthcare providers are required to report to child welfare authorities when they suspect a pregnant woman is dependent on drugs.³³³ This approach directly implicates patients’ right to medical confidentiality, as well as impacts the medical provider-patient relationship – both of which can have adverse consequences on pregnant women’s right to health and maternal and fetal health more broadly.

The UN CEDAW Committee has confirmed that: “While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and wellbeing.”³³⁴ This is particularly true for marginalized and under-served groups who already face barriers to accessing and adhering to necessary services and treatment. The UN Working Group on Discrimination against Women has stressed the importance of the rights to informed consent and confidentiality to ensuring that women can make decisions freely and autonomously as competent individuals.³³⁵

Similarly, the UN Special Rapporteur on the Right to Health found that “a lack of confidentiality may deter individuals from seeking advice and treatment, thereby jeopardizing their health and well-being. Thus States are obliged to take effective measures to ensure medical confidentiality and privacy.”³³⁶

324 Report of the Special Rapporteur on Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 August 2009, A/64/272 para. 32; see L. O. Gostin, ‘Public Health Strategies for Pandemic Influenza: Ethics and the Law’, *Journal of the American Medical Association*, vol. 295, issue 14 (2006), pp. 1700-1704.

325 See generally, Physicians for Human Rights, ‘Dual Loyalty and Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms’, 2002, https://s3.amazonaws.com/PHR_Reports/dualloyalties-2002-report.pdf

326 International Dual Loyalty Working Group, ‘Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms’, p. 11, 1993; see also, Open Society Foundations, *Advancing Human Rights in Patient Care: The Law in Seven Transitional Countries*, 2013, www.opensocietyfoundations.org/sites/default/files/Advancing-Human-Rights-in-Patient-Care-20130516.pdf

327 International Dual Loyalty Working Group, ‘Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms’, 2002, p. 11.

328 World Medical Association, *International Code of Medical Ethics*, www.wma.net/en/30publications/10policies/c8/

329 International Dual Loyalty Working Group, ‘Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms’, 2002, p. 12.

330 United States Supreme Court, *Crystal M. Ferguson et al. v The City of Charleston, South Carolina et al.*, (2001) No. 99-936.

331 International Dual Loyalty Working Group, ‘Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms’, 2002, p. 20.

332 CESCR, General Comment 14, para 12 (c).

333 Guttmacher Institute, *Substance Abuse During Pregnancy*.

334 CEDAW Committee, General Recommendation 24, para 12 (d).

335 Report of the Working Group on the issue of discrimination against women in law and practice. 8 April 2016. UN Doc. A/HRC/32/44, para. 86.

336 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 16 February 2004, U.N. Doc. E/CN.4/2004/49 at para 40.

The Inter-American Commission on Human Rights has also emphasized this point. Because issues related to sexuality and reproduction can be extremely sensitive, the fear that confidentiality will not be respected can deter women from seeking needed medical care.³³⁷ If an environment is safe and trusting, then a patient will more likely provide the medical professional with the information needed for effective diagnosis and treatment.³³⁸ The Commission has considered that physicians have “a right and an obligation to protect the confidentiality of the information” which they have access.³³⁹

6.3 RIGHT TO A FAIR TRIAL

Concerns regarding the right to a fair trial also emerged in Amnesty International’s research for this report. Many of the women, law enforcement and social service providers interviewed discussed the impact of drug courts on the rights, lives and health outcomes of women punished under Tennessee’s and Alabama’s pregnancy criminalization laws. Drug courts raise a range of human rights issues, including with regard to the right to a fair trial and to health.

The right to a fair trial is one of the universally applicable guarantees recognized in the Universal Declaration of Human Rights. This right has since become legally binding on all states as part of customary international law.³⁴⁰ The right to a fair trial has been reaffirmed and elaborated in legally binding treaties such as ICCPR.³⁴¹ It has been recognized and component parts (constituent rights) have been set out in numerous other international and regional treaties³⁴² as well as non-treaty standards adopted by the UN and by regional intergovernmental bodies.³⁴³ These human rights standards apply to investigations, arrests and detention as well as throughout the pre-trial proceedings, trial, appeal, sentencing and punishment.

Despite some amount of international support for drug courts, there is some research which identifies human rights concerns regarding these courts.³⁴⁴ For example, some research indicates that drug courts may afford fewer fair trial protections than ordinary courts.³⁴⁵ Special or specialized courts are also required to be competent, independent and impartial.³⁴⁶ Along these lines, fair trial guarantees enshrined in international law and standards apply equally to criminal proceedings in all courts, including drug courts.³⁴⁷

Analysis of the fairness of proceedings in a special or extraordinary court generally focuses on whether: the court is established by law; the jurisdiction of the court guarantees non-discrimination and equality; the judges are independent of the executive and other authorities; the judges are competent and impartial; and the procedures conform to international fair trial standards, including the right to appeal.³⁴⁸

A primary human rights concern around drug courts in the USA is the common requirement that an individual plead “guilty” to charges against them as a condition of the drug court diversion process and drug treatment. This is compounded by the fact that relapse is common for those dealing with drug dependency,

337 Inter-American Commission on Human Rights, ‘Access to information on reproductive health from a human rights perspective’, 2011, at para. 81.

338 Inter-American Commission on Human Rights, ‘Access to information on reproductive health from a human rights perspective’, 2011, at para. 81.

339 Inter-American Commission on Human Rights, ‘Access to information on reproductive health from a human rights perspective’, 2011, at para. 78, citing Inter-American Court of Human Rights, *De La Cruz-Flores v Peru Case*, Judgment of 18 November 2004.

340 HRC General Comment 32, para. 19, General Comment 29, para.16; UN General Assembly resolution 67/166, preamble para. 11 and 65/213, preamble para. 9; *Civil Liberties Organisation, Legal Defence Centre, Legal Defence and Assistance Project v Nigeria* (218/98), African Commission (2001) §27; *González del Río v Peru*, HRC, UN Doc. CCPR/C/46/D/263/1987 (1992) §5.1; *Reverón Trujillo v Venezuela*, Inter-American Court (2009) §68; See, Inter-American Court Advisory Opinions: OC-8/87 (1987) §§29-30, OC-9/87 (1987) §20; ICRC Study on Customary International Law, Volume 1, Rule 100, pp. 352-356.

341 See generally ICCPR, Art. 14 (fair trial) and Article 15 (no retroactive penal laws).

342 See generally American Convention on Human Rights, Art. 8 (fair trial) and Art. 9 (freedom from ex-post facto laws). According to Article 27 ACHR, judicial guarantees have been given non-derogable status, which means that certain aspects of the right to a fair trial are non-derogable.

343 Inter-American Commission on Human Rights (IACHR), American Declaration of the Rights and Duties of Man, 2 May 1948, Article XVIII.

344 Drug Policy Alliance, “Drug Courts Are Not the Answer: Toward a Health-Centered Approach, 2011, www.drugpolicy.org/docUploads/Drug_Courts_Are_Not_the_Answer_Final2.pdf; J. Csete and D. Tomasini-Joshi, ‘Drug Courts: Equivocal Evidence on a Popular Intervention’, Open Society Foundations, www.opensocietyfoundations.org/reports/drug-courts-equivocal-evidence-popular-intervention

345 See Report of the UN Working Group on Arbitrary Detention after their visit to Canada, 5 December 2005, UN Doc E/CN.4/2006/7/Add.2 para. 57.

346 ICCPR Article 14.

347 Human Rights Committee, General Comment 32 (Article 14: Right to equality before courts and tribunals and to a fair trial), 23 August 2007, UN Doc. CCPR/C/GC/32, para. 22; Universal Declaration of Human Rights Article 10; ICCPR Article 14.

348 See Inter-American Commission on Human Rights, ‘Report on Terrorism and Human Rights’, 22 October 2002, OEA/Ser.L/V/II.116 Doc. 5 rev.1 corr., Section D, para. 230.

as recognized by the Special Rapporteur on the right to health and other UN health guidelines.³⁴⁹ Relapsing, and thus violating the terms of drug court can then lead to people being returned to adversarial courts only to receive harsher sentences than if they had never been in the drug court. These outcomes implicate the right to not be compelled to incriminate oneself or to confess guilt and raises concerns about the presumption of innocence which is a fair trial guarantee that prohibits any form of coercion, whether direct or indirect, physical or psychological. It also prohibits the imposition of judicial sanctions to compel the accused to testify.³⁵⁰

The right to a fair trial also extends to how punishments are determined and what punishments may be imposed. Neither the punishment itself nor the manner in which it is imposed may violate international law and standards. Additionally, decisions on sentencing should be gender-sensitive, taking into account for example, a woman's pregnancy or care responsibilities.³⁵¹ Finally, groups with special needs, including women and people who use drugs, should have prompt access to legal aid and the tools necessary to claim their rights.³⁵²

A primary condition of drug courts is strict adherence to drug treatment. In some cases, such treatment requires complete abstinence from drug use. But, as referenced earlier, lapses in treatment compliance are a predictable feature of recovery from drug dependence, just as they are with other chronic conditions.³⁵³

In drug courts, the traditional role of the judge is altered, as the judge makes both treatment and punishment decisions. Judges, rather than trained healthcare providers, decide what type of treatment is mandated, for how long and whether medication-assisted treatment is acceptable.³⁵⁴ When individuals relapse or otherwise fail to abstain from drugs, drug court judges are often required to impose punishment, regardless of other indicators of wellbeing. While drug courts have proliferated in the USA and been applauded as providing an alternative to prison,³⁵⁵ they also have the effect of undermining a range of human rights, in particular those related to the right to a fair trial and in the end may entangle a wider-range of people in criminal justice systems.

349 Report of the U.N. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255, para. 7; National Institute on Drug Abuse, 'The Science of Drug Abuse and Addiction: The Basics', www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics; UN Office on Drugs and Crime and World Health Organization, Principles of Drug Dependence Treatment (Discussion paper), Vienna, 2008, www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf p.10

350 See M. Nowak, U.N. Covenant on Civil and Political Rights: CCPR Commentary, 2nd revised edition, Engel, 2005, p. 345, para. 75.

351 United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), UN General Assembly Resolution 65/229, 16 March 2011, UN Doc. A/RES/65/229, Rules 57, 58, 61 and 64; Special Rapporteur on the independence of judges and lawyers, 10 August 2011, UN Doc. A/66/289, para. 102; Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 10 March 2008, UN Doc. A/HRC/7/3, para. 41.

352 Report of the Special Rapporteur on the independence of judges and lawyers, 15 March 2013, UN Doc. A/HRC/23/43, para. 82.

353 Report of the U.N. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255 at para. 7; see Official Records of the Economic and Social Council, 2010, Supplement No. 8, UN Doc. E/2010/28, p. 47; National Institute on Drug Abuse, 'The Science of Drug Abuse and Addiction: The Basics', www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics

354 R. Boldt, 'A Circumspect Look at Problem-Solving Courts', in Problem-Solving Courts: Justice for the Twenty-First Century?, eds. P. Higgins and M. MacKinem, Santa Barbara: ABC-CLIO, 2009.

355 See: National Institute of Justice, Community Corrections, www.nij.gov/topics/corrections/community/pages/welcome.aspx

HUMAN RIGHTS PRINCIPLES LIMITING THE USE OF CRIMINAL LAW

Although states generally have latitude to determine what type of conduct is sufficiently harmful to others and the community at-large to merit criminal sanction, this policing power is not unlimited.³⁵⁶ Various human rights principles can be applied to limit the use of criminal sanctions to prevent and punish certain conduct. An overarching limit is the principle of *ultima ratio* – criminal law as a last resort.³⁵⁷ This is based on the understanding that criminal sanctions are one of the most severe forms of state intrusion on civil liberties and thus must be used with great caution and in limited circumstances. Some fundamental principles of human rights law, which limit the unrestricted use of criminal law include:

Legality: Crimes and punishments must be defined by law in a manner that is accessible to the population.³⁵⁸ People must be able to foresee what conduct is criminalized and the scope of possible penalties.³⁵⁹ Accordingly, retrospective application of criminal law is prohibited when it is used to an accused's disadvantage, both in terms of the criminalized conduct itself and the severity of punishment imposed.³⁶⁰

Legitimate Aim or Purpose: Restrictions on human rights (including through criminal law) must be for a legitimate purpose or aim.³⁶¹ The list of what may constitute a legitimate aim is not open-ended and is restricted only to specific grounds such as: protection of national security, public order, public health or morals or the rights and freedoms of others. In order to be lawful any restrictions on human rights, in addition to serving a legitimate aim or purpose, would also need to meet the principle of necessity and proportionality. Invoking morality alone as a reason to criminalize particular conduct will never be enough.³⁶²

Necessity: Restriction of individual's human rights can only be justified when other, less restrictive responses would be inadequate and unable to achieve the legitimate aim or purpose.³⁶³

Proportionality: State policies must be proportionate and suitable to pursue the legitimate aim.³⁶⁴ Deprivation of someone's liberty which results from the application of criminal law may not always meet the requirement of proportionality, especially if other less harsh measures could be similarly effective.

Non-discrimination: Criminal laws and policies must be applied equally to all people and must not have a discriminatory impact on particular groups of people.³⁶⁵

6.4 THE RIGHT TO EQUALITY AND NON-DISCRIMINATION

356 See generally UN Commission on Human Rights, 41st Sess., 28 September 1984, Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4, annex. [hereinafter Siracusa Principles] The Siracusa Principles lay out the extent to which states can limit and/or derogate from individual human rights to promote the 'public good.' They were initially adopted in relation to the International Covenant on Civil and Political Rights (ICCPR), but over time have been applied to analyze state restrictions on rights more broadly. See S. Abiola, 'The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant for Civil and Political Rights (ICCPR): History and Interpretation in Public Health Context' (Research Memorandum Prepared for the Open Society Institute's Public Health Program Law and Health Initiative) (2011); see also UN Commission on Human Rights, 43rd Sess., 8 January 1987, Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/CN.4/1987/17, annex [hereinafter Limburg Principles] (providing interpretive guidance regarding states' compliance with the International Covenant on Economic, Social and Cultural Rights); Masstricht Guidelines on Violations of Economic, Social and Cultural Rights (expert guidelines), 29 February 2012, (elaborating on the Limburg Principles regarding the nature and scope of violations of economic, social and cultural rights and appropriate responses and remedies). For additional expert and scholarly analysis of limits on states' policing power, see N. Jareborg 'Criminalization as Last Resort (Ultima Ratio)' (2005) 2 Ohio State Journal of Criminal Law 521; D. Husak 'The Criminal Law as a Last Resort' (2004) 24 Oxford Journal of Legal Studies 207.

357 See generally N. Jareborg, Criminalization as Last Resort (Ultima Ratio), 2 Ohio State Journal of Criminal Law 521 (2005); D. Husak, The Criminal Law as Last Resort, 24 OJLS 207 (2004).

358 See S. Lamb, 'Nullum Crimen, Nulla Poena Sine Lege in International Criminal Law', in A. Cassese & P. Gaeta, et al. (eds.), The Rome Statute of the International Criminal Court (2002) 19; Rome Statute of the International Criminal Court, opened for signature 17 July 1998, 2187 U.N.T.S. 90 (entered into force 1 July 2002) Art 22(1); Universal Declaration of Human Rights, adopted 10 December 1948, G.A. Res. 217A (III), UN Doc A/810, Art 11; European Convention for the Protection of Human Rights and Fundamental Freedoms, signed 4 November 1950, 213 U.N.T.S. 222 (entered into force 3 September 1953) Art 7; American Convention on Human Rights, 22 November 1969, O.A.S.T.S. No. 6, O.A.S. Off. Rec. OEA/Serv.L/V/II.23, doc. 21, rev. 6 (entered into force July 18 1978) Art 9; African Charter on Human and Peoples' Rights, adopted 27 June 1981, O.A.U. Doc CAB/LEG/67/3, rev.5, 21 I.L.M 58 (1982) (entered into force 21 October 1986) Art 7; League of Arab States, Arab Charter on Human Rights, May 22, 2004, reprinted in 12 International Human Rights Rep. 893 (2005) (entered into force March 15, 2008) Art 15.

Criminalizing pregnant women's drug use not only violates the right to health and implicates a range of other human rights, it is also discriminatory and can create a permissive environment for stigma and discrimination, in violation of the right to equality and the principle of non-discrimination,³⁶⁶ a principle of international human rights law contained in all human rights treaties.³⁶⁷

The principle of non-discrimination is essential to the realization of all human rights. Each of the core international human rights treaties reiterate this general principle, including the Universal Declaration of Human Rights.³⁶⁸ Every person is entitled to the full range of human rights without distinction of any kind, such as on the basis of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.³⁶⁹

Under international law, states have an obligation to refrain from having laws that are discriminatory and whose impact could be discriminatory with regard to certain groups or categories of individuals, even when there is no discriminatory intention. The impact of laws criminalizing pregnant women's drug use in the USA violates women's right to equality and the principle of non-discrimination. Tennessee's "fetal assault" law was directly discriminatory in specifically singling out pregnant women for their drug use. Alabama's "chemical endangerment" law appears gender-neutral, but is interpreted in a biased manner that indirectly discriminates against women due to their capacity to become pregnant. In both cases, these laws tend to be disproportionately enforced against low-income women and women of color people who are often already facing multiple levels of discrimination and who may already be involved in state regulatory systems including criminal justice and child welfare systems that use surveillance and stereotyping.

6.4.1 DIRECT DISCRIMINATION

Laws that criminalize women's actions during pregnancy are directly discriminatory in that they only apply to women who become pregnant. As women and girls have the capacity to become pregnant, these laws amount to prohibited discrimination on the basis of sex. International human rights law recognizes that women should not be discriminated against or subject to unique criminal penalties because of their

359 *Del Rio Prada v Spain*, European Court of Human Rights, Grand Chamber Judgment, 21 October 2013, para 91; *Kafkaris v Cyprus*, European Court of Human Rights, Grand Chamber Judgment, 12 February 2008, para. 150.

360 *Del Rio Prada v Spain*, European Court of Human Rights, Grand Chamber Judgment, 21 October 2013, para. 116.

361 See International Covenant on Civil and Political Rights, adopted 16 December 1966, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, UN Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) Arts 19, 21 and 22; International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, UN Doc. A/6316 (1966), 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) Art 4; Council of Europe, European Social Charter (revised) signed May 3, 1996, E.T.S. No 163 (entered into force 1 July 1999) Art 31.1; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), adopted 17 November 1988, O.A.S.T.S. No 69, O.A.S. Off. Rec. OEA/Ser.L.V/II.82doc.6 rev.1 (1992) (entered into force 16 November 1999) Art 5.

362 Human rights law recognizes that states have a legitimate interest in promoting public security, safety or order, public health, morals, or the protection of the rights and freedoms of others. Siracusa Principles, at paras 27-28. The Siracusa Principles affirm, however, that states' 'margin of discretion,' as it relates to morality, does not apply to the rule of non-discrimination as defined under the ICCPR. See also, Human Rights Committee, *Toonen v Australia*, UN Doc. CCPR/C/50/D/488/1992, para. 8.6, 1994 (rejecting Tasmania's argument that 'moral issues' were 'exclusively a matter of domestic concern, as this would open the door to withdrawing from the [Human Rights] Committee's scrutiny a potentially large number of statutes interfering with privacy'); *Naz Foundation (India) Trust v Government of NCT of Delhi and Others*, Writ Petition (Civil) No. 7455/2001, Delhi High Court (2 July 2009), at para. 91; *National Coalition for Gay and Lesbian Equality v Minister of Justice*, Constitutional Court of South Africa, CC 11/98, 9 October 1998, paras 79, 86; *Lawrence v Texas*, 539 US 558, 582 (2003) (J. O'Connor, Concurrence); *Ang Ladlad LGBT Party v Commission on Elections*, Republic of the Philippines Supreme Court, 8 April 2010, 13.

363 Both the Siracusa Principles and the Limburg principles require that a state's limitation or restriction on human rights be proportionate and no more restrictive than necessary. Read in conjunction with the principle of ultima ratio, states should thus only resort to criminal law if no other less punitive measures suffice. See Siracusa Principles, at paras 10-14; Limburg Principles, at paras 60-61.

364 See Siracusa Principles, at paras. 10(d) and 51; UN Human Rights Committee, General Comment 31, UN Doc. CCPR/C/21/Rev.1/Add.13, 2004, para. 6; UN Committee on Economic, Social and Cultural Rights, General Comment 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, UN Doc. E/C.12/GC/20, para. 13.

365 See Siracusa Principles, at paras. 9, 28; Limburg Principles, at paras 35-41, 49.

366 ICCPR, Articles 2 and 26; and American Convention, Articles 1 and 24; International Covenant on Economic, Social and Cultural Rights Article 2, para 2; CESCR General Comment 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, UN Doc E/C.12/GC/20; CEDAW, article 2(f).

367 See Charter of the United Nations, Articles 1(3) and 55; Universal Declaration of Human Rights, Article 2.

368 See Universal Declaration of Human Rights, Article 2; ICCPR, Articles 2 and 26; ICESCR, Article 2; CERD, Article 5; CEDAW, Article 2; CRC, Article 2; Convention on the Rights of Persons with Disabilities (CRPD), Article 4, between them comprehensively prohibit discrimination on all grounds, including age, race, caste, ethnicity, disability, sexual orientation, gender identity, and marital status. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires governments to address specifically discrimination against women and guarantee substantive gender equality in all areas.

369 Universal Declaration of Human Rights, Article 2.

reproductive capabilities.³⁷⁰ The CEDAW Committee has specifically stated that criminal codes “criminalizing behaviors that can only be performed by women” thereby discriminate against women.³⁷¹

The Tennessee “fetal assault” law is directly discriminatory in that it defines a form of “assault” that may only be performed by a “woman... while pregnant.”³⁷² Civil commitment laws that allow states to involuntarily place pregnant women in protective custody are also directly discriminatory in that they specifically address pregnant women.³⁷³ Child welfare statutes defining parental drug use as child abuse are applied to men after the birth of a child, but applied to women from the moment they become pregnant in some states.³⁷⁴

However, there is no legitimate or compelling reason to enshrine this sex-based distinction in law. While Tennessee legislators passed the “fetal assault” law as a means to dissuade acts perceived to cause “harm,” as referenced earlier, criminal laws must be necessary, proportionate, reasonable, and non-discriminatory.

States have an obligation to promote maternal, child and reproductive health.³⁷⁵ However, pregnancy criminalization laws defeat this purpose. Such laws are an ineffective and inappropriate means to achieve this aim. Instead of promoting health, criminalization results in a range of human rights violations including deterring prenatal care and increasing stigmatization among an already marginalized group. Criminalization is a disproportionate response to a health issue where non-punitive approaches would better achieve the aim. Criminalization does not promote prenatal healthcare, it even deters women from seeking care and erodes trust in healthcare providers.

6.4.2 INDIRECT DISCRIMINATION

Laws that are directly discriminatory are somewhat transparent given that the intent of the law is relatively clear. However, criminalization of pregnant women for drug use is often also manifest through unintended application of criminal law in a discriminatory manner. For example, while women and men can be charged with “chemical endangerment” under Alabama law, pregnant women are uniquely and disproportionately targeted for punishment under the law for drug use during pregnancy.³⁷⁶ The law also impacts certain groups of pregnant women more than others.³⁷⁷ Indirect discrimination can also “exacerbate existing inequalities owing to a failure to recognize structural patterns of discrimination and unequal power relationships between women and men.”³⁷⁸

In the context of the right to health, the CESCR Committee has said that the CESCR “proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status”.³⁷⁹ Women from marginalized groups, and particularly women with low incomes as they are more closely scrutinized and targeted by the State, are disproportionately affected by “pregnancy criminalization” laws.

The UN Human Rights Committee has also noted that the ICCPR’s prohibition of discrimination should be understood to encompass both discriminatory purposes and effects.³⁸⁰ Furthermore, the Inter-American Court of Human Rights has considered that a violation of the right to equality and non-discrimination also

370 See CEDAW Committee, General Recommendation 24 (article 12: women and health), para 6, U.N. Doc. HRI/GEN/1/Rev.6 (1999) (stating that equality requires that biological differences between men and women be taken into account); also at para 14 (criticizing laws that “criminalize medical procedures only needed by women and that punish women for undergoing those procedures.”); See Amnesty International, *The State as a Catalyst for Violence Against Women: Violence against women and torture or other ill-treatment in the context of sexual and reproductive health in Latin America and the Caribbean* (Index: AMR 01/3388/2016), pp. 58-59.

371 CEDAW General Recommendation 33, para. 48.

372 Tennessee Code Annotated 39-13-107. Fetus as victim, <https://apps.tn.gov/carat/pdf/tncchild-39-13-107.pdf>

373 See National Institute on Alcohol Abuse and Alcoholism, Alcohol Policy Information System, “Pregnancy and Alcohol: Civil Commitment”,

www.alcoholpolicy.niaaa.nih.gov/Alcohol_and_Pregnancy_Civil_Commitment.html?tab=specificDate&date=1%2f1%2f2015&dateStart=1%2f1%2f2015&dateEnd=1%2f1%2f2015&onlyChanges=False

374 US Government Child Welfare Information Gateway: Parental Drug Use as Child Abuse,

www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.pdf

375 See for example, Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, E/C.12/2000/4, para. 14.

376 According to a study of about 3,100 cases conducted by ProPublica and AL.com, more women have been charged than men even when looking beyond pregnancy prosecutions to include cases involving children, Pro Publica, ‘How We Identified Alabama Pregnancy Prosecutions’, www.propublica.org/article/how-we-identified-alabama-pregnancy-prosecutions

377 See CEDAW, General Recommendation No. 28 on the Core Obligations of States Parties under Article 2, 19 October 2010, U.N. Doc. CEDAW/C/2010/47/GC.2, 2010, para 5.

378 CEDAW, General Recommendation 28, para. 16.

379 CESCR, General Comment 14, para. 18; CESCR, General Comment 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, UN Doc. E/C.12/GC/20.

380 CCPR General Comment No.18: Non-discrimination, 10 November, 1989, HRI/GEN/1/Rev.6 at p. 146, para 7.

occurs in situations and cases of indirect discrimination reflected in the disproportionate impact of norms, actions, policies or other measures that, even when their formulation is or appears to be neutral, or their scope is general and undifferentiated, have negative effects on certain vulnerable groups.³⁸¹ Similarly, the CEDAW Committee recognizes the obligation to ensure that there is no direct or indirect discrimination against women in law, or in the public or private spheres.³⁸²

The right to equality and non-discrimination requires states to do more than refrain from discriminatory acts: where necessary, states must also devote “greater resources to traditionally neglected groups” and put in place measures that allow marginalized groups to access their rights and entitlements equally.³⁸³ This right also requires states to invest in addressing discriminatory attitudes, stereotypes and behaviors amongst populations as a way to address systemic discrimination.

Individuals are often subject to multiple and intersecting forms of discrimination, that is, discrimination based on multiple prohibited grounds which combine to produce distinct disadvantages, such as discrimination based on gender and health status. States must be aware of the impact of multiple and intersecting discrimination on individuals and take particular steps to eliminate it.

In its 2014 concluding observations to the USA, the CERD Committee reiterated its concern regarding the “persistence of racial disparities in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among African American Communities.”³⁸⁴ The Committee recommended that all states to effectively identify and address the causes of these disparities. Because laws that criminalize women’s actions during pregnancy discourage women from seeking prenatal care, these laws presumably contribute to these disparities.

6.4.3 EQUAL PROTECTION UNDER LAW

States are required to ensure people are treated equally under the law. Article 26 of the ICCPR states: “All persons are equal before the law and are entitled without discrimination to the equal protection of the law.”³⁸⁵ States are thus required to ensure the equal rights of all people within its jurisdiction. Under the ICERD, the USA must not only refrain from actions that may have discriminatory purpose or effect, but must also guarantee the right “to equality before the law, notably in the enjoyment of... the right to public health, [and] medical care.”³⁸⁶

Laws that specifically assign criminal liability based on one’s pregnancy status conflict with the concept of equal protection. Beyond this, criminalizing women for certain conduct during pregnancy has been shown to have a disproportionate impact on women who are already marginalized due to multiple, intersecting factors including poverty, ethnic or racial discrimination, drug dependence and a lack of access to healthcare. The effect of these laws is to leave pregnant women at heightened risks of prosecution for their actions, establishing a form of criminal liability that only applies to pregnant women.

Pregnant women have received criminal charges for actions that would not be a crime but for pregnancy status, including attempting suicide, falling down stairs and refusing medical treatment.³⁸⁷ Similarly, child welfare statutes defining parental drug use as child abuse are applied to both women and men after the birth of a child, but only applied to women for exposure during pregnancy in some states.³⁸⁸

381 See *Nadege Dorzema and others v Dominican Republic*, Inter-American Court of Human Rights, 24 October 2012, OEA/Ser.LV/II.130 Doc. 22, rev. 1, para. 235.

382 CEDAW General Recommendation No. 25, on article 4, para. 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures.

383 CESCR, General Comment 20, Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, UN Doc. E/C.12/GC/20, para 39.

384 International Convention on the Elimination of All Forms of Racial Discrimination, Concluding observations on the combined seventh to ninth periodic reports to the United States of America, 25 September 2014, UN Doc. CERD/C/USA/CO/7-9 at para. 15; for more on preventable maternal death and racial discrimination see: *Alyne da Silva Pimentel v Brazil*, Committee on the Elimination of Discrimination against Women, Communication No. 17/2008, 10 August 2011, CEDAW/C/49/D/17/2008.

385 International Covenant on Civil and Political Rights, Art. 26.

386 International Convention on the Elimination of All Forms of Racial Discrimination Article 5(e)(iv).

387 M. Goodwin, ‘Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield’, *California Law Review*, Vol 102: Number 4, August 2014.

388 US Government Child Welfare Information Gateway: Parental Drug Use as Child Abuse, www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.pdf

6.4.4 IMPACT OF STIGMA AND DISCRIMINATION ON HEALTH

Stigma and discrimination faced by people who use drugs, usually considered to be ill or criminal, has segregated and further marginalized these individuals from broader society. Pregnant women who use drugs face particular stigma and discrimination, which in turn can increase their health risks.³⁸⁹ Specifically, the targeting and surveillance of marginalized groups can lead these individuals to internalize their social suffering and to self-stigmatization.³⁹⁰

Women seeking sexual and reproductive healthcare services face discrimination based on stereotypes about their roles as child-bearers and social expectations defining how they should perform this role.³⁹¹ For pregnant women who are drug dependent, these expectations about motherhood intersect with stigma around drug use. Short of any evidence, one's status as a person who uses drugs can be used as a stand-alone basis to deny parental rights,³⁹² both reflecting and promoting discrimination.

Healthcare providers are generally in a position of authority over patients and thus patients find themselves in a position of relative powerlessness that renders them susceptible to judgment and inability to communicate freely. Pregnant women facing drug dependence occupy a vulnerable position due to these intersecting stigmas and stereotypes around women's roles and drug use.

Women who have historically been marginalized are the least likely to have the maternal health services they require. Addressing obligations to respect and guarantee human rights without discrimination may help overcome inequalities in access to maternal health services.³⁹³

Criminalization further amplifies intersecting forms of discrimination and makes it harder for women who are drug dependent to improve their lives.³⁹⁴

A public health expert explained:

“If they're active in addiction they have lost a lot. They may not have a job, and have limited resources. Add the fact that they just had a baby, and little means to take care of a baby and themselves. Now you throw them into the court system, there are going to be court costs. There's a woman now who got probation. She owes over \$5000 in court costs. You're pushing them even further down in their struggles. If she doesn't pay she's worried she's going to get arrested again.”³⁹⁵

Pregnant women who use drugs are frequently enmeshed in systems of discrimination and punishment that are difficult to escape. Once a woman is inside the criminal justice or child welfare system, she is subjected to increased policing of her actions, which increase the chances of additional punishment.

6.4.5 THE OBLIGATION TO COMBAT STEREOTYPES BASED ON SEX AND GENDER

Laws criminalizing women for their drug use during pregnancy are rooted in discriminatory and harmful sex and gender stereotypes about women, their bodies and their roles as mothers and caretakers. Gender stereotypes intersect with racial stereotypes to question and ultimately denigrate women's reproductive decision-making. For example, stereotypes perpetuate the devaluation of black women as mothers, they perpetuate stigma against low-income white women who transgress social norms and call into question Asian-American women's reproductive decision-making.³⁹⁶ These stereotypes have a direct impact on

389 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, U.N. Doc. A/65/255, para. 24.

390 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, U.N. Doc. A/65/255, para. 24.

391 Report of the Working Group on the issue of discrimination against women in law and practice, 8 April 2016, UN Doc. A/HRC/32/44, paras 42-60 and 96.

392 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, U.N. Doc A/HRC/22/53.

393 Inter-American Commission on Human Rights, “Access to Maternal Health Services from a Human Rights Perspective”, 2010.

394 Report of the Working Group on the issue of discrimination against women in law and practice, 8 April 2016, UN Doc. A/HRC/32/44, paras 29, 78.

395 Phone Interview, Public health expert, Knoxville, Tennessee, 4 March 2016.

396 National Asian Pacific American Women's Forum (NAPAWF), National Asian Pacific American Women's Forum Celebrates Release of Purvi Patel, Press Release 1 September 2016 (“In the anti-choice movement, Asian women are seen as having a predilection for abortion. At the hospital, police demanded to know over and over whether ‘the father’ was Indian, and there was an anti-Asian sex-selective abortion ban being debated in Indiana at the time of Purvi's sentencing.”), napawf.org/programs/reproductive-justice-2/supporting-purvi-patel/
G. Howard, ‘The Limits of Pure White: Raced Reproduction in the ‘Methamphetamine’ Crisis’, *Women's Rights Law Reporter*, 35, 2013; D. Roberts, ‘Unshackling Black Motherhood’, *Michigan Law Review*, 95, 1996-1997.

women's rights to bodily autonomy and their right to make free choices about their sexuality and reproduction. Those who are perceived as stepping outside of society's conception of the ideal caregiver and mother are specifically scrutinized, stigmatized and punished.³⁹⁷

The Human Rights Committee has also reaffirmed the notion that: "Inequality in the enjoyment of rights by women throughout the world is deeply embedded in tradition, history and culture, including religious attitudes."³⁹⁸ To that end, this Committee has called on state parties to "ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's... equal enjoyment of all Covenant rights."³⁹⁹

The CEDAW Committee has reaffirmed through its analysis of intersectional discrimination in General Recommendation 28 that:

"The discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste and sexual orientation and gender identity. Discrimination on the basis of sex or gender may affect women belonging to such groups to a different degree or in different ways to men. States parties must legally recognize such intersecting forms of discrimination and their compounded negative impact on the women concerned and prohibit them."⁴⁰⁰

Criminal laws which are used to surveil and punish pregnant women serve as a state-endorsed expression of stigma as they are driven by bias against women who are already marginalized due to structural factors. These laws also drive ongoing stigmatization, discrimination and stereotyping by confirming the perception that women who take actions perceived as harmful to their pregnancies are "criminals". Human rights bodies have confirmed that "protection of the fetus" over women's rights is discriminatory because it imposes a stereotype of women, viewing them as mere instruments of reproduction.⁴⁰¹ Fundamentally, protection of a woman's fetus is ensured via the pregnant woman or girl and by giving primacy to guaranteeing her life or health.⁴⁰²

International human rights law requires states to combat stereotypes and stereotyping, including gender stereotypes and stereotyping.⁴⁰³ Article 5 of CEDAW explicitly calls upon states to confront stereotyping by requiring state parties to take "all appropriate measures" to "modify the social and cultural patterns of conduct of men and women" in an effort to eliminate practices that "are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."⁴⁰⁴ Article 5 covers both gender stereotypes that are based on a view of women as being inferior to men and sex-role stereotypes.⁴⁰⁵ Additionally, Article 2(f) reinforces Article 5 by requiring state parties to take "all appropriate measures" to "modify or abolish... laws, regulations, customs and practices which constitute discriminat[ion] against women."⁴⁰⁶

The CEDAW Committee has further affirmed the importance of state parties' obligations around stereotyping in its General Recommendation 25 (temporary special measures) by identifying the requirement to "address prevailing gender relations and the persistence of gender-based stereotypes" as one of three categories of obligations central to the achievement of substantive equality.⁴⁰⁷

397 CESCR General Comment 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 2 May 2016, UN Doc E/C.12/GC/22 paras 27, 35.

398 See Human Rights Committee, General Comment 28 (Equality of rights between men and women (Article 3)), 29 March 2000, UN Doc. CCPR/C/21/Rev.1/Add.10, para. 5.

399 See Human Rights Committee, General Comment 28 (equality of rights between men and women (Article 3)), 29 March 2000, UN Doc. CCPR/C/21/Rev.1/Add.10, 2000, para. 5.

400 Convention on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 28, 19 October 2010 UN Doc. CEDAW/C/2010/47/GC.2, 2010, para. 18.

401 See Committee on the Elimination of Discrimination against Women, *L.C. v Peru*, Communication No. 22/2009, UN Doc CEDAW/C/50/D/22/2009, para. 8.15.

402 Committee on the Elimination of Discrimination against Women, *L.C. v Peru*, Communication No. 22/2009, UN Doc. CEDAW/C/50/D/22/2009, para. 8.15, 2011; Committee on the Elimination of Discrimination against Women, Concluding observations on Hungary, 2013, para. 30.

403 See CEDAW, Article 5; the Convention of Belém do Pará, Articles 6 and 8.

404 CEDAW, Article 5.

405 CEDAW, Article 5; see also OHCHR, Gender stereotyping as a human rights violation, 2013, p. 23

www.ohchr.org/EN/Issues/Women/WRGS/Pages/GenderStereotypes.aspx

406 CEDAW, Article 2(f); OHCHR Commissioned Report, Gender stereotyping as a human rights violation, 2013, p. 24,

www.ohchr.org/EN/Issues/Women/WRGS/Pages/GenderStereotypes.aspx

407 CEDAW, General Recommendation 25 (article 4, para.1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures), para. 7; see OHCHR, Gender Stereotypes and Stereotyping and Women's Rights, September 2014, www.ohchr.org/Documents/Issues/Women/WRGS/OnePagers/Gender_stereotyping.pdf

R. Cook and S. Cusack, *Gender Stereotyping: Transnational Legal Perspectives*, Philadelphia: University of Pennsylvania Press, 2010; see also Committee on the Elimination of Discrimination against Women, *R.K.B. v Turkey*, UN Doc. CEDAW/C/51/D/28/2010, 2012, para. 8.8; Committee on the Elimination of Discrimination against Women, *Vertido v Philippines*, UN Doc. CEDAW/C/46/D/18/2008, 2010; Committee on the Elimination of Discrimination against Women, *Gonzalez Carreño v Spain*, 2012, UN Doc. CEDAW/C/58/D/47/2012, 2012.

Similarly, the Inter-American Court of Human Rights has determined that the persistent socially dominated stereotypes that subordinate women, either implicitly or explicitly – a situation that is exacerbated when the stereotypes are reflected in laws, policies and practices – are contrary to the American Convention.⁴⁰⁸

In the end, the ongoing existence and enforcement of criminal laws that specifically punish pregnant women’s drug use indicate the US government is discriminating against women and not complying with its obligations to combat sex and gender stereotyping. As one woman in recovery from drug dependence summed it up:

“What we need is to not be judged and to be treated with respect.”⁴⁰⁹

408 Inter-American Court of Human Rights, *Gonzalez et al. (“Cotton Field”) v Mexico*, 2009, para. 401.

409 Participant, Nashville Focus Group with 8 women, 17 March 2015.

7. CONCLUSIONS AND RECOMMENDATIONS

The issues and realities described in this report demonstrate that the US is not complying with its international legal obligations to respect, protect and fulfill the human rights of pregnant women. Rather than promoting the health and rights of pregnant women, the existence and enforcement of “pregnancy criminalization” laws are violating of pregnant women’s human rights and are the mistaken legal and policy response to address an individual and public health issue.

Criminalization of drug use and other actions perceived to be harmful during pregnancy does not meet the aims of promoting health and reducing harm. These punitive approaches often deter women from seeking healthcare services, in particular vital prenatal care and drug treatment, are discriminatory in fact and in effect, as well as contravene equal protection guarantees. “Pregnancy criminalization” laws are discriminatory against all women due to their capacity to become pregnant and also particularly discriminatory against those from marginalized groups due to the existence of harmful gender stereotypes in accessing healthcare and justice. Such punitive approaches also reinforce stigma and discrimination against people who use drugs, which in turn may increase health risks⁴¹⁰ – all to the detriment of pregnant women’s human rights. Furthermore, fetal and newborn health is not promoted through punitive measures but rather placed in jeopardy when pregnant women face criminal charges and incarceration.

Rather than rely on criminal laws to attempt to control and punish drug use during pregnancy, the US government must promote the health and well-being of pregnant women by ensuring access to prenatal healthcare and drug treatment programs.

In the end, pregnant women who are dependent on drugs need support, assistance and access to healthcare and drug treatment services, which currently remain largely inaccessible for them, they should not receive punishment.

410 See Report of the U.N. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, UN Doc. A/65/255 para. 24.

RECOMMENDATIONS TO STATE & FEDERAL AUTHORITIES

HEALTHCARE SERVICES

- Ensure that healthcare information and services, including sexual and reproductive healthcare, are available, accessible, acceptable and of good quality throughout an individual's lifetime.
- Ensure that gaps in the healthcare system are eliminated so that all communities have access to comprehensive, quality treatment and services.
- Expand access to healthcare through increased funding for public healthcare systems.
- Ensure that no one is denied access to healthcare services by policies or practices that have the purpose or effect of discriminating on grounds such as gender, race, ethnicity or the ability to pay.
- Adopt guidelines to increase awareness about informed consent to ensure the requirements of informed consent are observed in all treatment settings, including with regard to the right to refuse treatment and to not be subjected to coerced or compulsory treatment.
- Implement training and guidelines to raise awareness of healthcare providers about patients' human rights, including respect for sexual and reproductive health and women's autonomy and decision-making.

DRUG TESTING AND TREATMENT

- Design drug treatment programs to prioritize access to pregnant women and disadvantaged groups.
- Ensure access to affordable, gender-responsive drug dependence treatment, harm reduction, and other drug-related healthcare for women without discrimination.
- Implement training and guidelines to ensure drug testing of pregnant women is only conducted with informed consent, including an explanation of the potential ramifications of a positive test.
- Ensure that drug treatment and rehabilitation programs for people who use drugs are evidence-based, voluntary and safeguarded by informed consent.
- Conduct a thorough analysis of drug policies to assess the potential discriminatory effect on pregnant women and marginalized and disadvantaged communities. Accordingly, amend or repeal laws and practices that reinforce stigma and discrimination against people who use drugs.
- Develop specific guidelines and training for healthcare professionals and administrators on drug treatment during pregnancy, highlighting the obligation to treat all patients with respect and without discrimination and to ensure the right to privacy.
- Ensure pregnant women in treatment programs have access to fair trial rights including timely access to legal representation.

CHILD WELFARE POLICIES

- Amend child welfare policies and procedures on the basis of evidence with the aim to promote health and human rights.
- Assess definitions of child abuse and neglect to ensure they are based in evidence rather than the presumption that prenatal drug exposure is child abuse short of any other indication.
- Expand access to residential drug treatment centers that prioritize admission of pregnant women and allow children to stay with their mothers.

RECOMMENDATIONS TO FEDERAL AUTHORITIES

- Ratify the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and its Optional Protocol.
- Ratify the International Covenant on Economic, Social and Cultural Rights (ICESCR) and its Optional Protocol.
- Review maternal healthcare policies and practices and the health system more broadly to ensure compliance with human rights standards.
- Increase federal funding for drug prevention and treatment programs that are evidence-based and respect patient autonomy and safeguard against discrimination.

RECOMMENDATIONS TO STATE AUTHORITIES

- Repeal or amend “fetal assault” and similar laws that do not exempt women from liability for conduct in relation to their own pregnancies.
- Repeal or amend laws criminalizing pregnant women for their use of drugs and other acts in relation to their own pregnancies.
- Assess all laws that have been used to punish women for conduct in relation to their own pregnancies and amend the laws to ensure that they cannot be used in this way.

RECOMMENDATIONS TO TENNESSEE AUTHORITIES

- Repeal the “fetal assault” law.
- Increase funding for and access to drug dependence treatment, including funding for family residential treatment programs which admit pregnant women and accommodate their children.
- Issue guidelines on drug testing practices to ensure pregnant women are not tested without their knowledge or consent and are aware of the ramifications of a positive test.
- Conduct human rights education and training for law enforcement, medical providers, and child protective services staff.

RECOMMENDATIONS TO ALABAMA AUTHORITIES

- End the use of the “chemical endangerment law” against women in relation to their own pregnancies. Limit enforcement of this law to its original intent by halting the law’s application against pregnant women for drug use during pregnancy.
- Increase funding for and access to drug dependence treatment, including funding for family residential treatment programs which admit pregnant women and accommodate their children.
- Issue guidelines on drug testing practices to ensure pregnant women are not tested without their knowledge or consent and are aware of the ramifications of a positive test.
- Conduct human rights education and training for law enforcement, medical providers, and child protective services staff.

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CRIMINALIZING PREGNANCY

POLICING PREGNANT WOMEN WHO USE DRUGS IN THE USA

In the USA, pregnant women lie at the center of a contested battleground over their sexual and reproductive rights. A series of laws police the behavior of pregnant women and particularly impact those who are marginalized and those who use drugs. Collectively called pregnancy criminalization laws, this report provides a basic overview of the impact of these laws on women's human rights and access to healthcare across the USA, and specifically focuses on two criminal laws in Alabama and Tennessee.

Pregnancy criminalization laws violate women's rights to health, privacy, equality and non-discrimination. Punitive approaches deter women from seeking healthcare services and have a discriminatory impact on low-income women and women of color.

Amnesty International is asking the authorities to repeal these laws. Instead of relying on punishment, states must ensure they are meeting their human rights obligations including ensuring access to healthcare.