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ARTICLES

RACE, PREGNANCY, AND THE OPIOID EPIDEMIC:
WHITE PRIVILEGE AND THE CRIMINALIZATION
OF OPIOID USE DURING PREGNANCY

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RACE, PREGNANCY, AND THE OPIOID EPIDEMIC: WHITE PRIVILEGE AND THE CRIMINALIZATION OF OPIOID USE DURING PREGNANCY

Khiara M. Bridges*

Common formulations of the concept of white privilege propose that white privilege guarantees white people positive results. So, when bad things happen to white people — when the jobs and the industries on which they once relied disappear, when they are denied admission to their preferred university, when they lose a promotion to a nonwhite candidate, when they die from suicide and drug overdoses at unprecedented rates — we are left to believe that white people experiencing these adverse consequences did not have white privilege or that their white privilege did not work for them. That is, we are left to conclude that white privilege is meaningless when white disadvantage is present. Further, given the undeniable fact of widespread white disadvantage, we are left vulnerable to the claim that for many, if not most, white people, white privilege is inconsequential, insignificant, or altogether nonexistent.

In reality, the fact of white privilege is much more complicated than this facile, mechanical formulation suggests. This Article proposes that we ought to understand white privilege to be something that can lead to unfavorable results just as capably as it can lead to favorable ones. That is, white privilege is a double-edged sword. Theorizing both edges of white privilege provides a more nuanced rendering of the concept. This complexly rendered formulation may help us understand how white privilege can coexist with white disadvantage. Indeed, it might help us understand how white privilege actively produces white disadvantage.

The Article uses the recent arrests and prosecutions of women for using opioids during their pregnancies as an opportunity to engage with and theorize the idea of white privilege. The analysis proceeds in four Parts. Part I explains the origins of the opioid epidemic as well as the government's response to it, emphasizing that the current drug crisis has hit white people and white communities the hardest and, further, that pregnant women have not been immune from it. Part II explores how the State has responded to substance use during pregnancy. At times, the State has responded with its civil systems, choosing to involve the child welfare system and child protective services; at other times, it has responded with its criminal systems, choosing to arrest and prosecute women for using substances while pregnant. Part III then analyzes the demographics of these arrests and prosecutions. It explains that prosecuting women for substance use during pregnancy began in earnest in the 1980s and 1990s, when the crack cocaine scare gripped the nation. During this time, those who were prosecuted were largely black women. However, the opioid epidemic (and the methamphetamine scare before it) has hit white communities particularly hard. Consequently, the demographics of arrests and prosecutions for substance use during pregnancy have shifted, with white women coming to predominate among those subjected to penal state power. Part IV theorizes the significance of these

* Professor of Law, University of California, Berkeley, School of Law. I am grateful to Wendy Bach, Leo Beletsky, Grace Howard, Yuvraj Joshi, Jules Netherland, and Lynn Paltrow for offering incredibly helpful and insightful comments on drafts of this Article. Thanks are also owed to Brian Flaherty in the Boston University Law Library, who provided phenomenal research support. Thanks also to Kristina Fried and Chelsea Tejada for superlative research assistance. Finally, thank you to Gert Reynaert, *mijn perfecte echtgenoot*, for finding me. All errors remain my own.

shifted demographics — investigating what they might mean for the concept of white privilege. A brief Conclusion follows.

“White people should worry about racism. They should worry about racism because it’s wrong. But if that’s not enough of a motivation, they should worry about it for their own damn good.”

— Lisa Wade¹

INTRODUCTION

Life expectancy in the United States has been declining. In 2017, the average lifespan was 78.6 years, a decline from 2016’s average of 78.7 years — which itself represented a decline from 2014’s average of 78.9 years.²

Many things make this decrease in life expectancy interesting. First, prior to the initial drop in 2015, the United States had not experienced a drop in overall life expectancy in twenty-two years.³ Further, the last time the average lifespan dropped three years in a row was between 1915 and 1918, when the nation had to contend with both World War I and a deadly influenza pandemic.⁴ Thus, the decrease in life expectancy between 2014 and 2017 is the first time in a *century* that there has been a three-year reduction in average lifespans.⁵

Second, most industrialized nations have experienced *increases* in life expectancy over the years; moreover, the life expectancies in those nations are projected to continue on their upward trajectories.⁶ The United States’s three-year losses reveal that in a significant respect, the nation is failing to keep up with the countries that it considers its peers.

¹ Lisa Wade, *Racialized Space: Whites, Blacks, and Kidney Failure*, SOC’Y PAGES: SOC. IMAGES (Aug. 11, 2010), <https://thesocietypages.org/socimages/2010/08/11/how-racism-against-blacks-hurts-whites-the-kidney-failure-edition> [<https://perma.cc/C6YB-XDH5>].

² SHERRY L. MURPHY ET AL., NAT’L CTR. FOR HEALTH STATISTICS, MORTALITY IN THE UNITED STATES, 2017, DATA BRIEF NO. 328, at 1 (2018), <https://www.cdc.gov/nchs/data/databriefs/db328-h.pdf> [<https://perma.cc/R2FU-gPW2>] (noting that figures for 2016 differ because “[l]ife expectancies for 2016 were revised using updated Medicare data”); NAT’L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2017, tbl.15 (2018), <https://www.cdc.gov/nchs/data/hus/2017/015.pdf> [<https://perma.cc/LC7A-XCS7>].

³ The last drop in life expectancy was during the AIDS/HIV crisis in 1993, which reduced life expectancy from 75.8 years in 1992 to 75.5 years in 1993. Elizabeth Arias & Jiaquan Xu, *United States Life Tables, 2017*, NAT’L VITAL STAT. REP., June 24, 2019, at 1, 46, https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_07-508.pdf [<https://perma.cc/94GR-5AV3>]. In 1994, life expectancy went back up to 75.7 years. *Id.*

⁴ Lenny Bernstein, *U.S. Life Expectancy Declines Again, a Dismal Trend Not Seen Since World War I*, WASH. POST (Nov. 29, 2018, 12:01 AM), https://www.washingtonpost.com/national/health-science/us-life-expectancy-declines-again-a-dismal-trend-not-seen-since-world-war-i/2018/11/28/ae58bc8c-f28c-11e8-bc79-68604ed88993_story.html [<https://perma.cc/7SHA-4VND>].

⁵ *Id.*

⁶ Vasilis Kontis et al., *Future Life Expectancy in 35 Industrialised Countries: Projections with a Bayesian Model Ensemble*, 389 LANCET 1323, 1323 (2017).

Third, the decline in life expectancy is notable because of its causes. Researchers have explained that increases in deaths from suicide and drug overdoses — opioid overdoses, specifically — account for the recent reductions in average lifespans.⁷ Crucially, deaths from these causes have disproportionately impacted white people.⁸ Indeed, white people — especially those with less than a high school education⁹ — have borne the brunt of deaths by suicide and drug overdoses so disproportionately that racial disparities in life expectancy have narrowed.¹⁰ While white people can still expect to live longer than black people, there has been a diminution of the difference in lengths of white and black lives.

What do these facts suggest about the significance of race in the United States today? Do they at all trouble the claim that there exists a racial hierarchy in the country — one in which white people exist at the top and nonwhite people occupy the lower ranks? If white people are dying from suicide and drug overdoses — deaths that Professors Anne Case and Angus Deaton call “deaths of despair”¹¹ — at rates that outstrip their nonwhite counterparts, is it accurate for progressive race scholars to continue to claim that white people comprise a *privileged* racial group? Indeed, are nonwhite people still the unprivileged complements to white people?

⁷ Colin Dwyer, *U.S. Life Expectancy Drops amid “Disturbing” Rise in Overdoses and Suicides*, NPR (Nov. 29, 2018, 1:54 PM), <https://www.npr.org/2018/11/29/671844884/u-s-life-expectancy-drops-amid-disturbing-rise-in-overdoses-and-suicides> [<https://perma.cc/UQG7-TYTN>]; Laura Santhanam, *The Opioid Crisis Is Driving Down U.S. Life Expectancy, New Data Shows*, PBS (Dec. 21, 2017, 2:02 PM), <https://www.pbs.org/newshour/health/the-opioid-crisis-is-driving-down-u-s-life-expectancy-new-data-shows> [<https://perma.cc/F3U4-VT5V>].

⁸ See Helena Hansen & Julie Netherland, Editorial, *Is the Prescription Opioid Epidemic a White Problem?*, 106 AM. J. PUB. HEALTH 2127, 2127 (2016) (“[L]ife expectancy of US White persons has declined, largely as a result of drug overdose in the context of increased opioid analgesic use.” (footnote omitted)); see also Anne Case & Angus Deaton, *Rising Morbidity and Mortality in Midlife Among White Non-Hispanic Americans in the 21st Century*, 112 PROC. NAT’L ACAD. SCI. U.S. 15078, 15079 (2015) [hereinafter Case & Deaton, *Rising Morbidity*] (noting that “suicide, drug and alcohol poisoning (accidental and intent undetermined), and chronic liver diseases and cirrhosis” explain the decrease in life expectancy among middle-aged white non-Hispanic people).

⁹ See Case & Deaton, *Rising Morbidity*, *supra* note 8, at 15079 (noting that middle-aged white non-Hispanic persons with a high school education or less experienced the greatest increase in death rates, while those with a college degree or more education enjoyed a decline in death rates).

¹⁰ See *id.* (“The ratio of black non-Hispanic to white non-Hispanic mortality rates for ages 45–54 fell from 2.09 in 1999 to 1.40 in 2013. . . . [T]he narrowing of the mortality rate ratio in this period was largely driven by increased white mortality . . .”). Professors Anne Case and Angus Deaton note that had white mortality rates continued to drop at the pace at which they were dropping in the decades preceding 1999, the ratio of black to white mortality rates would have been 1.97, *id.*, and 488,500 white people would not have died between 1999 and 2013, *id.* at 15078.

¹¹ Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, BROOKINGS PAPERS ON ECON. ACTIVITY, Spring 2017, at 397, 398 [hereinafter Case & Deaton, *Mortality and Morbidity*].

Recent decreases in white life expectancy may suggest that we ought to reconsider the concept of white privilege.¹² The concept is offered to explain a wide range of phenomena — from the depiction of white mass shooters in the media¹³ to the successes of white celebrities like Taylor Swift, Justin Timberlake, or Eminem.¹⁴ Now, identifying these phenomena as examples of white privilege has a problematic implication: the insinuation is that if things had turned out differently — if, for example, Dylann Roof had been described as a terrorist after he murdered the nine black churchgoers in South Carolina, or if the music careers of Taylor Swift, Justin Timberlake, or Eminem had never taken off — then white privilege would not have been operating. Essentially, classifying phenomena in which white people have had good outcomes as examples of white privilege suggests that white privilege has no role in those instances where white people have had bad outcomes. According to this logic, when we learn that white people are dying at terrifyingly high rates from suicide and drug overdoses, then we are left to conclude that, as white people are enduring decidedly bad outcomes, white privilege is not working.

The problem is that this rendering of white privilege essentially presupposes that white privilege guarantees white people good results. So, when bad things happen to white people — when the jobs and the industries on which they once relied disappear, when their preferred university denies them admission, when they lose a promotion to a nonwhite candidate, when they die from suicide and drug overdoses at unprecedented rates — we are left to believe that white people experiencing these negative consequences did not have white privilege or that

¹² There is a substantial literature devoted to studying the content and meaning of whiteness and the processes by which a racialized group known as “white people” was created. *See generally*, e.g., LINDA MARTÍN ALCOFF, *THE FUTURE OF WHITENESS* (2015); BARBARA J. FLAGG, *WAS BLIND BUT NOW I SEE: WHITE RACE CONSCIOUSNESS AND THE LAW* (1998); NOEL IGNATIEV, *HOW THE IRISH BECAME WHITE* (1995); NELL IRVIN PAINTER, *THE HISTORY OF WHITE PEOPLE* (2010); DAVID R. ROEDIGER, *THE WAGES OF WHITENESS: RACE AND THE MAKING OF THE AMERICAN WORKING CLASS* (rev. ed. 2007).

¹³ *See* Sarah Ruiz-Grossman, *The Double Standard in How the Media Is Portraying the Las Vegas Shooter*, HUFFPOST (Oct. 3, 2017, 7:30 PM), https://www.huffingtonpost.com/entry/double-standard-white-privilege-media-las-vegas-shooting_us_59d3da15e4b04b0f92058316 [https://perma.cc/B8Z3-7B9K].

¹⁴ *See* Constance Grady, *Justin Timberlake Is a White Man. That Grants Him Incredible Freedom in His Career*, VOX (Feb. 2, 2018, 1:30 PM), <https://www.vox.com/culture/2018/2/2/16947136/justin-timberlake-man-of-the-woods-white-masculinity> [https://perma.cc/UW3G-66GQ]; Christian Kennedy, *The Danger of Taylor Swift's Privileged Pop*, MICH. DAILY (Aug. 27, 2017, 9:32 PM), <https://www.michigandaily.com/section/arts/taylor-swift-and-branding-pop-stars-todays-age> [https://perma.cc/PTN3-BDXA]; Stereo Williams, *Eminem's White Privilege: How Slim Shady Was Crowned the “King of Hip-Hop,”* DAILY BEAST (Dec. 23, 2018, 4:10 AM), <https://www.thedailybeast.com/eminems-white-privilege-how-slim-shady-was-crowned-the-king-of-hip-hop> [https://perma.cc/3ADW-46EL].

their white privilege did not work for them.¹⁵ That is, *we are left to conclude that white privilege is meaningless when white disadvantage is present*. Further, given the undeniable fact of widespread white disadvantage, we are left vulnerable to the claim that for many, if not most, white people, white privilege is inconsequential, insignificant, or altogether nonexistent.

In reality, the fact of white privilege is much more complicated than this facile, mechanical formulation suggests. The analysis contained in this Article suggests that we ought to understand that white privilege can lead to disadvantageous results just as capably as it can lead to advantageous ones. That is, white privilege is a double-edged sword. Theorizing *both* edges of white privilege provides a more nuanced rendering of the concept. This complexly rendered formulation may help us understand how white privilege can coexist with white disadvantage. Indeed, it might help us understand how white privilege *actively produces* white disadvantage.

The Article uses the recent arrests and prosecutions of women for using opioids during their pregnancies as an opportunity to engage with and theorize the idea of white privilege. Historically speaking, black women have borne the brunt of punitive state responses to substance use during pregnancy. It was during the crack cocaine scare of the 1980s and 1990s that states first turned to the criminal legal system to address the phenomenon of substance use during pregnancy.¹⁶ Because that drug scare disproportionately impacted (poor) black people, (poor) black women overwhelmingly were the targets of prosecutors' efforts to jail those who used drugs while pregnant.¹⁷ Black women became the face of the criminalization of substance use during pregnancy.¹⁸

¹⁵ For the most part, I do not distinguish between *having* white privilege and *gaining/benefiting* from white privilege. I conflate the two because many propose that those who do not gain or benefit from white privilege are not privileged in the first instance. See Brando Simeo Starkey, Commentary, *Why Do So Many White People Deny the Existence of White Privilege?*, THE UNDEFEATED (Mar. 1, 2017), <https://theundefeated.com/features/why-do-so-many-white-people-deny-the-existence-of-white-privilege> [https://perma.cc/PA2R-ULN5]. Among white-privilege skeptics, the general sense is that having a privilege that does not confer advantages/benefits is worthless — tantamount to not having the privilege at all. See *id.* For this reason, I speak about a racial privilege that does not yield gains as equivalent to a nonexistent racial privilege.

¹⁶ See generally LAURA E. GÓMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE (1997) (providing an overview of this phenomenon).

¹⁷ See Julie B. Ehrlich, *Breaking the Law by Giving Birth: The War on Drugs, the War on Reproductive Rights, and the War on Women*, 32 N.Y.U. REV. L. & SOC. CHANGE 381, 387 (2008).

¹⁸ See Mina Dixon Davis, Note, *"Bad Moms" and Powerful Prosecutors: Why a Public Health Approach to Maternal Drug Use Is Necessary to Lessen the Hardship Borne by Women in the South*, 25 GEO. J. ON POVERTY L. & POL'Y 305, 310 (2018).

However, the demographics of the more recent arrests and prosecutions of women who use substances while pregnant are in keeping with the demographics of the opioid epidemic: as white people predominate among those struggling with opioid use, misuse, and dependence, *white women predominate among those who have faced criminal charges for opioid use during pregnancy*¹⁹ — a shift that many scholars and observers have yet to acknowledge. Analyzing the criminalization of opioid use during pregnancy — an occasion in which white people have experienced profoundly adverse outcomes — provides an opportunity to add some much-needed complexity to the concept of white privilege. Moreover, because pregnancy involves and implicates the bodies of women, investigating the criminalization of opioid use during pregnancy allows us to interrogate how whiteness and white privilege intersect with sex and gender.

Some might be tempted to argue that the white women who have been arrested and prosecuted for opioid use during pregnancy do not have white privilege or, alternately, that any white privilege that they have is meaningless and irrelevant. How can we say with a straight face that they are racially privileged when their race has not been able to protect them from excessive, abusive state power? This Article answers: it is *because* they are racially privileged that they have been subjected to excessive, abusive state power. This is to say that white privilege is present and operating even when white people experience bad outcomes. In many cases, those poor outcomes are direct consequences of white privilege.

In addition to demonstrating how white privilege may produce white disadvantage, this Article problematizes the concept of white privilege in three other ways. First, by taking seriously the proposition that race is a social construction, this Article offers that white privilege may not have protected the numerous white women who have been prosecuted for using opioids during their pregnancies because these women possess a compromised, marginalized, “not-quite” whiteness — a corrupted whiteness that has yielded to them a reduced racial privilege. Because the marginalized white women subject to arrest and prosecution for using opioids during pregnancy exist at the *limits* of whiteness, the racial privilege that they would otherwise have had has been *limited* — making it unable to protect its holders from penal state power.

Second, the Article proposes that because race and racial meanings are constantly contested, we might productively understand racially salient events, like the criminalization of opioid use during pregnancy, as contests over the benefits that white privilege will yield. What will whiteness guarantee? The prosecutions of opioid-using pregnant white women reveal that, in the face of the world’s most muscular criminal

¹⁹ See Wendy A. Bach, *Prosecuting Poverty, Criminalizing Care*, 60 WM. & MARY L. REV. 809, 842 n.213 (2019).

legal system, whiteness is not potent enough to guarantee its bearers the benefit of immunity from this system.

Third, the Article puts forward the claim that white privilege is attenuated by the reality of white disadvantage. As applied to the criminalization of opioid use during pregnancy, the racial privilege of pregnant white women struggling with substance use disorders has been attenuated by the nation's choice to treat pregnant black women struggling with substance use disorders during the crack cocaine scare harshly, callously, and punitively — that is, inhumanely. In other words, we have a racist precedent, crafted just a couple of decades ago, for dealing with substance use during pregnancy. This racist precedent has presently led the nation to be punitive toward a population — white women — that, due to its racial privilege, might otherwise have escaped our nation's punitive inclinations.

The analysis proceeds in four Parts. Before proceeding to Part I, the Introduction summarizes the various ways that theorists have defined white privilege — definitions that either imply that white privilege is incompatible with white disadvantage or suggest that white privilege is a psychological phenomenon, having few, if any, material impacts on the world.

Part I explains the origins of the opioid epidemic as well as the government's response to it, emphasizing that the current drug crisis has hit white people and white communities quite hard and, further, that pregnant women have not been immune from it.

Part II explores how the State has responded to substance use during pregnancy. At times, the State has responded with its civil systems, choosing to involve the child welfare system and child protective services; at other times, it has responded with its criminal systems, choosing to arrest and prosecute women for using substances while pregnant.

Part III then analyzes the demographics of these arrests and prosecutions. It explains that prosecuting women for substance use during pregnancy began in earnest in the 1980s and 1990s, when the crack cocaine scare gripped the nation.²⁰ During this time, those who were prosecuted were largely black women.²¹ However, the opioid epidemic (and the methamphetamine scare before it) has hit white communities particularly hard — touching these communities in a way that the crack cocaine scare of the 1980s and 1990s did not. Consequently, there has been a shift in the demographics of arrests and prosecutions for substance use during pregnancy, with white women coming to predominate among those who are currently subjected to penal state power.

²⁰ See AMNESTY INT'L, CRIMINALIZING PREGNANCY: POLICING PREGNANT WOMEN WHO USE DRUGS IN THE USA 22 (2017) [hereinafter CRIMINALIZING PREGNANCY].

²¹ See Ehrlich, *supra* note 17, at 387.

Part IV theorizes the significance of these shifted demographics — investigating what they might mean for the concept of white privilege. A short Conclusion follows.

Two brief notes before beginning: First, although cisgender women are not the only people who can become pregnant, this Article uses the term “women” to refer to those who can experience pregnancy. This is solely because the data collected around opioid use, and substance use generally, during pregnancy employ the category of “women.”

The second note relates to describing women as having been arrested and prosecuted “for using opioids during their pregnancies” or “for using substances while pregnant.” Although this Article uses these and similar phrases, they are misleading. To explain: most states and the federal government have criminalized drug *possession* — not drug *use*.²² Because drug use has not been criminalized, it is generally not a crime to test positive for a controlled substance.²³ Thus, when pregnant women are arrested and face criminal charges after a positive drug screen, it is because *pregnancy has transformed otherwise legal behavior into a crime*. Accordingly, it is more accurate to say that women are being arrested and prosecuted for being pregnant *and* using opioids, or for being pregnant *and* using controlled substances. This phrasing more clearly reveals that if women were not pregnant, their behavior would not be criminalized. This phrasing makes obvious that pregnancy is an element of the crimes that they face.²⁴ Nevertheless, for the sake of simplicity, this Article describes governments as arresting and prosecuting women “for using opioids/substances while pregnant.”

Formulations of White Privilege

We might begin our exploration of the concept of white privilege with the formulation that Professor Peggy McIntosh, a white scholar, proposed in her influential article, *White Privilege: Unpacking the Invisible Knapsack*.²⁵ We begin here because McIntosh’s formulation of white privilege is consistent with the most widely held and commonly deployed understanding of the concept. In the piece, McIntosh describes white privilege as “an invisible package of unearned assets which I can count on cashing in each day, but about which I was ‘meant’ to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools and

²² Courtney E. Lollar, *Criminalizing Pregnancy*, 92 IND. L.J. 947, 998 n.413 (2017).

²³ See *id.*

²⁴ Thanks to Lynn Paltrow for pressing me on this point.

²⁵ Peggy McIntosh, *White Privilege: Unpacking the Invisible Knapsack*, PEACE & FREEDOM, July–Aug. 1989. I have summarized the history of the concept of white privilege in an earlier work. Khiara M. Bridges, *White Privilege and White Disadvantage*, 105 VA. L. REV. 449, 456–62 (2019).

blank checks.”²⁶ As I have argued elsewhere, McIntosh proposed that the tools contained in the knapsack — tools that nonwhite people do not have at their disposal — confer special benefits on white people.²⁷ In McIntosh’s formulation, the instruments and devices that the knapsack holds make it easier for white people to navigate through social space and achieve positive outcomes.²⁸

More contemporary race scholars have offered a less metaphorical rendering of white privilege — although their formulations of *white privilege as a benefit to white people* do not depart significantly from McIntosh’s articulation.²⁹ Professors Devon Carbado and Mitu Gulati write that the concept of white privilege “is nothing more than a claim about the existence of discrimination. The notion is this: To the extent that race discrimination is a current social problem, there will be victims and beneficiaries of this discrimination. The former are disadvantaged; the latter are privileged.”³⁰ In this articulation, white people are the “beneficiaries of racial disadvantage” inflicted on nonwhite people.³¹ White privilege is a term that simply refers to those benefits.

Progressive race scholars propose that the evidence that white privilege — understood as a phenomenon that advantages white people — exists and meaningfully impacts white lives is everywhere.³² As mentioned earlier, even in the throes of a drug crisis that is shortening white lives, white people can expect to live longer than black people.³³ White women have a better chance at surviving pregnancy and childbirth than do black women.³⁴ The babies that white women birth are more likely to survive their first year of life than those born to black women.³⁵ Moreover, in terms of morbidity, nonwhite people tend to be sicker than their white counterparts.³⁶

²⁶ McIntosh, *supra* note 25, at 10; *see also* Bridges, *supra* note 25, at 456.

²⁷ Bridges, *supra* note 25, at 456.

²⁸ McIntosh, *supra* note 25, at 10–12.

²⁹ *See* Bridges, *supra* note 25, at 456.

³⁰ Devon W. Carbado & Mitu Gulati, *The Law and Economics of Critical Race Theory*, 112 YALE L.J. 1757, 1777 (2003) (book review); *see also* Bridges, *supra* note 25, at 456.

³¹ Jeremy Dunham & Holly Lawford-Smith, *Offsetting Race Privilege*, J. ETHICS & SOC. PHIL., Jan. 2017, at 1, 3.

³² *See* Bridges, *supra* note 25, at 456–47.

³³ NAT’L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2017, at 4, 8 & fig.1 (2018), <https://www.cdc.gov/nchs/data/abus/abus17.pdf> [<https://perma.cc/ZXS7-E5GB>].

³⁴ Allison S. Bryant et al., *Racial/Ethnic Disparities in Obstetric Outcomes and Care: Prevalence and Determinants*, 202 AM. J. OBSTETRICS & GYNECOLOGY 335, 338 (2010).

³⁵ MARIAN F. MACDORMAN & T.J. MATHEWS, NAT’L CTR. FOR HEALTH STATISTICS, UNDERSTANDING RACIAL AND ETHNIC DISPARITIES IN U.S. INFANT MORTALITY RATES, DATA BRIEF NO. 74, at 1 & fig.1 (2011), <https://www.cdc.gov/nchs/data/databriefs/db74.pdf> [<https://perma.cc/Z9ZG-59MJ>].

³⁶ *See generally* INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE (Brian D. Smedley et al. eds., 2003) (discussing the extent and sources of differences in healthcare and health status across racial groups).

In this vein, progressive race scholars assert that white privilege can be found in matters beyond life and death.³⁷ For example, white people lay claim to much more wealth than black people;³⁸ indeed, the median wealth of the lowest-income white families is comparable to that of middle-income black families.³⁹ According to these thinkers, white privilege is evidenced by statistics documenting that black people “are more likely than white Americans to be killed by police while unarmed; more likely to be stopped, searched, arrested and incarcerated; less likely to be hired by employers; less likely to be educated by prestigious institutions; and less likely to be protected by adequate healthcare.”⁴⁰ These statistics are offered as definitive proof of white privilege.

While progressive race scholars tend to be both the architects and defenders of the concept of white privilege, some thinkers who would identify as progressive race scholars have subjected the concept to some critique. For example, Professor Zeus Leonardo argues that we need to move “beyond the discourse of ‘white privilege’” and arrive at the language of “white supremacy.”⁴¹ Leonardo criticizes the concept of white privilege because it focuses on the benefits that white people receive by virtue of their race.⁴² The problem that Leonardo sees is that this narrow focus on white people’s benefits turns attention away from the oftentimes violent processes that have yielded those benefits.⁴³ He claims that the “discourse on privilege comes with the unfortunate consequence of masking history, obfuscating agents of domination, and removing the actions that make it clear who is doing what to whom. Instead of emphasizing the process of appropriation, the discourse of privilege centers the discussion on the advantages that whites receive.”⁴⁴

While Leonardo’s critique is a trenchant one, it does not deny the truth of the concept of white privilege. His critique is that the concept

³⁷ See Bridges, *supra* note 25, at 456–57.

³⁸ ANGELA HANKS ET AL., CTR. FOR AM. PROGRESS, SYSTEMATIC INEQUALITY: HOW AMERICA’S STRUCTURAL RACISM HELPED CREATE THE BLACK-WHITE WEALTH GAP ¶ 5 (2018), <https://www.americanprogress.org/issues/race/reports/2018/02/21/447051/systematic-inequality> [<https://perma.cc/DPF5-HQ9L>] (“African Americans own approximately one-tenth of the wealth of white Americans.”).

³⁹ See DARRICK HAMILTON ET AL., UMBRELLAS DON’T MAKE IT RAIN: WHY STUDYING HARD AND WORKING HARD ISN’T ENOUGH FOR BLACK AMERICANS 7 (2015) (noting that “white families at the lowest end of the income distribution have a higher median wealth than middle-income blacks” and that upper-middle class black families had a median wealth of only \$36,430 compared with upper-middle class white families’ median wealth of \$136,390).

⁴⁰ Dunham & Lawford-Smith, *supra* note 31, at 2.

⁴¹ Zeus Leonardo, *The Color of Supremacy: Beyond the Discourse of “White Privilege,”* 36 EDUC. PHIL. & THEORY 137, 137 (2004).

⁴² *Id.* at 138.

⁴³ *Id.*

⁴⁴ *Id.*

distracts — not that the concept misrepresents. However, other progressive race scholars have offered criticisms that call into question the concept’s correctness — the very accuracy with which it describes social life. Consider Professor Shannon Sullivan’s critique of the concept. Sullivan writes that *white privilege* implies that “all white people benefit from racial advantages to the same degree, lumping white people together into an indistinguishable, monolithic group.”⁴⁵ She charges that the concept does not “reflect class, ethnicity, gender, and other salient differences among white people.”⁴⁶ She finds disturbing the work that the concept does to obscure the disadvantages poor white people endure, arguing that “the concept of white privilege glosses over class differences among white people, erasing the ways in which middle- and upper-class white people serve as the normative model of whiteness.”⁴⁷

According to Sullivan, just as *white privilege* wrongly hides some white people’s profound lack of privilege, so too does it wrongly hide some nonwhite people’s substantial privilege. In Sullivan and Professor Naomi Zack’s reading, *white privilege* presupposes the existence of *nonwhite unprivilege* — a presupposition that conceals that “some middle- and upper-class people of color receive more societal privileges than lower-class white people do.”⁴⁸

Sullivan is not the only scholar who has observed that *white privilege* might inaccurately imply that white people’s lives are uniformly advantaged. For example, Professor Camille Gear Rich has acknowledged and underscored that different groups of white people have different access to white privilege.⁴⁹ She writes that “many whites do not benefit economically and socially from white privilege”⁵⁰ and are not always able to avail themselves of the “material and dignitary benefits associated with whiteness.”⁵¹ She observes that lack of privilege along the lines of “gender, class, ethnicity, sexual orientation, and religious background” may make it difficult for a white person who lives at the intersection of an ostensible racial privilege and an unprivilege along other lines to enjoy the racial privilege that she otherwise would be able to enjoy.⁵²

A conclusion that we might draw from these critiques is that *white privilege* improperly obscures nonwhite disadvantage and, accordingly, ought to be reimagined — or discarded. Indeed, this is the solution that Sullivan proposes, arguing that “the term should be modified to *white*

⁴⁵ Shannon Sullivan, *White Privilege*, in *THE OXFORD HANDBOOK OF PHILOSOPHY AND RACE* 331, 337 (Naomi Zack ed., 2017).

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ See Camille Gear Rich, *Marginal Whiteness*, 98 CALIF. L. REV. 1497, 1503–04 (2010).

⁵⁰ *Id.* at 1504 n.28 (emphasis omitted).

⁵¹ *Id.* at 1516.

⁵² *Id.* at 1519.

class privilege to better capture the stew of race and class that unevenly provides societal advantages to white people.⁵³

But many scholars of race would likely find Sullivan's proposal profoundly dissatisfying due to their conviction that whiteness advantages *all* white people — even those who are unprivileged by virtue of their class (and gender, sexuality, and so forth).⁵⁴ Sullivan's proposal denies that white privilege is a *racial* privilege; in her understanding, it is only a type of privilege that exists when it is simultaneous with other nonracial privileges.

Some theorists have argued for the continued utility of the concept of white privilege in the face of white privation or adversity by contending that *white privilege* does not refer to actual advantage, but rather the *statistical likelihood* of being advantaged. For example, Professor Joel Olson argues that white privilege is just “probabilities, not guarantees.”⁵⁵ Similarly, Professors Jeremy Dunham and Holly Lawford-Smith define white privilege as the “statistical probability of advantage.”⁵⁶ According to this formulation, white privilege can be meaningful even when white people endure an adverse outcome, as white privilege makes that adverse outcome less likely. White people may become dependent on controlled substances; they may become pregnant unintentionally; and they may face arrest and prosecution because their drug dependence intersects with their pregnancy. However, if white privilege is just the *statistical probability of advantage*, it means that white people are privileged even when they experience those poor outcomes, as they were less likely to experience them than their nonwhite peers.

Another proposal that progressive race scholars have offered to reconcile the concept of white privilege with the fact of white disadvantage is that white privilege may be mostly intangible.⁵⁷ It may be primarily

⁵³ Sullivan, *supra* note 45, at 337.

⁵⁴ See *infra* pp. 782–83.

⁵⁵ JOEL OLSON, *THE ABOLITION OF WHITE DEMOCRACY* 76 (2004).

⁵⁶ Dunham & Lawford-Smith, *supra* note 31, at 9 (emphasis omitted).

⁵⁷ See Bridges, *supra* note 25, at 460–61. Understanding white privilege as mostly intangible is in keeping with W.E.B. Du Bois's claim that all white people — even the disadvantaged ones — were paid a “public and psychological wage” during the days of formal racial inequality. W.E.B. DU BOIS, *BLACK RECONSTRUCTION IN AMERICA* 700 (Touchstone 1995) (1935). Du Bois argues that even poor white people enjoyed the nonmaterial benefits that accrued from the fact of their inclusion in the white race. He writes:

It must be remembered that the white group of laborers, *while they received a low wage*, were compensated in part by a sort of public and psychological wage. They were given public deference and titles of courtesy because they were white. They were admitted freely with all classes of white people to public functions [and] public parks The police were drawn from their ranks, and the courts, dependent upon their votes, treated them with such leniency as to encourage lawlessness. Their vote selected public officials, and while this had small effect upon the economic situation, it had great effect upon their

psychic or emotional — in most cases incapable of providing formal, institutionalized forms of power or wealth.⁵⁸ Professor Cheryl Harris has described white privilege in these terms, arguing that in the contemporary era of formal racial equality, the “wages of whiteness are available to all whites regardless of class position, even to those whites who are without power, money, or influence. Whiteness, the characteristic that distinguishes them from Blacks, serves as compensation even to those who lack material wealth.”⁵⁹ She contends that at present day, white privilege “may have been reduced to a claim of relative privilege only in comparison to people of color.”⁶⁰ Nevertheless, Harris writes, “whiteness retains its value as a ‘consolation prize’: it does not mean that all whites will win, but simply that they will not lose, if losing is defined as being on the bottom of the social and economic hierarchy — the position to which Blacks have been consigned.”⁶¹

This is not to say that Harris argues that whiteness has no material consequences. She notes that while whiteness may not lead to “actual economic gains,” it provides “political advantages.”⁶² However, she does not describe *how* those political advantages impact the material world. In a footnote, she writes that the benefits of whiteness “may be difficult to discern, yet they often remain crucial.”⁶³ She finds guidance in the work of Professor Albert Memmi,⁶⁴ who writes:

To different degrees every colonizer is privileged, at least comparatively so, ultimately to the detriment of the colonized. If the privileges of the masters of colonization are striking, the lesser privileges of the small colonizer, even the smallest, are very numerous. Every act of his daily life places him in a relationship with the colonized, and with each act his fundamental advantage is demonstrated.⁶⁵

personal treatment White schoolhouses were the best in the community, and conspicuously placed, and they cost anywhere from twice to ten times as much per capita as the colored schools.

Id. at 700–01 (emphasis added). In a paragraph closely preceding this passage, Du Bois notes the “astonishing economic results” that racial separation produced in the South. *Id.* at 700. But in light of Du Bois’s acknowledgment that white laborers “received a low wage,” it is appropriate to conclude that the “astonishing economic results” accrued solely to the benefit of the capital class, which exploited the racially divided laboring class. *Id.* (observing that the white workers allowed racial difference to blind them to the “common interest[s]” that they shared with the black workers, which functioned to prevent a “united fight for higher wage and better working conditions”). Thus, the “astonishing economic results” produced by “the doctrine of racial separation” that Du Bois indexes largely were not enjoyed by low-wage white workers. *Id.*

⁵⁸ See Bridges, *supra* note 25, at 460–61.

⁵⁹ Cheryl I. Harris, *Whiteness as Property*, 106 HARV. L. REV. 1707, 1759 (1993).

⁶⁰ *Id.* at 1758.

⁶¹ *Id.* at 1758–59 (footnote omitted).

⁶² *Id.* at 1759.

⁶³ *Id.* at 1760 n.227.

⁶⁴ See *id.*

⁶⁵ ALBERT MEMMI, *THE COLONIZER AND THE COLONIZED* 11–12 (Howard Greenfield trans., The Orion Press 1965) (1957).

However, neither Memmi nor Harris focuses on identifying material consequences of this fundamental advantage — leaving the reader with an incomplete picture of the material consequences of whiteness. We are left to conclude that perhaps the benefits that whiteness yields are, for the most part, intangible: emotional or psychological.

Conceptualizing white privilege as intangible could serve to explain how apparently disadvantaged white people can still be racially privileged. This definition of white privilege renders the concept consistent with manifest — and, we might add, widespread — white disadvantage. Nevertheless, the formulation may drain the concept of its meaningfulness. Why does white privilege *matter* if it cannot do things in society? Why should we care about the existence of white privilege if it is a psychic phenomenon, unable to affect the material world in any meaningful way?

Notably, the contemporary understanding of white privilege described here — as a phenomenon that inevitably benefits white people, even if only psychologically — is inconsistent with some of the earliest formulations of the concept. In a recent book, Asad Haider excavates a history of the concept in which white privilege was thought to be not an inevitable boon to white people, but rather a source of their subjugation.⁶⁶ Haider writes that some of critical scholar Noel Ignatiev’s earliest scholarship made an observation that many Marxists have made: race has functioned to disempower the working class because it blinds white workers to the reality that their interests are closely aligned with those of black workers.⁶⁷ Instead of uniting with black workers to defend their shared interests against the capital class, white workers prioritize their racial identity and identify with the white capital class, only to suffer the consequences of the exploitation that the capital class is able to inflict on a working class that has allowed race to divide it.⁶⁸ In Ignatiev’s reading, the “benefits” to the white working class of being white — of white privilege — are hardly beneficial, as they result in the white working class’s abuse at the hands of the capital class.⁶⁹ He writes:

White-skin privileges serve only the bourgeoisie. . . . To suggest that the acceptance of white-skin privilege is in the interests of white workers is equivalent to suggesting that swallowing the worm with the hook in it is in the interests of the fish. To argue that repudiating these privileges is a “sacrifice” is to argue that the fish is making a sacrifice when it leaps from the water, flips its tail, shakes its head furiously in every direction and throws the barbed offering.⁷⁰

⁶⁶ See ASAD HAIDER, *MISTAKEN IDENTITY: RACE AND CLASS IN THE AGE OF TRUMP* 47 (2018).

⁶⁷ See *id.* at 48–49 (quoting NOEL IGNATIN, *WITHOUT A SCIENCE OF NAVIGATION WE CANNOT SAIL IN STORMY SEAS*, in *DEBATE WITHIN SDS, RYM II V. WEATHERMAN* 31, 34 (1969)).

⁶⁸ See IGNATIN, *supra* note 67.

⁶⁹ See *id.*

⁷⁰ *Id.*

In Ignatiev's formulation, white privilege is harmful to white people — specifically, the white working class. It is “bourgeois poison aimed primarily at the white workers, utilized as a weapon by the ruling class to subjugate black and white workers.”⁷¹ Haider proposes that Ignatiev's rendering of white privilege accurately describes how it has operated in the nation, both historically and at present:

In exchange for white-skin privilege, the Euro-American workers accepted white identity and became active agents in the brutal oppression of African American laborers. But they also fundamentally degraded their own conditions of existence. As a consequence of this bargain with their exploiters, they allowed the conditions of the Southern white laborer to become the most impoverished in the nation, and they generated conditions that blocked the development of a viable mass workers' movement.⁷²

In this account, it is not uncommon for white privilege to lead to white disadvantage. In fact, white disadvantage is an expected, one might even say *intentional*, consequence of white privilege.

This Article analyzes the criminalization of opioid use during pregnancy with an eye toward understanding how white privilege, and whiteness, operates. The analysis reveals that we misunderstand white privilege when we conceptualize it in line with the formulations offered by McIntosh and many other contemporary scholars. That is, we misapprehend how white privilege operates when we suppose that it is present or works only when white people enjoy positive outcomes — a supposition that leaves us vulnerable to the claim that white privilege simply does not exist given the fact that millions of white people have experienced, and will continue to experience, unfavorable outcomes. The analysis also reveals that we miss important characteristics of white privilege when we focus on its manifestation as a psychological phenomenon rather than its concrete external impact. The examination reveals that, as Ignatiev offered many decades ago, white privilege certainly influences outcomes — but not always in expected ways. To be precise, the examination uncovers that white privilege, white disadvantage, and nonwhite disadvantage are all part of the same system of oppression. Indeed, the three phenomena are interconnected. As a result, when one is found, it is likely that the other two are nearby. Part IV undertakes this analysis. Part I, which immediately follows, provides background on the case study that yields these principles about white privilege: the opioid epidemic.

I. THE OPIOID EPIDEMIC

The opioid crisis has decimated communities, destroyed families, and produced death at record levels. The President's Commission on

⁷¹ Letter from Noel Ignatin to Progressive Labor (Mar. 1967), in *REVOLUTIONARY YOUTH & THE NEW WORKING CLASS* 148, 152 (Carl Davidson ed., 2011).

⁷² HAIDER, *supra* note 66, at 58.

Combating Drug Addiction and the Opioid Crisis has written that the current rate of deadly drug overdoses means that, in terms of the number of lives lost, the country experiences a September 11, 2001 attack every three weeks.⁷³ Noting that more than 64,000 people were believed to have died in 2016 from drug overdoses, the White House Office of the Press Secretary wrote that this number “exceeds the number of Americans killed during the Vietnam War.”⁷⁴ Opioids were responsible for 42,249, or about sixty-six percent, of those overdose deaths.⁷⁵ Indeed, close to 200 people die from a drug overdose every day in this country.⁷⁶ Between 1999 and 2017, overdoses killed some 700,000 people.⁷⁷ Opioids played a substantial role in producing those astonishing figures, responsible for nearly 400,000 overdose deaths during that period.⁷⁸

Epidemiologist Nabarun Dasgupta, Professor Leo Beletsky, and Professor Daniel Ciccarone describe three phases of the opioid epidemic.⁷⁹ They propose that the first phase, which spanned from about the 1980s to the 2000s, saw the growing use and misuse of prescription opioids.⁸⁰ In the second phase, beginning around 2010, concern increased about “intertwining opioid analgesic and heroin use.”⁸¹ And finally, the third phase, which began in 2013 and continues to the present, involves “illicitly manufactured fentanyl and its analogs, which are increasingly present in counterfeit pills and heroin.”⁸²

⁷³ THE PRESIDENT’S COMM’N ON COMBATING DRUG ADDICTION & THE OPIOID CRISIS, INTERIM REPORT 2 (2017) [hereinafter PRESIDENT’S COMM’N, INTERIM REPORT], <https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf> [<https://perma.cc/DB4U-TPHT>].

⁷⁴ Press Release, White House, Office of the Press Sec’y, President Donald J. Trump Is Taking Action on Drug Addiction and the Opioid Crisis (Oct. 26, 2017), <https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-taking-action-drug-addiction-opioid-crisis> [<https://perma.cc/8BVU-WMG4>].

⁷⁵ See *Opioid Overdose Deaths and Opioid Overdose Deaths as a Percent of All Drug Overdose Deaths*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/opioid-overdose-deaths> [<https://perma.cc/HZR8-3GQ7>] (select “2016” in the timeframe field).

⁷⁶ See HOLLY HEDEGAARD ET AL., NAT’L CTR. FOR HEALTH STATISTICS, DRUG OVERDOSE DEATHS IN THE UNITED STATES, 1999–2017, DATA BRIEF NO. 329, at 1 (2018), <https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf> [<https://perma.cc/4ZPQ-MW6F>] (noting that there were 70,237 overdose deaths in 2017, meaning that on average 192 people died every day from an overdose that year).

⁷⁷ *Opioid Overdose*, CENTERS FOR DISEASE CONTROL & PREVENTION (Dec. 19, 2018), <https://www.cdc.gov/drugoverdose/epidemic/index.html> [<https://perma.cc/Q8HY-MU8Y>]; see also PRESIDENT’S COMM’N, INTERIM REPORT, *supra* note 73, at 1 (noting that more than 560,000 people died from drug overdoses between 1999 and 2015).

⁷⁸ See *Opioid Overdose*, *supra* note 77.

⁷⁹ See Nabarun Dasgupta et al., Commentary, *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUB. HEALTH 182, 182–83 (2018).

⁸⁰ *Id.* at 182.

⁸¹ *Id.*

⁸² *Id.* at 183 (footnotes omitted).

By most accounts, the roots of the current epidemic are in the use, misuse, and abuse of prescription opioids.⁸³ Prescription opioids are painkillers, appropriately used to treat moderate to severe pain.⁸⁴ Healthcare providers appear to have underestimated just how addictive opioids can be and freely prescribed them — both to individuals for whom opioids might have been proper treatment and to those whose pain might have been competently managed by other means.⁸⁵

Moreover, to say that healthcare providers prescribed opioid painkillers *liberally* is an understatement. In 2012, when the number of prescriptions for opioid painkillers was at its highest, providers wrote over 255 million prescriptions.⁸⁶ This meant that there were about eighty-one prescriptions for every 100 people.⁸⁷ As the nation realized that it was in the throes of a massive epidemic, the number of opioid prescriptions written began to fall. In 2016, healthcare providers wrote about 215 million prescriptions, resulting in a rate of 66.5 prescriptions for every 100 people.⁸⁸ Yet, Professor Wendy Bach observes, national rates of opioid prescriptions “hide significant regional and state variations.”⁸⁹ She notes that opioid-prescription rates “remain tremendously high in . . . Appalachia, the South, and several states in the Midwest and Great Lakes Region. In 2016, in Tennessee, Arkansas, and Alabama, there were over 107 opiate prescriptions written for every 100 people.”⁹⁰ Researchers have observed a direct relationship between the number of

⁸³ Some have critiqued origin stories of the opioid epidemic that identify physician overprescribing as a “vector” through which the substances spread throughout the country. *See, e.g., id.* at 182–83. These critiques propose that accounts of the origins of the opioid epidemic ought to identify the structural and social context — like a dearth of safe, well-paying jobs — that enabled the opioid epidemic to flourish. *See id.*

⁸⁴ *See Prescription Opioids*, NAT’L INST. ON DRUG ABUSE (June 2019), <https://www.drugabuse.gov/publications/drugfacts/prescription-opioids> [<https://perma.cc/UF56-XZMB>]. Opioids relieve pain by binding to receptors throughout the body that play a role in feeling pain and pleasure. *Id.* “When opioids attach to these receptors, they block pain signals sent from the brain to the body . . .” *Id.*

⁸⁵ *See THE PRESIDENT’S COMM’N ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS, FINAL REPORT 20–23* (2017) [hereinafter PRESIDENT’S COMM’N, FINAL REPORT], https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf [<https://perma.cc/Q7S4-B5XE>] (noting historically widespread acceptance of claims that opioids were not addictive, and highlighting the underuse of alternative pain-management strategies).

⁸⁶ Bach, *supra* note 19, at 834.

⁸⁷ *Id.*; *see also* PRESIDENT’S COMM’N, INTERIM REPORT, *supra* note 73, at 1 (“[I]n 2015, the amount of opioids prescribed in the U.S. was enough for every American to be medicated around the clock for three weeks.”).

⁸⁸ Bach, *supra* note 19, at 834.

⁸⁹ *Id.*

⁹⁰ *Id.* As Barry Meier describes it in the *New York Times*, beginning in 2007, “distributors of prescription drugs sent enough pain pills to West Virginia over a five-year period to supply every man, woman and child there with 433 of them.” Barry Meier, *Origins of an Epidemic: Purdue Pharma Knew Its Opioids Were Widely Abused*, N.Y. TIMES (May 29, 2018), <https://nyti.ms/2GXDilN> [<https://perma.cc/ZV5H-3J9V>].

opioid prescriptions and the number of deaths from opioid overdoses.⁹¹ Those regions with the highest rates of opioid prescriptions tend to be those hit hardest by the epidemic.⁹²

Most would argue that the story of the origins of the opioid epidemic is incomplete if it omits discussion of Purdue Pharma, which manufactures the prescription opioid OxyContin.⁹³ Purdue Pharma knowingly misrepresented OxyContin as less addictive than competing products.⁹⁴ The company also poured large amounts of OxyContin pills into the market even though it was aware that individuals were misusing them — crushing them and then snorting, injecting, or swallowing them in order to get an intense, heroin-like high.⁹⁵ The company eventually admitted to wrongdoing, agreeing “to pay some \$600 million in fines” in the face of several federal civil and criminal suits — a sum that represents one of the largest payouts by a pharmaceutical company in such a context.⁹⁶

A. Race and the Opioid Epidemic

An important element of the opioid crisis is its whiteness: the large majority of people using, misusing, dependent on, and dying from opioids are white people.⁹⁷ Of the 47,600 people who died from opioid

⁹¹ See PRESIDENT’S COMM’N, INTERIM REPORT, *supra* note 73, at 1 (“Since 1999, the number of opioid overdoses in America have quadrupled Not coincidentally, in that same period, the amount of prescription opioids in America have quadrupled as well.”).

⁹² See Bach, *supra* note 19, at 834–35 (noting that opioid-overdose deaths are geographically concentrated in many of the areas with the highest opioid-prescription rates).

⁹³ See MEDICATION GUIDE: OXYCONTIN (2019), <http://app.purduepharma.com/xmlpublishing/pi.aspx?id=o&medguide=1> [<https://perma.cc/U9J7-U5LQ>].

⁹⁴ See Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221, 223 (2009).

⁹⁵ See, e.g., Jennifer Egan, Feature, *Children of the Opioid Epidemic*, N.Y. TIMES MAG. (May 9, 2018), <https://nyti.ms/2KNLh8a> [<https://perma.cc/AK37-598R>] (quoting one woman as recalling, “I sniffed the pill, and it gave me a different effect. It was a lot more intense.”); Meier, *supra* note 90.

⁹⁶ Barry Meier, *In Guilty Plea, OxyContin Maker to Pay \$600 Million*, N.Y. TIMES (May 10, 2007), <https://nyti.ms/2oiSkcz> [<https://perma.cc/SDV9-3MFD>].

⁹⁷ See Claire Felner, *The U.S. Opioid Epidemic*, COUNCIL ON FOREIGN REL. (Sept. 17, 2019), <https://www.cfr.org/backgrounder/us-opioid-epidemic> [<https://perma.cc/LM52-G2SC>] (“The vast majority of those who overdose on opioids are non-Hispanic white Americans, who make up close to 80 percent of the annual total. Non-Hispanic black Americans and Hispanic Americans account for about 11 and 8 percent of the cases, respectively.”); see also George Jay Unick & Daniel Ciccarone, *U.S. Regional and Demographic Differences in Prescription Opioid and Heroin-Related Overdose Hospitalizations*, 46 INT’L J. DRUG POL’Y 112, 118 fig.4 (2017) (illustrating the racial distribution of opioid hospitalizations).

Significantly, the race of the opioid epidemic may be shifting slightly, as the rates of overdose deaths among black people have increased more than twice as much as those among white people in recent years. See Peter Jamison, *Falling Out*, WASH. POST (Dec. 18, 2018), <http://wapo.st/national-opioids> [<https://perma.cc/NA6T-RHLX>] (“Between 2014 and 2017, the fatal overdose rate among African Americans shot up by 94.1 percent — more than double the 44.6 percent increase for whites.”). Moreover, the rates of overdose deaths among indigenous people have been disturbingly high. See ALBUQUERQUE AREA SW. TRIBAL EPIDEMIOLOGY CTR., THE OPIOID CRISIS: IMPACT ON NATIVE AMERICAN COMMUNITIES, <https://tribalepicenters.org/wp-content/>

overdoses in 2017, 37,113 (78%) were white; in comparison, black and Latinx people were 5513 (12%) and 3932 (8%) of those who overdosed, respectively.⁹⁸ Inasmuch as white people comprise some 77% of the U.S. population,⁹⁹ it is inaccurate to describe the opioid epidemic as *disproportionately* affecting white people. Nevertheless, because the absolute number of white people who have died from an opioid overdose is so stunning — and because of the attention that politicians, healthcare providers, the media, and others have paid to the white communities that have been wrecked by the crisis¹⁰⁰ — the opioid epidemic has been racialized as a white crisis.¹⁰¹ Rightly or wrongly, we have come to understand that the term “the opioid crisis” — like the methamphetamine scare that preceded it¹⁰² — is fundamentally *about* white people.

This, commentators say, explains why the government has been open to taking a less punitive approach to addressing it.¹⁰³ The whiteness of the opioid crisis, they say, explains why people with the ability to direct law and policy have been receptive to understanding substance dependence as a medical condition that needs treatment, as opposed to a moral failure that warrants punishment.¹⁰⁴

uploads/2018/03/AASTEC-opioids-fact-sheet.pdf [https://perma.cc/R2G9-QNAE]. Thus, to say that the opioid epidemic is a white crisis erases the thousands of nonwhite people who are struggling with, and dying from, opioid use disorders.

⁹⁸ See *Opioid Overdose Deaths by Race/Ethnicity*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity> [https://perma.cc/QB83-SY5Z].

⁹⁹ See *QuickFacts*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/fact/table/US/PST045218> [https://perma.cc/SRA3-AXQB].

¹⁰⁰ See Jamison, *supra* note 97.

¹⁰¹ The racialization of drug scares is a common phenomenon. Professor Naomi Murakawa has written about the racialization of various drug crises over the years — observing that the opium scare of the 1890s was racialized as Chinese, the marijuana scare of the 1930s was racialized as Mexican, the crack cocaine scare of the 1980s was racialized as black, and the methamphetamine scare of the aughts was racialized as white. Naomi Murakawa, *Toothless: The Methamphetamine “Epidemic,” “Meth Mouth,” and the Racial Construction of Drug Scares*, 8 DU BOIS REV. 219, 219–20 (2011).

¹⁰² See Grace Howard, *The Limits of Pure White: Raced Reproduction in the “Methamphetamine Crisis,”* 35 WOMEN’S RTS. L. REP. 373, 379 (2014) (stating that methamphetamine “is most often depicted as a drug primarily used by poor white people, and frequently in rural locales”).

¹⁰³ See, e.g., Egan, *supra* note 95 (“[T]he perception of our opioid crisis as an *epidemic*, rather than a racial pathology, owes much to the fact that white Americans have been hard hit.”).

¹⁰⁴ See DARLA BISHOP ET AL., JACOBS INST. OF WOMEN’S HEALTH, PREGNANT WOMEN AND SUBSTANCE USE: OVERVIEW OF RESEARCH & POLICY IN THE UNITED STATES 8 (2017), https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_updated.pdf [https://perma.cc/MCS9-DJM9] (stating that “[c]urrent efforts to address opioid-related problems have included greater recognition of the need for treatment” and querying “[w]hether this change reflects lessons learned from problematic past policies or is driven by policymakers who respond differently to the current epidemic because many of those with opioid use disorders are White”).

For decades, researchers specializing in substance use disorders have described these disorders, commonly called “addictions,” as “chronic disease[s] of the brain” that make affected individuals seek out drugs despite the known negative consequences of that behavior.¹⁰⁵ Experts have shown that quite frequently, persons with these disorders have histories with physical or sexual violence and are also struggling with anxiety, depression, post-traumatic stress disorder, and other forms of mental illness.¹⁰⁶ In this light, persons with substance use disorders are not bad actors who have behaved irresponsibly and need to be scared straight or penalized for their bad acts. Rather, this light casts people with substance use disorders as sick, as victims themselves — doing their best to silence the demons in their heads.¹⁰⁷ In the throes of the opioid epidemic, the nation has been more willing than ever to understand substance dependence in these terms. The whiteness of the epidemic, observers say, explains this willingness.¹⁰⁸

The framing of substance use disorders as an illness — a public health concern — has been ubiquitous during the current opioid crisis.¹⁰⁹ However, some commentators argue that the nation has not fully committed itself to approaching dependence on opioids, or any other drug, as an illness. Writes Professor Barry Lester and his coauthors: “[T]he drug control budget has more than doubled in the past decade. Yet the proportion of the budget devoted to treatment and prevention is unchanged, despite the gains made in science, and in our understanding of the nature of addiction in research showing that treatment and prevention are effective.”¹¹⁰ And yet the popular narrative continues to cast opioid dependence as an illness and the opioid epidemic as an issue of public health. Public officials have used this casting to carry out a gentler response to the crisis than if the epidemic were cast as a law

¹⁰⁵ *Id.* at 5. The authors explain that a substance use disorder develops as “repeated drug administration triggers changes to portions of the brain involved with rewards and impulsivity. These changes make people’s brains respond more to drug cues and less to non-drug rewards, while increasing sensitivity to stressful stimuli and weakening the ability to self-regulate.” *Id.* (citation omitted).

¹⁰⁶ *See id.* at 5–6 (“Research has consistently found strong associations between substance use disorders and other mental health conditions, particularly anxiety and depression. In the U.S., those with SUDs [(substance use disorders)] are up to 4.5 times more likely to also receive a diagnosis of another psychiatric disorder, compared to those without SUDs.” (citations omitted)).

¹⁰⁷ *Cf.* Murakawa, *supra* note 101, at 223 (“Although meth use is criminal, the meth user is frequently cast as a kind of victim. Indeed, meth-related news stories reference violent criminal activity far less frequently than do crack-related stories; instead, representations of meth’s harms emphasize health detriments to the user, as well as environmental damage, toxic byproducts, and fire risks associated with meth production.” (citation omitted)).

¹⁰⁸ *See supra* notes 103–104 and accompanying text.

¹⁰⁹ *See, e.g.*, PRESIDENT’S COMM’N, FINAL REPORT, *supra* note 85, at 6 (“It is time we all say what we know is true: addiction is a disease.”).

¹¹⁰ Barry M. Lester et al., Review, *Substance Use During Pregnancy: Time for Policy to Catch Up with Research*, HARM REDUCTION J., Apr. 20, 2004, at 39.

enforcement problem.¹¹¹ Notably, this latter framing was deployed during the crack cocaine scare of the 1980s.

As the opioid crisis has been identified with white people, the crack cocaine scare was identified with black people.¹¹² This identification is unsurprising due to crack cocaine's disproportionate impact on low-income black communities. Indeed, crack cocaine *ravaged* these communities. Professor Michelle Alexander's description is particularly evocative. Quoting Professor David Kennedy, she writes that "[c]rack blew through America's poor black neighborhoods like the Four Horsemen of the Apocalypse,' leaving behind unspeakable devastation and suffering."¹¹³ During that apocalyptic moment in this nation's history, however, one was hard pressed to find narratives that described the black persons dependent on crack cocaine as turning to drugs to cope with trauma, or mental health issues, or personal tragedy, or poverty.¹¹⁴ Few commentators broached the possibility that users of crack cocaine might have been trying to silence the demons in their heads. Instead, those who used the drug were themselves demonized. They were portrayed as highly dangerous, hopelessly pathological, and intrinsically criminal.¹¹⁵

Consistent with the generally unchallenged understanding that users of crack cocaine were criminals engaging in criminal acts, state and federal governments in the 1980s led with the criminal system — opting to build more prisons and jails, and to lengthen sentences for drug crimes, including nonviolent ones.¹¹⁶ In dramatic contrast, the nation is attempting to do something different during the present opioid epidemic, making interventions profoundly unlike the ones the state elected to

¹¹¹ See generally PRESIDENT'S COMM'N, INTERIM REPORT, *supra* note 73.

¹¹² See GÓMEZ, *supra* note 16, at 15 (stating that in the 1980s, the media portrayed the typical user of crack cocaine as black and poor and observing that "[n]early half of all the images that accompanied television news stories about the drug scourge featured Black people"); Davis, *supra* note 18, at 310 ("[T]he 1980s news media wove narratives featuring two 'leading characters — the pregnant addict and the crack baby, both irredeemable, both Black'" (quoting DOROTHY ROBERTS, *KILLING THE BLACK BODY* 156 (1997))).

¹¹³ MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* 51 (rev. ed. 2015) (alteration in original) (endnote omitted) (quoting DAVID M. KENNEDY, *DON'T SHOOT* 10 (2011)).

¹¹⁴ See GÓMEZ, *supra* note 16, at 15 ("[M]edia claims-makers told an etiological story about crack cocaine that began and ended in America's ghettos and barrios.").

¹¹⁵ *Id.* at 14–15.

¹¹⁶ See ALEXANDER, *supra* note 113, at 60 ("Drug arrests have tripled since 1980. . . . Despite the fact that most drug arrests are for nonviolent minor offenses, the war on drugs has ushered in an era of unprecedented punitiveness."); see also Donna Murch, *Crack in Los Angeles: Crisis, Militarization, and Black Response to the Late Twentieth-Century War on Drugs*, 102 J. AM. HIST. 162, 162 (2015) (noting that "African American communities of Los Angeles . . . faced an unprecedented scale in the militarization of policing, arrests, and incarceration" due to the drug war).

make during the “War on Drugs” in the 1980s.¹¹⁷ Indeed, the government’s current approach to substance use is remarkably less punitive than its approach just a couple of decades ago, with a few important exceptions.¹¹⁸ Instead of attempting to control the opioid crisis by incarcerating as many users as possible, the state has undertaken relatively progressive efforts to address the use and misuse of opioids, like “instituting] voluntary take-back programs for unused medication[] and disseminating] the opioid overdose reversal medication naloxone, while passing Good Samaritan laws to protect those calling for emergency assistance during an overdose from drug charges.”¹¹⁹

With regard to substance use during pregnancy, commentators have observed that white women who use opioids while pregnant have enjoyed portrayals in political and popular discourse that are more sympathetic than those of their crack cocaine-using counterparts of the 1980s. Discussing a *New York Times* article about opioid use during pregnancy, journalist Joyce McMillan writes: “The lives of the women profiled in the story are complex and the writer makes great effort to mute her judgments and witness the mothers nurturing their children.”¹²⁰ McMillan contrasts this story with articles that the *Times* published during the crack cocaine scare in the 1980s, where black people were depicted as “sex-crazed cocaine addicts[,] and black children born to mothers who used cocaine [were depicted] as broken and irredeemable.”¹²¹

¹¹⁷ See Hansen & Netherland, *supra* note 8, at 2128 (“[A]ddiction neuroscience, biotechnology, federal regulation, and drug marketing each contributed to the representation of the opioid overdose epidemic as a White problem, subject to interventions distinct from those of the US War on Drugs.”).

¹¹⁸ One important exception to the less-punitive approach that the nation has taken to the opioid epidemic is the proliferation of laws that punish those responsible for “drug-induced homicides” — efforts to punish “dealers.” *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane*, DRUG POL’Y ALLIANCE (Nov. 6, 2017), <http://www.drugpolicy.org/resource/DIH> [<https://perma.cc/N6A5-UV52>]. Another important exception, of course, is the criminalization of opioid use during pregnancy.

¹¹⁹ Hansen & Netherland, *supra* note 8, at 2128.

¹²⁰ Joyce McMillan, *How the Media Portrays Black and White Drug Users Differently*, SALON (May 27, 2018, 5:00 PM), <https://www.salon.com/2018/05/27/how-the-media-portrays-black-and-white-drug-users-differently> [<https://perma.cc/W8D9-UW2X>].

¹²¹ *Id.*; see also Editorial Board, Opinion, *The Feticide Playbook, Explained*, N.Y. TIMES (Dec. 28, 2018) [hereinafter *Feticide Playbook*], <https://nyti.ms/2RiAI3o> [<https://perma.cc/7JJN-Z9ES>] (offering contextualized and sympathetic portrayals of opioid-using and -dependent pregnant women). See generally Editorial Board, Opinion, *Slandering the Unborn*, N.Y. TIMES (Dec. 28, 2018) [hereinafter *Slandering the Unborn*], <https://nyti.ms/2RkPPZr> [<https://perma.cc/8CPH-U4F9>] (admitting that the *New York Times* published untruthful, racist descriptions of cocaine-exposed babies during the height of the crack cocaine scare).

Notably, not everyone agrees that contemporary media portrayals of women who use opioids during pregnancy have been compassionate. National Advocates for Pregnant Women — an organization that is at the forefront of theorizing the multiple ways that states have constrained pregnant women’s rights and that litigates on behalf of women whose rights have been diminished on account of their pregnancy — issued an open letter denouncing the “overwhelmingly inaccurate, alarmist and decidedly harmful” media coverage of opioid use by pregnant women. Open Letter

Many observers have concluded that this shift in orientation for dealing with and thinking about drug use is due to the change in the affected population. Because the crack cocaine scare of the 1980s was racialized as black, the nation decided to try to imprison its way out of it.¹²² Because the contemporary opioid crisis has been racialized as white, the nation has been receptive to trying to treat its way out of it.¹²³ The Trump Administration's choice to declare the epidemic a public health emergency is a telling illustration of this new, shifted orientation.¹²⁴

B. Pregnancy and the Opioid Epidemic

This section explores how healthcare providers and researchers have approached opioid use during pregnancy. While precise numbers are difficult to acquire, it appears that tens of thousands of pregnant women use opioids. There is substantial agreement among healthcare providers about how to care for pregnant users of opioids as well as infants who have been exposed to opioids in utero. Notably, none of these courses of care involve criminal punishment.

According to the Substance Abuse and Mental Health Services Administration, the government agency that is responsible for studying and mitigating the effects of substance use and dependence,¹²⁵ from 2007–2012, 21,000 (0.9% of) pregnant women ages fifteen to forty-four reported misusing opioids, with “misuse” defined as use of heroin or nonmedical use of prescription-type pain relievers in the past month.¹²⁶

from the Nat'l Advocates for Pregnant Women to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opioid Use by Pregnant Women (Mar. 11, 2013) [hereinafter Nat'l Advocates, Open Letter], <http://advocatesforpregnantwomen.org/Opioid%20Open%20Letter%20-%20March%202013%20-%20FINAL.pdf> [https://perma.cc/GVA6-YDPK].

¹²² See Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299, 334 (2013) (“[T]he willingness to believe that cocaine, and especially crack cocaine, required uniquely punitive responses was derived in large measure from racist assumptions about African Americans in general and African American mothers in particular.” (citation omitted)).

¹²³ See Egan, *supra* note 95 (“[T]he perception of our opioid crisis as an *epidemic*, rather than a racial pathology, owes much to the fact that white Americans have been hard hit.”).

¹²⁴ See James G. Hodge, Jr., et al., *Redefining Public Health Emergencies: The Opioid Epidemic*, 58 JURIMETRICS 1, 3–4 (2017).

¹²⁵ *About Us*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., <https://www.samhsa.gov/about-us> [https://perma.cc/2FFJ-MQH9].

¹²⁶ Kelley Smith & Rachel Lipari, Substance Abuse & Mental Health Servs. Admin., *Women of Childbearing Age and Opioids*, CBHSQ REP. (Jan. 17, 2017), https://www.samhsa.gov/data/sites/default/files/report_2724/ShortReport-2724.html [https://perma.cc/Y96F-BVSE]. More generally, 4.5% of pregnant women ages fifteen to forty-four reported using illicit drugs during their pregnancies. See Sarah E. Smith, Note, *No Safe Harbors: Examining the Shift from Voluntary Treatment Options to Criminalization of Maternal Drug Use in Tennessee*, 46 U. MEM. L. REV. 203, 207 (2015) [hereinafter *No Safe Harbors*]. In reality, *most* pregnant women take controlled substances at some point during their pregnancies. As Nina Martin reports, “as many as 9 in 10 expectant mothers use medications — for ailments that occur before they even realize they’re pregnant; for complications

(However, this may be a substantial undercount, as another study reports that in 2007, 22.8% of Medicaid-enrolled women in forty-six states who completed pregnancies filled an opioid prescription while pregnant.¹²⁷)

It is worth noting that opioid use is not opioid use disorder. Some of the tens of thousands of pregnant women who use opioids each year do so pursuant to physician-prescribed pain management plans.¹²⁸ Others use opioids as appropriate treatment for an opioid dependence.¹²⁹ And still others use opioids as a result of an uncontrolled opioid use disorder.

Most healthcare professionals propose that when opioid use has developed into an opioid use disorder, and when that opioid use disorder intersects with pregnancy, the best response is not to arrest and prosecute the pregnant woman, but rather to ensure that she receives prenatal care.¹³⁰ Prenatal care (and healthcare, generally¹³¹) demonstrably improves pregnancy outcomes — even if the pregnant woman continues to use opioids.¹³²

Further, most providers agree that the best course of action is to use medication-assisted treatment (MAT) to stabilize a pregnant woman with an opioid use disorder.¹³³ Close to half of the 8292 treatment episodes of pregnant persons with opioid use disorder in 2012 involved

such as morning sickness, early labor, or gestational diabetes; and for chronic conditions such as epilepsy, high blood pressure, or depression that often become more challenging to manage as the months pass.” Nina Martin, *Most Drugs Aren’t Tested on Pregnant Women. This Anti-nausea Cure Shows Why That’s a Problem*, PROPUBLICA (May 26, 2016, 8:00 AM), <https://www.propublica.org/article/most-drugs-not-tested-pregnant-women-anti-nausea-cure-why-thats-a-problem> [<https://perma.cc/75P8-GXJJ>]; see also *Treating for Two: Medicine and Pregnancy*, CENTERS FOR DISEASE CONTROL & PREVENTION (May 28, 2018), <https://www.cdc.gov/pregnancy/meds/treatingfortwofacts.html> [<https://perma.cc/6WQ8-T8SR>] (“9 in 10 women report taking some type of medicine during pregnancy, and 7 in 10 report taking at least one prescription medicine.”). Nevertheless, policymakers have decided to focus on pregnant women’s use of opioids.

¹²⁷ See Comm. on Obstetric Practice & Am. Soc’y of Addiction Med., *ACOG Committee Opinion Number 711: Opioid Use and Opioid Use Disorder in Pregnancy*, 130 OBSTETRICS & GYNECOLOGY e81, e82 (2017) [hereinafter *Committee Opinion Number 711*].

¹²⁸ See *Committee Opinion Number 711*, *supra* note 127, at e83 (“[A] cautious approach to prescribing opioids should be balanced with the need to address pain in the pregnant woman. Pregnancy should not be a reason to avoid treating acute pain because of concern for opioid misuse or [neonatal abstinence syndrome].”).

¹²⁹ See *id.* at e86.

¹³⁰ See *id.* at e81 (“In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families.”).

¹³¹ See generally MIRANDA R. WAGGONER, *THE ZERO TRIMESTER: PRE-PREGNANCY CARE AND THE POLITICS OF REPRODUCTIVE RISK* (2017).

¹³² See *Committee Opinion Number 711*, *supra* note 127, at e90.

¹³³ See *id.* at e82 (recommending opioid agonist pharmacotherapy instead of medically supervised withdrawal for pregnant women with an opioid use disorder). Some researchers reject the term “medication-assisted treatment,” preferring “medication” or “treatment” instead, as “medication-assisted treatment” implies that the opioid substitute must be given *in addition to* another, primary treatment modality. See Sarah E. Wakeman, Comment, *Medications for Addiction Treatment: Changing Language to Improve Care*, 11 J. ADDICTION MED. 1, 1 (2017). “Medication-assisted treatment” implies that the opioid substitute is insufficient in itself. *Id.*

MAT¹³⁴ — a percentage that most experts believe ought to be increased.¹³⁵ MAT consists of a constant, usually daily, dosage of methadone or another opioid substitute.¹³⁶ The substitute “binds to the body’s opioid receptors to prevent withdrawal symptoms, usually without causing the euphoric sensations that commandeer the brain’s dopamine system into a relentless quest for more.”¹³⁷ MAT is the standard of care for treating opioid use disorder during pregnancy.¹³⁸ MAT is preferred to complete abstinence from opioids because complete withdrawal, even when medically supervised, has relapse rates of fifty-nine percent to greater than ninety percent.¹³⁹ Further, relapses after complete abstinence are particularly deadly.¹⁴⁰ Additionally, complete withdrawal from opioids may cause the uterus to contract, which may result in miscarriage or premature delivery.¹⁴¹

The effects that opioids have on babies who are exposed prenatally arguably bear the most responsibility for the punitive approach that many states have been willing to take to opioid use during pregnancy. Infants exposed to opioids in utero, including those born to women who have been maintained on methadone or another opioid substitute,¹⁴² may develop neonatal abstinence syndrome (NAS).¹⁴³ NAS develops in some, but not all, infants exposed to narcotics in utero.¹⁴⁴ Symptoms of

¹³⁴ See Cara Angelotta et al., *A Moral or Medical Problem? The Relationship Between Legal Penalties and Treatment Practices for Opioid Use Disorders in Pregnant Women*, 26 WOMEN’S HEALTH ISSUES 595, 598 (2016) (“Overall in the United States in 2012, MAT was used in 46.64% . . . of treatment episodes of pregnant women with a primary opioid use disorder.”). Of note, eighty-five percent of the 8292 pregnant women treated for opioid use disorders were white, and eighty-three percent of those who received MAT were white. See *id.* at 598 tbl.2.

¹³⁵ See *id.* at 599 (observing that less than half of pregnant people with an addiction to opioids received MAT and stating that “[t]his suggests that too few pregnant women with opioid use disorders are receiving a treatment that improves outcomes for both mother and infant”).

¹³⁶ See Egan, *supra* note 95.

¹³⁷ *Id.*

¹³⁸ *Id.*; see also *Committee Opinion Number 711*, *supra* note 127, at e87.

¹³⁹ See *Committee Opinion Number 711*, *supra* note 127, at e87.

¹⁴⁰ David Sack, *When Relapse Turns Deadly: What You Need to Know About Drug Overdose*, HUFFINGTON POST (Sept. 21, 2013), https://www.huffingtonpost.com/david-sack-md/drug-overdose_b_3634486.html [<https://perma.cc/5PEQ-VD2W>].

¹⁴¹ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., METHADONE TREATMENT FOR PREGNANT WOMEN (2014) [hereinafter SAMHSA, METHADONE TREATMENT FOR PREGNANT WOMEN], <https://store.samhsa.gov/system/files/sma14-4124.pdf> [<https://perma.cc/4ASZ-76YT>].

¹⁴² Between forty-seven and fifty-seven percent of pregnant women receiving MAT give birth to infants that exhibit symptoms of NAS. See Jason R. Wiles et al., *Current Management of Neonatal Abstinence Syndrome Secondary to Intrauterine Opioid Exposure*, 165 J. PEDIATRICS 440, 440 (2014).

¹⁴³ Most experts agree that the dangers of an infant being born with NAS as a result of its mother’s MAT are fewer than the dangers of a pregnant woman with opioid use disorder going untreated or abstaining from opioid use altogether. Jennifer Egan quotes a neonatologist as saying: “As a society, if we’re thinking about the trade-off, it is much better to get Mom into treatment, for her health and her infant’s health, and then have some risk of neonatal abstinence syndrome” Egan, *supra* note 95.

¹⁴⁴ See Bach, *supra* note 19, at 831–32.

NAS, which typically develop within twenty-four to seventy-two hours after birth, include uncontrollable shaking and seizures, constant crying, vomiting and diarrhea, and a rapid respiratory rate.¹⁴⁵ Neonatologists have demonstrated that NAS symptoms can be reduced or eliminated¹⁴⁶ by simply allowing babies to breastfeed and have skin-to-skin contact with their mothers.¹⁴⁷ Indeed, officials advise that properly swaddling a baby with NAS and placing it in a comfortable environment can alleviate its symptoms.¹⁴⁸ Nevertheless, at present, many hospitals tend to take infants with NAS away from their mothers and place them in neonatal intensive care units.¹⁴⁹ And many times, hospitals give infants with severe symptoms an opioid, like methadone or morphine, to help alleviate their symptoms¹⁵⁰ — a course of treatment that many experts believe to be unnecessary, as a host of studies shows that “rooming in” can better achieve the same goal.¹⁵¹ While some research reports that babies with NAS are at risk for negative health outcomes,¹⁵² there is widespread agreement that NAS is transitory and treatable.¹⁵³ Although there is no evidence NAS has any lasting adverse

¹⁴⁵ See BISHOP ET AL., *supra* note 104, at 17 (describing NAS symptoms).

¹⁴⁶ See Megan W. Stover & Jonathan M. Davis, *Opioids in Pregnancy and Neonatal Abstinence Syndrome*, 39 SEMINARS PERINATOLOGY 561, 563 (2015) (noting that “breastfeeding has been associated with a decrease in the incidence and severity of NAS”).

¹⁴⁷ See, e.g., Gabrielle K. Welle-Strand et al., *Breastfeeding Reduces the Need for Withdrawal Treatment in Opioid-Exposed Infants*, 102 ACTA PAEDIATRICA 1060, 1064 (2013).

¹⁴⁸ SAMHSA, METHADONE TREATMENT FOR PREGNANT WOMEN, *supra* note 141 (stating that “[m]any times a quiet, comfortable environment is enough to provide comfort to” babies with NAS).

¹⁴⁹ Lauren Vogel, *Newborns Exposed to Opioids Need Mothers More Than NICU, Say Pediatricians*, 190 CANADIAN MED. ASS’N J. E123, E123 (2018).

¹⁵⁰ *Id.*

¹⁵¹ Kathryn Dee L. MacMillan et al., *Association of Rooming-in with Outcomes for Neonatal Abstinence Syndrome: A Systematic Review and Meta-analysis*, 172 JAMA PEDIATRICS 345, 346 (2018) (concluding that “rooming-in was associated with a reduction in the need for pharmacologic treatment and a shorter hospital stay when rooming-in was compared with standard neonatal intensive care unit admission for neonatal abstinence syndrome”); Tolulope Saiki et al., *Neonatal Abstinence Syndrome — Postnatal Ward Versus Neonatal Unit Management*, 169 EUR. J. PEDIATRICS 95, 96, 97 tbl.2 (2010) (reporting that eleven percent of babies with NAS who stayed with their mothers required an opioid to alleviate their symptoms, while close to half of their counterparts who were placed in a neonatal intensive care unit required the same).

¹⁵² See BISHOP ET AL., *supra* note 104, at 16 (noting that babies born with NAS “are more likely to exhibit intrauterine growth restriction, lower birth weight, and smaller head circumference, and to be smaller for gestational age”); Bach, *supra* note 19, at 832 (stating that infants with NAS “can have increased rates of perinatal mortality” and are at increased risk of sudden infant death syndrome).

¹⁵³ See Bach, *supra* note 19, at 832–33.

consequences,¹⁵⁴ the first study on the long-term effects of NAS is still underway.¹⁵⁵

The documented number of babies born with NAS has increased since the opioid epidemic first enveloped the nation — in part because healthcare workers are now on the lookout for it.¹⁵⁶ One study reports that between 2004 and 2013, rates of NAS increased sevenfold in rural areas and fourfold in urban areas.¹⁵⁷ Documented cases of NAS have been more ubiquitous in the regions of the country hit hardest by the opioid epidemic. In Tennessee, where the crisis has been particularly devastating, there were only fifty-seven cases of NAS in 2000.¹⁵⁸ However, by 2013, the state had around 900 cases;¹⁵⁹ by 2017, the figure had climbed to 1090 cases.¹⁶⁰

The use of opioids during pregnancy has been an aspect of the current epidemic with which healthcare providers — and governments — have wrestled.¹⁶¹ And as it turns out, pregnancy may represent an exception to the overall national willingness to treat the opioid epidemic as an issue of public health and not of law enforcement. As journalist Melissa Jeltsen writes: “There’s a growing consensus in the U.S. that drug addiction is a public health issue, and sufferers need treatment, not prison time. But good luck if you are pregnant.”¹⁶² The next Part explores this pregnancy exception to the general rule.

¹⁵⁴ *Id.*; Walter K. Kraft & John N. van den Anker, *Pharmacologic Management of the Opioid Neonatal Abstinence Syndrome*, 59 PEDIATRIC CLINICS N. AM. 1147, 1150 (2012) (stating that “there is no evidence of long-term adverse outcomes in children treated with pharmacologic agents in comparison with infants who do not require treatment for NAS”).

¹⁵⁵ See Stephen W. Patrick, Editorial, *The Triple Aim for Neonatal Abstinence Syndrome*, 167 J. PEDIATRICS 1189, 1190–91 (2015); Egan, *supra* note 95.

¹⁵⁶ This is to say that while some of the increase in the documented number of babies born with NAS may be due to an increase in opioid use during pregnancy, some of the increase may be due to healthcare workers looking for signs of NAS in babies. Before the opioid epidemic, those same symptoms might have been treated (or not) without the label of NAS being attached to them.

¹⁵⁷ See Davis, *supra* note 18, at 309.

¹⁵⁸ See *No Safe Harbors*, *supra* note 126, at 208.

¹⁵⁹ ANGELA MILLER & MICHAEL WARREN, TENN. DEP’T OF HEALTH, HOSPITAL-BASED SURVEILLANCE FOR NEONATAL ABSTINENCE SYNDROME IN TENNESSEE, 2013, https://www.tn.gov/content/dam/tn/health/documents/nas/NAS_Annual_report_2013_FINAL.pdf [<https://perma.cc/QFQ6-946J>]; *No Safe Harbors*, *supra* note 126, at 208.

¹⁶⁰ ANGELA M. MILLER ET AL., TENN. DEP’T OF HEALTH, NEONATAL ABSTINENCE SYNDROME SURVEILLANCE ANNUAL REPORT 2017, at 3, <https://www.tn.gov/content/dam/tn/health/documents/nas/NAS%20Annual%20Report%202017%20FINAL.pdf> [<https://perma.cc/SLY8-96Q9>].

¹⁶¹ *Committee Opinion Number 711*, *supra* note 127, at e81 (“Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population.”).

¹⁶² Melissa Jeltsen, *Please, Stop Locking Up Pregnant Women for Using Drugs*, HUFFINGTON POST (Jan. 11, 2016, 2:32 PM), https://www.huffingtonpost.com/entry/pregnant-drugs-crime_us_5692eagee4bocad15e653ddo [<https://perma.cc/FMD2-CDD5>]. Egan expresses a similar sentiment when she writes: “Addiction is now widely recognized as a mental disorder, and the medical establishment and communities are more likely to treat people with drug dependency as victims

II. SUBSTANCE USE DURING PREGNANCY AND THE LAW

Historically and presently, lawmakers have felt the need to address the fact of substance use during pregnancy.¹⁶³ At times, they have attempted to assist pregnant women struggling with substance use disorders — helping them find treatment for their conditions; at other times, lawmakers have sought to penalize pregnant women for using drugs and thereby risking harm to their fetuses. At all times, however, the state professes to act in pursuit of the health and safety of infants.

The state's approach to substance use during pregnancy might be schematized into those efforts that involve civil systems and those that involve criminal systems. The following sections describe these two approaches.

A. Civil Systems

Addressing substance use during pregnancy through civil systems reflects a state's sense that substance use during pregnancy involves questions of child abuse and neglect.¹⁶⁴ Exposing a fetus to substances in utero might be understood as a pregnant woman actively harming a fetus — that is, as an issue of child abuse. Alternatively, substance use during pregnancy might be understood as casting doubt on the ability of the pregnant woman to meet a child's basic needs — that is, as an issue of child neglect. However conceptualized, states that choose to deal with substance use during pregnancy with civil systems call upon their existing child welfare bureaucracies to assess parental fitness and, when deemed appropriate, to remove infants from their birth parents and place them in homes that the child welfare agencies believe to be more suitable.

of an illness. *But this more generous spirit rarely extends to pregnant women . . . , who are still widely seen as perpetrators.*" Egan, *supra* note 95 (emphasis added).

¹⁶³ It bears noting that many find problematic the attention that lawmakers have paid to substance use during pregnancy. This disquietude is due to the sense that lawmakers myopically worry about the effects that *controlled* substances may have on fetuses while ignoring the vast amounts of *uncontrolled* substances, as well as structural conditions (like poverty, police violence in communities of color, the inaccessibility of health insurance and healthcare for many, and so forth), that have been demonstrated to negatively impact fetal health and people's health, generally. See generally CTR. FOR REPROD. RIGHTS, PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY: AN APPROACH THAT UNDERMINES WOMEN'S HEALTH AND CHILDREN'S INTERESTS (2000), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_punishingwomen.pdf [<https://perma.cc/4XR9-KFST>].

¹⁶⁴ Understanding pregnancy — a condition that many believe does not involve children, but rather *fetuses* — to implicate questions of *child* maltreatment arguably reflects the hotly contested view that fetuses are indistinct from already-born children. This view has been advanced to argue against the constitutionality and legality of abortion. See Paltrow & Flavin, *supra* note 122, at 322–23.

As an expression of their police powers, states have the primary authority to address child abuse and neglect.¹⁶⁵ However, in 1974,¹⁶⁶ Congress passed the Child Abuse Prevention and Treatment Act¹⁶⁷ (CAPTA), providing federal monies to states that reformed their child protection systems in line with federal guidelines.¹⁶⁸ The 2003 amendment to CAPTA requires states receiving these federal grants to have in place policies and procedures that “address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.”¹⁶⁹ The statute specifies that these policies and procedures must include “referrals to and delivery of appropriate services for the infant and affected family or caregiver.”¹⁷⁰ Largely in response to CAPTA,¹⁷¹ twenty-three states and the District of Columbia currently have laws that require healthcare providers to report substance use during pregnancy to the state’s child protective agency.¹⁷² The twenty-seven states that have not passed laws specifying providers’ responsibilities “are still required under federal law to have policies or procedures in place to address needs of infants exposed to substances in utero, although these policies might not be enacted by statute or codified in regulations.”¹⁷³

Although CAPTA creates a floor under which states’ regulation of substance use during pregnancy ought not to dip, there is still significant

¹⁶⁵ See ROGER J.R. LEVESQUE, CHILD MALTREATMENT AND THE LAW: RETURNING TO FIRST PRINCIPLES 25 (2008).

¹⁶⁶ Child Abuse Prevention and Treatment Act, Pub. L. No. 93-247, 88 Stat. 4 (1974) (codified as amended at 42 U.S.C. §§ 5101–5106, 5108, 5116 (2012)).

¹⁶⁷ 42 U.S.C. §§ 5101–5106, 5108, 5116.

¹⁶⁸ See Gerard F. Glynn, *The Child’s Representation Under CAPTA: It Is Time for Enforcement*, 6 NEV. L.J. 1250, 1251–52 (2006).

¹⁶⁹ Keeping Children and Families Safe Act of 2003, Pub. L. No. 108-36, § 114(b)(1)(B)(ii), 117 Stat. 800, 809 (codified at 42 U.S.C. § 5106(a)). In 2016, CAPTA was amended by the Comprehensive Addiction and Recovery Act of 2016 (CARA), Pub. L. No. 114-198, 130 Stat. 695 (codified in scattered sections of 21, 34, 38, and 42 U.S.C.). CARA requires states that receive CAPTA funds to produce an annual report detailing the number of substance-exposed infants born in the state as well as information describing how the state managed those cases. See *id.* § 503(c), 130 Stat. at 730. CARA also amended CAPTA to oblige healthcare providers in states receiving CAPTA funds to report cases of infants who had been born affected by alcohol — a substance that was omitted from the 2003 statute. See *id.* § 503(b), 130 Stat. at 729–30.

¹⁷⁰ § 503(b), 130 Stat. at 730.

¹⁷¹ While the passage of CAPTA may have prompted some states to pass laws requiring providers to report a pregnant woman’s substance use to child protection authorities, other states’ laws equating substance use during pregnancy with child maltreatment preceded the 2003 CAPTA amendment. See, e.g., *In re Baby Boy Blackshear*, 736 N.E.2d 462, 465 (Ohio 2000) (holding that prenatal exposure to illegal drugs constitutes child abuse under state law).

¹⁷² See Marian Jarlenski et al., *Characterization of U.S. State Laws Requiring Health Care Provider Reporting of Perinatal Substance Use*, 27 WOMEN’S HEALTH ISSUES 264, 266 (2017). In four states, statutes expressly state that when healthcare providers report substance use during pregnancy to child welfare authorities, those reports cannot be used in a subsequent criminal prosecution of the pregnant person. *Id.* at 267.

¹⁷³ *Id.* at 266.

state-by-state variation in the practice of reporting substance use during pregnancy. This is largely because CAPTA left a lot of room for interpretation. Namely, what does it mean for an infant to be “affected by” substance use during pregnancy? Must a pregnant woman’s substance use be *severe* in order for her fetus to be “affected by” it? Or is *any* substance use sufficient to come within the terms of the statute? If an infant shows signs of withdrawal from prenatal substance exposure, is that a necessary condition for triggering the reporting obligation? Is it a sufficient condition? Expectedly, states have arrived at different answers to these questions. Among the twenty-four jurisdictions with specific laws around healthcare providers’ reporting obligations, twenty jurisdictions require providers to report any and all substance use.¹⁷⁴ Meanwhile, four states require reporting only when “the substance use was associated with child maltreatment,” thus letting providers determine whether substance use during pregnancy has resulted in actual harm to the infant or whether the substance use is so severe as to suggest that it will interfere with the individual’s ability to adequately parent her child.¹⁷⁵

Within the state-by-state variation exists practice-by-practice variation. When states have given providers the discretion to report substance use only when it rises to the level of child maltreatment, providers will answer the question differently. The result is that a finding of substance use during pregnancy has very different consequences throughout the fifty states. The American College of Obstetricians and Gynecologists has noted this variability, writing that when it comes to providers’ reporting obligations, “South Carolina relies on a single positive drug test result, Florida mandates reporting newborns that are ‘demonstrably adversely affected’ by prenatal drug exposure, and in Texas, an infant must be ‘addicted’ to an illegal substance at birth.”¹⁷⁶

Another key axis of variation between states is how they define *child abuse* and *child neglect*. It is within the purview of the state to provide

¹⁷⁴ See *id.* at 264.

¹⁷⁵ See *id.* Many researchers believe that an obligation to report all substance use during pregnancy to child welfare authorities is overbroad, arguing that substance use is only a “risk factor” for child maltreatment. Lester et al., *supra* note 110, at 36. Lester and his coauthors contend that “[r]eporting to CPS [ought to be required only] when the standardized assessment battery indicates evidence of inadequate parenting that places the child at risk for abuse/neglect in addition to drug use.” *Id.* Moreover, the Jacobs Institute of Women’s Health states that even when substance use during pregnancy is severe enough to produce withdrawal symptoms in an infant, it still may not be enough to constitute child maltreatment. See BISHOP ET AL., *supra* note 104, at 47 (“[M]edical experts agree that withdrawal symptoms in an infant are not evidence of harm or abuse by the mother.”).

¹⁷⁶ COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION NUMBER 473: SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST 1 (2011).

those definitions.¹⁷⁷ A provider's obligation to report substance use during pregnancy does not mean that the substance use constitutes child abuse and neglect sufficient to open a child protective services investigation¹⁷⁸ — which might culminate in the removal of the infant from the home and the termination of parental rights. Authorities that receive a provider's report of a case of substance use during pregnancy may simply choose to do nothing more than follow up with the pregnant woman over the course of her pregnancy, intervening only if it appears that her drug use is so severe that it has made her incapable of adequately caring for her child.¹⁷⁹ However, twenty-three states and D.C. have rejected this less-intrusive possibility, specifically defining substance use during pregnancy as child abuse under state law.¹⁸⁰

Another key axis on which states vary is how they handle drug testing. Although CAPTA obligates states to develop policies and procedures around reporting substance use during pregnancy to child welfare authorities, there remains the question of how substance use during pregnancy will come to the attention of healthcare providers. That is, how will a doctor or nurse know that a pregnant patient has been using substances? The answer is that drug testing usually will reveal it. But toxicology testing is not a standard element of prenatal care;¹⁸¹ nor are drug tests typically part of the battery of tests that are given to infants upon birth.¹⁸² Accordingly, there is a question about which pregnant women and which infants healthcare providers will test for the presence of drugs or drug metabolites in their systems.¹⁸³ Eight states mandate that providers test for prenatal drug exposure where they have a suspicion that there might have been substance use during pregnancy.¹⁸⁴ But

¹⁷⁷ CAPTA does not provide a robust definition of child abuse and neglect, allowing states to work out definitions on their own. See 42 U.S.C. §§ 5101–5106, 5108, 5116 (2012).

¹⁷⁸ See CRIMINALIZING PREGNANCY, *supra* note 20, at 20 (“Though reporting cases of child abuse or neglect to child protective services (CPS) is required, it is up to each state . . . to decide if the infant was in fact ‘affected’ by an illegal substance and if this qualifies as child abuse. . . . [N]ot all states include drug exposure in their definitions of child abuse and neglect.”); U.S. CHILDREN’S BUREAU, PARENTAL DRUG USE AS CHILD ABUSE 2, www.childwelfare.gov/pubPDFs/drugexposed.pdf [<https://perma.cc/L3MG-7EXN>].

¹⁷⁹ See CRIMINALIZING PREGNANCY, *supra* note 20, at 20; NAT’L ADVOCATES FOR PREGNANT WOMEN, UNDERSTANDING CAPTA AND STATE OBLIGATIONS 2 (2018).

¹⁸⁰ See *Substance Use During Pregnancy*, GUTTMACHER INST. (Oct. 1, 2019), <https://www.guttmacher.org/print/state-policy/explore/substance-use-during-pregnancy> [<https://perma.cc/AEP4-WBRC>]. The Pennsylvania Supreme Court recently held that substance use during pregnancy should not be understood as civil child abuse under state law. *In re L.J.B.*, 199 A.3d 868, 870 (Pa. 2018).

¹⁸¹ Adam J. Zolotor & Martha C. Carlough, *Update on Prenatal Care*, 89 AM. FAM. PHYSICIAN 199, 200 tbl.1 (2014) (failing to list toxicology tests among typical prenatal tests).

¹⁸² See Karen J. Farst et al., *Drug Testing for Newborn Exposure to Illicit Substances in Pregnancy: Pitfalls and Pearls*, INT’L J. PEDIATRICS, 2011, at 1, 1–2 (“[Alcohol and nicotine] are rarely included in newborn screening or reporting policies.” (endnote omitted)).

¹⁸³ *Id.* at 2 (“[CAPTA] leaves the decision [of] who should be tested to the healthcare provider.”).

¹⁸⁴ See *Substance Use During Pregnancy*, *supra* note 180.

the behavior or characteristics that raise a provider's suspicions are subjective, allowing for a great deal of variability as to whom a provider tests for substances in the first instance.¹⁸⁵ Many have held selective testing responsible for the higher rates by which marginalized women — that is, poor women and women of color — are identified as having used substances during pregnancy, are reported to child protective services, and are prosecuted for their substance use during pregnancy.¹⁸⁶ One study found that the overall prevalence of drug or alcohol use was similar among women who received care from private physicians and those who received care at public health clinics.¹⁸⁷ Further, studies have found rates of substance use during pregnancy to be similar across racial groups.¹⁸⁸ Nevertheless, poor women are overrepresented among those who are subject to “court-ordered interventions” during pregnancy.¹⁸⁹ The same has been true for women of color — at least historically.¹⁹⁰ Scholars, understanding selective testing to explain this happenstance, have proposed that the way to eliminate discriminatory consequences is to institute policies requiring drug testing for all pregnant women.¹⁹¹

On top of the state-by-state variation in using child welfare bureaucracies to address substance use during pregnancy, some states have

¹⁸⁵ See Lester et al., *supra* note 110, at 32 (“Targeted testing . . . introduces the possibility of significant bias in decision-making. Tremendous inconsistency is inevitable with targeted testing because it is highly plausible that identification can more be a function of area of residence, hospital policy, and physician prerogative.” (endnote omitted)).

¹⁸⁶ See, e.g., Ira J. Chasnoff et al., Special Article, *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1206 (1990) (“[T]he preconception that substance abuse . . . is a problem that affects minority . . . and lower socioeconomic groups could bias physicians in identifying substance exposure in newborn infants. This would result in more frequent suspicion of intrauterine drug exposure and, thus, a higher rate of testing and reporting of infants born to black or poor women.”).

¹⁸⁷ See *id.* at 1205.

¹⁸⁸ See, e.g., Lester et al., *supra* note 110, at 33.

¹⁸⁹ See *id.*; Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, HEALTH & JUST., Feb. 12, 2015, at 1, 3.

¹⁹⁰ See Stone, *supra* note 189, at 3; *supra* notes 16–18 and accompanying text.

¹⁹¹ See Sarah C.M. Roberts & Amani Nuru-Jeter, *Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting*, 39 J. BEHAV. HEALTH SERVS. & RES. 3, 4 (2012) (“With few exceptions, there is a growing consensus that universal screening for alcohol and illicit drug use should be the standard of care in prenatal care.” (endnotes omitted)). However, at least one set of researchers has called into question the assumption that universal drug testing will eradicate the disproportionate rates by which healthcare providers report poor women and women of color to child welfare bureaucracies and law enforcement. Professors Sarah Roberts and Amani Nuru-Jeter conducted a study showing that even in a program of universal screening, black women are still more likely to be reported to child welfare authorities. See *id.* at 14 (“[T]his study shows that rates of [child protective services] reporting of White newborns are lower than Black newborns . . .”). In light of their findings, Roberts and Nuru-Jeter conclude that “universal screening alone does not eliminate reporting disparities.” *Id.* at 15.

moved beyond these organizations when electing to use their civil systems to address this issue. Three states provide that a pregnant woman can be civilly committed if she uses certain substances.¹⁹²

Advocates for addressing substance use during pregnancy through states' child welfare bureaucracies invariably defend the approach as one that protects the health and safety of infants. However, opponents of this approach wholeheartedly reject this claim, insisting that child welfare bureaucracies' impulse to separate babies from their birth parents is brutal, inhumane, and does more harm than good.¹⁹³

While states have relied quite extensively on civil systems to address substance use during pregnancy, they have deployed criminal systems abundantly as well. Further, in the throes of the opioid epidemic, the women swept within the jurisdiction of these systems are frequently white. The next section describes the ways that states have used criminal systems to confront substance use during pregnancy.

B. Criminal Systems

Every medical and public health organization of record that has addressed the issue of pregnant women and drug use has opposed arresting and prosecuting pregnant women with a substance use disorder.¹⁹⁴ The general sense is that punishing any person for having a substance use disorder while pregnant is analogous to pressing charges against a person for having schizophrenia or Tourette syndrome while pregnant: the person would be punished for being pregnant while suffering from a

¹⁹² See *Substance Use During Pregnancy*, *supra* note 180. One of the states, Wisconsin, passed the law authorizing the civil detention of women for substance use during pregnancy after the Wisconsin Supreme Court held that although the existing law allowed for the state to take protective custody of a "child" when it appears that the child's welfare is endangered, the term "child" did not apply to an entity that is not yet born. See *State ex rel. Angela M.W. v. Kruzicki*, 561 N.W.2d 729, 736 (Wis. 1997).

¹⁹³ See *Committee Opinion Number 711*, *supra* note 127, at e83 ("[O]bstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed."); Lester et al., *supra* note 110, at 39 ("The great tragedy is that we are only harming the children. We harm them by denying service, by increasing the number of children in out of home placement, by undermining the ability of the children to form attachment relationships, and by labeling these children as damaged.")

¹⁹⁴ See Stephen W. Patrick & Davida M. Schiff, Comm. on Substance Use & Prevention, *A Public Health Response to Opioid Use in Pregnancy*, PEDIATRICS, Mar. 2017, at 1, 3 ("More than 20 national organizations have . . . published statements against the prosecution and punishment of pregnant women who use illicit substances . . ."). Among these organizations are:

[T]he American Medical Association, the [American Academy of Family Physicians], the [American College of Obstetricians and Gynecologists], the American Public Health Association, the American Nurses Association, the American Psychiatric Association, the National Perinatal Association, the American Society of Addiction Medicine, the March of Dimes, and the Association of Women's Health, Obstetric and Neonatal Nurses.

Id.

medical condition.¹⁹⁵ Nevertheless, despite the near unanimous opinion of experts in the health sciences, arrests and prosecutions of women for substance use during pregnancy occur. Scholars estimate that at least 1000 women have been arrested for drug use during pregnancy.¹⁹⁶ More than half of those prosecutions have taken place within the last ten years.¹⁹⁷

Positive toxicology screens administered by healthcare providers trigger most of the prosecutions of women for substance use during pregnancy.¹⁹⁸ Sometimes providers share these results with law enforcement agents directly;¹⁹⁹ at other times, they share the results with child welfare authorities, who then pass them along to police or the local prosecutor.²⁰⁰

The most repeated justification for criminalizing substance use during pregnancy is that the criminal legal system is an effective mechanism for convincing pregnant women with a substance use disorder to get treatment. While some efforts to criminalize are retributive,²⁰¹ the dominant impulse has been deterrent.²⁰² The idea is that if the state has the

¹⁹⁵ See Lester et al., *supra* note 110, at 12 (describing a view that suggests that “not only is it ineffective to treat drug and alcohol addiction as a criminal act, but it is also a punitive approach that is akin to criminalizing mental illness”).

¹⁹⁶ See Bach, *supra* note 19, at 840 n.213 (estimating that over 1000 women have been prosecuted for substance use during pregnancy); see also *If Roe Goes — More Than Abortion Is at Stake*, NAT’L ADVOCATES FOR PREGNANT WOMEN (Sept. 28, 2018), http://advocatesforpregnantwomen.org/issues/the_abortion_diversion/if_roe_goes_graphic.php [https://perma.cc/27BE-SSJN] (showing that over 1200 pregnant women have been arrested for crimes in which pregnancy was a necessary element of the crime). It is difficult to get an accurate count of the number of prosecutions of pregnant women for their substance use because many criminal courts in the various states do not have consistent or reliable systems for keeping this data. See Bach, *supra* note 19, at 841 n.213 (noting that the data likely undercounts prosecutions because “every researcher who has attempted to gather this data has noted the significant difficulties in finding complete data due in large part to the ways criminal court records are kept”).

¹⁹⁷ See Priscilla A. Ocen, *Birth Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163, 1174 (2017).

¹⁹⁸ Of course, as noted above, there are no universal rules or standards regarding when providers will administer drug screens to pregnant women or their infants. See *supra* pp. 801–02.

¹⁹⁹ Paltrow & Flavin, *supra* note 122, at 328.

²⁰⁰ See CRIMINALIZING PREGNANCY, *supra* note 20, at 9 (noting that in the states surveyed in the report, healthcare providers called child welfare officials to report a positive drug screen and that these officials decided whether to share with law enforcement the results of their initial investigations). Of course, it is entirely within the discretion of the prosecutor to bring charges — or not — against any person who tests positive for substances while pregnant. See *id.* (observing that the evidence from Tennessee “indicates that some prosecutors were enforcing the [state’s fetal assault] law much more aggressively than others”).

²⁰¹ See Lester et al., *supra* note 110, at 12 (describing a view that conceptualizes drug use during pregnancy as involving “a voluntary and illegal act that requires significant neglect of the rights of the fetus” and observing that this view sees “women who use drugs during their pregnancy [as] willfully committing a criminal act, deserving a legal response”).

²⁰² See CRIMINALIZING PREGNANCY, *supra* note 20, at 9 (stating that “the intention of promoting maternal and infant health” may undergird criminalization of substance use during pregnancy).

ability to prosecute a pregnant woman with a substance use disorder, it can then offer her a choice: criminal charges or drug treatment.²⁰³ The expectation is that when faced with such a choice, a pregnant woman with a drug dependence will choose treatment, thereby increasing the chances that she will stop using drugs and ultimately give birth to an infant unaffected by drugs.²⁰⁴

Proponents of criminalization who justify the approach in this way assume that there are treatment options readily available to pregnant women struggling with substance use disorders. But this is not an accurate assumption — especially in the context of the opioid crisis.²⁰⁵ As of 2014, only sixty percent of treatment facilities accepted Medicaid, while only sixty-seven percent accepted private insurance²⁰⁶ — meaning that a significant number of facilities are available only to those who can afford to pay out of pocket for care. Further, the number of facilities that offer care that is responsive to the needs of pregnant or postpartum women is disturbingly low. Researchers calculate that fewer than twenty percent of all facilities that offer treatment for substance use disorder have programs for pregnant or recently postpartum women, resulting in eighty-one to ninety-five percent of need going unmet.²⁰⁷ While many pregnant women with substance use disorder are responsible for the care of older children, only seven percent of outpatient treatment facilities offer childcare,²⁰⁸ and only three percent of inpatient treatment facilities have beds for clients' children²⁰⁹ — a circumstance that makes it extremely difficult, and in many cases impossible, for a person who is parenting older children to receive inpatient treatment. Thirty-one states do not have treatment facilities with programs designed to address the needs of pregnant women; and in the nineteen states that do have such facilities, they tend to be found in areas that

²⁰³ Erin D. Kampschmidt, *Prosecuting Women for Drug Use During Pregnancy: The Criminal Justice System Should Step Out and the Affordable Care Act Should Step Up*, 25 HEALTH MATRIX 487, 501–02 (2012).

²⁰⁴ *Id.*

²⁰⁵ The federal government has attempted to address the dearth of available treatment facilities for pregnant women with opioid use disorder by providing grants to states that give pregnant women priority in admission to treatment programs. See BISHOP ET AL., *supra* note 104, at 43. This federal policy provides that residential inpatient facilities must allow a pregnant woman's minor children to stay with her. See *id.* Additionally, the programs "must . . . make available a set of supplemental services that includes, among others: prenatal and post-natal healthcare; pediatric healthcare . . . ; counseling and comprehensive social services for the infants and children of women admitted; therapeutic, comprehensive childcare during the times when a woman is unavailable due to her own treatment services; [and] parenting training." *Id.* Further, CARA specifically authorizes the federal government to provide grants to state agencies that develop outpatient programs for pregnant women with substance use disorders. *Id.*

²⁰⁶ *Id.* at 42.

²⁰⁷ See Jarlenski et al., *supra* note 172, at 268.

²⁰⁸ See BISHOP ET AL., *supra* note 104, at 29.

²⁰⁹ See *id.* at 28.

are far from the rural communities that the opioid epidemic hit the hardest.²¹⁰ Amnesty International found that in Alabama — which, as discussed below, enthusiastically prosecutes substance use during pregnancy — there was only one treatment facility with available beds that provided care that was responsive to the needs of pregnant or recently postpartum women and accepted everyone without regard to their ability to pay.²¹¹ The dearth of available facilities that can treat pregnant women for opioid use disorder has helped to produce a state of affairs in which there is a *negative* relationship between the criminal prosecution of substance use during pregnancy and pregnant women's receipt of MAT, the treatment that is the standard of care for opioid use disorder during pregnancy.²¹²

It bears underscoring that proponents of criminalization often justify criminalizing substance use during pregnancy with the claim that threatening a pregnant woman with a criminal conviction and jail time effectively protects her health and the health of the fetus that she carries.²¹³ However, healthcare providers and researchers assert that criminal laws have not had the effect of improving maternal and infant health outcomes.²¹⁴ Instead, they say, addressing substance use disorder during pregnancy with criminal law worsens maternal and infant health outcomes.²¹⁵ They argue that criminal penalties scare pregnant women with substance use disorders away from prenatal care altogether, giving them a reasonable fear that their healthcare providers will turn them over to the police upon discovery of their drug use.²¹⁶ Indeed, this is precisely what has happened to many women in states that have criminalized drug use during pregnancy.²¹⁷

²¹⁰ See Patrick & Schiff, *supra* note 194, at 2–3 (noting that the majority of treatment centers offering specific services to pregnant women are located in urban areas).

²¹¹ See CRIMINALIZING PREGNANCY, *supra* note 20, at 9.

²¹² See Angelotta et al., *supra* note 134, at 599 (“[P]regnant women referred to treatment by the criminal justice system were the least likely to receive the standard of care.”).

²¹³ See *id.* at 596.

²¹⁴ See *id.*; see also *No Safe Harbors*, *supra* note 126, at 229 (“There has not been a change in the rate of maternal drug use nationally since the rise of child abuse statutes punishing women for drug use during pregnancy . . .”).

²¹⁵ See Angelotta et al., *supra* note 134, at 596.

²¹⁶ See *id.*; see also CRIMINALIZING PREGNANCY, *supra* note 20, at 9 (stating that women in drug treatment facilities whom Amnesty International interviewed reported that “the threat of criminal punishment for drug use during pregnancy drives pregnant women away from healthcare, prenatal care and even drug treatment”); *No Safe Harbors*, *supra* note 126, at 229 (“[F]ear of criminal retribution discourages women from seeking prenatal care, undermining both the health of the mother and the health of the fetus.”).

Criminalizing drug use during pregnancy scares pregnant women away not only from prenatal care, but also from treatment for their substance use disorder. See *id.* at 230 (“After criminal prosecutions of maternal drug use began in South Carolina, there was an 80% reduction in admissions of pregnant women in drug treatment programs.”).

²¹⁷ See Paltrow & Flavin, *supra* note 122, at 329–30.

Despite the reality that criminalizing substance use during pregnancy has not had the effect of getting pregnant women with disorders into treatment, and despite the negative effects that this approach has had on maternal and infant health, states have insisted upon prosecuting pregnant women for exposing their fetuses to controlled substances. At present, Tennessee is the only state that has passed a law specifically criminalizing substance use during pregnancy²¹⁸ — a law that the state allowed to expire in 2016 after a host of organizations and experts rallied to produce that very result.²¹⁹ In the other states where prosecutions have taken place — practically every state in the country — prosecutors have relied on existing criminal statutes.²²⁰ Under this approach, states have prosecuted women who have used drugs during their pregnancies for criminal child abuse or neglect, delivering drugs to a minor, criminal endangerment, assault with a deadly weapon, and even manslaughter and murder when a pregnancy loss occurred.²²¹

When women have appealed their convictions of these crimes or have challenged their prosecutions in their early stages, most appellate courts have overturned the convictions or thrown out the charges.²²² Sometimes courts have held that the statutes' plain meanings precluded their application to drug use during pregnancy.²²³ At other times, they have held that the legislatures that drafted the relevant criminal statutes did not intend to criminalize behavior that occurs during pregnancy.²²⁴ In the face of ambiguous statutes, courts have held that the rule of lenity requires that they construe the statutes in favor of the criminal defendant.²²⁵ Additionally, they have held that permitting the prosecution of substance use during pregnancy would violate pregnant women's due

²¹⁸ See Angelotta et al., *supra* note 134, at 596; Davis, *supra* note 18, at 313 ("In 2014, Tennessee became the first state in the nation to pass a statute that explicitly, directly criminalized prenatal substance abuse.")

²¹⁹ See Melissa Jeltsen, *Wave Goodbye to Harsh Tennessee Law Targeting Pregnant Drug Users*, HUFFINGTON POST (Mar. 23, 2016, 10:55 AM), https://www.huffingtonpost.com/entry/tennessee-pregnant-women-drugs_us_56e862b3e4b065e2e3d79320 [<https://perma.cc/3MJ4-B2E7>]; Melissa Jeltsen, *Why Some Tennessee Women Are Afraid to Give Birth at the Hospital*, HUFFINGTON POST (Oct. 9, 2015, 10:20 AM), https://www.huffpost.com/entry/pregnant-women-tennessee_n_560da1b2e4boaf3706e01fb3 [<https://perma.cc/93LP-F9UV>].

²²⁰ See Paltrow & Flavin, *supra* note 122, at 309, 321.

²²¹ April L. Cherry, *Shifting Our Focus from Retribution to Social Justice: An Alternative Vision for the Treatment of Pregnant Women Who Harm Their Fetuses*, 28 J.L. & HEALTH 6, 32 (2015); Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense*, 29 J. ADDICTIVE DISEASES 231, 235, 238 (2010).

²²² See Cara Angelotta & Paul S. Appelbaum, *Criminal Charges for Child Harm from Substance Use in Pregnancy*, 45 J. AM. ACAD. PSYCHIATRY & L. 193, 200 (2017) ("Women charged with or convicted of crimes against their child or fetus related to substance use during pregnancy have won on appeal much more often than they have lost.")

²²³ Flavin & Paltrow, *supra* note 221, at 235.

²²⁴ See *id.*

²²⁵ See Angelotta & Appelbaum, *supra* note 222, at 199.

process rights, as women would have had no notice that being pregnant and using controlled substances was subject to criminal punishment.²²⁶

However, the fact that most prosecutions or convictions for substance use during pregnancy have not been sustained on appeal should not be taken to mean that state efforts to criminalize substance use during pregnancy are irrelevant or insignificant. Far from it.

First, because most states and the federal government criminalize substance *possession*, not *use*, criminalizing substance *use* during pregnancy represents an expansion of the criminal law.²²⁷ Further, it is an expansion of the criminal law that is reserved for people who can experience pregnancy — people who are primarily cisgender women.²²⁸ Because pregnancy is a necessary element of crimes that punish substance use during pregnancy — that is, substance use without pregnancy is not punishable behavior — this criminalization creates a gender-based crime.²²⁹

Second, criminalizing substance use during pregnancy may open the door for the criminalization of otherwise perfectly legal activity that can harm — or pose risks of harm to — fetuses.²³⁰ The result is the creation of a class of people — pregnant women — who can be policed and punished in ways that other people cannot.

Third, pregnant women have pleaded guilty to charges that prosecutors have brought for substance use during pregnancy.²³¹ While these guilty pleas do not create a legal precedent that is binding on future cases,²³² they nevertheless result in the conviction of pregnant women

²²⁶ See Flavin & Paltrow, *supra* note 221, at 235.

²²⁷ See Lollar, *supra* note 22, at 998 & n.413.

²²⁸ See *id.* at 1003–04 (discussing the gendered aspects of criminalizing drug use during pregnancy).

²²⁹ See Ocen, *supra* note 197, at 1167 (“[B]y treating pregnancy as an essential element for criminal prosecution, the state has constructed a status through which a unique set of criminal penalties applies to pregnant women and to no one else.”); Paltrow & Flavin, *supra* note 122, at 299, 301 (noting that in most of the more than 400 forced interventions on pregnant women between 1973 and 2005 that the researchers documented — interventions that included arrests and prosecutions of women for substance use during pregnancy, *id.* at 299 — “pregnancy provided a ‘but for’ factor, meaning that but for the pregnancy, the action taken against the woman would not have occurred,” *id.* at 301).

²³⁰ See CRIMINALIZING PREGNANCY, *supra* note 20, at 8 (discussing cases in which pregnant women were arrested for “otherwise legal activities such as refusing medical interventions including caesarean surgery or even for attempting suicide” and noting that these arrests are due to the “vague and overbroad nature of pregnancy criminalization laws”); see also Ocen, *supra* note 197, at 1171 (“The expansive use of criminal law to regulate pregnant women . . . has extended beyond drug use to legal conduct that is believed to be harmful to fetal life. These prosecutions place all pregnant women at risk for criminalization if they engage in behavior that does not assure optimal fetal health, including failing to exercise, eating badly, taking prescribed medication, and failing to follow doctor’s orders.”).

²³¹ See Flavin & Paltrow, *supra* note 221, at 235.

²³² See Sarah Blustein, *This Is Murder?*, AM. PROSPECT (Nov. 19, 2007), <https://prospect.org/article/murder> [<https://perma.cc/MY4D-LK9C>].

for crimes involving substance use during pregnancy.²³³ These guilty pleas result in pregnant women having to shoulder the substantial burdens, including jail time, that come with a criminal conviction.²³⁴

Fourth, state efforts to criminalize substance use during pregnancy are significant because prosecutors continue to threaten to bring charges against women for substance use during pregnancy.²³⁵ Although a higher court might ultimately reverse these charges on appeal if they were to result in a conviction, the possibility that a higher court *might not* reverse them gives prosecutors significant leverage.²³⁶ It generates pressure on pregnant women to plead guilty to other charges that the prosecutor brings — charges to which the woman might not plead guilty if severe charges related to substance use during pregnancy, like murder or assault with a deadly weapon, were not on the table.²³⁷

Finally, the criminalization of substance use during pregnancy matters because some state courts have upheld convictions for substance use during pregnancy. Namely, the supreme courts in Alabama and South Carolina have held that the states' chemical endangerment statute and criminal child abuse statute, respectively, are properly interpreted to apply to substance use during pregnancy.²³⁸ Consequently, prosecutors consistently charge women for using controlled substances while pregnant in those states.²³⁹ Additionally, although the Tennessee statute that explicitly criminalized substance use during pregnancy expired, it does

²³³ See Flavin & Paltrow, *supra* note 221, at 235.

²³⁴ See *id.*; ROBERT C. BORUCHOWITZ ET AL., NAT'L ASS'N OF CRIMINAL DEF. LAWYERS, MINOR CRIMES, MASSIVE WASTE: THE TERRIBLE TOLL OF AMERICA'S BROKEN MISDEMEANOR COURTS 34 (2009), <https://www.nacdl.org/getattachment/20b7a219-b631-48b7-b34a-2d1cb758bdb4/minor-crimes-massive-waste-the-terrible-toll-of-america-s-broken-misdemeanor-courts.pdf> [<https://perma.cc/8GRE-DNEV>] (noting that guilty pleas “can result in deportation, eviction, loss of government benefits,” and other serious consequences (quoting *A Statement by Kaye Commission Member Steven Zeidman*, NYCLU: ACLU N.Y., <https://www.nyclu.org/en/statement-kaye-commission-member-steven-zeidman> [<https://perma.cc/W6Z9-JPFU>])).

²³⁵ See, e.g., *Feticide Playbook*, *supra* note 121 (noting that although a Texas court held that prosecutors could not use existing law to prosecute women who use substances during pregnancy, “authorities in Texas have arrested or taken action against at least 17 pregnant women since” the court’s decision).

²³⁶ Flavin & Paltrow, *supra* note 221, at 235 (“[I]n many cases women have pleaded guilty or accepted plea bargains rather than risk a protracted legal challenge that could result in an even longer period of incarceration.”); see also Paul H. Robinson & Michael T. Cahill, *The Accelerating Degradation of American Criminal Codes*, 56 HASTINGS L.J. 633, 645–46 (2005) (discussing the leverage prosecutors gain in plea bargaining by having a larger number of potential charges available).

²³⁷ See Andrew Manuel Crespo, *The Hidden Law of Plea Bargaining*, 118 COLUM. L. REV. 1303, 1313–14 (2018) (describing potential for prosecutors to use multiple or inflated charges to coerce a plea bargain).

²³⁸ See *Ex parte Ankrom*, 152 So. 3d 397, 421 (Ala. 2013); *Whitner v. State*, 492 S.E.2d 777, 778 (S.C. 1997).

²³⁹ See Grace Elizabeth Howard, *The Criminalization of Pregnancy: Rights, Discretion, and the Law* 64–65, 68–70 (Oct. 2017) (unpublished Ph.D. dissertation, Rutgers University) (on file with the Harvard Law School Library).

not mean that the use of the criminal law to address substance use during pregnancy will stop altogether in the state.²⁴⁰

The next sections explore the legal landscapes of Alabama, South Carolina, and Tennessee. Because these states have most clearly established the legality of criminalizing substance use during pregnancy, understanding their laws provides an understanding of the legal architecture that has supported the arrest and prosecution of pregnant white women with opioid use disorder.

1. *Alabama.* — In 2006, the Alabama state legislature passed a law that made it a felony for a person to “expose[] a child to an environment in which [the person] causes or permits [the] child to be exposed to, to ingest or inhale, or to have contact with a controlled substance, chemical substance, or drug paraphernalia.”²⁴¹ Penalties increased when the substance exposure caused actual harm to a child.²⁴² The legislature passed the statute, titled “Chemical endangerment of a child,” when Alabama was confronting a methamphetamine scare in the early aughts.²⁴³ The manufacture of methamphetamine occasionally results in explosions that kill or severely injure those close by.²⁴⁴ Faced with the fear that many people had converted their homes into places where they could manufacture methamphetamine, legislators were concerned that the children who lived in these homes were being put in danger.²⁴⁵ The Alabama chemical endangerment statute was meant to punish those who exposed children to the risk of harm posed by exploding home meth labs.²⁴⁶

Eventually, however, prosecutors began charging women who used controlled substances during their pregnancies with violating the statute.²⁴⁷ They argued that the fetus was a “child” and the uterus was an “environment.”²⁴⁸ Thus, when a woman used controlled substances during her pregnancy, she exposed a fetus qua child to a uterus qua environment where controlled substances were found.²⁴⁹ Many women

²⁴⁰ See Paltrow & Flavin, *supra* note 122, at 321 (describing prosecutors’ use of general criminal statutes “to punish women in relationship to their own pregnancies”). In a study by Lynn Paltrow and Professor Jeanne Flavin (who surveyed all of the arrests and arrest equivalents of pregnant women that took place between 1973 and 2005 in which pregnancy was a necessary element of the crime), eighty-four percent of the cases studied mentioned illicit drug use. *Id.* at 310 tbl.1.

²⁴¹ ALA. CODE § 26-15-3.2 (2019).

²⁴² *Id.*

²⁴³ Howard, *supra* note 102, at 373.

²⁴⁴ Natalia Melnikova et al., *Hazards of Illicit Methamphetamine Production and Efforts at Reduction: Data from the Hazardous Substances Emergency Events Surveillance System*, 126 PUB. HEALTH REP. 116, 117 (Supp. 1 2011).

²⁴⁵ See Bach, *supra* note 19, at 840 n.213.

²⁴⁶ See *id.*; Howard, *supra* note 102, at 374 (stating that the Alabama legislature “originally intended” the chemical endangerment statute “to further criminalize illegal methamphetamine manufacturing and trade”).

²⁴⁷ See Howard, *supra* note 102, at 374.

²⁴⁸ See *id.*

²⁴⁹ See *id.*

pleaded guilty to these charges on the condition that the state would not seek to strip them of custody of their children upon their release from jail.²⁵⁰ However, no court had established the constitutionality of these prosecutions and convictions.

In its 2013 decision in *Ex parte Ankrom*,²⁵¹ the Alabama Supreme Court declared that the chemical endangerment statute properly applied to substance use during pregnancy.²⁵² The court held that the plain meaning of “child” in the statute encompassed fetuses — including those that were not yet viable.²⁵³ Since 2006, prosecutors have charged over 450 women under the criminal endangerment law — more prosecutions of women for purportedly harming their fetuses “than have been documented under any other single law.”²⁵⁴

2. *South Carolina.* — In 1997, the South Carolina Supreme Court held in *Whitner v. State*²⁵⁵ that “child” in the state’s criminal child neglect statute applies to fetuses.²⁵⁶ The case centered around Cornelia Whitner, a black woman whose baby, although born completely healthy, tested positive for cocaine metabolites immediately after its birth.²⁵⁷ With its holding in *Whitner*, the court laid down a red carpet for prosecutors who wanted to bring criminal charges against women for substance use during pregnancy. Five years later, a prosecutor charged Regina McKnight, a homeless woman, with murder when her baby was stillborn and tested positive for cocaine metabolites.²⁵⁸ McKnight’s medical records indicated that she had an infection that likely caused the death of her fetus.²⁵⁹ This, of course, meant that the cocaine that McKnight ingested while pregnant was probably not responsible for the fetal demise.²⁶⁰ Nevertheless, a jury convicted her of murder, and a judge sentenced her to twenty years in prison.²⁶¹ She appealed her conviction all the way up to the state’s supreme court, which affirmed it.²⁶²

²⁵⁰ See LINDA C. FENTIMAN, *BLAMING MOTHERS* 111 (2017).

²⁵¹ 152 So. 3d 397 (Ala. 2013).

²⁵² See *id.* at 421.

²⁵³ See *id.* at 419, 421.

²⁵⁴ CRIMINALIZING PREGNANCY, *supra* note 20, at 8.

²⁵⁵ 492 S.E.2d 777 (S.C. 1997).

²⁵⁶ *Id.* at 778. The criminal child neglect statute in effect when the court decided *Whitner* made it a misdemeanor for a person with legal “charge or custody of a child” to neglect the child so as to “place the child at unreasonable risk of harm affecting the child’s life, physical or mental health, or safety.” S.C. CODE ANN. § 20-7-50 (1985), amended by S.C. CODE ANN. § 63-5-70 (2010).

²⁵⁷ See *Whitner*, 492 S.E.2d at 778–79; Flavin & Paltrow, *supra* note 221, at 232–33.

²⁵⁸ *State v. McKnight*, 576 S.E.2d 168, 171 (S.C. 2003); see also Bob Herbert, Opinion, *In America; Stillborn Justice*, N.Y. TIMES (May 24, 2001), <https://www.nytimes.com/2001/05/24/opinion/in-america-stillborn-justice.html> [<https://perma.cc/RXT4-R585>].

²⁵⁹ Flavin & Paltrow, *supra* note 221, at 235.

²⁶⁰ See *id.*

²⁶¹ *Id.*

²⁶² See *McKnight*, 576 S.E.2d at 171.

She served almost eight years of her sentence before the conviction was overturned.²⁶³

Although McKnight's conviction was ultimately thrown out, she pleaded guilty to manslaughter to avoid reincarceration, and prosecutions for substance use during pregnancy continue at a healthy pace in South Carolina.²⁶⁴

3. *Tennessee*. — In 2014, Tennessee amended its existing “fetal assault” law to explicitly authorize the criminal punishment of pregnant women who use opioids.²⁶⁵ The legislature amended the law after a state court held that an aggravated child abuse statute could not apply to a woman who had ingested cocaine while pregnant.²⁶⁶ The amendment to the fetal assault law provided an unambiguous tool with which the state could criminally punish substance use during pregnancy.²⁶⁷ From 2014 until 2016, when the law expired, Tennessee prosecuted at least 124 women under the law.²⁶⁸

While advocates of the Tennessee law described it as a “velvet hammer” that would softly pummel pregnant women with opioid use

²⁶³ See Flavin & Paltrow, *supra* note 221, at 235.

²⁶⁴ See CRIMINALIZING PREGNANCY, *supra* note 20, at 8.

²⁶⁵ See 2014 Tenn. Pub. Acts 820. Although the text of the law — which authorized the arrest and prosecution of a woman for “the illegal use of a narcotic drug . . . while pregnant,” *id.* — suggests that the legislature sought to criminalize opioid use during pregnancy, the first person prosecuted under the Tennessee statute had tested positive for methamphetamine, which is not a narcotic, see BISHOP ET AL., *supra* note 104, at 50.

Further, the statute made it a crime for a person, including a pregnant woman, to intentionally, knowingly, or recklessly endanger a fetus, without limiting the covered stage of gestation or requiring an affirmative act. Compare TENN. CODE ANN. §§ 39-13-101, -103, -107 (2012), with 2014 Tenn. Pub. Acts 820. The question becomes: What is an unlawful act or unlawful omission? As the National Advocates for Pregnant Women asks: “Is refusing a doctor’s recommendation of cesarean surgery” an unlawful omission? Memorandum from Nat’l Advocates for Pregnant Women, What the Tennessee Law Permitting Arrests of Pregnant Women Actually Says (on file with the Harvard Law School Library). Clearly, the law goes beyond criminalizing opioid use during pregnancy, as prosecutors have used it to bring charges against a pregnant woman who drove without wearing a seatbelt and ran away from a police officer when he attempted to pull her over. See *Deputy: Pregnant Woman Tries to Evade Arrest*, GREENEVILLE SUN (Nov. 11, 2014), https://www.greenevillesun.com/xml/nitf/deputy-pregnant-woman-tries-to-evade-arrest/article_fec891ba-1860-5cce-9b5d-2ff25df4b236.html [<https://perma.cc/35YC-NKNC>].

²⁶⁶ See *No Safe Harbors*, *supra* note 126, at 215.

²⁶⁷ The statute also represented a dramatic reversal from the state’s prior approach, which conceptualized substance use during pregnancy as a public health issue. In 2013, just a year before the state criminalized substance use during pregnancy explicitly, the legislature passed the Safe Harbor Act, which gave pregnant women with opioid use disorder priority in treatment facilities and safeguarded their parental rights in child welfare proceedings. See *id.* at 216–17. With the 2014 amendment of the fetal assault law, the state apparently abandoned treating substance use during pregnancy through a medical model, embracing a decidedly punitive approach instead. See *id.* at 205 (noting that the 2014 amendment was “inconsistent” with the state’s previous approach).

²⁶⁸ See Bach, *supra* note 19, at 814.

disorder into treatment,²⁶⁹ facilities that were willing to offer treatment to pregnant women were few and far between. Bach identified only twenty-three facilities in the state that were willing to treat pregnant or recently postpartum women and accepted Medicaid²⁷⁰ — an important condition, given that most of the women prosecuted under the fetal assault statute were poor.²⁷¹ Only two inpatient facilities in the state provided prenatal care and allowed a client's older children to stay with her.²⁷² Putting treatment even further out of many individuals' reach, Tennessee's Medicaid program does not cover MAT, forcing individuals to pay the \$4500/year price tag out of pocket.²⁷³

* * *

Despite the admonition of public health experts, healthcare providers, scholars, advocates, and activists, criminal prosecutions of substance-using and -dependent pregnant women continue. Indeed, prosecutors in Oklahoma and Montana have announced that they intend to step up their prosecutions for substance use during pregnancy.²⁷⁴ Additionally, in more recent years, prosecutors have been inclined to bring charges for more serious felonies — like homicide when a substance-using pregnant woman experiences a stillbirth — as opposed to the minor felonies that they once brought when prosecutions for substance use during pregnancy began forty years ago.²⁷⁵ As Professor Linda Fentiman notes: “[O]ver the past two decades both the rhetoric of prosecutors and the severity of the charges they have brought have escalated.”²⁷⁶ In fact, “[t]he trend toward prosecution and other punitive sanctions appears to have accelerated over the past decade.”²⁷⁷ Thus,

²⁶⁹ See Tony Gonzalez, *House Passes Prenatal Drug Use Bill*, TENNESSEAN (Apr. 9, 2014, 6:34 PM), <https://www.tennessean.com/story/news/politics/2014/04/09/criminal-penalty-prenatal-drug-use-passes-house/7526877> [<https://perma.cc/4S7S-ZZGA>].

²⁷⁰ Bach, *supra* note 19, at 838.

²⁷¹ See CRIMINALIZING PREGNANCY, *supra* note 20, at 10 (“Nearly all of the arrested women [in Tennessee under the fetal assault law] had low-incomes and qualified for indigent defense.”).

²⁷² See *id.* at 30.

²⁷³ See *id.* at 9–10.

²⁷⁴ See Matt Payne, *District Attorney, County Entities Actively Target Pregnant Drug-Abusers*, DAILY ARDMOREITE (Dec. 4, 2017, 11:00 AM), <https://www.ardmoreite.com/news/20171204/district-attorney-county-entities-actively-target-pregnant-drug-abusers> [<https://perma.cc/X36E-CLWG>]; Press Release, Gerald “Jay” Harris, Big Horn County Attorney’s Office Announces Immediate Crackdown of Pregnant, Expecting Mothers Consuming Alcohol or Dangerous Drugs, Particularly Methamphetamine and Opioids (Jan. 11, 2018), <http://advocatesforpregnantwomen.org/blog/PUBLIC%20NOTICE.pdf> [<https://perma.cc/5H9F-QJXU>].

²⁷⁵ See Davis, *supra* note 18, at 314 (noting that there has been a “shift to homicide prosecution, seen first in the late 1990s and early aughts” that “reflects a more aggressive approach to punitive sanctions against pregnant women”).

²⁷⁶ FENTIMAN, *supra* note 250, at 131.

²⁷⁷ *Id.* at 112.

the use of criminal systems to address substance use during pregnancy is a phenomenon that scholars should take seriously and theorize accordingly.

III. THE DEMOGRAPHICS OF CRIMINAL PROSECUTIONS

A. Socioeconomic Status and Criminal Prosecutions

Given that those swept up within the United States' robust criminal legal system are overwhelmingly poor,²⁷⁸ it should be no surprise that those who have faced criminal prosecution for substance use during pregnancy typically are poor as well.²⁷⁹ Indeed, of the women who were arrested under Tennessee's fetal assault law, "nearly all" of them "qualified for indigent defense."²⁸⁰ Of the women prosecuted for substance use during pregnancy in Alabama from 2006 to 2015, eighty-nine percent relied on a public defender.²⁸¹ More generally, Lynn Paltrow and Professor Jeanne Flavin attempted to survey all of the arrests and arrest equivalents of pregnant women in which pregnancy was a necessary element of the crime that took place between 1973 and 2005.²⁸² Eighty-four percent of the cases included an allegation of drug use.²⁸³ Significantly, seventy-one percent of those facing criminal charges were poor enough to qualify for indigent defense.²⁸⁴

The relative scarcity of prosecutions of more affluent people for substance use during pregnancy is *not* because poor people are the only ones using substances during pregnancy. Substance use and dependence exist across the socioeconomic ladder. Professor Michele Goodwin notes that "studies suggest white women and women with higher levels of education are more likely than others to seek and acquire prescription medications, including Xanax, Oxycontin, Demerol, . . . and Tylenol with codeine during their pregnancies."²⁸⁵ However, while the drugs in these prescription medications may have the same effects on fetuses as drugs that are not prescribed or can be purchased on the street,²⁸⁶ white women with some degree of class privilege are rarely, if ever, prosecuted

²⁷⁸ James Forman, Jr., *Racial Critiques of Mass Incarceration: Beyond the New Jim Crow*, 87 N.Y.U. L. REV. 21, 54–55 (2012).

²⁷⁹ See Lester et al., *supra* note 110, at 33 ("The government prosecutes more impoverished women than those in the middle class." (endnote omitted)).

²⁸⁰ CRIMINALIZING PREGNANCY, *supra* note 20, at 10.

²⁸¹ See *id.* at 8.

²⁸² See Paltrow & Flavin, *supra* note 122, at 299. Paltrow and Flavin report that their survey was likely a "substantial undercount." *Id.* at 304.

²⁸³ *Id.* at 310 tbl.1.

²⁸⁴ *Id.*

²⁸⁵ Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield*, 102 CALIF. L. REV. 781, 793–94 (2014); see also Flavin & Paltrow, *supra* note 221, at 233 ("[T]he percent of White, Black, and Hispanic women in metropolitan areas who have used an illicit drug in the past month is 8.6%, 8.4%, and 5.6%, respectively.")

²⁸⁶ See Goodwin, *supra* note 285, at 794.

for substance use during pregnancy. As Goodwin summarizes, although “educated, white women are more likely to take prescription medications during pregnancy generally, and use more prescription medications during pregnancy as they age,” prosecutors nevertheless “ignore that cohort of gestating mothers,” choosing instead to target poor women.²⁸⁷

It does not overstate things to describe criminal prosecutions for substance use during pregnancy as having been reserved for the poor. Scholars have explained poor people’s overrepresentation among those prosecuted for substance use during pregnancy in terms of the increased likelihood that a healthcare provider will test a patient for substance use if she is poor,²⁸⁸ the increased likelihood that a provider will report a patient’s positive drug screen to civil and criminal systems if she is poor,²⁸⁹ and the increased likelihood that a prosecutor will choose to press charges against a person with a positive drug screen if she is poor.²⁹⁰

B. Race and Criminal Prosecutions

The received wisdom is that pregnant women of color with positive drug screens are much more likely to be reported to law enforcement and are much more likely to be prosecuted than their white counterparts.²⁹¹ However, the race of the current opioid epidemic has complicated this historic truth.

i. Prosecutions of Substance Use During Pregnancy amid the Crack Cocaine Scare. — Prosecutions for substance use during pregnancy began in earnest during the crack cocaine scare in the 1980s²⁹² — a scare that, as noted above, was racialized as black. During this time, politicians, policymakers, and media outlets portrayed the infants who were

²⁸⁷ *Id.* at 874.

²⁸⁸ See Lester et al., *supra* note 110, at 33 (“Private physicians who treat middle class and wealthy women are less likely to question their patients’ behavior based on an unsubstantiated belief that wealthier women are less likely to use or abuse substances.”).

²⁸⁹ See *id.* (noting that physicians are more likely to report poor patients’ substance use to authorities).

²⁹⁰ See Goodwin, *supra* note 285, at 795 (arguing that states’ “[s]elective prosecutions” “reflect suspect judgments about . . . poor pregnant women”); *id.* at 853–54 (“[S]tates seek to intervene in women’s pregnancies on health grounds rooted in . . . class stereotyping and bias . . .” *Id.* at 853.).

²⁹¹ See, e.g., Katrina Hui et al., *Chemical Endangerment Laws Hurt Pregnant Women*, PUB. HEALTH POST (Mar. 12, 2018), <https://www.publichealthpost.org/viewpoints/chemical-endangerment-laws-hurt-pregnant-women> [<https://perma.cc/AQH2-FD88>] (“Although rates of substance use during pregnancy are similar across racial and socioeconomic groups, women of color are more likely to be reported to child protective services, even when drug screening policies are in place to universally test all women.”).

²⁹² See CRIMINALIZING PREGNANCY, *supra* note 20, at 22 (“Criminal prosecutions of women in the USA based on their actions during pregnancy began to increase sharply in the late 1980s At that time, the media focused on crime in American cities and the perceived ‘epidemic’ of crack cocaine use.”).

exposed to crack cocaine in utero as hopelessly damaged.²⁹³ They depicted these children as the country's eventual juvenile delinquents, criminals, welfare queens, and budget drains. Goodwin evocatively describes the political and popular discourse during this period:

Speculations describing the children as abnormal and predicting their inability "to enter classic school room[s] and function in large groups of children" stoked national concern. . . .

Legislators assumed that crack and the pregnant women addicted to the drug caused a medical scourge on African American fetuses, and potentially the nation. Politicians expected these babies to require sophisticated medical treatments and, eventually, special needs services at public schools. One politician claimed that crack babies would be "the most expensive babies ever born in America" and that they were "going to overwhelm every social service" program that they would encounter until their deaths. . . .

. . . Charles Krauthammer's *Philadelphia Inquirer* article, "Worse Than 'Brave New World': Newborns Permanently Damaged By Cocaine" reflects the tone of news media investigating crack babies. Krauthammer, a Pulitzer Prize-winning journalist, warned readers that the "newest horror" was being born in American inner cities. That horror, "a bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth," lurked among Americans in poor neighborhoods, born to black mothers.²⁹⁴

Essentially, babies exposed to crack cocaine in utero were represented as the future problems of America.²⁹⁵ Further, the women who smoked crack cocaine while pregnant were portrayed as heartless, irresponsible, and selfish.²⁹⁶ If empathetic stories about them existed — stories that humanized them, that told the origins of their dependence, that described their use of crack cocaine as a "chronic, relapsing disease[]"²⁹⁷ consistent with the medical model of substance use disorders — these stories could rarely be found in mainstream media outlets or general

²⁹³ See Goodwin, *supra* note 285, at 846 (discussing an early study of infants exposed to cocaine in utero that claimed that the babies were "born brain damaged," were "overwhelmed by eye contact with their mothers," "exhibited tremulous symptoms," and "were too difficult to hold because they cried and flailed their arms"). It turns out that prematurity caused many of these symptoms, not crack cocaine. See *id.* at 848.

²⁹⁴ *Id.* at 846–48 (alteration in original) (footnotes omitted); see also McMillan, *supra* note 120 (describing an article that the *New York Times* published on Mother's Day in 1989 that "decri[ed] the fact that Mother's Day [that] year [would] be spent thinking about babies tethered to tubes in the intensive care units who [would] eventually be turned over to foster care, instead of thinking of fancy strollers and bassinets").

²⁹⁵ For a discussion of whether there have been similar declarations that the babies born to women with opioid use disorders — babies who may have NAS — are America's future criminals, welfare beneficiaries, and drains on society, see *infra* p. 835.

²⁹⁶ See McMillan, *supra* note 120.

²⁹⁷ Angelotta & Appelbaum, *supra* note 222, at 193.

political and popular discourse.²⁹⁸ The negative portrayal of these women in mainstream media perhaps made it easy to want to punish them — for using crack while pregnant, for “ruining” their fetuses, and for burdening society with their costly babies. And that is precisely what prosecutors did during the crack cocaine scare of the 1980s: they tried to punish these women — prosecuting them for child maltreatment, assault, homicide, and an array of other crimes.²⁹⁹

Because a disproportionate number of black people were users of crack cocaine, black people — black women — were largely those facing criminal prosecution for substance use during pregnancy at this time.³⁰⁰ As Julie Ehrlich describes it: “[T]he War on Drugs became a war on women of color, with prosecutions of pregnant women focusing on those women who used crack cocaine, a drug predominantly found in low-income communities of color.”³⁰¹ It is from this era that we get the disturbing statistics documenting the overrepresentation of women of color among those facing criminal charges for substance use during pregnancy. Data show that of the forty-one pregnant women arrested for substance use during pregnancy in South Carolina between 1989 and 1992, *forty* of the women were black.³⁰² A review of the police records in thirty-five states during that time reveals that seventy to eighty percent of the pregnant women who were arrested for substance use during pregnancy were “members of minority groups, primarily blacks and Hispanics.”³⁰³ Similarly, Paltrow and Flavin’s 2013 study described the demographics of pregnant women who had been arrested for substance use during pregnancy between 1973 and 2005 — before the contemporary opioid crisis swept the nation.³⁰⁴ The report revealed that women of color, specifically black women, were disproportionately represented

²⁹⁸ For a rare, fairly empathetic portrayal of a crack cocaine-dependent mother during this era, see Jan Hoffman, *Pregnant, Addicted — and Guilty?*, N.Y. TIMES MAG., Aug. 19, 1990, at 34.

²⁹⁹ See generally GÓMEZ, *supra* note 16.

³⁰⁰ Had prosecutors in the 1980s brought charges against *all* pregnant women who used substances — not just those who used cocaine — women of all races and classes would have been represented among the population of women facing charges for substance use during pregnancy. See FENTIMAN, *supra* note 250, at 109 (“Pregnant drug users come from all races and social classes. Their rates of drug use are similar across ethnic and income groups, although the drug of choice may vary.”). Nevertheless, only the use of cocaine during pregnancy was problematized during the heady days of the crack cocaine scare. CRIMINALIZING PREGNANCY, *supra* note 20, at 22. Consequently, the users of crack cocaine during pregnancy — that is, black women — were those who faced prosecution during this time.

³⁰¹ Ehrlich, *supra* note 17, at 387 (footnote omitted).

³⁰² Charles Marwick, *Challenging Report on Pregnancy and Drug Abuse*, 280 JAMA 1039, 1040 (1998).

³⁰³ *Id.*

³⁰⁴ See Paltrow & Flavin, *supra* note 122, at 309, 310 tbl.1. Notably, Paltrow and Flavin state that while 282 of the arrested women had allegedly used cocaine during pregnancy, only twenty-three had used opioids. See *id.* at 315–16.

among those arrested. Indeed, fifty-two percent of the women arrested were black.³⁰⁵

It bears noting that if the justification for prosecuting black women struggling with a cocaine dependence during the crack cocaine scare of the 1980s was that the women deserved punishment for harming their fetuses through their substance use, then the prosecutions were unjustified. While many of the babies born to women who struggled with crack cocaine dependence were small or sick, there is very little evidence to suggest that their exposure to cocaine alone caused their poor health outcomes.³⁰⁶ That is, the evidence cannot support the claim that, all other things being equal, these babies would have been born completely healthy had their mothers abstained from using crack cocaine during their pregnancies.³⁰⁷ Instead, the evidence establishes that poverty and unhealthy neighborhoods much more likely caused these babies' poor health outcomes.³⁰⁸ The longitudinal studies that have been conducted on children who had been exposed to cocaine in utero show that they do not differ from children who did not sustain in utero exposure to cocaine.³⁰⁹ These studies establish that while cocaine may have a nominal effect on children exposed to it in utero, poverty, by far, bears the greatest responsibility for infant morbidity and mortality.³¹⁰ As neonatologist Hallam Hurt concludes: "Poverty is a more powerful influence on the outcome of inner-city children than gestational exposure to cocaine . . ."³¹¹ Nevertheless, during the crack cocaine scare, the impoverished, unhealthy environments in which poor black women lived were

³⁰⁵ *Id.* at 311.

³⁰⁶ See, e.g., Lawrence M. Berger & Jane Waldfogel, *Prenatal Cocaine Exposure: Long-Run Effects and Policy Implications*, 74 SOC. SERV. REV. 28, 30–31, 33–34 (2000).

³⁰⁷ See Lester et al., *supra* note 110, at 31 ("[D]rug effects have not been 'isolated' from other effects (environmental as well as genetic) . . .").

³⁰⁸ See *id.* at 11 ("[E]ffects must be understood in the context of the child's overall development.").

³⁰⁹ See BISHOP ET AL., *supra* note 104, at 14 (discussing longitudinal studies that followed a group of poor children who were exposed to cocaine in utero and a group of poor children who had no exposure and describing the studies' conclusion that cocaine-exposed children "do not differ in their health, development, or academic achievement").

³¹⁰ This should not be read to suggest that cocaine has *no* effect on fetal development. As the Jacobs Institute of Women's Health reports, studies have concluded that if a person uses cocaine during the stage in pregnancy when the fetal brain and nervous system are developing, it can irreversibly alter those structures, resulting in "underdevelopment in the parts of the brain that regulate attention and executive functioning." *Id.* at 13. Nevertheless, "[a]lthough some studies have found differences in attention and behavior in the brains of children exposed to cocaine in the womb, the dramatic deficits predicted by the earlier studies have not borne out." Olga Khazan, *Into the Body of Another*, THE ATLANTIC (May 8, 2015), <https://www.theatlantic.com/health/archive/2015/05/into-the-body-of-another/392522> [<https://perma.cc/9NZA-Y8NA>].

³¹¹ Susan FitzGerald, "Crack Baby" Study Ends with Unexpected but Clear Result, PHILA. INQUIRER (July 21, 2013), https://www.philly.com/philly/health/20130721_Crack_baby_study_ends_with_unexpected_but_clear_result.html [<https://perma.cc/L6CM-VKNZ>]. Ira Chasnoff — a neonatologist whose early study purported to establish crack cocaine as a substance that irreparably harmed fetuses and who, accordingly, bears some responsibility for the hysteria over "crack babies"

erased from view. Context obscured, women's use of crack cocaine was identified as the sole cause of their infants' poor health. Thus framed, prosecutors endeavored to bring the full weight of the criminal legal system on these women for supposedly permanently damaging their babies with the crack cocaine that they smoked while pregnant.

Even if cocaine use during pregnancy could cause permanent or significant harm to fetuses, and even if poor black women did, in fact, harm their fetuses by using cocaine while pregnant, there remains the question of why the penal state chose to single out women who used *that* particular substance while pregnant. A number of other substances can harm fetuses.³¹² Why punish the individuals who exposed their fetuses to one specific harmful substance when many substances — some illegal, many legal — also cause harm? For example, cigarette smoke is exceedingly harmful to the fetus: “[T]he 2014 Surgeon General Report on smoking explains that its effects extend from fertility through gestation and beyond, resulting in cases of fetal growth restriction, pre-term delivery, placenta previa, placental abruption, some congenital abnormalities, and impaired lung development.”³¹³ Yet, during the crack cocaine scare of the 1980s, prosecutors did not bring criminal charges against the hundreds of thousands of women who smoked cigarettes while pregnant and exposed their fetuses to *known* harm.³¹⁴ Instead, prosecutors brought charges only against the women who used one highly stigmatized drug that was *imagined* to harm fetuses — crack cocaine. Scholars have argued that the state's choice to single out users of crack cocaine for criminal punishment, while ignoring users of the abundance of other substances that are unhealthy to fetuses, is a consequence of crack cocaine having been racialized as black.³¹⁵

Black women dependent on crack cocaine have been the face of the excesses and abuses of the criminal legal system when it is used to address substance use during pregnancy. Consider that, as discussed above, Cornelia Whitner — whose successful prosecution for substance

in the 1980s — has made the same point, arguing that children who were exposed to cocaine in utero “are no different from other children growing up. . . . [T]he placenta does a better job of protecting the child than we do as a society.” Ellen Goodman, “*Crack Baby*” *Hyperbole*, WASH. POST, Jan. 11, 1992, at A19.

³¹² See Goodman, *supra* note 311, at A19 (explaining that alcohol and tobacco can cause as much damage as cocaine to fetuses).

³¹³ Goodwin, *supra* note 285, at 852.

³¹⁴ See *id.* (stating that maternal smoking exposes over 400,000 infants to cigarette smoke in utero).

³¹⁵ See, e.g., Dwight L. Greene, *Abusive Prosecutors: Gender, Race & Class Discretion and the Prosecution of Drug-Addicted Mothers*, 39 BUFF. L. REV. 737, 745 (1991) (noting that the prosecutors' offices that brought charges against poor black women for prenatal cocaine use in the 1980s were largely headed by white males and questioning whether these “white male prosecutors” were genuinely concerned about “the welfare of mostly poor, African-American, Hispanic, and a few white infants”).

use during pregnancy in South Carolina opened the door to other successful prosecutions in the state and beyond — was a black woman who used crack cocaine.³¹⁶ Consider that Regina McKnight, the first person convicted of *murder* on account of her substance use during pregnancy, was a black woman who was dependent on crack cocaine.³¹⁷ Moreover, consider *Ferguson v. City of Charleston*,³¹⁸ the only Supreme Court case to concern the prosecution of substance use during pregnancy. The case involved a public hospital's program of screening women for substance use during pregnancy with the purpose of turning over positive results to a prosecutor.³¹⁹ All of the forty-two women whom the hospital referred to law enforcement pursuant to the program were dependent on cocaine, and *all but one* of the women were black.³²⁰ Which is to say: black women dependent on cocaine have been the highly visible subjects of prosecutors' and judges' exceedingly creative manipulations of existing criminal law — and their overstepping of the limits of state and federal constitutions — to penalize pregnant women for purportedly exposing their fetuses to harm.

Thus, historically speaking, prosecutions for substance use during pregnancy have tended to fall on the shoulders of black women. However, there has been a shift. Because the opioid epidemic has significantly affected white people,³²¹ a substantial number of white women have found themselves pregnant while struggling with opioid use disorder. The consequence is that although black women may be *overrepresented* among those facing criminal charges for using substances during

³¹⁶ See Flavin & Paltrow, *supra* note 221, at 232–33; Tamar Lewin, *Abuse Laws Cover Fetus, a High Court Rules*, N.Y. TIMES, Oct. 30, 1997, at A22.

³¹⁷ See FENTIMAN, *supra* note 250, at 111.

³¹⁸ 532 U.S. 67 (2001).

³¹⁹ The Supreme Court held that the program violated the Fourth Amendment rights of the women whom the State had prosecuted under the program, finding that the testing of their urine for the presence of cocaine *with the express purpose of gathering evidence for use in a criminal prosecution* was a search that required either a warrant or the woman's consent. See *id.* at 84–86. The Court's finding that the hospital's program involved a Fourth Amendment search was informed by the fact that law enforcement worked closely with the hospital in developing the protocol for whom to test and how to use the test results. See *id.* at 80–81. Thus, after *Ferguson*, hospitals are free to turn over positive drug screens to law enforcement if they obtain women's consent to the drug screen for law enforcement purposes or if law enforcement is not closely involved in the development of the drug testing program.

³²⁰ See FENTIMAN, *supra* note 250, at 141. The only nonblack woman whom the State prosecuted under the program was a white woman who, according to a notation that a nurse made in her medical records, lived “with her boyfriend who is a Negro.” Lynn M. Paltrow, *Punishment and Prejudice: Judging Drug-Using Pregnant Women*, in MOTHER TROUBLES: RETHINKING CONTEMPORARY MATERNAL DILEMMAS 59, 65 (Julia E. Hanigsberg & Sara Ruddick eds., 1999) (citation omitted).

³²¹ See *supra*, pp. 788–89.

pregnancy,³²² it is white women who nevertheless predominate among those who have been arrested and prosecuted.³²³

2. *Prosecutions of Substance Use During Pregnancy amid the Opioid Epidemic.* — Tennessee is exemplary of the change in the racial demographics of those who are prosecuted for substance use during pregnancy. Bach documents that of the women whose race was known and who were prosecuted under the state's fetal assault law between the law's passage in 2014 and its expiration in 2016, eighty-three percent were white.³²⁴ Indeed, the first person arrested under the law was a white woman who had used methamphetamine during her pregnancy.³²⁵ Although prosecutors appeared to target black women in Shelby County — where Memphis sits and nearly half of the entire black population in Tennessee lives³²⁶ — most of the prosecutions took place in the state's overwhelmingly white northeastern quadrant³²⁷ — the site of

³²² It is essential to note that although white women tend to be the contemporary subjects of arrests and prosecutions for crimes involving opioid (and methamphetamine) use during pregnancy, it still may be true that black women are *overrepresented* among those facing criminal charges for substance use during pregnancy. That is, even though more white women than black women currently are being arrested and prosecuted for using substances while pregnant, there remains the possibility that the number of black women who have been arrested and prosecuted for this behavior is higher than it should be considering their representation among the population of women using drugs while pregnant. While the data does not yet exist to prove or disprove this supposition, four centuries of antiblack racism should lead us to expect such a state of affairs.

³²³ See Bach, *supra* note 19, at 841 n.213 (noting that there were two waves of prosecutions for drug use during pregnancy, that the second wave began in the mid-2000s “with the rise of methamphetamine and opiates,” and that the prosecutions during this second wave have shifted “both empirically and as a matter of rhetoric[] to poor white women”).

³²⁴ See Memorandum from Wendy A. Bach, Professor, Univ. of Tenn. Coll. of Law, Study of TN-ST 39-13-107 Prosecutions, 2014–2016 (on file with the Harvard Law School Library) [hereinafter Bach Memorandum].

³²⁵ See *New Mother Charged with Assault for Using Meth During Pregnancy*, NBC NEWS (July 14, 2014, 12:20 PM), <https://www.nbcnews.com/news/us-news/new-mother-charged-assault-using-meth-during-pregnancy-n155381> [<https://perma.cc/ZFV7-8WWW>] (reporting the arrest of Mallory Loyola, a twenty-six-year-old woman whose baby tested positive for methamphetamine at birth, and noting that it was the “first arrest applying a new Tennessee law that charges a woman with assault for taking illegal drugs while pregnant”).

³²⁶ The U.S. Census Bureau estimates that as of July 2018, 54.2% of Shelby County's population of 935,764 is black, *QuickFacts: Shelby County, Tennessee*, U.S. CENSUS BUREAU (July 1, 2018), <https://www.census.gov/quickfacts/shelbycountytennessee> [<https://perma.cc/NHH6-WGGG>], and that 17.1% of Tennessee's population of 6,770,010 is black, *QuickFacts: Tennessee*, U.S. CENSUS BUREAU (July 1, 2018), <https://www.census.gov/quickfacts/TN> [<https://perma.cc/FZN8-WUKU>].

³²⁷ See Nate Morabito, *2010 Census Reveals Growing Population in NE TN*, BRISTOL HERALD COURIER (Mar. 22, 2011), https://www.heraldcourier.com/news/census-reveals-growing-population-in-ne-tn/article_a7faf928-dfd6-51f2-9849-026126113c46.html [<https://perma.cc/gLR8-A9LP>] (reporting that ninety-seven percent of Northeastern Tennessee's population was white in the 2010 census); Bach Memorandum, *supra* note 324.

Appalachia and a seat of the opioid epidemic.³²⁸ Hence, the whiteness of the criminalization of opioid use during pregnancy.

Bach describes the prosecutions for substance use during pregnancy in terms of waves. She notes that the first wave of prosecutions occurred in the years preceding 2005.³²⁹ The subjects of the prosecutions during that time were largely black women who had used cocaine.³³⁰ According to Bach, the second wave of prosecutions began in the mid-2000s.³³¹ These prosecutions were mostly white.³³² She writes: “[A]s the targeted substances shifted from cocaine to methamphetamine and opiates, the racial makeup of defendants shifted overall from black to white.”³³³

The changing demographics of the criminalization of substance use during pregnancy have been similar in South Carolina, with “black defendants outnumber[ing] white defendants . . . through 2003. After 2003[,] the demographic composition of women arrested for pregnancy-related crimes in the state shifted dramatically. In 2014, the ratio of white to black defendants was 16:1.”³³⁴ There also has been a similar shift in Alabama in the racial demographics of criminalizing the use of substances while pregnant, with white women comprising 83.33 percent of the people arrested on such grounds for whom race could be determined.³³⁵ Black women have been only a small minority of the defendants in these cases,³³⁶ reflecting their general representation in the jurisdictions where prosecutions are taking place.³³⁷ Bach concludes that what is true in Tennessee, South Carolina, and Alabama is true across the country, describing the national data as confirming a “shift in the overall racial makeup of these prosecutions.”³³⁸

Significantly, scholars and other observers, for the most part,³³⁹ have not acknowledged the change in the race of the women being prosecuted

³²⁸ Tom Humphrey, *DAs in Three Northeast TN Counties File Lawsuit Against Opioid Manufacturers*, TNJ: ON THE HILL (June 14, 2017), <http://onthehill.tnjournal.net/das-in-three-northeast-tn-counties-file-lawsuit-against-opioid-manufacturers> [<https://perma.cc/4X7C-E86V>].

³²⁹ Bach, *supra* note 19, at 841 n.213.

³³⁰ *See id.*

³³¹ *See id.*

³³² *See id.*

³³³ *Id.* at 842 n.213.

³³⁴ Howard, *supra* note 239, at 91 (emphasis added).

³³⁵ Howard, *supra* note 102, at 385.

³³⁶ *See id.* (noting that black women are 15.27% of criminal defendants in the cases surveyed).

³³⁷ In fact, the percentage of black women prosecuted in Alabama may be lower than the percentage of black people living in Alabama. Compare *id.*, with *QuickFacts: Alabama*, U.S. CENSUS BUREAU (July 1, 2018), <https://www.census.gov/quickfacts/AL> [<https://perma.cc/VB8M-7DQX>] (estimating that black people make up 26.8% of Alabama’s population).

³³⁸ Bach, *supra* note 19, at 851.

³³⁹ A few scholars have begun to take notice of the change in the racial demographics of criminal prosecutions for substance use during pregnancy. See, e.g., Goodwin, *supra* note 285, at 786 (stating that “African American and Latina women no longer serve as the default targets of fetal protections laws” and noting that many of those prosecuted in Alabama were white); Ocen, *supra* note 197, at

for substance use during pregnancy. They have continued to expect that black women will remain the disproportionate targets of states' punitive zeal. For example, in an article published in 2018 in the *New York Times Magazine* about substance use during pregnancy, the author uses Paltrow and Flavin's 2013 study to reach the conclusion that "[r]ace and class biases may be active here [in the context of the opioid crisis], too. In [the Flavin and Paltrow study], low-income and African-American women were more likely than other women to be arrested for possibly causing harm to their fetuses during their pregnancies."³⁴⁰ This statement remains true with regard to low-income women; however, it is simply not true with regard to African American women.

Scholars analyzing prosecutions of substance use during pregnancy during the crack cocaine scare — that is, *first-generation prosecutions* — argued that the race of the impacted women informed society's choice to use one of the most brutal tools at its disposal, the criminal legal system, to address substance use during pregnancy. In these theories, the blackness of these women offered a total explanation for why the country felt that prosecution was appropriate and just. For example, Professor Priscilla Ocen reflects on first-generation prosecutions and appropriately concludes:

Indeed, Black women are often cast as paradigmatic deviant mothers who are uncaring and whose childbearing is responsible for broader social ills, including violence and poverty. It is unsurprising, then, that Black women have been the disproportionate targets of pregnancy prosecutions as the state attempts to regulate their reproductive capacities through the criminal law.³⁴¹

Similarly, Goodwin writes that the use of the criminal legal system to address substance use during pregnancy during the crack cocaine scare was a result of black women having been racially condemned as bad mothers. She argues that the "image of the bad mother is depicted and personified in deeply racialized ways in U.S. society. The crack scare provides one disturbing example."³⁴²

1171 (noting that "poor pregnant white women have increasingly been subject to criminalization, especially in the wake of the opioid crisis and the rise in methamphetamine use"); *id.* at 1174 (observing that "poor white women struggling with addiction to opioids or methamphetamine are increasingly subject to criminal prosecution").

³⁴⁰ Egan, *supra* note 95. A series about the various attacks on pregnant women's rights published by the *New York Times* at the tail end of 2018 made a passing reference to the changing demographics of the population of women subjected to criminal punishment for drug use during pregnancy. See *Feticide Playbook*, *supra* note 121 ("In recent years, the opioid epidemic — and the spike in methamphetamine addiction before it — has begun to change the racial makeup of those arrested, since white Americans more often use both drugs."). Notably, this reference is made in a section that begins with the claim that "[i]n reality, women charged with pregnancy-related crimes are often poor and nonwhite . . ." *Id.*

³⁴¹ Ocen, *supra* note 197, at 1170–71 (footnotes omitted).

³⁴² Goodwin, *supra* note 285, at 853 (footnote omitted).

If Ocen and Goodwin are correct about first-generation prosecutions — and they certainly are — what are we to make of the reality that with respect to contemporary prosecutions for substance use during pregnancy, what we might call *second-generation prosecutions*,³⁴³ prosecutions for substance use during pregnancy largely target *white women*? Have narratives *also* cast white women as abnormal, callous mothers whose fertility yields more general social problems? If so, do we accurately describe these narratives as racial, racialized, or racist if they also apply to white women? Does race have anything to do with it?³⁴⁴ Indeed, what are we to make of the fact that being white has not been able to protect white women from the muscularity of the United States' criminal legal system? What do whiteness and white privilege mean when they cannot protect their holders from excessive — indeed, abusive — state power? The next Part will begin an answer to these questions, an endeavor that allows us to complicate our understandings of white privilege.

The analysis contained in the next Part is based on the more than 1000 women in the United States who have been arrested and prosecuted for using substances while pregnant,³⁴⁵ it is based on the increasing number of white women whom this population has come to include as a consequence of the opioid epidemic's heavy impact on white communities. The following analysis derives from a small dataset, but the amount of data does not impeach the legitimacy of the investigation or the conclusions it reaches. In keeping with Foucauldian discourse analysis, the next Part inquires into “what is said” about white women who use controlled substances during pregnancy, comparing it to “what is said” (or rather, what has been said) about black women who use

³⁴³ We might understand second-generation prosecutions as those whose subjects are largely pregnant white women who use either opioids or methamphetamines — a drug that, like opioids, has greatly impacted white people and white communities.

While opioid use has received a lot of attention of late, methamphetamine usage during pregnancy is a significant phenomenon. See Tricia E. Wright et al., *Methamphetamines and Pregnancy Outcomes*, 9 J. ADDICTION MED. 111, 111 (2015) (“Methamphetamine (MA) is one of the most commonly abused drugs during pregnancy, with prevalence estimates ranging from 0.7% to 4.8% in highly endemic areas.” (citation omitted)); Khazan, *supra* note 310 (“Though heroin has become a more pressing crisis in some parts of the country, meth addiction still ravages many southern and western states. After marijuana, meth was the second-most common illegal drug found among the 375 newborns who tested positive for substances in Oklahoma hospitals last year.”).

³⁴⁴ Scholars have offered theories that do not center on race and racism to explain the criminalization of substance use during pregnancy. The whiteness of second-generation prosecutions does not call into question these theories. For example, Ocen writes that “the criminalization of the status of pregnancy has much in common with its historical forebearers with regard to the management of people deemed to present a risk to the public, their removal from society through incarceration, and the erasure of structural inequality as an explanation for [their] social problems.” Ocen, *supra* note 197, at 1198. This explanation seems as true of second-generation prosecutions as it does of first-generation prosecutions.

³⁴⁵ See *supra* note 196.

controlled substances during pregnancy.³⁴⁶ Analyzing the profoundly different discourses that have been generated about these otherwise similarly situated populations allows us to theorize the concept of white privilege. The following analysis, then, is not really *about* the 1000 women who have come within the jurisdiction of the criminal system after having used controlled substances during their pregnancies. Instead, the following analysis is about white privilege and whiteness, and race generally, as revealed by our discourse around these women.

IV. LESSONS FROM THE CRIMINALIZATION OF OPIOID USE DURING PREGNANCY: GUIDING MAXIMS FOR STUDIES OF WHITE PRIVILEGE

Even if some groups of white people have been punished for using opioids, the country's overall willingness to use the tools of public health to engender a more empathetic, less punitive response to the opioid epidemic is an example of white privilege.³⁴⁷ White privilege is apparent

³⁴⁶ MICHEL FOUCAULT, *THE ARCHAEOLOGY OF KNOWLEDGE* (A.M. Sheridan Smith trans., Pantheon Books 1972) (1969).

³⁴⁷ There are tensions in the community of public health scholars about what white disadvantage ought to mean for public health intervention. On one side sit scholars who insist that reducing or eliminating racial disparities in health outcomes should remain the focus of efforts to produce health equity and to improve population health. See, e.g., Zinzi D. Bailey et al., *Structural Racism and Health Inequities in the USA: Evidence and Interventions*, 389 *THE LANCET* 1453, 1461 (2017) ("Without a vision of health equity and the commitment to tackle structural racism, health inequities will persist, thwarting efforts to eliminate disparities and improve the health of all groups — the overarching goals for US health policy as enunciated by the official Healthy People 2020 objectives."); Rachel R. Hardeman et al., Letter to the Editor, *Race vs Burden in Understanding Health Equity*, 317 *JAMA* 2133, 2133 (2017) ("Certainly white individuals face important risks; yet disparate risk exposure by race is a threat to population health, and favoring burden over rate differences does nothing to address this threat."). In this view, recent increases in premature white mortality are lamentable, but ultimately should not take attention away from the fact that nonwhite people are still sicker and die earlier than white people.

On the other side sit scholars who insist that although there are higher rates of mortality and morbidity among nonwhite people, white people should be the focus of health interventions because there is a higher absolute number of them. As a result, white people — specifically, poor white people — bear a greater burden of morbidity and mortality and, as such, should be the focus of efforts designed to improve overall population health. See David Kindig, *Population Health Equity: Race and Burden, Race and Class*, 317 *JAMA* 467, 467 (2017) (stating that "poor health is not limited to the black population or other people of color" and noting that "the total burden of poor health . . . is often greater among white than black individuals simply because there are more white than black individuals of lower socioeconomic status"); David A. Kindig, Letter in Reply, *Race vs Burden in Understanding Health Equity*, 317 *JAMA* 2133, 2133–34 (2017) (arguing that conversations around health equity tend to focus on *racial* health equity, which ignores class, and proposing that if these conversations considered class, they would lead to better solutions and health outcomes for all people — including poor white people). If this latter view wins, then the country will give its attention — and money — to improving poor white people's health outcomes. We can predict that these efforts would not improve nonwhite people's health outcomes. In this way, white disadvantage would have the effect of producing even more nonwhite disadvantage. That is, white

in the nation's general disposition to conceptualize those who are addicted to opioids as people who, being "just like us," need treatment — and not incarceration.³⁴⁸

The theories that scholars have offered to explain why the opioid epidemic has greatly impacted white communities similarly evince white privilege. For example, economists Case and Deaton offer an account of the whiteness of the opioid epidemic that has enjoyed some degree of popularity: economic vulnerability has made white people susceptible to substance use, misuse, and dependency.³⁴⁹ Attempting to explain the increase in midlife morbidity and mortality among white people, they write:

Although the epidemic of pain, suicide, and drug overdoses preceded the financial crisis, ties to economic insecurity are possible. After the productivity slowdown in the early 1970s, and with widening income inequality, many of the baby-boom generation are the first to find, in midlife, that they will not be better off than were their parents. Growth in real median earnings has been slow for this group, especially those with only a high school education.³⁵⁰

Case and Deaton, along with others, theorize that white people's failure to achieve the lives that they thought were promised to them, and the uncertainty they feel as a result of a fragile financial condition that manifests this failed promise, puts them at risk of turning to drugs — substances that can temporarily assuage the pain that they feel about their humbled status.³⁵¹

privilege would result in the insistence of foregrounding white disadvantage, to nonwhite people's detriment.

³⁴⁸ For example, former New Jersey Governor Chris Christie attributed his commitment to combating the opioid epidemic in the state to his experience with a law school classmate, who died after battling addiction to prescription painkillers. See Andrew Kitchenman, *Friend's Death Leads Christie to Underscore Overdose Concerns to Doctors*, N.J. SPOTLIGHT (May 19, 2014), <https://www.njspotlight.com/stories/14/05/19/death-of-friend-leads-christie-to-emphasize-overdose-concerns-to-doctors/?p=all> [<https://perma.cc/B649-TCGL>].

³⁴⁹ Case & Deaton, *Rising Morbidity*, *supra* note 8, at 15081.

³⁵⁰ *Id.* Case and Deaton go on to observe that the countries that the United States tends to think of as peers have not battled similar negative health outcomes — although they, too, have had to deal with slowdowns in productivity. See *id.* While some of these countries "have seen even slower growth in median earnings than the United States, . . . none have had the same mortality experience." *Id.* Case and Deaton theorize that economic insecurity has not pushed the residents of other industrialized nations to suicide and substance dependency because defined-benefit pensions have abated their insecurity. *Id.* Meanwhile, people in the United States have had to rely on "defined-contribution pension plans with associated stock market risk." *Id.* Case and Deaton posit that Americans' need to rely on relatively unreliable financial instruments may have exacerbated their sense of financial precarity. See *id.* This perceived financial insecurity may explain the increase in suicide and substance dependency. See *id.*

³⁵¹ See *id.*; Paola Scommegna, *Opioid Overdose Epidemic Hits Hardest for the Least Educated*, POPULATION REFERENCE BUREAU (Jan. 10, 2018), <https://www.prb.org/people-and-places-hardest-hit-by-the-drug-overdose-epidemic> [<https://perma.cc/9SKZ-CEF6>]. See generally ROBIN GHERTNER & LINCOLN GROVES, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE OPIOID

These types of explanations of the whiteness of the opioid crisis demonstrate white privilege in two ways. First, they refuse to explain the epidemic's whiteness in terms of an immoral or deviant mindset possessed by those who use controlled substances — an explanation that was ubiquitous during the racialized black crack cocaine scare of the 1980s.³⁵² This forgiving portrayal of white substance users is white privilege. That is, white privilege is on full display when white people's shortcomings are accounted for in terms that eschew individual pathology. Second, these explanations propose that the epidemic results from white people having failed to achieve a racial/economic status that they *anticipated*. Differently stated, these accounts propose that white people's drug use is a result of their disappointment with their current social and financial condition — a disappointment produced by the belief that they were going to be better off. White people's *expectation* of a certain status, category, or position — and their substance use-inducing disappointment when that expectation goes unrealized — is a *consequence* of white privilege.³⁵³ When theorists explain the whiteness of the opioid crisis in terms of unmet expectations, these theorists acknowledge white privilege's existence.³⁵⁴

Professor Naomi Murakawa has made an analogous point in the context of the methamphetamine scare of the early aughts, which was also racialized as white. Writing of the panic that surrounded white people's use of methamphetamine, Murakawa notes: "While drug scares focused on people of color demonize users along with dealers and producers, the constructed meth epidemic often grants users a more contextualized victim status, emphasizing not only fear *of* White drug users, but also fear *for* White drug users."³⁵⁵ During the methamphetamine scare, white people were depicted as victims — of the economic precarity that late

CRISIS AND ECONOMIC OPPORTUNITY: GEOGRAPHIC AND ECONOMIC TRENDS (2018), <https://aspe.hhs.gov/system/files/pdf/259261/ASPEconomicOpportunityOpioidCrisis.pdf> [<https://perma.cc/4EQM-STV6>].

³⁵² See, e.g., Charles Krauthammer, *Children of Cocaine*, WASH. POST, July 30, 1989, at C7.

³⁵³ See Jessie Daniels & Julie Netherland, *White Death and the Legacy of Racism* 21 (unpublished manuscript) (on file with the Harvard Law School Library) (describing the "dashed expectations" hypothesis, which proposes that white people "experience economic downturn, job loss, and diminished opportunities (especially in relationship to Blacks) as particularly catastrophic because they feel entitled to a certain amount of privilege" and noting that "[w]hen people have their expectations dashed, this can lead to negative emotions, which in turn, can lead to destructive forms of self-medication").

³⁵⁴ See, e.g., *id.* at 22 (arguing that the increase in rates of premature death among white people is due to "the expectation among whites that they should live lives free of pain — whether physical, psychic, and emotional" and stating that "[o]pioids, alcohol, and suicide all provide relief from the unexpected pain and challenges of job loss, marginalization, and criminalization — challenges that most white people may not anticipate and find hard to accept, as part of their lived experience" (citation omitted)).

³⁵⁵ Murakawa, *supra* note 101, at 220.

capitalism produced.³⁵⁶ Murakawa argues that this framing of methamphetamine users as victims “preserves the default assumption that Whites deserve their White privilege.”³⁵⁷ Understanding white users of methamphetamine as pitiable actors struggling for a meaningful existence in late capitalism both reveals and reinforces white privilege. “[T]he emphasis on White decline ultimately maintains a kind of White privilege: while all are economically vulnerable, only White economic decline is catastrophized through the meth epidemic.”³⁵⁸

We can offer a comparable analysis of the opioid epidemic. Inasmuch as scholars theorize that the opioid crisis is an effect of white people’s disappointment in their financial insecurity, then the crisis suggests that white people expected financial security. This expectation is white privilege. It is also relevant that nonwhite people have not turned to drugs and suicide at rates that match those of their white counterparts.³⁵⁹ If this disparity is due to nonwhite people having *not* been dismayed by their economic precarity, then this also demonstrates the existence of white privilege: nonwhite people do not experience financial insecurity as a disappointment. Unlike white people, nonwhite people have learned to expect uncertainty, misfortune, and adversity.³⁶⁰

A. *White Privilege Can Betray*

Ironically, white people are at times made vulnerable to disadvantage *because* they occupy a privileged social location. This is to say: membership in a race that enjoys a socially dominant status can sometimes endanger white people. On these occasions, their racial privilege can actively produce disadvantage.

The eugenics movement of the early twentieth century is a helpful guide to how white privilege can put those who possess it at risk of harm. Indeed, the eugenics movement might be an expected guide for understanding the import of contemporary prosecutions of opioid use during pregnancy inasmuch as both contexts involve state efforts to control the reproduction of socially disfavored groups.³⁶¹

³⁵⁶ *Id.* at 224–25.

³⁵⁷ *Id.* at 225.

³⁵⁸ *Id.*

³⁵⁹ See Case & Deaton, *Mortality and Morbidity*, *supra* note 11, at 398, 408–09.

³⁶⁰ *Cf. id.* at 429.

³⁶¹ Professor Grace Howard has also recognized the parallels between eugenic sterilizations of the early twentieth century and more recent prosecutions of white women for substance use during pregnancy, writing: “In the name of protecting mothers and babies, but ultimately, by sparing ‘society’ from the perverse horror of the mythical ‘meth baby,’ the actions taken by Alabama officials [who arrest white women for methamphetamine use during pregnancy] echo the early eugenic attempts at eradicating the polluted whites, the peripheral whites, the white trash.” Howard, *supra* note 102, at 398.

The overarching theme of the eugenics movement, which was at its most powerful and influential in the United States in the early 1920s,³⁶² was genetic determinism. The movement was premised on the idea that an individual's genes determined whether he would succeed or fail in life.³⁶³ Eugenists argued that those with power, affluence, and influence in society occupied their lofty social positions because their genes enabled and predicted their social success.³⁶⁴ At the same time, those disempowered folks mired in poverty and incapacitated in prisons and mental institutions had genes that made their failure to thrive predictable and inevitable.³⁶⁵ Essentially, eugenists proposed that the country's existing social hierarchy simply manifested the quality of the genes possessed by those who occupied the various social tiers.³⁶⁶ Grander still, eugenists proposed that global hierarchies — with some countries being wealthier and more powerful than others — were the product of the overall quality of the genes held by the residents of the various nations.³⁶⁷

Eugenics was a profoundly racist social philosophy, with its architects and exponents proposing that by racial fiat, white people had the highest-quality genes.³⁶⁸ The superior genetic inheritance of white people with Northern European ancestry explained why they existed at the apex of the social hierarchy in the United States.³⁶⁹ (Conversely, nonwhite people's inferior genetic inheritance explained why they tended to be impoverished and bereft of power in the country. Eugenists denied that Jim Crow in the case of black people, forced relocation in the case of indigenous peoples, and restrictive immigration laws in the case of Asian and Latinx peoples — all set in a context of ubiquitous

³⁶² MATT WRAY, NOT QUITE WHITE 72–73 (2006) (“[E]ugenics as a social movement peaked in the 1920s, when urbanization, industrialization, and massive immigration sparked cultural anxieties and political unease about national identity, shifting racial and social hierarchies, and gender roles.”).

³⁶³ See Garland E. Allen, *The Social and Economic Origins of Genetic Determinism: A Case History of the American Eugenics Movement, 1900–1940 and Its Lessons for Today*, 99 GENETICA 77, 78–79 (1997).

³⁶⁴ See WRAY, *supra* note 362, at 69.

³⁶⁵ See Allen, *supra* note 363, at 79.

³⁶⁶ Victoria Nourse, *Buck v. Bell: A Constitutional Tragedy from a Lost World*, 39 PEPP. L. REV. 101, 105 (2011).

³⁶⁷ Randall Hansen & Desmond King, *Eugenic Ideas, Political Interests, and Policy Variance: Immigration and Sterilization Policy in Britain and the U.S.*, 53 WORLD POL. 237, 252 (2001) (quoting a eugenicist saying that “the character of a nation is determined primarily by its racial qualities: that is, by the hereditary physical, mental, and moral or temperamental traits of its people”).

³⁶⁸ See *id.* at 248 (noting American eugenists believed those of Nordic or Aryan descent were genetically superior).

³⁶⁹ See WRAY, *supra* note 362, at 73, 94.

private discrimination — explained nonwhite people's subordinate social status.³⁷⁰) Further, eugenicists proposed that white people's superior genetic inheritance explained why white countries — England, Norway, the United States, and others — were the most dominant on the world stage.³⁷¹

Intrinsic to the eugenics movement was a preoccupation with the possibility of genetic debasement. Eugenicists worried that people with problematic genes — the ones that caused mental illness, feeble-mindedness, physical disabilities, laziness, promiscuity, and so forth — would reproduce at high rates, producing large numbers of children who carried their parents' and grandparents' (and great-grandparents') same unfortunate genes.³⁷² Eugenicists envisioned a dystopic future in which, due to the distressingly high birth rates of people with inferior genes, these lamentable genes would come to outnumber, outstrip, and altogether overwhelm the genes that produced superior social traits.³⁷³ According to eugenicists, the country would fall into disrepair at that point.³⁷⁴

Eugenicists refused to sit back idly and wait for the inevitable to happen. Instead, they were intensely proactive with regard to salvaging and protecting the genetic inheritance of the country. One essential element of their program to guard against the debasement of the white race was the sterilization of those imagined to bear substandard genes.³⁷⁵ The idea here was that people with inferior genes had to be prevented — by compulsion, if necessary — from transmitting their disadvantageous genetic inheritance to future generations. The most

³⁷⁰ See Garland E. Allen, *Eugenics and Modern Biology: Critiques of Eugenics, 1910-1945*, 75 ANNALS HUM. GENETICS 314, 317-18 (2011) (describing anthropological and psychological critiques of eugenics, which emphasized the absence of social and structural explanations for social positions).

³⁷¹ See Hansen & King, *supra* note 367, at 249 (describing American eugenicists' claims that other groups "were inferior to those from Northern Europe").

³⁷² Allen, *supra* note 370, at 314.

³⁷³ FRANCIS GALTON, HEREDITARY GENIUS 343 (London, MacMillan & Co., 2d ed. 1892) (calling it "monstrous that the races best fitted to play their part on the stage of life, should be crowded out by the incompetent, the ailing, and the desponding"); see also Hansen & King, *supra* note 367, at 248 (discussing American eugenicists' "fear of racial degeneration").

³⁷⁴ See Hansen & King, *supra* note 367, at 249.

³⁷⁵ See Alexandra Minna Stern, *Eugenics, Sterilization, and Historical Memory in the United States*, 23 HISTÓRIA, CIÊNCIAS, SAÚDE — MANGUINHOS 195, 196 (Supp. 2016). Eugenicists in Nazi Germany learned from their counterparts in the United States — forcibly sterilizing some 400,000 people. CLYDE CHITTY, EUGENICS, RACE AND INTELLIGENCE IN EDUCATION 42 (2007). The Third Reich eventually took the American eugenics movement to its logical conclusion, murdering over 6,000,000 Jewish people in the Holocaust in the pursuit of racial hygiene. See Israel Shenker, *Holocaust: Systematic Slaughter of Six Million of Europe's Jews*, N.Y. TIMES, Apr. 18, 1978, at 78.

secure mechanism for ensuring this result was through an extensive program of coercive sterilization.³⁷⁶ In 1927 in *Buck v. Bell*,³⁷⁷ the Supreme Court infamously held that coercive sterilization did not run afoul of the Constitution, with Justice Holmes's brutal declaration that "[t]hree generations of imbeciles are enough."³⁷⁸

Those who were most vulnerable to eugenic sterilization during the early twentieth century were white people. Indeed, Carrie Buck, the plaintiff at the center of *Buck v. Bell*, was a white woman.³⁷⁹ This was no accident.³⁸⁰ At the dawn of the twentieth century, eugenic sterilization was about *white* racial improvement. It was designed to protect and perfect *white* racial stock. As a result, white people were those who were in the crosshairs of pseudoscientists operating under the banner of eugenics.³⁸¹ For the most part, nonwhite people were not subjects of eugenic sterilization during this time.³⁸² Nonwhite people were a concern to eugenicists only to the extent that they wanted to keep these patently inferior people, and their obviously substandard genes, away from white people. Thus, antimiscegenation laws evidenced the only site at which eugenicists were interested in nonwhite people.³⁸³ The other two points of eugenicists' program for racial improvement — immigration reform³⁸⁴ and coercive sterilization laws — were solely, and doggedly, about white people.

Thus, it was because eugenicists imagined the white race to be the finest, most exceptional group of people that has ever walked the earth that they believed the race to be in need of protection — from degradation, from corruption, from its fall. As a consequence, white people — and not people of color — were made vulnerable to state power. The

³⁷⁶ See Daniel J. Kevles, *Eugenics and Human Rights*, 319 THE BMJ 435, 436 (1999).

³⁷⁷ 274 U.S. 200 (1927).

³⁷⁸ *Id.* at 207.

³⁷⁹ *Id.* at 205 ("Carrie Buck is a feeble minded white woman . . .").

³⁸⁰ See Bridges, *supra* note 25, at 465.

³⁸¹ As Professor Matt Wray tells this history:

If, in 1850, professional scientists in this rising class were obsessed with inventing and classifying the nature and meanings of boundaries of racial difference, by 1880 they had shifted focus. Cutting-edge research no longer focused on differences *between* races, but instead on recognizing and delineating differences *within* races. Presumably this was because by 1880, racial science had established beyond scientific doubt the racial inferiority of people of color. Further investigations on the question were simply not needed. Turning the scientific gaze to various biological and cultural distinctions among whites was an obvious next step.

WRAY, *supra* note 362, at 76 (footnote omitted).

³⁸² Bridges, *supra* note 25, at 465–66.

³⁸³ See ADAM COHEN, IMBECILES: THE SUPREME COURT, AMERICAN EUGENICS, AND THE STERILIZATION OF CARRIE BUCK 58 (2016) (describing eugenicists' "primary interest" as white preservation, accomplished, in part, by laws barring interracial sex); see also WRAY, *supra* note 362, at 73 (noting that eugenic research on nonwhite people was "almost nonexistent").

³⁸⁴ Hansen & King, *supra* note 367, at 252–54.

most violent manifestation of this vulnerability was the coercive sterilizations to which thousands of white people were subjected in the early twentieth century.³⁸⁵ Meanwhile, nonwhite people's imagined racial inferiority bestowed them with a certain degree of protection during this time, largely saving them from the eugenicist's knife.³⁸⁶

Thus, Buck's status as a member of the most powerful race in the nation effected a kind of marginalization on her: she was marginalized inasmuch as she was imagined to be the stuff upon which the race to which she belonged could be perfected. As I have written elsewhere:

[Carrie Buck's whiteness] granted her admission to a race that the most powerful people of the day believed to be superior to all others. However, her membership in that race made her body an object of racial improvement. Differently stated, Carrie Buck's whiteness allowed her inclusion into the highest-quality race. [As a direct result of that inclusion], Carrie Buck's whiteness rendered her vulnerable to quality control.³⁸⁷

This is to say that Buck's whiteness saddled her with extreme liabilities — like the construction of her fertility as a danger to continued white supremacy. In this way, Buck's whiteness was a privilege and a curse. It was a privilege in the sense that it gave her access to opportunities that were completely foreclosed to nonwhite people, like access to a home in which white people with mental disabilities could be cared for.³⁸⁸ However, her whiteness was also a curse insofar as it “made her reproduction an object of interest to eugenicists — pseudoscientists who then conceptualized it as a problem that needed to be solved.”³⁸⁹

We can draw an analogy to the recent prosecutions for substance use during pregnancy. Have prosecutors identified white women who use opioids (and methamphetamine) during their pregnancies as appropriate targets for punishment because there is a concern that they are ruining their white babies? Have these white women become a target of state violence because, as with the eugenics movement, the state is concerned with preserving white futures? Do states want to punish white women who use substances during their pregnancies because they have risked harm to white babies and, in so doing, threatened the vitality of the white race?

If the desire to protect *white* babies has motivated recent prosecutions for opioid use during pregnancy, consciously or unconsciously, then there is a parallel between our contemporary moment and our eugenic

³⁸⁵ ALEXANDRA MINNA STERN, *EUGENIC NATION: FAULTS AND FRONTIERS OF BETTER BREEDING IN MODERN AMERICA* 115 (2d ed. 2016) (noting that in the first half of the twentieth century, eugenic sterilization laws allowed approximately 60,000 sterilizations to occur).

³⁸⁶ See Bridges, *supra* note 25, at 465–66.

³⁸⁷ *Id.* at 468.

³⁸⁸ See *id.* at 474–75.

³⁸⁹ *Id.* at 481.

past. During the eugenics movement, the state's concern with white reproduction evidenced white privilege. It was only because white reproduction was valued that the state sought to safeguard it, improve it, and perfect it. The state neglected and disregarded nonwhite reproduction, perceiving it to be worthless during the early twentieth century.³⁹⁰ However, the interest in white reproduction — an interest that was a consequence of the value placed on white fertility — exposed white people to the threat of coercive sterilization. We could similarly interpret the present. That is: it is not preposterous to claim that contemporary society values white reproduction and white babies more than their nonwhite counterparts. Certainly, explicit declarations that white fertility is preferred to nonwhite fertility are uncommon in mainstream political and popular discourse. But implicit demonstrations of the differential values placed on white and nonwhite reproduction are plentiful — from the reluctance with which the welfare state supports poor, disproportionately nonwhite³⁹¹ families,³⁹² to the aggressiveness with which the state separates and dissolves nonwhite families,³⁹³ to the way that nonwhite fertility figures in cultural narratives as a source of social problems.³⁹⁴ Inasmuch as society prizes white procreation over its nonwhite complement, the higher esteem in which it is held has made white reproduction a site of particular interest to the state. This interest, in turn, has opened white people up to state violence — this time in the form of prosecutions for opioid use during pregnancy. As white privilege

³⁹⁰ Of course, during the days of chattel slavery, nonwhite reproduction — specifically, black reproduction — was an object of incredible interest, as it was a means by which slaveholders could multiply the value of their claimed property. See DOROTHY ROBERTS, *KILLING THE BLACK BODY* 25–26 (Vintage Books 2d ed. 2017) (1997).

³⁹¹ See Tracy Jan, *States with More Black People Have Less Generous Welfare Benefits, Study Says*, WASH. POST. (June 6, 2017, 6:00 AM), <https://www.washingtonpost.com/news/wnk/wp/2017/06/06/states-with-more-black-people-have-less-generous-welfare-benefits-study-says> [<https://perma.cc/6ZBY-WJKV>].

³⁹² See ASHLEY BURNSIDE & IFE FLOYD, *CTR. ON BUDGET & POLICY PRIORITIES, TANF BENEFITS REMAIN LOW DESPITE RECENT INCREASES IN SOME STATES* 4–5 (2019) (“[Temporary Assistance for Needy Families] benefits still leave family incomes at or below 60 percent of the poverty line in every state. . . . Moreover, the country’s black population is more likely than the white population to live in the states with the lowest benefit levels.” (footnote omitted)).

³⁹³ See Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 *UCLA L. REV.* 1474, 1483–84 (2012) (noting that “[b]lack children are still grossly overrepresented in the U.S. child welfare system,” and that “state agents forcibly remove most of these children,” *id.* at 1484); Caitlin Dickerson, *Hundreds of Immigrant Children Have Been Taken from Parents at U.S. Border*, N.Y. TIMES (Apr. 20, 2018), <https://nyti.ms/2vzDl6K> [<https://perma.cc/ZVN4-AD93>] (discussing the Trump administration’s family separation policy).

³⁹⁴ See Jamelle Bouie, *The Most Discriminatory Law in the Land*, SLATE (June 17, 2014, 11:47 PM), <https://slate.com/news-and-politics/2014/06/the-maximum-family-grant-and-family-caps-a-racist-law-that-punishes-the-poor.html> [<https://perma.cc/P652-5QJL>] (discussing the argument that family caps “end[] the ‘incentive’ of reproduction, . . . arrest the spiral of moral decline and pathology in poor black communities, and end the crime and poverty that presumably flows from black single motherhood”).

betrayed white people in the heyday of the eugenics movement, white privilege is similarly betraying white people — the pregnant ones — in the context of the opioid epidemic. That is, as white privilege actively produced white disadvantage during the eugenics movement, white privilege is actively producing white disadvantage during the opioid epidemic. The conclusion we might draw is that it is not odd for white privilege to coexist with white hardship: the former oftentimes generates the latter.

Insofar as contemporary prosecutions of pregnant women who have used opioids are examples of white privilege betraying those who possess it — of white privilege producing white adversity — then we have to recognize that different meanings can attach to the same phenomenon. That is, the meaning of using the criminal legal system to address substance use during pregnancy has varied across historical contexts. In the setting of the crack cocaine scare of the 1980s, the interest that the state showed in black reproduction was not due to its perceived value; it was not because the state thought black fertility was in need of defense, lest it be corrupted and rendered worthless. Rather, the interest that the state showed in black reproduction seemed to be due to a concern that without regulation, black reproduction would come to burden the state. Observers frequently described the crisis of the “crack baby” in terms of the costs that these infants would impose on the state.³⁹⁵ In the popular and political discourse of the time, crack babies were depicted as *expensive*.³⁹⁶ The narrative was that the state, and ultimately society, was going to have to pay for these infants: in neonatal intensive care units, which would have to provide costly healthcare to them; in the public schools, which would have to design special programs to attempt to educate them despite their deficiencies; in the foster care system, which would have to care for them in the face of their parents’ inadequacy; in the jails and prisons, which would inevitably come to manage the boys upon their reaching adulthood; and in welfare programs, which would subsidize the lives of the girls once they were old enough to reproduce. With babies framed as costly problems, the prosecutions of the black women who carried these babies were about punishing the people who would burden the state with future social ills.³⁹⁷

³⁹⁵ See, e.g., Opinion, *The Cost of Not Preventing Crack Babies*, N.Y. TIMES, Oct. 10, 1991, at A26.

³⁹⁶ For example, U.S. Representative George Miller (D-CA) of the U.S. House Select Committee on Children said: “We are going to have these children, who are the most expensive babies ever born in America [and] are going to overwhelm every social service delivery system that they come in contact with throughout the rest of their lives” Jimmie L. Reeves, *Re-covering Racism: Crack Mothers, Reaganism, and the Network News*, in *LIVING COLOR: RACE AND TELEVISION IN THE UNITED STATES* 97, 111 (Sasha Torres ed., 1998).

³⁹⁷ See, e.g., Hoffman, *supra* note 298 (noting that the suffering of babies born dependent on cocaine, “to say nothing of the long-term social costs, is so staggering that people understandably want to turn on their perceived torturers: their mothers” (emphasis added)).

However, in the context of the opioid epidemic, prosecutions for substance use during pregnancy are about something different. While the history of our present social moment is still being written, it seems safe to conclude that we will look upon the current public discourse about babies exposed to opioids in utero as less cruel — less unkind — than the discourse that circulated in the 1980s and 1990s about the babies that black mothers exposed to crack cocaine in utero.³⁹⁸ An investigation of opioid use during pregnancy that the news organization *Reuters* conducted is an excellent illustration of the overall refusal to malign opioid-exposed babies and dismiss them as a drug-damaged underclass.³⁹⁹ The *Reuters* coverage might be fairly described as a paradigm of sensationalism: when accessed online, the series is preceded by a disturbing, up-close video of a “baby boy suffer[ing] severe leg tremors as he goes through drug withdrawal.”⁴⁰⁰ Further, the series is replete with story after story of babies dying — being smothered, being placed in a washing machine, being given lethal amounts of methadone — after being left in the care of parents who were struggling with substance use disorders.⁴⁰¹ Although the series is lurid, its shocking tone never extends to the descriptions of the babies born to opioid-dependent parents. Repeatedly, the reporters insist that the babies were, on the whole, fine (after the symptoms of their NAS had subsided); however, parental behavior *after* they were born was that which seriously jeopardized their health and ultimately ended their lives.⁴⁰² In telling contrast, news organizations dismissed babies exposed to crack cocaine in utero as the

³⁹⁸ It may be that *national* media outlets are less likely to publish stories about opioid-exposed babies that predict that they will be the future social problems of America, that is to say, its criminals and welfare queens. When these stories exist, they are often found in local media outlets. See, e.g., Anna Merod, *Drug-Exposed Babies Face Health Struggles*, WINCHESTER STAR (Jan. 16, 2019), https://www.winchesterstar.com/winchester_star/opioid-exposed-babies-face-struggles/article_a40da893-1166-581b-a16c-7aacba16cc26.html [https://perma.cc/VK8A-NHJE] (providing a fairly sympathetic account but noting that “[g]etting kicked out of preschool is fairly common for [opioid-exposed] children”); George Myers, “*A Hard Road*”: *Nearly 1 in 5 Howard Co. Babies Born Exposed to Drugs*, KOKOMO TRIB. (Dec. 16, 2018), https://www.kokomotribune.com/news/local_news/a-hard-road-nearly-in-howard-co-babies-born-exposed/article_ccae45bo-0044-11e9-911a-0b6b9b436470.html [https://perma.cc/2VPG-R8FZ] (noting that while long-term effects are still being researched, prenatal opioid exposure could lead to kids with learning disabilities and emotional connection issues).

Although, as a general matter, media coverage of babies exposed to opioids in utero has not been as *cruel* as the coverage in the 1980s and 1990s of babies exposed to crack cocaine in utero, contemporary coverage has not always been *accurate*. See Nat’l Advocates, Open Letter, *supra* note 121.

³⁹⁹ See Duff Wilson & John Shiffman, *Helpless & Hooked*, REUTERS, <https://www.reuters.com/investigates/special-report/baby-opioids> [https://perma.cc/2SN4-R4UU].

⁴⁰⁰ *Id.*

⁴⁰¹ See *id.*

⁴⁰² See *id.* (“Being born drug-dependent didn’t kill these children. Each recovered enough to be discharged from the hospital. What sealed their fates was being sent home to families ill-equipped

brain-damaged future problems of America. As the *New York Times* notes: “Americans were told on the nightly news that crack exposure in the womb destroyed the unique brain functions that distinguish human beings from animals”⁴⁰³ In the context of the contemporary opioid crisis, however, discourse that quite literally *dehumanizes* the babies exposed to opioids in utero is an exception, rather than the rule. As a general matter, we talk about these babies as victims.⁴⁰⁴ They are victims of the opioid scourge that has swept the nation.⁴⁰⁵ They are victims of their mothers’ choice to use opioids in the first instance and, in the second instance, of their mothers’ choice to continue using drugs upon learning of their pregnancies.⁴⁰⁶ They are victims of society’s failure to provide treatment to all who struggle with opioid use disorder.⁴⁰⁷ With babies framed as victims, the prosecutions of the women who played some role in victimizing these babies are about vindicating the interests of innocents.

Which is to say: in a society organized by and around race, race alters the meaning of phenomena. In one historical moment, when the subjects of the criminal legal system were black, the rush to punish evidenced a retaliatory instinct: Prosecutions were a form of payback. They were a reprisal for those who generated the social ills with which the nation would have to wrestle. In another historical moment, when the subjects of the criminal system are white, the rush to punish evidences a different instinct. Today, prosecutions are about using state power to affirm that an innocent has been wronged and to penalize those who are believed to have committed that wrong.

to care for them. . . . Other children died of drug poisoning — not from the narcotics in their bodies at birth but from doses administered after they left the hospital.”)

⁴⁰³ *Slandering the Unborn*, *supra* note 121.

⁴⁰⁴ We should note, however, that describing these babies as victims is not a benign affair. As National Advocates for Pregnant Women states in its open letter regarding the media coverage of babies exposed to opioids in utero, “where there are victims, there also are perpetrators.” Nat’l Advocates, Open Letter, *supra* note 121. The worry is that if society conceptualizes babies as victims, then it will conceptualize pregnant women who expose their fetuses to opioids as perpetrators, that is to say, bad actors who deserve punishment.

⁴⁰⁵ See, e.g., Hannah Rappleye et al., *Born Addicted: The Number of Opioid-Addicted Babies is Soaring*, NBC NEWS (Oct. 9, 2017, 9:25 AM), <https://www.nbcnews.com/storyline/americas-heroin-epidemic/born-addicted-number-opioid-addicted-babies-soaring-n806346> [<https://perma.cc/4DNB-DUS6>] (calling a baby born dependent on opioids and “thousands like him . . . the smallest victims of the opioid epidemic”).

⁴⁰⁶ See, e.g., Georgea Kovanis, *The Tiniest Addicts: How U.P. Babies Became Part of Opioid Epidemic*, DETROIT FREE PRESS (May 30, 2018, 1:13 PM), <https://www.freep.com/story/news/local/michigan/2018/05/03/opioid-epidemic-drug-addicted-babies/335398002> [<https://perma.cc/GK2G-DYM8>] (“The new baby was dope sick. He was in full-on, cold-turkey withdrawal from the opioids his mother took while pregnant.”).

⁴⁰⁷ See Stephanie Dubick, *Pregnant and Addicted to Heroin, with Nowhere to Turn for Help*, VICE (June 15, 2017, 1:35 PM), https://broadly.vice.com/en_us/article/payvbg/pregnant-and-addicted-to-heroin-with-nowhere-to-turn-for-help [<https://perma.cc/L8TT-QJ47>] (noting a severe lack of social support or recovery programs available for pregnant women with substance dependencies).

B. *Whiteness Is a Contested Process (with Consequences for White Privilege)*

When we conceptualize race as a static entity, interrogating the significance of prosecuting white women for opioid use during pregnancy is a question about what white privilege means for people who are, without question, white. However, different questions are raised if we take seriously the teachings of scholars who have proposed that race is a social construction. Through this alternative lens, we can understand the prosecutions of pregnant women who use opioids as contests over who can lay claim to inclusion in the white race. Indeed, we can understand them as a site wherein people and groups are being qualified and disqualified from whiteness.

To explain this idea, we should begin with a description of what it means to propose that race is a social construction.⁴⁰⁸ This proposal begins with rejecting understandings that race is a natural, biologically based entity that predates society.⁴⁰⁹ To say that race is a social construction is to deny that race is “in the genes” — that genetic difference can divide humans into four, or five, or six (or more, or fewer) groups of individuals who are more biologically or genetically similar to one another than they are to individuals in outgroups.⁴¹⁰ While there are certainly *populations* of humans that may be united by the genes they share, these populations are not coextensive with the groups that are referred to as *races*, that is, black, white, Asian, indigenous, and so forth.⁴¹¹

Claiming that race is a social construction is not equivalent to claiming that race is not real.⁴¹² Quite the contrary, despite its lack of moorings in biology, race is *very* real. Race has profound social consequences — influencing and overdetermining where individuals live,⁴¹³ whether they

⁴⁰⁸ The claim that race is a social construction is not *new*. Indeed, scholars from a century ago have argued that society has fabricated the groups that we think of as races. See, e.g., FREDERICK DOUGLASS, *The Kansas-Nebraska Bill* [1854], in 2 *THE LIFE AND WRITINGS OF FREDERICK DOUGLASS* 317 (Philip S. Foner ed., 1950) (“The word white is a modern term in the legislation of this country. It was never used in the better days of the Republic, but has sprung up within the period of our national degeneracy.”).

⁴⁰⁹ Ian F. Haney López, *The Social Construction of Race: Some Observations on Illusion, Fabrication, and Choice*, 29 HARV. C.R.-C.L. L. REV. 1, 11–20 (1994) (considering and rejecting the idea of “biological” race).

⁴¹⁰ *Id.* at 13 (“The notion that humankind can be divided along White, Black and Yellow lines reveals the social rather than the scientific origin of race.”).

⁴¹¹ *Id.* at 12–13; see also DOROTHY ROBERTS, *FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY* 74–75 (2011).

⁴¹² Haney López, *supra* note 409, at 7 (“Race is neither an essence nor an illusion . . .”).

⁴¹³ See Kriston Capps & Kate Rabinowitz, *How the Fair Housing Act Failed Black Homeowners*, CITYLAB (Apr. 11, 2018), <https://www.citylab.com/equity/2018/04/how-the-fair-housing-act-failed-black-homeowners/557576> [<https://perma.cc/LV8Q-DRWQ>] (explaining how banks approving and rejecting mortgages along racial lines reinforce segregation in housing).

are employed or jobless,⁴¹⁴ whether they are incarcerated or free,⁴¹⁵ whether they are sick or healthy,⁴¹⁶ and whether they live or die.⁴¹⁷

Scholars propose that societies construct race because they have needs that the concept of race will satisfy. That is, race serves purposes.⁴¹⁸ There are things that race does quite effectively. It distributes wealth to some and keeps it from others.⁴¹⁹ It explains away and legitimates social stratification and hierarchy.⁴²⁰ It provides a category around which nationalities can cohere.⁴²¹ Indeed, the uses of race are endless.

Thinkers writing in this area have emphasized that the social construction of race is not a process that stops at any particular time. They

⁴¹⁴ See generally Lincoln Quillian et al., *Meta-analysis of Field Experiments Shows No Change in Racial Discrimination in Hiring over Time*, 114 PROC. NAT'L ACAD. SCI. 10870, 10874 (2017) (“[A]t the initial point of entry — hiring decisions — African Americans remain substantially disadvantaged relative to equally qualified whites . . .”).

⁴¹⁵ See SENTENCING PROJECT, REPORT OF THE SENTENCING PROJECT TO THE UNITED NATIONS HUMAN RIGHTS COMMITTEE REGARDING RACIAL DISPARITIES IN THE UNITED STATES CRIMINAL JUSTICE SYSTEM 1 (2013) (“Racial minorities are more likely than white Americans to be arrested; once arrested, they are more likely to be convicted; and once convicted, they are more likely to face stiff sentences.”).

⁴¹⁶ See, e.g., H. Jack Geiger, *Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes*, in INST. OF MED., *supra* note 36, at 417, 437–38.

⁴¹⁷ See NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 33, at 8 (showing comparatively low life expectancy for Blacks).

⁴¹⁸ The American Anthropological Association's *Statement on Race* describes the purposes race served at the dawn of the United States, writing:

“[R]ace” was a mode of classification linked specifically to peoples in the colonial situation. It subsumed a growing ideology of inequality devised to rationalize European attitudes and treatment of the conquered and enslaved peoples. Proponents of slavery in particular during the 19th century used “race” to justify the retention of slavery. The ideology magnified the differences among Europeans, Africans, and Indians, established a rigid hierarchy of socially exclusive categories[,] underscored and bolstered unequal rank and status differences, and provided the rationalization that the inequality was natural or God-given. . . .

As they were constructing US society, leaders among European-Americans fabricated the cultural/behavioral characteristics associated with each “race,” linking superior traits with Europeans and negative and inferior ones to blacks and Indians. Numerous arbitrary and fictitious beliefs about the different peoples were institutionalized and deeply embedded in American thought.

Statement on Race, AM. ANTHROPOLOGICAL ASS'N (May 17, 1998), <http://www.aaanet.org/stmts/racepp.htm> [<https://perma.cc/7JXW-F65C>].

⁴¹⁹ See generally DEMOS & INST. ON ASSETS & SOC. POLICY, THE RACIAL WEALTH GAP (2015) (explaining the existence of a racial wealth gap in America driven by public policy).

⁴²⁰ Katherine Mason, *Social Stratification and the Body: Gender, Race, and Class*, 7 SOC. COMPASS 686, 687 (2013) (“Scientists and physicians presented certain people — either groups or individuals — as icons of embodied racial difference in order to justify White political power and Western colonialism.” (citation omitted)); see also Dawn G. Williams & Roderic R. Land, *The Legitimation of Black Subordination: The Impact of Color-Blind Ideology on African American Education*, 75 J. NEGRO EDUC. 579, 580 (2006) (“Racist ideologies were developed to provide a rationale for the social, economic, and political domination . . .”).

⁴²¹ See generally Rogers Brubaker, *Ethnicity, Race, and Nationalism*, 35 ANN. REV. SOC. 21 (2009) (providing an overview on the study of race, ethnicity, and national identity).

posit that it misapprehends the phenomenon to believe that societies have had the same races — in the same forms, with the same meanings — since social imperatives first counseled that societies ought to divide humans into races. This misapprehension suggests that if race exists today, it is because we have inherited it from our past. Instead, progressive race scholars argue, race exists today because we constantly remake it in the present.⁴²² This is to say that the social construction of race is an ongoing process.⁴²³ As Professor Ian Haney López evocatively describes it: “Accretions of racial meaning are not sedimentary products that, once deposited, remain solid and unchanged, or subject only to a slow process of abrasion, erosion and build-up. Instead, the processes of racial fabrication continuously melt down, mold, twist, and recast races: races are not rocks, they are plastics.”⁴²⁴

If the social construction of race is an ongoing process, it means that race has changed over time.⁴²⁵ Race is constantly in flux. On this point, Professors Michael Omi and Howard Winant, whose theory of racial formation has been quite influential, have written:

To say that race is socially constructed is to argue that it varies according to time and place. Concepts and ideologies of race have shifted over historical time and differ according to the sociohistorical conditions in which race is embedded. There are many examples. Consider the Irish and the Jews, groups who were not considered racially “white” earlier in the U.S. history, yet eventually became white. Consider Asian Americans, who have been popularly regarded as either a “yellow peril” or a “model minority” depending on the historical period in question, the configuration of racial hierarchy in the United States, and the prevailing tenor of United States–Asia Relations.⁴²⁶

Theorists have underscored that the construction of racial categories is not necessarily a slow process that happens over an extended period of

⁴²² Haney López, *supra* note 409, at 7 (“Race is . . . an ongoing, contradictory, self-reinforcing process . . .”).

⁴²³ In order to amplify the process-based nature of race, some scholars have rejected the use of the term “race” and instead have embraced alternative terms. For example, Professors Karim Murji and John Solomos prefer the term “racialization” to “race”:

The concept of racialization . . . offer[s] a better way of grasping the dynamic and processual nature of identities[] than the idea of race does. . . . [R]acialization . . . emphasizes the social and psychological processes that puts people into racial categories; and second, it therefore entails that race is [no] longer seen as fixed or natural, but as the outcome of particular ways in which people are classified and seen. The concept of racialization in this view does the same work as putting “race” in quotation marks, in showing that race does not have a biological basis but that it becomes significant through social, economic, cultural, and psychological practices.

Karim Murji & John Solomos, *Introduction: Racialization in Theory and Practice*, in *RACIALIZATION: STUDIES IN THEORY AND PRACTICE* 1, 8 (Karim Murji & John Solomos eds., 2005) (citation omitted).

⁴²⁴ Haney López, *supra* note 409, at 33.

⁴²⁵ MICHAEL OMI & HOWARD WINANT, *RACIAL FORMATION IN THE UNITED STATES* 4 (3d ed. 2015) (“Over the ages these [racial] categories’ meanings have varied a great deal . . .”).

⁴²⁶ *Id.* at 13 (endnote omitted) (citations omitted).

time — a phenomenon so protracted and gradual that the formation and reformation of racial categories are largely imperceptible. Instead, some thinkers have proposed that, at times, races form and reform rapidly. Racial meanings can come to be attached to a group, or come to be disassociated from a group, in a short span of time.⁴²⁷

Further, and crucially, race and racial meanings are contested — sometimes viciously. As Omi and Winant describe it, race is “constantly being transformed by political struggle.”⁴²⁸ Accordingly, we might understand many of the political controversies to which we bear witness as struggles over the form that race will take in the future: the battles over immigration and immigration reform, the litigation surrounding affirmative action, contests over voting rights, the discursive and material attacks on Muslims and people who might be mistaken for Muslims, the attention paid to the high unemployment rates in coal country and the Rust Belt (especially when compared to the relative apathy toward the high unemployment rates in poor communities of color), the rhetorical construction of the opioid epidemic as a crisis of public health as opposed to law enforcement, and so forth. All of these contemporary controversies might be understood as sites wherein race is recreated or modified, racial meanings are reaffirmed or transformed, and racial boundaries are reinstated or shifted.⁴²⁹

Indeed, Omi and Winant have defined race *in terms of* the social controversies that produce race and change its meanings. They define race as “a concept that signifies and symbolizes social conflicts and interests by referring to different types of human bodies.”⁴³⁰

As it relates to prosecutions of white women for opioid use during pregnancy, it deserves underscoring that the construction of race is not limited to nonwhite races. That is, the *white race* is subject to the same processes that form and reform nonwhite races. Haney López writes: “It is not only people of color who find their identities mediated by race, or who are implicated in the building and maintenance of racial constructs. White identity is just as much a racial fabrication . . .”⁴³¹ Moreover, that to which the term “white race” refers is subject to change. As Haney López reminds us, the “color line defining Whites was only moved outward to include all of Europe in the 1920s and 1930s” — a fact that serves to underscore that the referent in the term “white per-

⁴²⁷ See Haney López, *supra* note 409, at 28 (“[T]he meaning-systems surrounding race change quickly rather than slowly.”).

⁴²⁸ See OMI & WINANT, *supra* note 425, at 110.

⁴²⁹ See *id.* at 137 (“[T]hrough politics, through struggles over power and freedom, we can see race and racism being remade both social structurally and experientially.”).

⁴³⁰ *Id.* at 110 (emphasis omitted).

⁴³¹ Haney López, *supra* note 409, at 8.

son' . . . is an ill-defined social group subject to expansion and retrenchment."⁴³² Thus, that which is indexed by terms like "the white race" or "a white person" is marked by a certain instability and contestability. Indeed, the entire "racial regime remains unstable and contested."⁴³³ Depending on one's commitments to one's own racial identity or the existing racial hierarchy, the idea that the racial order of things is variable and changeable may be liberating — or terrifying.

Prosecutions of pregnant users of opioids speak to the social construction of race in a number of ways. The most radical interpretation of these prosecutions would be that *they are about the desire to exclude from the white race a segment of people with a nominal claim to inclusion.*

Theorists' reflections on the term *white trash* are instructive here. At present, most people likely understand the term to be a derogatory reference to poor white people. However, this understanding may assume that white people comprise a stable group. If we take seriously the fluidity of racial groups — acknowledging that the boundaries of racial categories can and do shift, sometimes rapidly — then we may be missing something when we suppose that *white trash* refers simply to white people without class privilege. *White trash* may refer to a group of people who exist on the margins of whiteness — a group that is at risk of finding itself expelled from the category of white people. *White trash* is a group that, over time and given the right conditions, may no longer be white.

Professor Matt Wray has made this argument, writing: "[W]hite trash is a puzzle with two pieces. Which word is the modifier and which the modified? Does *white* modify *trash* or is it the other way around? Is this a story about a residual, disposable class, or one about a despised ethnoracial group?"⁴³⁴ If *white trash* is a disposable class, the whiteness of the group indexed by the term is not disputed. However, if *white trash* is an ethnoracial group, the analysis shifts significantly. The group's claim to whiteness becomes more tentative.

Again, the eugenics movement of the early twentieth century is instructive here. As noted above, the movement, at its inception, focused on white people.⁴³⁵ Specifically, the goal of the movement was to eliminate within the white population the genes that led to penury, miscegenation, criminality, indolence, stupidity, insanity, alcoholism, and so forth.⁴³⁶ Eugenicists, committed as they were to the most exaggerated form of genetic determinism, essentially endeavored to eliminate *nonwhite* traits and *nonwhite* behavior from the white race. They

⁴³² *Id.* at 37.

⁴³³ OMI & WINANT, *supra* note 425, at 137.

⁴³⁴ WRAY, *supra* note 362, at 3.

⁴³⁵ See *supra* pp. 829–32.

⁴³⁶ See COHEN, *supra* note 383, at 51 (noting that eugenicists targeted "feeble-mindedness, drunkenness, criminality, and moral degeneracy"); *id.* at 58 ("[E]ugenicists in the South generally focused their attention on whites.").

sought to return white people to the purified, honorable, and nonpareil station that was their birthright and racial legacy. In identifying white people who possessed nonwhite traits and engaged in nonwhite behaviors, eugenics raised questions about the nature of whiteness: Were these “white” people really white? Was it accurate to think of the white race as a homogeneous whole?⁴³⁷ Eugenics asked whether there were meaningful *racial* stratifications within the white race, and it answered the question in the affirmative.

Similarly, we can interpret prosecutions of white women for opioid use during pregnancy as efforts to police the boundaries of whiteness — as instances where police power is directed toward a group that has a weak claim to membership in the white race.⁴³⁸

Of course, white women who have been arrested and prosecuted for using opioids while pregnant are nominally white. When their demographic information appears in state records, their race is listed as “white.” Indeed, it is because records identify them as “white” that we can compile statistics and talk about the overwhelming whiteness of second-generation prosecutions for substance use during pregnancy. However, the lives lived by the white women who have faced criminal charges for opioid use during pregnancy represent extraordinary departures from what whiteness is supposed to be and guarantee. Hegemonic constructions of whiteness establish it as superior — indeed, superlative.⁴³⁹ If whiteness is anything, it is not debasement. It is not poverty. It is not criminal activity. It is not substance dependence. It is certainly not pregnancy while struggling with substance dependence. Accordingly, the white women who have been the targets of punitive state power for their drug use during pregnancy embody a debased form of whiteness.⁴⁴⁰ Through this lens, then, prosecutions for opioid use during

⁴³⁷ See WRAY, *supra* note 362, at 73 (“Poor whites . . . once again posed a serious problem of classification and categorization [during the eugenics era], as they always have.”); see also Travis Linnemann & Tyler Wall, “*This Is Your Face on Meth: The Punitive Spectacle of ‘White Trash’ in the Rural War on Drugs*,” 17 THEORETICAL CRIMINOLOGY 315, 324 (2013) (describing the possibility of “carving a raced and classed hierarchy from [the] relative homogeneity” that the white race would otherwise represent). Professors Travis Linnemann and Tyler Wall posit that publicly shaming white people who use methamphetamine is one method for creating racial heterogeneity within the white race. See *id.*

⁴³⁸ For an instructive parallel, see Linnemann & Wall, *supra* note 437, at 318 (arguing that public campaigns ostensibly designed to warn individuals away from methamphetamine use are better understood as a “project that polices moral boundaries and fabricates social order through the specter of a ‘white trash’ Other who threatens the supposed purity of hegemonic whiteness and white social position” (citations omitted)).

⁴³⁹ See, e.g., Harris, *supra* note 59, at 1721 (“White identity and whiteness were sources of privilege and protection . . .”).

⁴⁴⁰ Wray observes a similar phenomenon at work in the term “white trash,” writing that “if whiteness bespoke purity and godliness, then *poor white trash* implied an ungodly, desecralized, polluted whiteness.” WRAY, *supra* note 362, at 47; see also *id.* at 55 (“Under the logic of white supremacy, wherein all whites are imagined to be superior to all people of color, the low social

pregnancy appear to be instances of the state's identifying — and punishing — a population of people who have been disloyal to their whiteness.⁴⁴¹ These prosecutions are declarations that, while the subjects of these prosecutions are white, *they are not quite white*.⁴⁴² If it strikes some as odd that white privilege has not protected these particular white people from a brutal form of state power, it may be due to their compromised whiteness compromising the power of the racial privilege that they would otherwise possess.

The identification of a group that represents degraded whiteness — a group that exists on the margins of whiteness — functions to establish what whiteness really is.⁴⁴³ Whiteness is not poverty, criminality, substance dependence, or corrupted pregnancy. Quite the contrary, whiteness is that which will repel those very things. Accordingly, prosecutions of white women for opioid use during pregnancy are as much about identifying what whiteness *is not* as they are about identifying what whiteness *is*. In this way, these prosecutions serve to reinforce racial meanings as well as the social order that is built around those meanings.

Some will find jarring the proposition that prosecutions for opioid use during pregnancy are part of a process that ends with a group losing its whiteness. However, it will be less jarring to those who take seriously the claim that race is a social construction. That race is socially constructed means that racial boundaries transform and shift. As such, *whiteness* can transform and shift. As Professor Grace Howard has emphasized: “Though whiteness as a socially defined and constructed racial category is often conceptualized as a static and uniform racial

status, impoverishment, and immoral and lazy behavior of *poor whites* were damning evidence to the contrary. *Poor white trash* required explanation — how could a free white person sink so low as to be beneath a black slave?” Opioid-using pregnant white women may similarly imply “an ungodly, desacralized, polluted whiteness.” *Id.* at 47.

⁴⁴¹ Linnemann and Wall identify a comparable phenomenon in the panic that ensued when the nation witnessed an increase in the usage of methamphetamine, which tends to be concentrated among rural white populations. They write that “the abject horrors built into the imaginary of methamphetamine[] [are] not simply about crossing juridical boundaries, but also about defiling and polluting one’s own body, a white body in particular and giving up the esteemed value of white privilege and bourgeois sensibilities in general.” Linnemann & Wall, *supra* note 437, at 325. As the public shaming of white persons who use and are dependent on methamphetamine raises “the specter of ‘white trash’ polluting and defiling a hegemonic whiteness,” *id.* at 327, prosecutions of white women for opioid use during pregnancy do similar work.

⁴⁴² Howard reaches a similar conclusion about the arrests and prosecutions of white women for using methamphetamine during their pregnancies. She writes that the whiteness of the arrest demographics for methamphetamine use during pregnancy reflects an “anxiety about perceived white degeneracy — that this population of deviant whites are perceived as polluting the white race and violating the norms of supposed white moral superiority.” Howard, *supra* note 102, at 375.

⁴⁴³ Cf. WRAY, *supra* note 362, at 68 (noting that during the early twentieth century, when professionals would turn “their analytical gaze toward poor rural whites,” they accomplished “some of the boundary work necessary for the formation of their own group and individual identities,” and going on to conclude that “[i]n this way, poor rural whites played a crucial role in the self-fashioning of turn-of-the-century white middle-class American identity”).

category, or perhaps as a non-raced, racially ‘neutral’ category, *it more often functions as a fluid construct.*”⁴⁴⁴ If whiteness is fluid, it means that some groups who at one historical moment are identified as white may not be so identified in a different historical moment. Poor, pregnant women who use opioids — with their claim to whiteness made tenuous by their failure to live lives that are consistent with hegemonic ideas of whiteness — currently exist at the bottom of intraracial hierarchies of the white race. If racial boundaries are to shift, members of this group are the most vulnerable to exclusion from the race to which they currently belong. Time will reveal their racial fortunes.

C. *The Promises of White Privilege Are Subject to Negotiation*

If races are constantly in flux, then whiteness is constantly in flux. And if whiteness is constantly in flux, then white privilege is similarly in flux. Accordingly, when we bear witness to occasions that we understand to be racially significant, we might conceptualize them as times when the meaning of whiteness is being debated and the promises of white privilege are being negotiated.

Consider the civil rights movement. One of the myriad ways in which we might understand this historical moment is as a struggle over the benefits that whiteness would yield. What would white privilege guarantee? Would white privilege guarantee white people the ability to move throughout public spaces without the necessity of encountering nonwhite people as their formal equals?⁴⁴⁵ Would white privilege guarantee white people the ability to decide solely among themselves — even when they disagreed with one another — who would occupy political office?⁴⁴⁶ Would white privilege guarantee white people the ability to compete only among themselves for jobs, income, and wealth?⁴⁴⁷ Or would white privilege no longer guarantee those things? Would white people be compelled to share space with nonwhite people, cast votes alongside nonwhite people, and compete with nonwhite people in the employment arena?

Consider the contemporary debate over the constitutionality of affirmative action. We might similarly conceptualize that debate as a struggle over the benefits that whiteness will yield. Will white privilege

⁴⁴⁴ Howard, *supra* note 102, at 378–79 (emphasis added).

⁴⁴⁵ See Christopher W. Schmidt, *Litigating Against the Civil Rights Movement*, 86 U. COLO. L. REV. 1173, 1179–81 (2015) (discussing segregationist litigation strategies in the face of civil rights challenges to Jim Crow laws).

⁴⁴⁶ See generally GARY MAY, *BENDING TOWARD JUSTICE: THE VOTING RIGHTS ACT AND THE TRANSFORMATION OF AMERICAN DEMOCRACY* (2013) (outlining the context in which the Voting Rights Act was passed).

⁴⁴⁷ See Paulette Brown, *The Civil Rights Act of 1964*, 92 WASH. U. L. REV. 527, 527–28 (2014) (noting that the Civil Rights Act of 1964, including Title VII’s provision for equal employment opportunity, was born from an “era of protest and violence,” *id.* at 527).

guarantee those who would win seats in an incoming class if they were judged by traditional indicia of merit the ability to compete for *all* of those seats — a result that some claim the Constitution requires?⁴⁴⁸ Or will white privilege guarantee white people only the ability to compete for the *majority* of seats in an incoming class — with a portion reserved for those who have not reaped the benefits of historical white privilege?⁴⁴⁹ Will white privilege guarantee blindness to the race of the applicant in admissions — a result that would advantage white people much more than it would nonwhite people?⁴⁵⁰ Or will white privilege no longer make that guarantee? Will white privilege ensure only that race has no definitive role in admissions decisions?⁴⁵¹

We might similarly conceptualize the conversation about reparations. Those who support reparations argue that white privilege ought not to guarantee white people living today — who have inherited the economic benefits of their forebears' existence at the top of this nation's racial hierarchy during the centuries of formal racial inequality — the ability to hold onto the ill-gotten economic gains that their predecessors accrued as a result of nonwhite subordination.⁴⁵² To the extent that reparations have been defeated — indeed, to the extent that most consider reparations to be unimaginable in the United States⁴⁵³ — then white privilege operates to ensure that white people can continue to claim this inheritance as their own.

We can productively apply this framework to the prosecutions of white women for opioid use during pregnancy. These prosecutions mean that white privilege will not guarantee white people immunity

⁴⁴⁸ See, e.g., *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 277–78 (1978) (involving a white applicant who “alleged that the Medical School’s special admissions program operated to exclude him from the school on the basis of his race, in violation of his rights under the Equal Protection Clause”).

⁴⁴⁹ See *id.* at 274–76 (describing the university’s “quota” system wherein faculty prescribed a certain number of seats in each class to be reserved for “economically and/or educationally disadvantaged’ applicants,” *id.* at 274).

⁴⁵⁰ See Edmund Zagorin, *Race-Blind Admissions Are Affirmative Action for Whites*, AM. PROSPECT (Apr. 21, 2014), <https://prospect.org/article/race-blind-admissions-are-affirmative-action-whites> [<https://perma.cc/MQY8-W3VQ>].

⁴⁵¹ See *Fisher v. Univ. of Tex. at Austin*, 136 S. Ct. 2198, 2214–15 (2016) (upholding university’s consideration of race in its “holistic review” of applications); *Grutter v. Bollinger*, 539 U.S. 306, 337, 343–44 (2003) (finding constitutional an “individualized, holistic review of each applicant’s file” that does not “make[] an applicant’s race or ethnicity the defining feature of his or her application,” *id.* at 337).

⁴⁵² Ta-Nehisi Coates, *The Case for Reparations*, THE ATLANTIC (June 2014), <https://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631> [<https://perma.cc/PM3R-FZ2K>].

⁴⁵³ See Mohamed Younis, *As Redress for Slavery, Americans Oppose Cash Reparations*, GALLUP (July 29, 2019), <https://news.gallup.com/poll/261722/redress-slavery-americans-oppose-cash-reparations.aspx> [<https://perma.cc/FJM3-GYKN>] (finding that sixty-seven percent of Americans oppose reparations in the form of cash payments to the descendants of American slaves).

from the country's muscular criminal legal system — a system that has led this nation to having the world's highest incarceration rate and the largest incarcerated population.⁴⁵⁴ White privilege does not guarantee white people struggling with substance dependence during pregnancy a state response that is different from the one that nonwhite people struggling with substance dependence during pregnancy received in the 1980s.

That this particular struggle over the benefits of whiteness has been resolved in the way that it has suggests that we ought to pay attention to the power of the fetus.⁴⁵⁵ More precisely, we ought to recognize the strength of societal convictions that the fetus is an entity that needs protection. And we ought to acknowledge the profound disdain that many have felt for the individual who would harm the fetus — especially when the individual who poses a danger to the fetus is its “mother.” Professor Laura Gómez has argued that society's willingness to prosecute pregnant users of crack cocaine during the 1980s was due not solely to the race of these women, but also to the proliferation of arguments during this time that the fetus was an entity that was in desperate need of state protection.⁴⁵⁶ She argues that “the intensified abortion debate” was a key “social trend that laid the groundwork” for the rush to respond to cocaine use during pregnancy with arrest, prosecution, and incarceration.⁴⁵⁷ She claims that criminalizing substance use during pregnancy in the 1980s was informed by the increasingly “popular conviction that the fetus possessed at least some of the qualities of personhood. . . . This collective consciousness about the fetus made it all the more difficult to draw a sharp line between ‘fetal abuse’ — the prenatal damage caused by maternal drug use — and postnatal child abuse.”⁴⁵⁸

Something similar is operating at present. That is, there has been no real reduction in the intensity of the abortion debate since the crack cocaine scare. Over the course of the past three decades, the power of

⁴⁵⁴ TODD R. CLEAR & NATASHA A. FROST, *THE PUNISHMENT IMPERATIVE* 17–19 (2014) (“[W]e now incarcerate more people than any other nation in the world, in terms of both the absolute number of people in prison and the incarceration rate per one hundred thousand people.” *Id.* at 18.).

⁴⁵⁵ This does not undermine the argument that the rush to punish cocaine-using pregnant women during the heyday of the crack cocaine scare was due to the desire to punish women whom many believed were birthing the future social problems of the country. Instead, the argument that the veneration of the fetus partly explains society's comfort with responding to substance use during pregnancy with the criminal legal system simply shows that multiple factors explain social phenomena. That is, the prosecutions of pregnant users of crack cocaine were both about punishing the women who would burden society with its future ills *and* about protecting a (deracialized) fetus that antiabortion activists believed was under attack. One motivation does not eliminate the possibility of the other.

⁴⁵⁶ See GÓMEZ, *supra* note 16, at 2–3.

⁴⁵⁷ *Id.* at 2.

⁴⁵⁸ *Id.* at 2–3.

the idea that fetuses are innocents who are under attack has not lessened.⁴⁵⁹ Indeed, there is a strong argument to be made that the strength of this idea has increased over time.⁴⁶⁰ Accordingly, if some powerful actors felt that the fetus needed protection back then, we can reasonably conclude that some powerful actors feel the same way now. Moreover, if some swaths of society were comfortable in the 1980s with criminalizing substance use during pregnancy because they believed that it protected and promoted fetal life, then we can reasonably conclude that some swaths of society are comfortable with criminalizing substance use during pregnancy for the same reasons now.

In this way, we should recognize the fetus as an entity that can play a significant role in struggles over the promises of white privilege — directing the resolution of these struggles in particular ways. That is, white privilege may explain why the country has taken a public health approach, at least rhetorically, to the opioid epidemic. However, in legislators' and judges' rush to protect fetuses, they may be willing to forego public health lenses and lead with the criminal law. Thus, the reverence that our nation gives to fetuses may have compromised and diminished white privilege.

The diminution of white privilege effected by the reverence for fetuses is one that only cisgender women, transgender men, and nonbinary persons who become pregnant endure. Cisgender men remain free to enjoy a more unbounded white privilege. As such, we see how sex and gender constrain the promises of white privilege — an insight that students of intersectionality have long recognized.⁴⁶¹ In other words, privilege along the lines of race may be transformed or reduced by lack of privilege along other lines. In the context of prosecutions for substance use during pregnancy, sex unprivilege — the reality that due to their capacity to carry fetuses, cisgender women, transgender men, and nonbinary persons are those who are most directly affected by society's veneration of the fetus — profoundly limits the power of white privilege to

⁴⁵⁹ See Glen A. Halva-Neubauer & Sara L. Zeigler, *Promoting Fetal Personhood: The Rhetorical and Legislative Strategies of the Pro-life Movement After Planned Parenthood v. Casey*, 22 FEMINIST FORMATIONS 101, 102 (2010) (noting that since 1992, “the pro-life movement [has] engaged in an effective strategy of . . . portraying the fetus as a living infant”).

⁴⁶⁰ See Editorial Board, Opinion, *A Woman's Rights*, N.Y. TIMES (Dec. 28, 2018), <https://nyti.ms/2RgmzTS> [<https://perma.cc/L6EP-ABR5>] (noting “a deep shift in American society . . . toward the embrace of a relatively new concept: that a fetus in the womb has the same rights as a fully formed person”).

⁴⁶¹ See, e.g., Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 140 (illustrating the problems associated with “think[ing] about subordination as disadvantage occurring along a single categorical axis”); Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1242 (1991) (highlighting the fact that “identity politics . . . frequently conflates or ignores intragroup differences”).

protect its holders from punitive state power and other negative outcomes.⁴⁶²

D. White Privilege Can Be Attenuated by Nonwhite Disadvantage

The fourth and final maxim for studies of white privilege that prosecutions for opioid use during pregnancy reveal is that white privilege can be attenuated by nonwhite disadvantage. That is, the existence of nonwhite disadvantage can foil white privilege's ability to deliver benefits to white people.

There might be something contradictory in the idea that nonwhite disadvantage can weaken the power of white privilege. This is because scholars have proposed that white privilege is merely the converse of nonwhite disadvantage. As Dunham and Lawford-Smith describe it, white privilege is the term that refers to the benefits that white people enjoy as a direct consequence of nonwhite people having been racially disadvantaged.⁴⁶³ Carbado and Gulati's formulation, described above, is similar.⁴⁶⁴ They propose that white privilege "is nothing more than a claim about the existence of discrimination. . . . To the extent that race discrimination is a current social problem, there will be victims and beneficiaries of this discrimination. The former are disadvantaged; the latter are privileged."⁴⁶⁵

This is to say that white privilege and nonwhite disadvantage are two sides of the same coin. One produces the other. Thus, it may fly in the face of our intuitions to suggest that nonwhite disadvantage tempers the power of white privilege. But this is precisely what prosecutions for opioid use during pregnancy lead us to conclude.

In the 1980s, the nation was confronted with a frightening drug scare and the possibility that infants were being irreparably harmed by a substance that was decimating communities. Society chose to address this phenomenon with the criminal system. Moreover, as discussed above,

⁴⁶² In a similar vein, Gómez has written about the gendered nature of the 1980s "crack babies" scare:

The 1980s discovery of prenatal drug exposure as a distinct social problem mirrored a broader mother-blaming trend. Medical researchers and the news media, whether intentionally or not, fed into existing anxieties (shared by both women and men) about the changing role of women, especially the perception that motherhood was taking a second seat to women's other roles. Media horror stories about female "crackheads" bereft of "maternal instincts" — stories that proliferated in both print and television news in the late 1980s — . . . reaffirm[ed] social norms by exposing their violation to public scrutiny. GÓMEZ, *supra* note 16, at 117 (footnotes omitted) (citation omitted).

While sex unprivilege presently limits the benefits that white privilege can guarantee white women who use opioids, sex unprivilege *exacerbated* the racial unprivilege lived by pregnant black women who used cocaine in the 1980s and 1990s.

⁴⁶³ Dunham & Lawford-Smith, *supra* note 31, at 5–6.

⁴⁶⁴ See Carbado & Gulati, *supra* note 30, at 1777.

⁴⁶⁵ *Id.*

society chose this path and rejected less punitive alternatives, in part because the phenomenon was racialized as black.⁴⁶⁶ More than three decades later, the nation faces an equally frightening drug scare and the possibility that infants are being irreparably harmed by a substance that is decimating communities. The thing is: we have a racist precedent for dealing with this very situation. This racist precedent constrains the ability of society to imagine and implement different mechanisms for addressing the phenomenon. As a nation, we might have a path dependence.⁴⁶⁷ The racist path that we generated in the 1980s has led us to be punitive toward a population that, due to its racial privilege, might have escaped our nation's punitive inclinations.

Which is to say: in the 1980s, when faced with the fact of pregnant women who used and were dependent on substances, we chose the path of prosecution. We made this choice, in part, because so many of the women were black. Throwing these women in jail was politically acceptable — and desirable — because they were black.⁴⁶⁸ Now, in the early decades of the twenty-first century, we have a racist model to guide us in managing the social problem of pregnant women who use and are dependent on substances. White women facing criminal charges for opioid use during pregnancy may just be reaping the bitter seeds of the racism that the government directed toward — and designed for — people of color.⁴⁶⁹

⁴⁶⁶ See *supra* p. 791.

⁴⁶⁷ Path dependence is the “[t]endency of a past or traditional practice or preference to continue even if better alternatives are available.” *Path Dependency*, BUSINESSDICTIONARY, <http://www.businessdictionary.com/definition/path-dependency.html> [<https://perma.cc/HT7S-QESK>]; see also Dave Praeger, *Our Love of Sewers: A Lesson in Path Dependence*, DAILY KOS (June 15, 2007, 10:24 AM), <https://www.dailykos.com/stories/2007/06/15/346883/-Our-Love-Of-Sewers-A-Lesson-in-Path-Dependence> [<https://perma.cc/7XPL-VS3B>] (“The economic concept of path dependence explains how the set of decisions one faces for any given circumstance is limited by the decisions one has made in the past, even though past circumstances may no longer be relevant.”).

⁴⁶⁸ See *supra* p. 793.

⁴⁶⁹ The Wisconsin law that allows for the civil commitment of pregnant women whom authorities believe to suffer from dependencies that threaten their fetuses offers a clear example of white people suffering the consequences of nonwhite disadvantage. See WIS. STAT. § 48.193 (2019). Tamara Loertscher, a white woman, challenged the law's constitutionality after she was detained under it. *Loertscher v. Anderson*, 259 F. Supp. 3d 902, 906 (W.D. Wis. 2017), *vacated as moot*, 893 F.3d 386 (7th Cir. 2018); Dee J. Hall, *Medford Woman to Challenge State's "Cocaine Mom" Law*, WIS. ST. J. (Dec. 12, 2014), https://madison.com/wsj/news/local/crime_and_courts/medford-woman-to-challenge-state-s-cocaine-mom-law/article_4a9e1844-2fc9-5def-bbec-72958b54656d.html [<https://perma.cc/B972-EB6G>]. Fascinatingly, the legislature passed the law — often referred to as the “Cocaine Mom” law — to address *cocaine* use during pregnancy, a phenomenon that has been racialized as black. See David Wahlberg, *Suit Against Wisconsin's "Cocaine Mom" Law Could Go to Trial This Year*, WIS. ST. J. (Feb. 12, 2017), https://madison.com/wsj/news/local/health-med-fit/suit-against-wisconsin-s-cocaine-mom-law-could-go-to/article_41041f19-c1d7-5e69-837b-aa182549ac16.html [<https://perma.cc/GCR5-YCTQ>] (noting that the Wisconsin civil commitment

On this point, Professor Dwight Greene has observed “the tendency of prosecutors to expand abusive behavior initially targeted at powerless groups to the relatively more privileged. Abusive practices and accretions of state power legitimized in the context of the war on minority drug users establish[] precedents easily extended to the general population.”⁴⁷⁰ Without the precedent that prosecutors established in the 1980s, white privilege may have operated to protect pregnant white women who use opioids from having their behavior conceptualized as a problem that the criminal system can solve. Indeed, when the use of opioids has developed into an opioid use disorder, white privilege may have operated to make inconceivable the prosecution of a white person suffering with what healthcare providers call a chronic, relapsing disease of the brain.⁴⁷¹ However, the racist prosecutions that took place during the crack cocaine scare might have normalized this approach — making it socially and politically defensible. The result is the reduction of white privilege’s power to protect its holders from disadvantage.

More broadly, the absence in this country of an infrastructure that is designed to address dependence on opioids — and the excess deaths among white people that this absence has generated in light of the current opioid crisis — may be similarly understood as an example of white privilege having been attenuated by nonwhite disadvantage. Consider Professor Helena Hansen and Julie Netherland’s discussion of the uptick in heroin usage that the country witnessed in the 1970s.⁴⁷² The opioid crisis of that decade, however, “was centered in communities of color.”⁴⁷³ Given that this crisis disproportionately affected nonwhite people, the country responded with “harsher penalties and criminalization.”⁴⁷⁴ Hansen and Netherland note: “If we had invested in harm reduction programs and increased the availability and quality of addiction treatment then, we would have been better positioned to reduce the toll of the current opioid crisis.”⁴⁷⁵

To the extent that the country is receptive to responding to the present opioid crisis through the lens of public health, this forgiving approach might be an example of white privilege at work. However, this white privilege, evidenced by the political will to get people dependent on opioids into treatment as opposed to into jails and prisons, might be attenuated by the dearth of treatment facilities for opioid use disorder.

law “is sometimes called the ‘cocaine mom’ law because concern about ‘crack babies’ was paramount at the time” that it was passed). Thus, Loertscher, a white woman, was subjected to inhumane treatment under a law that, in essence, was designed for black women.

⁴⁷⁰ Greene, *supra* note 315, at 743.

⁴⁷¹ See Julie Netherland & Helena Hansen, *White Opioids: Pharmaceutical Race and the War on Drugs that Wasn’t*, 12 *BIOsocieties* 217, 220–23 (2016).

⁴⁷² Hansen & Netherland, *supra* note 8, at 2128.

⁴⁷³ *Id.*

⁴⁷⁴ *Id.*

⁴⁷⁵ *Id.* (endnote omitted).

Importantly, this is a dearth that is directly linked to the nation's refusal to cognize the people of color who struggled with opioid use disorder in the 1970s as in need of treatment, as opposed to punishment. In this way, nonwhite disadvantage, in the form of the lack of a political will in the 1970s to create an infrastructure that could have helped those struggling with opioid dependence, has attenuated white privilege in the present. Indeed, nonwhite disadvantage has facilitated excessive white death.

CONCLUSION

The discussion above should demonstrate that while white privilege certainly harms the nonwhite people who cannot lay claim to it, it also harms scores of white people who are supposed to benefit from it. That is, white privilege is a disloyal friend to white people. This is especially true with respect to those who exist at the intersections of other categories of disadvantage — like those who are poor, transgender, not straight, or disabled. It is disloyal when it opens the doors for white people to a wide range of opportunities — including those with exceedingly deadly consequences, like unmediated access to opioid prescriptions. It is disloyal when it strips a group of its membership in the white race when that group fails to live up to hegemonic ideals of whiteness. It is disloyal when it creates expectations in white people that white privilege and the things that it guarantees are static — as if contexts do not change, or as if nonwhite people will not demand changes to the racial status quo.

The overarching lesson, though, is that when white privilege betrays, we err when we conclude that it never existed in the first place. It certainly exists. And it is not unusual for white people to be found in the carnage that it inevitably leaves in its wake.