REPRODUCTIVE ABILITY FOR SALE, DO I HEAR $200?: PRIVATE CASH-FOR-CONTRACEPTION AGREEMENTS AS AN ALTERNATIVE TO MATERNAL SUBSTANCE ABUSE

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I. INTRODUCTION

> "I wish you had come to me with your birth control offer years ago so I wouldn't have had 14 babies."
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> —Sharon, client #24.[1]

Would you take two hundred dollars to stop having children? What if you were addicted to drugs and that two hundred dollars could buy your next hit? To most the proposition seems a bit farfetched, yet 355 drug addicts have done just that.[2] The addicts can take their money and do with it whatever they want—except have children.

What would motivate one to make such an offer? Perhaps the sight of a sickly, premature infant suffering through withdrawal from crack cocaine or maybe heroin, drugs that his mother took to get high while she was pregnant. Or possibly watching the child grow up, spending his first few months hooked up to machines, next as a boarder baby at the hospital after child protective services removed him from his mother's custody, then his childhood in the foster care system being supported by taxpayers. Granted, not all cases of maternal substance abuse are this dramatic, but nor are these cases rare. About eleven to fifteen

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1. *C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/quotes/>. "Sharon" is a drug addict who was offered $200 in exchange for her use of long-term or permanent birth control by an organization coined Children Requiring a Caring Kommunity ("C.R.A.C.K."). *See id.*

2. Although two men have participated in the C.R.A.C.K. program, the scope of this Note is limited to female participants.

percent of all babies in the United States are born after in utero exposure to illegal drugs.[3]

The outrage over substance-exposed infants and maternal substance abuse is not new. But a private non-profit organization, Children Requiring a Caring Kommunity ("C.R.A.C.K."), is offering a novel approach to the problem: cash for contraception. In other words, C.R.A.C.K. offers a monetary incentive to drug addicts to be medically sterilized or to use long-term birth control.[4] It has caused a stir across the nation and raised the question—is it "right" to offer money to get others to stop having babies?

Initially, C.R.A.C.K. may appear to be an isolated group with an eccentric plan, easily dismissed by the public and of no real concern. But C.R.A.C.K. will not pass with little consequence or quietly fade away: it has much broader implications. Although C.R.A.C.K.'s goals are narrowly focused on stopping the numerous births of substance-exposed infants to mothers that cannot care for them, other groups with less benevolent or downright evil motives may create copycat programs.[5] For example, C.R.A.C.K. has already inspired one similar program that has paid thirty-one women to use birth control.[6] A Scottish man now seeks to bring the C.R.A.C.K. program to Scotland and expand those qualified for the offer to from drug addicts to include smokers as well as persons with cancer, diabetes, a history of heart disease, etc.[7] He claims, "A child has the right to be born to parents free from terrible diseases and addictions....Humans are the sickest species on this planet. No animal would tolerate the diseases we pass on to our young. Why should we?"[8]

Nor is sterilization for the less fortunate a concept without a history in this country. In the early twentieth century, the eugenic movement influenced the passage of several state statutes authorizing involuntary sterilization of various

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3. *See* Victoria J. Swenson & Cheryl Crabbe, *Pregnant Substance Abusers: A Problem That Won't Go Away*, 25 ST. MARY'S L.J. 623, 625 (1994).

4. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/cgi-bin/jump>.

5. A financial supporter of C.R.A.C.K. (*not* C.R.A.C.K. itself) has hired a self-proclaimed "intellectual racist" as a consultant. *See Doctor Fury over Charity*, EVENING NEWS (Scotland), August 1, 2000 at 4; Jean West & Jenny Shields, *Sacked Race Row Lecturer Offered Job by Millionaire*, SUNDAY TIMES (London), July 23, 2000, at 3.

The United Nations Population Fund has been criticized for shipping abortifacient morning-after pills to Kosovo refugees, with one official commenting "We have to stop them reproducing....Don't you see they are refugees; they can't have children!" *See* Catherine Edwards, *U.N. Plans Ways to Limit Births*, INSIGHT MAG., June 12, 1999, at 16. Some have suggested that the U.N. Population Fund was involved in program that forced the sterilization of 243 women in Peru. *See id.*

6. *See* David Feld, *Program Pays the Price of Pregnancy Prevention $200 to Addicts Who Use Birth Control*, SEATTLE POST-INTELLIGENCER, Dec. 4, 2000, at A1. The motives of this program appear to be similar to those of C.R.A.C.K.

7. *See* Donna White, *The Crack Pot; Vet Joins US Militants Who Want to Pay Scots Junkies to Be Sterilised*, SUNDAY MAIL (Scotland), August 6, 2000, at 19.

8. *Id.*

classes of persons, such as the mentally ill or certain classes of criminals.[9] Even the Supreme Court has condoned involuntary sterilization; when it upheld the sterilization of a "feeble-minded" woman in a state institution.[10] Writing for the majority in *Buck v. Bell*, Justice Oliver Wendell Holmes stated:

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices...in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime...society can prevent those who are manifestly unfit from continuing their kind.[11]

Although referring to involuntary sterilization, the words of Justice Holmes may be illustrative of a sentiment present in the C.R.A.C.K. program. Because of their drug use during pregnancy, expectant mothers expose their unborn children to physical risks, and then the mothers are often unable to properly care for these children after birth. C.R.A.C.K. seeks to call upon these drug addicts to sacrifice their reproductive ability for the sake of the children and for society, in exchange for money.

In the late 1980s and early 1990s, the problem of substance-exposed infants was brought to the forefront by sensational media coverage of the so-called "crack epidemic": sympathetic images of sickly, trembling crack babies suffering the effects of withdrawal and less sympathetic portraits of the women whose mothering instincts had been destroyed by crack cocaine.[12] Commentators noted that the widespread effects of the epidemic affected crime, healthcare, and even reduced work productivity.[13] The combination of moral outrage at the mother's actions,[14] sympathy for the affected children, and the high economic cost served as a catalyst that heightened awareness of prenatal drug exposure and launched campaigns to stop it.

The states responded by prosecuting mothers for their use of illegal drugs during pregnancy, using a variety of criminal statutes intended for different

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9. *See* HOMER H. CLARK, JR. THE LAW OF DOMESTIC RELATIONS IN THE UNITED STATES 383 (2d ed. 1988) ("Eugenics may be defined as the application of genetic principles to the improvement of human populations."). Eugenics fell out of favor in part due to the recognition that eugenic could be used as a pretext for the sterilization of unpopular political or racial groups, as in Nazi Germany. *See id.*

10. Buck v. Bell, 274 U.S. 200, 205-06 (1927).

11. *Id.* at 207.

12. *See* SHEIGLA MURPHY & MARSHA ROSENBAUM, PREGNANT WOMEN ON DRUGS: COMBATING STEREOTYPES AND STIGMA 102–03 (1999). Critics charge that the epidemic was not as extensive as the media led the public to believe. *See, e.g.*, LAURA E. GOMEZ, MISCONCEIVING MOTHERS 21–25 (1997).

13. *See* STEPHEN R. KANDALL, SUBSTANCE AND SHADOW 1 (1996) (placing the cost of the "crack epidemic" devastation to be $300 billion annually).

14. *See* Michelle D. Mills, *Fetal Abuse Prosecutions: The Triumph of Reaction over Reason*, 47 DEPAUL L. REV. 989, 990 (1998); Murphy & Rosenbaum, *supra* note 12, at 102–03.

purposes. With few exceptions, these prosecutions have been unsuccessful in sentencing women.[15] As the courts shot down prosecutions and the debate over fetal rights and women's rights began to heat up, some states enacted legislation that explicitly included prenatal substance exposure in child abuse and neglect statutes and the accompanying mandatory reporting statutes.[16] Critics question both criminal prosecutions and fetal abuse statutes, suggesting that these methods violate women's constitutional rights and personal liberties.[17] States have implemented non-punitive methods, such as drug treatment and education programs, but these too have not always been able to effectively manage the unique problems of drug-addicted mothers or pregnant addicts.[18]

On the other hand, C.R.A.C.K. seeks to prevent addicted mothers from becoming pregnant in the first place, rather than punishing or treating the mothers and infants after the damage has been done. C.R.A.C.K.'s cash-for-contraception approach raises ethical, moral, and public policy issues, issues similar to those in surrogacy agreements and the sale of human organs suggesting closer state oversight. Yet, C.R.A.C.K.'s cash-for-contraception contract appears to occur in a "regulatory vacuum" of sorts.[19]

In light of past encounters with coercive sterilizations, critics justifiably view C.R.A.C.K.'s offer with intense skepticism and question whether this too is a way to coerce a vulnerable group into limiting their reproductive rights.[20] But a look at the alternatives shows that the mother's rights aren't the only ones involved. Substance-exposed infants and prenatal drug abuse illustrate the collision of women's rights, fetal rights, and the war on drugs. When C.R.A.C.K.'s cash-for-contraception offer is analyzed in the bigger picture, it may be a viable option when one balances the seriousness of the maternal substance abuse problem, the alternative state responses, and the rights of all parties involved.

Part II of this Note describes the problem of maternal substance abuse and substance exposed infants. This Part examines the current state responses to the problem in order to put C.R.A.C.K. in perspective and to illustrate the difficulties in finding a workable solution. Part III describes the C.R.A.C.K. program and its cash-for-contraception agreement in detail. Part IV analyzes C.R.A.C.K. in light of current laws and regulations. This Part examines the

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15. *See* discussion *infra* Part II.B.1.

16. *See* discussion *infra* Part II.B.

17. *See* discussion *infra* Part II.B.

18. *See* discussion *infra* Part II.B.2.

19. *See* Bruce A. Boyer, *Who Is Fit to Parent?*, CHICAGO TRIB., July 29, 1999, at 21. As C.R.A.C.K. plays out in practice, there may be some regulatory oversight involved. *See also*, discussion *supra* Part V.A.

20. *See* discussion *infra* Part III. C.R.A.C.K. is aimed at persons with substance abuse problems. Critics of the program claim that the program is racist, because minority populations are targeted, and that it exploits the participants. *See* Michelle Cottle, *Say Yes to Crack (Cash for Contraception)*, THE NEW REPUBLIC, Aug. 23, 1999, at 16; V. Dion Haynes, *To Curb Pregnancies, Project Pays Addicts $200 to be Sterilized*, CHICAGO TRIB., May 3, 1998, at 3; *see also* discussion *infra* Part V.A.

enforceability of C.R.A.C.K.'s cash-for-contraception contract and the possibility that the contract is unconscionable or voidable for lack of capacity. It draws an analogy to surrogacy agreements and the sale of human organs, in which the government and courts have regulated and limited what is otherwise a private agreement. Part V elaborates on what makes C.R.A.C.K. defensible, namely a woman's constitutionally protected reproductive rights and the requirements of informed consent and voluntariness. This Note concludes by acknowledging C.R.A.C.K.'s potential limitations but argues that it remains a viable alternative that avoids many of the problems with existing state methods, as the program is currently structured and plays out in practice.

II. BACKGROUND

A. Defining the Problem of Maternal Substance Abuse and Substance-Exposed Infants

1. Substance-Exposed Infants

C.R.A.C.K. is best understood in the context of the problem that it seeks to prevent: substance-exposed infants. Illicit as well as legal drugs, such as alcohol and tobacco, can have a negative impact on a developing fetus and result in the birth of a substance-exposed infant with a host of accompanying physical and mental problems.[21]

Maternal use of drugs during pregnancy affects fetal development and can lead to serious, permanent health problems for the infant. When a pregnant mother ingests drugs or alcohol, the substance passes through the placenta to the developing fetus, where it can potentially remain longer than it does in the mother.[22] Prenatal exposure to drugs has been shown to lead to a variety of health problems, including low birth weight, premature birth, Sudden Infant Death Syndrome, withdrawal syndrome, physical deformities, intrauterine growth retardation, irritability, and decreased appetite.[23] Well-documented evidence shows that exposure to alcohol in the womb can lead to Fetal Alcohol Syndrome, a major cause of mental retardation that has been linked to congenital birth defects.[24]

The exact numbers of substance-exposed infants are difficult to determine. One study estimates that infants who are exposed prenatally to illicit

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21. *See* JEANETTE M. SOBY, PRENATAL EXPOSURE TO DRUGS/ALCOHOL 5–28 (1994).

22. *See* Janna C. Merrick, *Maternal Substance Abuse During Pregnancy. Policy Implications in the United States*, 14 J. LEGAL MED. 57, 58 (1993).

23. *See* Ann Marie Pagliaro & Louis A. Pagliaro, *Teratogenic Effects of In Utero Exposure to Alcohol and Other Abusable Psychotropics, in* DRUG-DEPENDENT MOTHERS AND THEIR CHILDREN 31, 31–57 (Mary R. Haack ed., 1997). These health problems may be aggravated by other aspects of the mother's lifestyle. *See* discussion *supra* Part II.A.3.

24. *See* Carolyn Coffey, Whitner v. State: *Aberrational Judicial Response or Wave of the Future for Maternal Substance Abuse Cases?*, 14 J. CONTEMP. HEALTH L. & POL'Y 211, 212 (1997); *see generally* SOBY, *supra* note 21, at 5–28.

drugs compose approximately 11–15% of the births in the United States.[25] Another approximates that 5% of women who gave birth used illegal drugs during pregnancy.[26] A Boston hospital reported that 31% of pregnant women giving birth at its facilities had used marijuana and 18% had used cocaine,[27] while one Los Angeles hospital reported that 40% of the babies born there tested positive for illicit drugs in their systems at birth.[28] The prevalence of mothers using alcohol during pregnancy is even higher, between 7 and 73%, depending on the study cited.[29]

The effects of substance exposure can also lead to emotional and behavioral complications after birth. Exposure to some drugs, such as cocaine, causes a significantly higher incidence of behavioral and learning disorders.[30] As adults, they have an increased chance of continuing the cycle of substance abuse and dysfunctional behavior learned from their parents and are more likely to engage in criminal activity to support a learned drug habit.[31]

2. The Cost of Maternal Substance Abuse

The maternal substance abuse problem encompasses more than the health effects on infants; there is also a high financial cost. Estimates place the annual national total for treating substance-exposed infants in the three-billion-dollar range.[32] The hospital stays of infants exposed to drug or alcohol in utero are, on average, three times longer than infants born to mothers who did not abuse substances while pregnant;[33] median hospital costs are $1100 to $8450 higher.[34]

In addition to medical costs, infants continue to require extra financial support after leaving the hospital. Many will not go home with their mothers, either because the infant is removed from the mother's custody or abandoned.[35] Subsequently, abandoned infants may become "boarder" babies for several months while awaiting placement with a foster or temporary home.[36] Other costs

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25. *See* Swenson & Crabbe, *supra* note 3, at 625.

26. *See* Robert Mathias, *NIDA Survey Provides First National Data on Drug Use During Pregnancy*, in 10 NIDA Notes (1995), *available at* <http://www.nida.nih.gov/NIDA_Notes/NNVol10N1/NIDASurvey.html> (visited February 4, 2001) [hereinafter *NIDA Survey*].

27. *See* KANDALL, supra note 13, at 257–59.

28. *See* Swenson & Crabbe, *supra* note 3, at 625.

29. *See* GOMEZ, supra note 12, at 21–25.

30. *See* Pagliaro & Pagliaro, *supra* note 23, at 53–54.

31. *See id.*

32. *See* Mary R. Haack, *Comprehensive Community-Based Care: The Link Between Public Policy and Public Health*, in DRUG-DEPENDENT MOTHERS AND THEIR CHILDREN 1, 2 (Mary R. Haack ed., 1997).

33. *See* Coffey, *supra* note 24, at 213.

34. *See* Haack, *supra* note 32, at 2.

35. *See id.* (citing study that 22,000 babies are abandoned at birth annually, 80% of which test positive for drugs).

36. *See* Swenson & Crabbe, *supra* note 3, at 628 (citing a cost of $100,000 per "boarder" baby annually).

may include social workers, foster caregivers, and court costs.[37] Once the babies leave the hospital, their learning, behavioral, and developmental problems must be treated and managed.[38] As the child grows up, he or she will likely require state services to help meet these additional needs.[39] When substance-exposed infants are born to low-income mothers, the taxpayers fund a large part of the costs involved in supporting these infants and children.[40]

3. Pregnant Women with a Substance Abuse Problem

Some aspects of the mother's lifestyle that accompany substance abuse often compound the effects of in utero drug exposure. Complex societal and personal issues surround addiction, such as physical and sexual abuse, and incest, which are known to influence addictive behaviors, and addiction is also involuntary in nature.[41] Addicted mothers are more likely to live in poor conditions and be subjected to violence;[42] drug addicts often fail to seek prenatal care and receive inadequate nutrition during their pregnancies.[43] Polydrug use is also common among drug addicts.[44] The transient nature of a drug-seeking lifestyle may inhibit follow-up care or treatment of the child and mother.[45] Women with addictions to particular drugs, e.g., crack cocaine, may partake in risky sexual

37. Email from Barbara Harris, C.R.A.C.K. founder, to Jennifer Johnson (Apr. 20, 2000) (on file with Author); *see also C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/>.

38. *See* Swenson & Crabbe, *supra* note 3, at 628–29 (documenting problems with prenatally exposed school-age children such as delayed speech, the inability to sit still, short attention span, deafness, blindness, a tendency toward violent temper tantrums, and difficulty making friends).

39. *See* Coffey, *supra* note 24, at 213.

40. *See* Mills, *supra* note 14, at 990. The founder of C.R.A.C.K., Barbara Harris, told the story of baby Jason, an infant born addicted to drugs. He was born weighing less than two pounds and lived only three years. Because of his condition he required around the clock nursing care. The nurses alone cost county taxpayers four million dollars, and there were additional expenses for medication, multiple surgeries and hospital stays, social workers, and foster caretakers. Email from Barbara Harris, C.R.A.C.K. founder, to Jennifer Johnson (Apr. 20, 2000) (on file with Author). *See also C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/>.

41. *See* KANDALL, supra note 13, at 273.

42. *See* Murphy & Rosenbaum, *supra* note 12, at 13.

43. *See id.* at 58 (citing a study performed in New York City that found only 42% of substance abusing mothers report receiving prenatal care); Murphy & Rosenbaum, *supra* note 12, at 13.

44. *See* SOBY, *supra* note 21, at 5. Polydrug use involves taking or abusing drugs, alcohol, or tobacco products in addition to the primary drug of addiction. *See* Merrick, *supra* note 22, at 58. One study reported that 20.4% of women smoked cigarettes during pregnancy and 18.8% drank alcohol. *See NIDA Survey*, *supra* note 26, at 1.

45. *See* Merrick, *supra* note 22, at 58. Polydrug use, inadequate nutrition, lack of prenatal care, and the transient nature of the drug-seeking environment also make it difficult to isolate and analyze the impact of individual factors on the child. *See id.*

behavior such as having unprotected sex and trading sex for drugs, which can increase the risk of HIV and other sexually transmitted diseases.[46]

Pregnant drug addicts may be considered a vulnerable group in need of additional protections in some circumstances. A cash offer might improperly motivate anyone to make a decision regarding her reproductive ability, much less someone willing to prostitute herself for drugs. Because of the addiction, she may not be able to make decisions in her own best interests or with proper consideration to the future, especially when a financial incentive is presented. It may be more inappropriate if the offer is knowingly and intentionally made to a class of persons, drug addicts, with problems that often affect rational decision-making.[47]

B. State Responses to the Problem of Maternal Substance Abuse

In recent years, expectant mothers who use illegal drugs have been prosecuted under existing criminal laws, and there has been a push for new legislation that specifically tackles maternal drug use.[48] Despite these efforts, the ability of states to criminally punish mothers through incarceration for their destructive actions while pregnant remains limited, as prosecution attempts under pre-existing laws usually fail in most states.[49] The new batch of so-called "fetal abuse" statutes makes state intervention easier, although these statutes also encounter practical and legal problems.

1. Criminalization—Prosecutions Under Pre-Existing Laws

One count shows that since the early 1980s, more than 200 women in thirty states have been prosecuted for substance use during pregnancy under various criminal statutes that were already on the books.[50] Prosecutors attempted to extend the current criminal statutes, generally aimed at different activities, to include women's behaviors during pregnancy that were harmful or risked harm to the developing fetus.[51] Pregnant mothers have been prosecuted for crimes such as

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46. *See* KANDALL, supra note 13, at 247–48.

47. *See* Salim Muwakkil, *Don't Get Hooked on Sterilization*, THE NEWS & OBSERVER (Raleigh, N.C.), Sept. 24, 1999, at A23.

48. *See id.*; *see also* Robert Holland, Note, *Criminal Sanctions for Drug Abuse During Pregnancy: The Antithesis of Fetal Health*, 8 N.Y.L. SCH. J. HUM. RTS. 415, 434–36 (1991). *See generally* Christina von Cannon Burdette, *Fetal Protection—An Overview Of Recent State Legislative Response To Crack Cocaine Abuse By Pregnant Women*, 22 MEM. ST. U. L. REV. 119, 128–32 (1991) (discussing proposed state legislation). The web site for South Carolina's Family Preservation & Child Welfare Network provides state by state compilations of prosecutions and fetal abuse bills introduced in the early 1990s. *See* <http://hadm.sph.sc.edu/students/kbelew/fetalab.htm> (visited February 4, 2001).

49. *See* discussion *infra* Part II.B.1.

50. *See* Mills, *supra* note 14, at 990–91; Philip H. Jos et al., *Criminalization of Drug Use During Pregnancy: A Case Study, in* DRUG-DEPENDENT MOTHERS AND THEIR CHILDREN 91, (Mary R. Haack ed., 1997).

51. *See* Coffey *supra* note 24, at 211.

child abuse and neglect, child endangerment, drug delivery (to the fetus), involuntary manslaughter, and attempted homicide.[52]

These cases, where expectant mothers were charged with criminal acts involving their unborn child under criminal statutes,[53] have generally failed.[54] Most frequently, courts refuse to read the statutory definition of "child" or "person" in the various statutes to include an unborn fetus or to encompass prenatal harms.[55] Other courts find that the legislative history and plain meaning of the laws do not indicate a legislative intent to include prenatal harms within the statutes.[56]

To avoid the definitional problem of calling a fetus a "child," some prosecutors have charged expecting mothers with "delivering" illegal drugs to their fetuses. The "delivery" is made through the mother's bloodstream via the umbilical cord to the fetus for the few moments after the infant is born but before the umbilical cord is severed.[57] This legal fiction avoids the need to interpret

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52. *See* State v. Deborah J.Z., 596 N.W.2d 490 (Wis. Ct. App. 1999) (attempted homicide); Commonwealth v. Welch, 864 S.W.2d 280 (Ky. 1993) (criminal child abuse); State v. Gray, 584 N.E.2d 710 (Ohio 1992) (child endangerment); State v. Gethers, 585 So.2d 1140 (Fla. D. Ct. App. 1991) (aggravated child abuse); Reyes v. Superior Court, 141 Cal. Rptr. 912 (Ct. App. 1977) (felony child endangerment). A grand jury refused to indict a mother for manslaughter after her alleged drug use during pregnancy lead to the death of her infant forty-three hours after birth. *See* Patrick Reardon, *Grand Jury Won't Indict Mother in Baby's Drug Death*, CHICAGO TRIB., May 27, 1989 at 1.

53. *See* cases cited *supra* note 52; *see also* Coffey, *supra* note 24, at 211.

54. *See* Mills, *supra* note 14, at 994. Even though many prosecutions may fail in the end, there is no assurance that pregnant women won't be incarcerated. Several women have entered into plea bargains and have been sentenced under lesser charges. *See* KANDALL, *supra* note 13, at 274–75.

55. *See Reyes*, 141 Cal. Rptr. at 913; *see also* Mills, *supra* note 14, at 994.

In a rare case, *Whitner v. State*, a prosecution succeeded under a South Carolina child neglect statute that forbade a person with legal custody of a child to refuse or neglect to provide proper care and attention to the child so that the "life, health, or comfort of the child is endangered or is likely to be endangered." Whitner v. State, 492 S.E.2d 777, 784–85 (S.C. 1997), *reh'g denied*, 523 U.S. 1145 (1998). In this case, a woman who had used cocaine during the third trimester of her pregnancy was charged with child endangerment after the child was born with cocaine in its system. *See id.*

Interpreting South Carolina's child abuse and endangerment statute, the court held that the definition of "child" included a viable fetus. *See id.* The court noted that a viable fetus was also considered a "person" under state homicide and wrongful death statutes. *See id.* at 780. The court distinguished the case law of other states that have reached the opposite conclusion. *See id.* at 782–83. While the mother made two constitutional claims—that her right to privacy was burdened and that she lacked notice that her behavior was proscribed—both claims were rejected. *See id.*

56. *See Welch*, 864 S.W.2d at 283–85; *Gray*, 584 N.E.2d at 711–12; *see also* Mills, *supra* note 14, at 994.

57. *See, e.g.*, Johnson v. State, 602 So.2d 1288 (Fla. 1992); State v. Luster, 419 S.E.2d 32 (Ga. Ct. App. 1992); People v. Hardy, 469 N.W.2d 50 (Mich. Ct. App. 1991). *See generally* Margaret Phillips, *Umbilical Cords: The New Drug Connection*, 40 BUFF. L. REV. 525 (1992) (discussing prosecutions involving criminal drug delivery and trafficking statutes).

"child," because the alleged drug delivery occurs after birth, when the fetus has become a person by legal definition.[58] However, these prosecutions have also proven unsuccessful. Although this theory does not require an expansive interpretation of "child," courts still have found that bending the drug delivery statutes to fit this situation poses notice problems, since this type of delivery (via the umbilical cord) is not one that most would expect.[59] Furthermore, courts found the "delivery" of the drugs to be an involuntary act; therefore, the mother lacked the requisite intent.[60]

2. The Shortcomings of Criminalization

Not only has the criminalization of maternal substance abuse been unsuccessful, but it faces criticisms and challenges on several different levels.

The nature of addiction itself makes a strong case against punishing substance abusing mothers. Addiction is often viewed as an involuntary condition, and it involves complex personal and societal issues.[61] Supreme Court precedent condemns the criminalization of drug addiction,[62] and many major public health organizations, such as the American Medical Association, National Association of Public Child Welfare Administrators, and the March of Dimes disapprove of this type of prosecution.[63]

In a practical sense, criminalization is ineffective in helping the mothers or the infants and potentially can make the situation worse. Punishment of mothers after abuse of drugs or alcohol does not benefit a fetus that may have already been permanently damaged by the exposure. Furthermore, medical professionals warn that the threat of arrest will dissuade these women from seeking prenatal care altogether.[64] Because women are hesitant to visit a doctor for fear of arrest, the risk of harm to the fetus increases.[65] The end result is detrimental to the population the statutes are trying to protect—the babies.[66]

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58. *See* Mills, *supra* note 14, at 995.

59. *See Luster*, 419 S.E.2d at 33–34 (pointing out that one of the purposes of the criminal code is to give fair warning and that in statutory construction, words should be giving their ordinary or logical meaning absent clear legislative intent otherwise); *Hardy*, 469 N.W.2d at 52 ("[A] penal statute must be sufficiently definite and explicit to inform those who are subject to it what conduct will render them liable to its penalties"); *see also* Mills, *supra* note 14, at 996.

60. *See Johnson*, 602 So.2d at 1292–93 (noting there was no evidence that the mother time her ingestion of cocaine so that she could transfer some amount to her child after birth).

61. *See* KANDALL, *supra* note 13, at 273; *see also* discussion *supra* Part II.A.3.

62. *See, e.g.*, Robinson v. California, 370 U.S. 660, 675–76 (1962) (holding that a state law which made the status of narcotic addiction a criminal offense requiring imprisonment was a cruel and unusual punishment in violation of the Eighth Amendment).

63. *See* KANDALL, *supra* note 13, at 273.

64. *See* Haynes, *supra* note 20, at 3.

65. *See* Maureen A. Norton Hawk, *How Social Policies Make Matters Worse: The Case of Maternal Substance Abuse*, 24 J. DRUG ISSUES 517, 521–22 (1994).

66. *See* Holland, *supra* note 48, at 458.

Furthermore, when an expectant mother is imprisoned, she is confined in an unhealthy environment. Jails are often grossly overcrowded and unsanitary.[67] The confined quarters and lack of fresh air may expose the expectant mother to sicknesses such as tuberculosis, hepatitis, and measles.[68] Drugs may still be available, and close contact with the inmate subculture provides the woman with additional drug contacts upon release,[69] as most incarcerated women have a history of drug use.[70]

Legally, criminalization is problematic. Courts are concerned that giving pre-existing criminal statutes an expansive interpretation would be unconstitutional.[71] A woman could claim she lacked notice the statute applied to her or that the statute was unconstitutionally vague.[72] Criminal laws specifically addressing maternal substance abuse are also susceptible to constitutional challenges.[73] The statutes may deny equal protection, infringe the mother's rights to privacy and liberty, be void for vagueness,[74] or interfere with a woman's reproductive freedom[75] or bodily integrity.[76] In addition, procreation is an area traditionally shielded from state involvement.[77] Others have argued that since there are less restrictive alternatives, such as voluntary counseling or outpatient treatment,[78] the statutes could not withstand strict scrutiny.[79]

A recent case, *Ferguson v. City of Charleston*,[80] illustrates additional constitutional issues and practical concerns with a policy tailor-made for drug abusing pregnant women that leads to imprisonment. In *Ferguson*, a state hospital policy required any pregnant woman showing certain physical signs of cocaine use

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67. *See* Hawk, *supra* note 65, at 520.
68. *See id.*
69. *See id.* at 520–21.
70. *See* KANDALL, *supra* note 13, at 252.
71. State v. Luster, 419 S.E.2d 32, 33 (Ga. Ct. App. 1992).
72. *See, e.g.*, cases cited *supra* note 59.
73. *See* Holland, *supra* note 48, at 439–40; Mills, *supra* note 14, at 989; Molly McNulty, *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 N.Y.U. REV. L. & SOC. CHANGE 277, 278, 309–17 (1987–88). If a statute is interpreted to forbid the mothers' ingestion of other harmful but legal substances (e.g., nicotine, caffeine, or alcohol) during pregnancy, the constitutional arguments may be even stronger, since it would emphasize that the ingestion of the harmful substances is illegal, and not the substances themselves. *See* Mills, *supra* note 14, at 994.
74. *See* McNulty, *supra* note 73, at 278, 309–317.
75. *See* Mills, *supra* note 14, at 1023–25.
76. *See* James M. Wilton, *Compelled Hospitalization and Treatment During Pregnancy: Mental Health Statutes As Models for Legislation to Protect Children from Prenatal Drug and Alcohol Exposure*, 25 FAM. L.Q. 149, 157–60 (1991).
77. *See* James Denison, *The Efficacy and Constitutionality of Criminal Punishment for Maternal Substance Abuse*, 64 S. CAL. L. REV. 1103, 1135 (1991); *see also* discussion *infra* Part V.B.
78. *See* Wilton, *supra* note 76, at 160.
79. *See* Denison, *supra* note 77, at 1140; discussion *infra* Part V.B.
80. 186 F.3d 469 (4th Cir. 1999), *cert. granted*, 528 U.S. 1187 (Feb 28, 2000).

who sought treatment at the hospital to take a urine drug test.[81] If the test was positive, the woman had a choice: face arrest for distributing cocaine to a minor (the fetus) when the hospital reported the test results to the city police department or the Solicitor's Office, or enter drug treatment (and the test results would not be reported).[82] The women could also avoid prosecution after the positive results were reported by entering drug treatment; upon successful completion, the charges would be dropped.[83]

The plaintiffs, ten women who were tested under the policy, claimed: 1) the testing was a warrantless search in violation of the Fourth Amendment; 2) the policy had a racially disparate impact in violation of Title VI of the Civil Rights Act of 1964; 3) the disclosure of medical information to law enforcement violated their constitutional right to privacy; and 4) the hospital staff committed abuse of process in administering the policy, a state law tort.[84]

The Fourth Circuit gave weight to the state's interests and concluded that the warrantless searches were acceptable as reasonable "special needs" searches,[85] and that the government had an interest in the disclosure of the medical records which outweighed the women's privacy interests.[86] The plaintiff's disparate impact and abuse of process claims failed as well.[87] The United States Supreme Court granted certiorari, but it has not yet ruled.[88]

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81. *See id.* at 474. The indicia of cocaine use included physical symptoms such as unexplained birth defects and separation of the placenta from the uterine wall, but also non-physical indicia including late or incomplete prenatal care. *See id.* The policy was limited to testing and prosecuting for cocaine use, not other drugs or legal yet harmful substances. *See id.*

82. *See id.* As the policy was originally instituted, when a patient tested positive, the test result was reported and the woman was arrested; the option of seeking treatment to avoid being reported did not exist. *See id.* at 474–75.

83. *See id.*

84. *See id.* at 473.

85. *See id.* at 476. The court found the rising use of cocaine among women and the "public health problems associated with maternal cocaine use created a special need beyond normal law enforcement goals." *Id.* at 479. The drug screens advanced the public interest and were considered only a minimal intrusion into the women's privacy. *See id.*

86. *See id.* at 482.

87. *See id.* at 482–84. The plaintiffs failed to demonstrate an equally effective method of meeting the policy goals that would have a less disparate impact. *See id.* at 481.

88. *Cert. granted*, 528 U.S. 1187 (Feb. 28, 2001). As this Note was going to press, the Supreme Court ruled on *Ferguson*. *See* Ferguson v. City of Charleston, 2001 WL 273220, ___ S. Ct. ___ (2001). The majority in the 6-3 decision held that the urine drug tests were indeed searches, but that the searches did not fall within the "special needs" exception to the warrant requirement. *See id.* at *7 ("Given the primary purpose of the Charleston program, which was to use the threat of arrest and prosecution in order to force women into treatment, and given the extensive involvement of law enforcement officials at every stage of the policy, this case simply does not fit within the closely guarded category of "special needs.'"). The Fourth Amendment's general prohibition against nonconsensual, warrantless, and suspicionless searches was applicable to the hospital's drug testing policy. *See id.* at *8. The case was remanded to determine if the women tested under the policy consented to the drug tests. *See id.*

The criminalization of maternal substance abuse can be attacked on several fronts ranging from constitutional challenges and common-law torts to more practical arguments that criminalization fails to meet its objectives of protecting the fetus. Given all of the problems that surround the criminalization, it should come as no surprise that states have turned to non-punitive methods.

3. Civil Responses—Confinement and Removal of the Child from Custody

Non-punitive civil processes attempt to protect the unborn fetus. These include the committing the mother to a treatment facility during pregnancy, as well as child welfare services asserting jurisdiction over the fetus (as opposed to the mother) so the agency can have custody of the fetus along with the mother.[89] States have implemented a variety of programs involving education, funding, and treatment. As a last-ditch effort to protect the infant, child welfare services may seek removal of the child from the mother's custody or termination of parental rights.[90]

It is clear that after birth a "child" exists, and child protective services can then remove the child from the mother's custody.[91] The expectant mother's drug use during pregnancy is evidence of child abuse or neglect, which serves as grounds for removal of the child to the custody of protective services.[92] If the custody is temporary, the mother will be able to regain custody when she is able to stop using drugs and thus care for the child.[93]

The Supreme Court's holding in *Ferguson* further demonstrates the difficulties that face states when they attempt to combat maternal substance abuse using criminal means.

89. *See* Coffey, *supra* note 24, at 216.

90 *See supra* notes 91–92 and accompanying discussion.

91. *See, e.g., In re* Baby Boy Blackshear, 736 N.E.2d 462, 465 (Ohio 2000) (holding that "when a newborn child's toxicology screen yields a positive result for an illegal drug due to prenatal maternal drug abuse, the newborn is...per se an abused child" under the civil child abuse statute); *In re* Ruiz, 500 N.E.2d 935, 939 (Ohio Com. Pl. 1986) (finding mother's use of heroin within several weeks of birth leading to the newborn having withdrawal was civil child abuse). In *Blackshear*, the Ohio court distinguished earlier precedent that held a fetus was not a child, because the prior case was in the criminal context requiring strict construction of the statutes. *See Blackshear*, 736 N.E.2d at 464 n.2.

92. *See, e.g.*, UTAH CODE ANN. § 62A-4a-409 (1997) (requiring a pre-removal investigation that may result in removal of the child from the home upon receipt of a report of, or reasonable suspicions of fetal drug dependency); Johnson v. State, 602 So. 2d 1288, 1295 (Fla. 1992); *In re* Baby X, 293 N.W.2d 736, 739 (Mich. Ct. App. 1980); *In re* Fathima Ashanti K.J., 558 N.Y.S.2d 447, 449 (Fam. Ct. 1990). However, courts may require more than drug addiction before terminating the mother's parental rights. *See e.g.*, Adoption of Katharine, 674 N.E.2d 256, 261 (Mass. App. Ct. 1997) ("[W]e do not think a cocaine habit, without more, translates automatically into legal unfitness to act as a parent.").

93. *See* Coffey, *supra* note 24, at 216. South Carolina requires that a treatment program must be completed and that the mother must be drug free for a specified period of time before the child is returned to the home. *See* S.C. CODE ANN. § 20-7-765(A) (Law. Co-op. Supp. 1999). This requirement applies not only to the mother, but also to any other adult person living in the home who contributed to the mother's addiction. *See id.* § 20-7-765(A)(2).

State agencies can remove a child after birth without having to interpret any statutes creatively, and there is generally a procedure in place for doing so through child protective services when the child is in need of protection. But this approach is not ideal, either. It offers little deterrence during pregnancy[94] and is ineffective in stopping the ongoing harm that occurs during the pregnancy when a mother continues to use drugs. In a sense, the state stands back and lets the harm occur, then cleans up the mess afterwards.

To prevent further harm to the fetus, states have attempted to confine expectant mothers in a treatment center or hospital through involuntary civil commitment, though most of these procedures are not established for the express purpose of confining pregnant drug addicts. Almost every state permits involuntary civil commitment for individuals that pose a danger to themselves or to others because of a mental or physical disability.[95] Approximately thirty-five states specifically allow chemically dependent persons, independent of pregnancy, to be involuntarily committed.[96]

An alternate method requires child protective services to petition the courts for protective custody or jurisdiction over the unborn child, as opposed to the mother herself, by asserting that the fetus has been, or will be, abused or neglected.[97] Child protective services can then require treatment or confinement of the expectant mother to protect the fetus.[98] In *Angela M.W. v. Kruzicki*,[99] a Wisconsin appellate court allowed a hospital to detain a viable fetus, in utero, for protection and inpatient treatment of the mother after the mother's obstetrician reported the mother was using cocaine during her third trimester.[100] Echoing the problems faced by prosecutors charging mothers under existing criminal statutes,[101] the Wisconsin Supreme Court overruled the decision, finding the

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94. *See* Denison, *supra* note 77, at 1116–17 (suggesting that many of these women do not want custody of their children).

95. *See* Bonnie B. Wilford, *Policy Choices and Legislative Mandates*, in DRUG-DEPENDENT MOTHERS AND THEIR CHILDREN 149, 157 (Mary R. Haack ed., 1997). Who may institute a civil commitment and the specific grounds required vary by state. *See* Deborah Appel, *Drug Use During Pregnancy: State Strategies to Reduce the Prevalence of Prenatal Drug Exposure*, 5 U. FLA. J.L. & PUB. POL'Y 103, 128–29 (1992).

96. *See id; see e.g.*, IND. CODE ANN. § 12-23-11-1 (West 2000).

97. *See, e.g.*, In the Matter of Unborn Child, 683 N.Y.S.2d 366, 371 (Fam. Ct. 1998) ("It defies logical reasoning that our laws and society would preclude a mother from illegally introducing narcotics and other illegal drugs into her child, and yet not protect the unborn child from those same dangers while the child is still in the womb.").

98. *See, e.g.*, State *ex rel.* Angela M.W. v. Kruzicki, 541 N.W.2d 482, 484 (Wis. Ct. App. 1995), *rev'd*, 561 N.W.2d 729 (Wis. 1997); *see generally*, Appel, *supra* note 95, at 123–24; Carol Gosain, Note, *Protective Custody For Fetuses: A Solution to the Problem of Maternal Drug Use? Casenote on Wisconsin ex rel.* Angela v. Kruzicki (1997), 5 GEORGE MASON L. REV. 799 (discussing *Angela* and the issues that surround the use of the civil commitment process to combat maternal substance abuse).

99. 541 N.W.2d 482 (Wis. Ct. App. 1995), *rev'd*, 561 N.W.2d 729 (Wis. 1997).

100. *See Angela*, 541 N.W.2d at 485.

101. *See* discussion supra Part II.B.2.

statutory definition of "child" in the protective custody provisions did not include an unborn fetus.[102]

Other courts have agreed that child protection laws do not apply to an unborn fetus unless the laws either specifically include an unborn fetus in their definition of "child," or if there is clear legislative intent to include an unborn fetus in the laws.[103] Again, the recurring interpretation problem rears its ugly head, and states are left with problematic or awkward means to manage maternal substance abuse.

4. "Fetal Abuse" Statutes and Other Legislative Responses

In response to the ineffective prosecutions under existing criminal statutes and difficulties with the current civil system, states have taken a more direct approach. They have passed "fetal abuse" statutes that by their very language include unborn children within their protection, making state intervention easier and the law more straightforward.

Some states modified their definitions of child abuse and neglect so infants born after fetal exposure to a controlled substance would be protected explicitly under their existing statutes,[104] while others made indicia of maternal drug use subject to mandatory child abuse and neglect reporting statutes.[105] Some reporting laws require physicians to test women while pregnant, or just after giving birth, for the presence of drugs in their systems and to report positive test results.[106] Testing the newborn often can be done in this situation without the

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102. *See Angela*, 541 N.W.2d at 485.

103. *See* Appel, *supra* note 95, at 123. *See, e.g.* In the Matter of Steven S., 178 Cal. Rptr. 525, 527–28 (Ct. App. 1981) (holding that an unborn fetus is not a person within the meaning of the child welfare statutes).

104. *See* Child Protection Reform Act of 1996, S.C. CODE ANN. § 20-7-736(G) (Law. Co-op. Supp. 1999) (presuming that a newborn is an abused or neglected child if a blood or urine test of the infant or mother shows the presence of a controlled substance and requiring the placement of the child in protective custody); S.D. CODIFIED LAWS § 26-8A-2(9) (Michie 1999) (defining an abused or neglected child as one "subject to prenatal exposure to mother's abusive use of alcohol or any controlled drugs"); WIS. STAT. ANN. § 48.02(1)(am) (West 1999) (including as abuse the serious physical harm to an unborn child caused by an expectant mother's "habitual lack of self-control" with regard to drugs and alcohol). In South Carolina, the mother may also be required to complete a drug treatment program and be drug free for a period of time before the child is returned to the home. *See* S.C. CODE ANN. § 20-7-764(A). Wisconsin specifically recognizes that unborn children have certain basic needs, which include developing physically to their potential and being free from physical harm due to their expectant mother's use of drugs and alcohol. *See* WIS. STAT. ANN. §§ 48.01(1)(am), (2)(bm).

105. *See, e.g.*, 325 ILL. COMP. STAT. ANN. 5/3 (West Supp. 1999); OKLA. STAT. ANN. tit. 10, § 7103(2) (West Supp. 2000); Wilford, *supra* note 95, at 156–57. *See generally* Erin Atkins, *Reporting Fetal Abuse Through California's Child Abuse and Neglect Reporting Act*, 21 SW. U. L. REV. 105 (1992).

106. *See* MINN. STAT. ANN. § 626.5562(2) (West Supp. 2000); WIS. STAT. ANN. § 146.0255(2)(b) (West 1999) (requiring mandatory reporting of positive tests on infants and discretionary reporting of positive tests performed on expectant mothers).

mother's informed consent.[107] The toxicology results can potentially be used as evidence in a criminal prosecution, unless specifically excluded by the statute.[108] For example, Minnesota has broadened the definition of neglect within its reporting statute so that it now includes:

> [P]renatal exposure to a controlled substance...used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure....[109]

Physicians are required to perform toxicology tests if, based on a medical assessment, the physician believes the mother used a controlled substance for a nonmedical purpose during the pregnancy.[110] If the test is positive, or there is other medical evidence of exposure, the physician is required to report the results as child neglect.[111]

To overcome the interpretation issues in civil confinement, a handful of states have, in one way or another, explicitly made drug use during pregnancy grounds for involuntary civil commitment.[112] Minnesota defines a "chemically dependent person," for purposes of involuntary civil commitment, to include "a pregnant women who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of [specified] controlled substances."[113] Wisconsin revised its child abuse laws and took a slightly different approach by focusing on "the best interests of...the unborn child."[114] If the judge determines that the "unborn child of an adult expectant mother" is in need of protection or services, then courts can require that an expectant mother receive treatment, including inpatient treatment.[115] The statutory scheme even permits law enforcement officers

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107. *See* Wilford, *supra* note 95, at 156–57.

108. *See id.*

109. MINN. STAT. ANN. § 626.566(2)(c)(6) (West Supp. 2000).

110. *See id.* § 626.5562(2).

111. *See id.* §§ 626.5562(2), 626.566(2)(c). After receiving a report of a woman's drug use during pregnancy, Minnesota child welfare agencies are required to conduct an assessment and offer appropriate services such as referrals for treatment or prenatal care. *See id.* § 626.5561(2). The agencies are also required to seek emergency admission to a treatment facility through the state's civil commitment act if the expectant woman refuses the recommended services or treatment. *See id.*

112. *See, e.g.*, MINN. STAT. ANN. § 253B.02(2) (West Supp. 2000); S.D. CODIFIED LAWS § 34-20A-70 (2000); WIS. STAT. ANN. § 48.347 (West Supp. 2000).

113. MINN. STAT. ANN. § 253B.02(2) (West Supp. 2000).

114. WIS. STAT. ANN. § 48.01(1) (West Supp. 2000). *See generally*, Kenneth A. DeVille & Loretta M. Kopelman, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy*, 27 J.L. MED. & ETHICS 332, 333 (1999).

115. WIS. STAT. ANN. § 48.347 (West Supp. 2000). Treatment "may include, but is not limited to, medical, psychological, or psychiatric treatment, as well as alcohol or other drug abuse treatment or other services that the court finds necessary and appropriate." DeVille, *supra* note 114, at 333. There is also a requirement that directs health care workers

to take an expectant mother into custody for up to forty-eight hours without a hearing.[116] When a full adversarial hearing does occur, the statute requires that a guardian ad litem be appointed to represent the fetus and serve as an advocate for the unborn child.[117]

In some ways, civil fetal abuse statues avoid what is wrong with criminalization. Under civil fetal abuse statutes, there is no fear of imprisonment in jail, which somewhat mitigates the punishment mentality, and expectant mothers do get some treatment or counseling.[118] Proponents view it as a tentative balance between mothers' rights and fetal rights.[119] But there are still problems. Involuntary confinement doesn't accommodate a woman's other obligations such as caring for other children or working at a job.[120] Again, women are scared away from seeking prenatal care if they are threatened by involuntary confinement when they visit a physician. Studies have also shown that forced treatment is less effective than voluntary treatment.[121]

A different legislative response to maternal substance abuse focuses on treatment, counseling, rehabilitation, public education campaigns, and increased funding.[122] Some statutes require giving or posting warnings to pregnant women that advise of the "possible problems, complications, and injuries which may result to [the mothers] and/or to the fetus from their consumption or use of alcohol, cocaine, marijuana, heroin or other narcotics during their pregnancy"[123] or to make this information available for hospitals and clinics to distribute to patients.[124] In Illinois, the Department of Human Services is required to exchange referral information between medical, social, and treatment agencies that provide services to pregnant women and drug-addicted women.[125] In addition, they must maintain a directory of treatment services for pregnant women.[126] Other states

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and certain other professionals to report their suspicions if they believe an unborn child has been or is at substantial risk of abuse. WIS. STAT. ANN. § 48.981(1)–(3) (West Supp. 2000).

116. *See* WIS. STAT. ANN. § 48.193(1) (permitting law enforcement to take expectant woman into custody); § 48.213(1) (requiring a hearing within forty-eight hours); § 48.205 (outlining the criteria for holding an expectant mother in physical custody). This is not, however, considered an arrest. *See id.* at § 48.193(3).

117. *See id.* § 48.213(2) (requiring guardian for the unborn child be involved in the hearing), § 48.235(1) (calling for the appointment of a guardian for an unborn child in need of protection).

118. *See* Appel, *supra* note 95, at 130.

119. *See id.*

120. *See id.*

121. *See id.* In practice, fetal abuse statutes may raise constitutional concerns similar to those discussed in connection with criminalization. *See supra* Part II.B.2. Some fetal abuse statutes involve testing blood and urine for drugs and disclosing private information to authorities, which can infringe on a mother's freedom during pregnancy. *See, e.g.*, MINN. STAT. ANN. § 626.5562(2) (West Supp. 2000)

122. *See* Wilford, *supra* note 105, at 158–59.

123. *See, e.g.*, DEL. CODE ANN. tit. 16 §190 (2000).

124. *See, e.g.*, ALASKA STAT. § 18.05.037 (Michie 2000).

125. *See* 20 ILL. COMP. STAT. ANN. 301/35-5(a), (f) (West Supp. 1999).

126. *See id.*

have created treatment programs,[127] required that pregnant drug addicts receive priority in obtaining treatment,[128] and increased allocation of resources for other services.[129] South Dakota has created a prenatal education program,[130] and in South Carolina, a statute threatens to disqualify the mother from receiving public assistance unless she participates in a drug treatment program.[131] Federal efforts have focused on increasing the availability of treatment programs designed for women by funding various projects and grants.[132]

While treatment programs seem like the most humane and least controversial methods, they have their share of problems as well. Existing treatment centers often use methods geared toward male drug addicts, which are not sensitive to the special needs of pregnant women, especially those who already have children.[133] Most in-patient treatment centers do not accept children, and many have a thirty-day minimum commitment.[134] This structure is incompatible with women's family and child-care obligations.[135] Pregnant women addicted to cocaine or on Medicaid have not always been welcome in treatment centers.[136] Centers further claim they are unable to provide adequate prenatal services or care during detoxification[137]

Despite an increase in the number of programs and the trend toward specialized treatment,[138] the need for treatment exceeds the resources available.[139] Furthermore, women may not utilize the services that are available or may lack the resources to pay for private programs.[140] Some women face social stigma and a

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127. *See, e.g., id.* § 301/35-5(h)(2).

128. *See e.g., id.* § 301/35-5(h)(3); MD. CODE ANN., HEALTH—GEN. § 8-403.1 (2000); WIS. STAT. ANN. § 51.46 (West 1997) (giving pregnant women who suffer from alcoholism or drug dependency first priority for services in private facilities provided on a voluntary or involuntary basis).

129. *See, e.g.*, WIS. STAT. ANN. § 46.51 (West 1997).

130. *See* S.D. CODIFIED LAWS § 34-23B-2 (Michie 1999).

131. *See* S.C. CODE ANN. § 43-5-1190 (Law. Co-op. Supp. 1999) (providing that a mother who gives birth to a baby with evidence of the effects of maternal substance abuse is ineligible for Family Independence Aid, unless she submits to random drugs tests or participates in an approved drug treatment program).

132. *See* Lucy Salcido Carter & Carol S. Larson, *Drug Exposed Infants*, 7 FUTURE OF CHILDREN 157, 158 (1997) (discussing federally funding programs and initiatives).

133. *See* Coffey, *supra* note 24, at 213.

134. *See* MURPHY & ROSENBAUM, *supra* note 12, at 150.

135. *See id.* Outpatient treatment centers usually do not provide supervised child-care areas or services either. *See id.* at 150–151.

136. *See* Hawk, *supra* note 65, at 521; KANDALL, *supra* note 13, at 271 (citing a study of New York treatment centers where "fifty-four percent excluded pregnant women, sixty-seven percent denied care to pregnant women on Medicaid and eighty-seven percent refused to treat pregnant Medicaid patients who were using crack cocaine").

137. *See* Hawk, *supra* note 65, at 521.

138. *See* KANDALL, *supra* note 13, at 261–72 (discussing various treatment programs and centers).

139. *See id.* at 269.

140. *See* KANDALL, *supra* note 13, at 271–72.

sense of shame that may deter them from getting help.[141] According to some public voices, not only are these women failures because of their addiction, but they are also "bad mothers" who hurt their defenseless babies—an accusation that is not easy to face up to. As with any intervention, it is possible that drug-addicted women will not respond to drug education or voluntary treatment programs because of their strong physical and emotional dependence on the drugs.[142]

As the above survey indicates, current state responses, methods, and programs face many difficulties in trying to manage maternal substance abuse. It is in this context of climbing substance-exposed infant rates, combined with the inability of states to effectively handle maternal substance abuse, that the C.R.A.C.K. program began in 1994.[143]

III. THE C.R.A.C.K. PROGRAM

The stated objective of C.R.A.C.K. is "to offer effective preventative measures to reduce the tragedy of numerous drug affected pregnancies...[and] reduce the high number of drug damaged children that result from their parents' drug abuse."[144] C.R.A.C.K. founder Barbara Harris began the program after legislation that would have mandated contraception for drug addicts failed in her home state of California.[145]

Participants in C.R.A.C.K. receive $200 in exchange for their use of either long-term or permanent birth control.[146] The permanent options are a tubal ligation for women or a vasectomy for men.[147] Temporary birth control options are either Depo-Provera, an IUD, or Norplant.[148]

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141. *See id.* at 270. As Kandall wrote:

> That programs for women existed, however, did not guarantee that addicted women would be able to overcome their sense of shame and guilt, both self and societally imposed, to avail themselves of treatment services....Likewise, women continued to find themselves in male-dominated, sexist "therapeutic settings," where voyeurism, ridicule, or unwanted sexual advances, quite clearly counterproductive to treatment goals, occurred.

See id.

142. *See* Wilton, *supra* note 76, at 167.

143. *See* Drew Dixon, *Group's Billboards Offer Addicts Cash if They Agree to Be Sterilized*, FORT PIERCE NEWS (Fort Pierce, Fla.), June 18, 1999, at A3.

144. *C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/objectives/>.

145. *See* Muwakkil, *supra* note 47, at A23.

146. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

147. In a majority of cases, vasectomies and tubal ligations cannot be reversed, so as a practical matter the procedures are considered permanent. *See* CLARK, *supra* note 9, at 374.

148. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

The $200 offer is open to both women and men of child-bearing age that have a drug or alcohol abuse problem.[149] To demonstrate their problem, participants are required to submit evidence such as arrest reports, drug treatment records, or court papers showing that their children were removed from their custody because of the drug problem.[150] To participate, the person must contact C.R.A.C.K. to obtain the paperwork.[151] After receiving the paperwork, the applicant's offer remains open for sixty days.[152] The applicant must meet with a physician to receive counseling on, select, and begin using one of the specified birth control methods within the sixty-day time period.[153] If a participant opts for sterilization through a clinic subsidized by the federal government, a mandatory thirty-day waiting period is required before undergoing the procedure.[154] Once the applicant returns the paperwork so C.R.A.C.K. can verify that the procedure was performed, the participant is paid.[155]

As of January 2, 2001, 353 women and two men have taken advantage of C.R.A.C.K.'s offer, and of the women, 158 have opted for sterilization.[156] The women were pregnant a combined total of 2023 times before participating in C.R.A.C.K. (averaging just under six pregnancies per woman).[157] Of the 2023 prior pregnancies, 689 were aborted, and 1322 were born.[158] Of those births, 139 were stillborn, and forty-five more died from complications at or shortly after birth. More than half the surviving children are still in foster care.[159]

C.R.A.C.K. has placed billboards offering cash for sterilization or long-term birth control in cities across the nation.[160] The program's other advertising tactics have included distributing flyers at health clinics,[161] hospitals, police departments, probation departments, and jails and placing advertisements on bus

149. *See id.* at <http://www.cracksterilization.com/>; *see also* Pam Belluck, *Addicts Offered $200 to Get Sterilized*, THE PLAIN DEALER (Cleveland, Ohio), July 25, 1999, at 19A.

150. Email from Barbara Harris, C.R.A.C.K. founder, to Jennifer Johnson (April 20, 2000) (on file with Author).

151. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

152. *See id.*

153. *See id.* C.R.A.C.K. provides referrals to Planned Parenthood and clinics but is otherwise not involved with the selection of a health care provider. *See* Belluck *supra* note 149, at 19A; *C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>. In most cases the contraception can be obtained at low or no cost to the participant. *See id.*

154. *See* discussion *infra* Part IV.B.

155. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

156. *See id.* at <http://www.cracksterilization.com/stats/stats.html>.

157. *See id.*

158. *See id.*

159. *See id.* (noting that 719 children are in the foster care system).

160. *See* Dixon, *supra* note 143, at A3.

161. *See* Belluck, *supra* note 149, at 19A; *see also* Haynes, *supra* note 20, at 3 (quoting a C.R.A.C.K. flyer that stated, "Don't let a pregnancy ruin your drug habit.").

benches outside welfare offices.[162] C.R.A.C.K. chapters are operated by volunteers in thirteen metropolitan areas across the country in addition to the main office in Orange County, California.[163]

The program has gained attention and publicity on television and radio and in newspapers and magazines.[164] The opening of the Chicago chapter received attention from such notables as Oprah Winfrey and Barbara Walters.[165] Syndicated columnist George Will has defended C.R.A.C.K. in his column.[166] Moreover, C.R.A.C.K. receives significant monetary donations from well-known persons, private donors, and anonymous persons. Radio personality Dr. Laura Schlessinger contributed $5000, a conservative talk-show host raised money through his San Diego radio program, and an anonymous businessman contributed $25,000.[167] In 1997, the program raised approximately $80,000 in donations.[168] However, the fanfare has not all been positive. Leaders from Planned Parenthood and the American Civil Liberties Union have complained about C.R.A.C.K.'s "coercive" tactics.[169] Organized protesters tore down a billboard advertising the program in Oakland, California.[170]

C.R.A.C.K.'s most significant difference from other approaches to the problem of substance-exposed infants and maternal substance abuse is that C.R.A.C.K. is a preventative program,[171] whereas the other methods are reactive. In other words, the other efforts do not come into play until after risking harm to the fetus. The goal of C.R.A.C.K. is to avoid the pregnancy in the first place. Since the woman does not get pregnant, she does not risk harm to a fetus.

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162. *See* Lynn Smith, *Addicts Can Get Paid $200 to Be Sterilized*, SEATTLE TIMES, April 16, 1998, at A10.

163. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/chapters/>.

164. *See, e.g.*, Haynes, *supra* note 20 at 3; Margot Hornblower, *Benevolent Bribery—Or Racism? A California Mom Stirs Debate by Paying Drug Users to Stop Having Kids*, TIME MAG., August 23, 1999, at 47; Boyer, *supra* note 19, at 21; *see also C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/media/television.html> (listing more than 50 local, national, and international television programs where C.R.A.C.K. has been featured, including *Oprah* and *20–20*).

165. *See* Hornblower, *supra* note 164, at 47.

166. *See* George Will, *One Small Step to Curb Chemical Assault in the Womb*, THE CINCINNATI POST, November 2, 1999, at 15A.

167. *See* Smith, *supra* note 162, at A10. C.R.A.C.K., a nonprofit organization, also highlights donors on its web site. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/donations/>.

168. *See* Dixon, *supra* note 143, at A3.

169. *See id.*; Smith, *supra* note 162, at A10; Muwakkil, *supra* note 47, at A23.

170. *See* Jo Ann Zuniga, *A Program Offers Birth Control to Addicts*, HOUS. CHRON., Jan. 22, 2000, at A35.

171. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/objectives/> (citing "preventative measures" as an objective).

C.R.A.C.K.'s preventative approach also avoids many of the constitutional issues surrounding the criminalization of maternal substance abuse.[172] Participants are not punished or confined for their destructive behavior while pregnant. There is no interference with a woman's privacy rights, bodily integrity, or reproductive freedom, because the woman makes a personal choice to use birth control. She is not compelled to by the state or courts to do so. Nor are the woman's rights trumped by those of the fetus, because there is no fetus in the equation.

In economic terms, C.R.A.C.K. is cost-effective. At first C.R.A.C.K. may slightly increase the cost to the government, because the program encourages persons who are not currently using the available subsidized contraceptives and sterilization to begin using these services. C.R.A.C.K. encourages contraception for drug addicts generally, but also provides referrals to subsidized clinics.[173] One reason the monetary incentive is so appealing to participants is that the sterilization procedures and contraceptives are usually available for little or no cost.[174]

However, the increased cost of providing subsidized contraception is a fraction of the costs associated with the birth of each substance-exposed infant.[175] Many of these babies will be placed in foster homes, or, if they are at home with their mothers, they will depend on public assistance. For example, of the 355 C.R.A.C.K. participants,[176] 719 of their children are currently in foster care.[177] Although C.R.A.C.K. statistics specifically cite the number of children in foster care, the remaining children are not necessarily in their mother's custody or care. There is no mention of how many children have been adopted by other families or are being cared for through alternate or informal arrangements. The women participants have averaged just under six pregnancies each before obtaining birth control through the program.[178] It is apparent that many of these women cannot, or choose not to, support the children they are conceiving.

For an initial, privately funded cost of $200, countless births are avoided. In the long run, C.R.A.C.K. will save state and federal governments money by reducing the population of substance-exposed infants and lessening the burden on the child welfare system and family support programs.[179]

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172. *See* discussion *infra* Part II.B.1.

173. *See* Belluck, *supra* note 149, at 19A; *see also C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

174. C.R.A.C.K. also mentions the low cost or no cost of birth control on its web site. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

175. *See generally* discussion *infra* Part II.A.

176. There were 355 paid participants, including two men, as of Jan. 2, 2001. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/stats/stats.html> (citing program statistics).

177. *See id.*

178. *See id.*

179. *See* Wilford, *supra* note 105, at 164.

However, there are several areas of concern with the program despite the benefits. There are the questions of whether contracts with drug addicts that involve financial incentives should require additional governmental protection, and whether individuals should be allowed to contract away reproductive ability. If additional protections are warranted, how can this be accomplished without infringing on the mother's rights while still effectively reducing the number of substance-exposed infants?

IV. ANALYSIS UNDER CURRENT REGULATORY SCHEMES

The most problematic aspect of C.R.A.C.K. is when a woman opts for permanent birth control, a sterilization. Generally, voluntary non-therapeutic sterilization is legal if participants can give competent consent.[180] It is viewed by the public as an acceptable birth control method and may even be constitutionally protected.[181] A woman's choice to undergo a tubal ligation of her own free will normally would not give rise to any particular public policy concerns so long as state and federal informed consent procedures are followed.[182] But when a woman is *paid* to limit, or permanently give up, her reproductive abilities, the situation may become an area where the state should intervene.

While there may be no direct regulation of private programs like C.R.A.C.K., an analogy may be drawn to contracts involving similarly sensitive subject matter. These analogous contracts suggest programs offering money for sterilization or contraception can, to some extent, be limited and regulated based on public policy. Before delving into analogous situations and invoking broader public policies in analyzing C.R.A.C.K. as a whole, it is worth exploring whether the program's cash-for-contraception arrangement can be invalidated using traditional contract analysis.

A. The Cash-for-Contraception Contract

In essence, the transactions that occur between C.R.A.C.K. and program participants are private contracts.[183] The discussion here focuses on whether contract remedies would provide a participant with any protection or relief if she had a change of heart and did not want to fulfill her contractual obligations to use

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180. *See* 1 AM. JUR. 2d *Abortion and Birth Control* §16 (1994); *see generally* IRVING J. SLOAN, THE LAW GOVERNING ABORTION, CONTRACEPTION AND STERILIZATION 37–44 (1988).

181. *See id.*; Jessin v. County of Shasta, 79 Cal. Rptr. 359 (Ct. App. 1969); K.S. Krohn, Annotation, *Legality of Voluntary Nontherapeutic Sterilization*, 35 A.L.R. 3d 1444 (1971).

182. *See* discussion *infra* Part V.A.

183. When C.R.A.C.K. advertises a $200 cash incentive, it manifests an intent to enter into an agreement by setting forth detailed terms of acceptance. The offer is accepted by the performance of a qualified applicant who agrees to use long-term or permanent birth control.

birth control.[184] If adequate protection is available, then it may be unnecessary to invoke public policy to mitigate the effects of cash-for-contraception agreements.

Conventional contract analysis suggests that the contract could be unenforceable because of its unconscionable nature. Yet, the possibility of a court finding the contract unenforceable does not offer C.R.A.C.K. participants much protection because of the contract's structure. By the time a contract reaches the court, it is essentially too late for participants who opted for sterilization. A woman must begin the use of birth control before a contract is formed at all.

1. Unconscionability

A basic tenet of contract law provides that:

> competent parties may make contracts on their own terms, provided such contracts are neither illegal nor contrary to public policy, and in the absence of fraud, mistake or duress, a party who has entered into such contract is bound thereby....The rule even applies when the contract turns out to be disadvantageous to the complaining party.[185]

However, this rule has been qualified by the doctrine of unconscionability,[186] which permits a court to refuse to enforce a contract, enforce the remainder of the contract without the unconscionable term, or limit the application of any unconscionable term as to avoid an unconscionable result.[187] The contract is not necessarily deemed "illegal," but instead, it "drives too hard a bargain for a court of conscience to assist."[188] Courts generally refer to two facets of unconscionability: 1) substantive, which involves the fairness of the contract terms and obligations assumed by the parties, and 2) procedural, which involves the manner in which the contract came about.[189]

Indicators of substantive unconscionability include contract terms that are "so one-sided as to oppress or unfairly surprise the innocent party, an overall imbalance in the obligations and rights imposed by the bargain...or significant cost-price disparity" (usually seen with the sale of goods or services),[190] although to find unconscionability there must be suspicious factors beyond a questionable

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184. Hypothetically, both C.R.A.C.K. and participants could seek enforcement of the contract. If C.R.A.C.K. sought enforcement to require the woman to continue her use of long-term birth control, it would encounter the same problems seen in the enforcement of surrogacy contract provisions. *See infra* notes 218–219 and accompanying text.

185. John Deere Leasing Co. v. Blubaugh, 636 F. Supp. 1569, 1572 (D. Kan. 1986) (internal citations omitted).

186. *See id.*

187. *See* RESTATEMENT (SECOND) OF CONTRACTS § 208 (1981). The Restatement does not, however, provide an explicit definition of unconscionability.

188. Campbell Soup Co. v. Wentz, 172 F.2d 80, 84 (3d Cir. 1949).

189. *See* Maxwell v. Fidelity Fin. Servs., Inc., 907 P.2d 51, 56–57 (Ariz. 1995).

190. *See* Resource Mgmt. Co. v. Weston Ranch & Livestock Co., 706 P.2d 1028, 1041 (Utah 1985) (internal citations and quotations omitted).

or unbalanced level of consideration.[191] Frequently, cases finding contracts to be unconscionable also involve elements such as actual misrepresentations or gross mistreatment of people who are already disadvantaged.[192]

The very substance of a C.R.A.C.K. contract, restricting a woman's reproductive ability, makes a strong argument for substantive unconscionability.[193] In addition, the terms of the C.R.A.C.K. contract potentially can impose a heavy obligation on the woman, depending on her individual circumstances. For one who planned to use birth control or did not want to have children, it is not much of a burden to send in some paperwork verifying the procedure. But viewed in the abstract, a woman who gives up her reproductive ability for at least one year and possibly permanently has taken on a significant obligation. There are potential complications and side effects with the use of any birth control, and then there are the obvious risks that accompany a sterilization operation. Contrasted with C.R.A.C.K.'s contractual obligation to pay $200, the terms may be very one-sided.

The procedural aspect of unconscionability considers those factors that affect a true and voluntary meeting of the minds of the contracting parties such as "age, education, intelligence, business acumen and experience, relative bargaining power, who drafted the contract, whether the terms were explained to the weaker party, [and] whether alterations in the printed terms were possible."[194] The potential difficulty with C.R.A.C.K. contracts is the voluntary meeting of the minds. Critics urge that the participants' agreement to the contract is not voluntary at all, that the women are coerced into agreement by the money.[195] These women have an addiction, and C.R.A.C.K. is obviously aware of it since the offer is only open to those with substance abuse problems.

Although the participants have no opportunity to bargain for different contract terms, the contract does provide the participants several options, such as choice of birth control and health care provider, and the program pays the same amount regardless of whether the participant selects long-term birth control or sterilization.[196] While C.R.A.C.K. may not explain the pros and cons of the different contraception options to the women, health care providers should provide this information and help the woman decide which, if any, is appropriate.[197] Having an independent health care provider also distances C.R.A.C.K. from influencing the woman's decision to some extent. Additionally, C.R.A.C.K. is not

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191. *See* ARTHUR LINTON CORBIN, CORBIN ON CONTRACTS § 5.15 (Joseph M. Perillo, revised ed. 1993). Generally, the law does not question the adequacy of consideration. *See id.*

192. *See Maxwell*, 907 P.2d at 59.

193. *See* discussion *infra* Part IV.B.

194. *See* Johnson v. Mobil Oil Corp., 415 F. Supp. 264, 268 (E.D. Mich. 1976) (internal quotations omitted); *see also* Kinney v. United Health Care Servs., Inc., 70 Cal. App. 4th 1322, 1329 (1999).

195. *See infra* note 237.

196. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

197. *But see* notes 248–249 and accompanying text (suggesting that a health care provider's biases may improperly influence the woman's choice of birth control).

providing an essential service for the women, such as food during a natural disaster, that would provide it with heightened bargaining power. Most of the women that participate in the program qualify for low or no cost birth control, so the $200 is not necessary to obtain contraception.[198]

Because finding unconscionability is such a fact-specific inquiry, it is challenging to predict a court's ruling in the abstract. The subject matter is questionable, but there are some checks on C.R.A.C.K.'s bargaining power by the involvement of an independent health care provider. The circumstances of the individual woman could plausibly swing the finding of unconscionability one way or the other.

2. Capacity to Contract

The mental capacity of a woman with a drug addiction arguably could make the contract voidable, if she was so impaired that she did not "understand in a reasonable manner the nature and consequence of the transaction" when agreeing to the contract.[199] This may be particularly relevant because C.R.A.C.K. clearly has notice of the individual's substance abuse problem, as it is a requirement to participate in the program.[200] It is very unlikely that a woman could accept C.R.A.C.K.'s offer (by performance) while physically under the influence of drugs; normally, a health care provider would not prescribe any long-term contraception or perform a sterilization in this circumstance. The question then becomes whether the woman's obligations should be voidable simply because she has a drug addiction, even though she may not be under the influence at the time the contract is formed.

Drug addiction alone is probably not enough for a court to consider a person incompetent. Illustrations of incompetence severe enough to make a party's contractual obligations voidable include brain damage caused by accident or organic disease, mental illness with symptoms such as delusions and hallucinations, and congenital intelligence deficiencies.[201] One could question whether the law should consider addiction an "incapacity" at all.[202]

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198. As of April 2000, all but two of the participants qualified for free birth control. Email from Barbara Harris, C.R.A.C.K. founder, to Jennifer Johnson (April 20, 2000) (on file with Author).

199. RESTATEMENT, *supra* note 187, §15(1)(a).

200. C.R.A.C.K.'s offer is open only to persons that have a substance-abuse problem. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/>. For a contract to be voidable due to lack of capacity, the contracting party must have notice of the other's impaired mental capacity. *See* RESTATEMENT *supra* note 187, § 15(1)(b).

201. *See* RESTATEMENT *supra* note 187, § 15 cmt. B.

202. The Supreme Court has forbidden making the status of being an addict a crime. *See* Robinson v. California, 370 U.S. 660, 675–76 (1962) (Douglas, J., concurring) (observing that a state law criminalizing the status of narcotics addiction violates the Eighth Amendment). It would be a punishment of sorts to addicts to make contracts entered into with addicts voidable. Others may be less likely to contract with them knowing the contract

Finding a C.R.A.C.K. contract unenforceable because it is unconscionable, or voidable due to the incapacity of the woman, offers little protection to program participants—it is too little too late for the woman seeking to avoid the contract. Given the structure of C.R.A.C.K.'s offer, no contract exists until the individual demonstrates acceptance by beginning the use of birth control or being sterilized. When the woman challenges the contract, she is already permanently sterilized or she must take steps to cease use of the long-term birth control.[203] In sum, an attack on the validity of the C.R.A.C.K. contract itself is a fairly ineffective way to reign in or regulate the program. Hence, analogous private contracts that are regulated despite their legality and validity are relevant to this inquiry.

B. Reproductive Rights in the Marketplace

The law can intervene on what would otherwise be private contracts in the name of public policy. States currently regulate private agreements when they involve reproductive rights and parent-child relationships in the marketplace.[204] In other words, when buying and selling occur in the context of family relations or reproduction, the state may permissibly impose regulations.[205] C.R.A.C.K. enters the marketplace by offering to "purchase" the non-use of a drug addict's reproductive ability. Although C.R.A.C.K. simply facilitates private agreements, public policy may nevertheless demand protection of the expectant mothers in the "reproductive marketplace."[206]

1. Use of Reproductive Ability—Surrogacy Agreements

There are many reasons, based on public policy concerns, why courts[207] and legislatures[208] are hesitant to recognize surrogacy agreements. Some aspects of the C.R.A.C.K. cash-for-contraception contract raise parallel public policy issues.

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may not stand. Furthermore, persons with addictions may not be under the physical influence of the drugs all the time and may function normally in society. A full discussion of this point is beyond the scope of this Note.

203. For example, an IUD is implanted in the woman's body and cannot be removed without medical assistance.

204. *See* Boyer, *supra* note 19, at 21.

205. *See id.*

206. *Id.*

207. *See, e.g., In re* Marriage of Moschetta, 30 Cal. Rptr. 2d 893 (Ct. App. 1994); R.R. v. M.H., 689 N.E.2d 790 (Mass. 1998); Matter of Baby M, 537 A.2d 1227 (N.J. 1988); *compare* Johnson v. Calvert, 851 P.2d 776, 783 (Cal. 1993) (en banc) ("In deciding the issue of maternity under the [Uniform Parentage] Act we have felt free to take into account the parties' intentions, as expressed in the surrogacy contract, because in our view the agreement is not, on its face, inconsistent with public policy.").

208. Some legislatures completely deny enforcement of surrogacy agreements. *See, e.g.*, ARIZ. REV. STAT. ANN. §25-218 (West 1998); D.C. CODE ANN. §16-402 (1997); N.Y. DOM. REL. LAW §122 (McKinney 1999). Other states have limited the circumstances in which a surrogacy agreement is lawful, such as when the surrogate is unpaid, or they

A surrogacy agreement is a private contract in which the biological mother, for a fee, agrees to conceive a child through artificial insemination, carry the child to term, and deliver the child.[209] Upon giving birth, the biological mother terminates all of her parental rights via adoption in favor of the other contracting party.[210] This differs from an adoption in that the woman is paid to give birth to a child she would not otherwise conceive, whereas adoptions involve arrangements made after the child is conceived.[211]

Because the contract is formed before conception, for the express purpose of giving the child up for adoption, surrogacy arrangements can straddle the line between a legitimate contract and "baby selling."[212] The sale of children is illegal in all states and may even violate the Thirteenth Amendment ban on servitude.[213]

Although decided with reference to state statutes, the *Baby M* case nevertheless illustrates additional public policy concerns with surrogacy contracts.[214] First, the court found these contracts run counter to state laws and policies regarding private adoptions, specifically: "(1) laws prohibiting the use of money in connection with adoptions; (2) laws requiring proof of parental unfitness or abandonment before termination of parental rights is ordered or an adoption is granted; and (3) laws that make surrender of custody and consent to adoption revocable in private placement adoptions."[215] Second, surrogacy ignores more general child welfare policies. The goal of adoption and child custody laws is the furtherance of the best interests of the child, yet the surrogacy contract's basic premise, that the natural parents can decide in advance of birth who is to have custody of the child, bears no relationship to the settled law in this area.[216] Another

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have limited who can be a surrogate. *See R.R.*, 689 N.E.2d at 793–94 (reviewing legislation addressing surrogacy agreements).

209. *See* Danny R. Veilleux, Annotation, *Validity and Construction of Surrogate Parenting Agreement*, 77 A.L.R. 4TH 70 (1989).

210. *See id.*

211. *See, e.g., In re* Marriage of Moschetta, 30 Cal. Rptr. 2d 893, 903 (Ct. App. 1994) ("[S]urrogacy is fundamentally different than adoption, which contemplates a child already conceived."); PATRICIA MCGEE CROTTY, FAMILY LAW IN THE UNITED STATES 110 (1999). With surrogacy there may be additional issues, since the woman carrying the child may not be the biological mother, as the embryo may not contain her genetic material. *See id.*

212. *See* discussion *supra* Part IV.B.2. *See Baby M*, 537 A.2d at 1242 ("Baby-selling potentially results in the exploitation of all parties involved....The negative consequences of baby-buying are potentially present in the surrogacy context, especially the potential for placing and adopting a child without regard to the interest of the child or the natural mother.").

213. *See* CROTTY, *supra* note 211, at 113; *see also* U.S. CONST. amend. XIII; ARIZ. REV. STAT. § 13-3625 (2000) (making the sale or purchase a child a felony); COLO. REV. STAT. ANN. § 18-6-402 (West 2000) (creating the felony of "trafficking in children"); WASH. REV. CODE ANN. § 9A.64.030 (West 1999) (delineating child buying and child selling as felonies).

214. 537 A.2d 1227 (N.J. 1988).

215. *Id.* (excepting, in the first clause, payment for health-care expenses and fees of approved non-profit adoption agencies) *See id.* at 1240.

216. *Id.* at 1242, 1246.

core policy is that children should remain with and be raised by their natural parents.[217]

Enforcement is also problematic with surrogacy agreements. Contract provisions may obligate the surrogate mother to submit to medical procedures, such as prenatal exams, and may require restraint from smoking and consuming alcohol. Required compliance with these terms may interfere with a woman's autonomy and right to personal freedom. [218] A court order requiring specific performance by the surrogate mother has the potential to interfere with the mother's individual rights to engage in otherwise legal activities, or she may be sued for breach of contract for failure to comply.[219]

Women serving as surrogates are usually from a lower socioeconomic class than the adopting parents.[220] There is a paternalistic concern that certain women, mainly poor women, need to be protected from exploitation.[221] Women in need of money may be more inclined to participate in surrogacy agreements while the wealthier adoptive parents derive the benefits from them.[222]

Because of the aforementioned problems, states have taken various approaches to limiting surrogacy agreements. Several prohibit the agreements completely, others refuse to enforce them, and some make the agreement a voidable contract.[223]

C.R.A.C.K. and surrogacy contracts share some important similarities. First, there is the potentially inappropriate or unconscionable subject matter of the contract–the use (surrogacy)[224] or disuse (C.R.A.C.K.) of reproductive ability.[225] Second, an expectant mother with a drug addiction is analogous to the surrogate mother in that they are may both be considered vulnerable to some extent.[226] As noted previously, surrogates tend to be poorer than the adoptive parents; with

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217. *Id.* at 1246–47.

218. *See* CROTTY, *supra* note 211, at 113.

219. *See id.*; *see also In re* Marriage of Moschetta, 30 Cal. Rptr. 2d 893, 903 (Ct. App. 1994) (mentioning that "there is also no doubt that enforcement of a surrogacy contract prior to a child's birth presents a host of thorny legal problems, particularly if such contracts were specifically enforced"). The court pondered: "What if a surrogate mother took drugs or alcohol during her pregnancy in violation of her contract? Or wanted an abortion? Could the contract be enforced by court order and subsequent contempt? Would there be a 'surrogate mother's tank' in the local jail?" *See id.* at 903 n.23.

220. *See* CROTTY, *supra* note 211, at 113. *Cf.* Margaret Jane Radin, *Market-Inalienability* 100 HARV. L. REV. 1849, 1930 (1987) (commenting that surrogates, while not "rich," are not necessarily the poorest either).

221. *See* CROTTY, *supra* note 211, at 113.

222. *See id*; R.R. v. M.H., 689 N.E.2d 790, 796–97 (Mass. 1998) (suggesting that financial incentives offered to surrogate mothers, "who may well be a member of an economically vulnerable class," may exert economic pressure to act as a surrogate).

223. *See* Veilleux, *supra* note 209, at 70.

224. The subject matter of a surrogacy could also be conceptualized as the fetus or infant itself.

225. *See* 17A AM. JUR. 2D *Contracts* § 295 (1991).

226. *See* discussion *supra* Part II.A.3.

C.R.A.C.K., the expectant mothers are being offered an amount that arguably can be considered nominal to all but the poor. The motivations for these women may indeed be the money in both cases.[227] Note that at the outset, the surrogates are not having children because they want to parent a child;[228] likewise, C.R.A.C.K. participants are often not using birth control consistently until the monetary offer is made.

C.R.A.C.K. departs from surrogacy on one key point—the public policy against "baby selling" does not come into play when contracting only for the disuse of reproductive ability. The C.R.A.C.K. contract also avoids some of the enforcement and bodily integrity problems because no contract exists until the woman accepts the offer by using long-term or permanent contraception. Thus, there is no need to use a court's contempt power to coerce the woman to have an IUD implanted, be sterilized, or use any of the other contraception options.

2. Commodification of Reproductive Ability

Part of the uproar over C.R.A.C.K. is a feeling that some things are considered sacred and thus beyond buying and selling on the market like a coffee pot or a T-bone steak.[229] Conceptualization of the use or disuse of a woman's reproductive ability as a commodity available for sale in the marketplace helps to illustrate why C.R.A.C.K. runs amok of current societal mores.[230] This feeling that some "things" should not be bought and sold may also be a way to justify the public policies behind the current regulation of particular private sales. For example, the law prohibits selling children, regulates surrogacy agreements, requires a social agency to intervene before a parent can surrender a child voluntarily,[231] and regulates the harvesting of fetal organs.[232] There is also ban on sale of human body parts, organs, and tissues for valuable consideration above and beyond the costs of the implantation process such as removal, transportation, and storage.[233] In fact, violation of the organ sale statutes is often a felony.[234] Some of

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227. This is not to say that all surrogate mothers are solely driven by money; one could have altruistic reasons for being a surrogate.

228. However, it may not be surprising that after the woman is successfully artificially inseminated, she would want to keep her baby, as was the case in *Baby M. See* Matter of Baby M, 537 A.2d 1227 (N.J. 1988).

229. *See, e.g.*, R.R. v. M.H., 689 N.E.2d 790, 796–97 (Mass. 1988) (noting that problems arise when a surrogate mother is offered compensation beyond pregnancy-related expenses).

230. *See generally* Radin, *supra* note 220.

231. *See* Boyer, *supra* note 19.

232. *See* Muwakkil, *supra* note 47, at A23.

233. *See, e.g.*, OHIO REV. CODE ANN. § 2108.12 (West 2000) (prohibiting the transfer of human organ, tissue, or eyes for valuable consideration); S.D. CODIFIED LAWS § 34-26-44 (Michie 2000) (making it a felony to sell or acquire human organs for valuable consideration); TEX. PENAL CODE ANN. §48.02 (2000) (prohibiting the transfer of human organs for valuable consideration); WIS. STAT. ANN. § 146.345 (West 2000) (acquiring or transferring any human organ for use in transplantation for valuable consideration is punishable by fine, imprisonment, or both).

these state controls are in place in part to protect vulnerable groups from exploitation.[235] The idea that a woman could sell her ability to have children, even for a limited time, seems to track the notions present in these laws. Reproduction is a personal matter. It could be argued that one's reproductive ability is such a personal concern that one should no put a price tag on it.

C.R.A.C.K. agreements, surrogacy contracts, and the sale of human organs share similar attributes, mainly the sensitive nature of the subject matter and the potential exploitation of one party. The intersection of reproductive rights, financial incentives, and a vulnerable contracting party hints that C.R.A.C.K. should be in the category of agreements that warrants closer inspection based on public policy, despite the fact that it is a private contract. But the private C.R.A.C.K. contract does not involve a child, which means that it also lacks some of the policy backing that justifies limiting surrogacy.[236]

V. C.R.A.C.K.'S DEFENSES

A. Voluntariness and Informed Consent Requirements

A common criticism of C.R.A.C.K. is that the financial incentive overcomes the participant's free will; therefore, the woman's use of birth control is not voluntary.[237] The most problematic version of the C.R.A.C.K. agreement is when the woman is sterilized, because it is essentially a permanent procedure. Yet this option is often subject to federal regulations that cut against the involuntariness argument.

Voluntary consent is an important element in medical procedures generally, but it is essential in the sterilization context if the procedure is to be "legal." [238] In the 1970s, a rash of sterilization abuse resulted in the passage of regulatory procedures[239] for sterilizations reimbursed under Medicaid or performed by health service programs supported in whole or in part by federal

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234. *See e.g.*, OHIO REV. CODE ANN. § 2108.99 (West 2000); S.D. CODIFIED LAWS § 34-26-44 (Michie 2000) (making it a felony to sell or acquire human organs for valuable consideration); WIS. STAT. ANN. § 146.345 (West 2000) (acquiring or transferring any human organ for use in transplantation for valuable consideration is punishable by fine, imprisonment, or both).

235. *See* Boyer, *supra* note 19, at 21; Muwakkil, *supra* note 47, at A23.

236. *See supra* notes 214–217 and accompanying text (discussing state laws and general child welfare policies).

237. *See* Smith, *supra* note 162, at A10; Muwakkil, *supra* note 47, at A23.

238. *See* 1 AM. JUR. 2d *Abortion and Birth Control* § 16 (1994).

239. During this period, doctors conditioned the performance of an abortion on consent to a concurrent sterilization; illiterate African American welfare recipients were tricked into sterilizing their teenage daughters, and Native American women were subjected to radical hysterectomies without the benefit of informed consent procedures. *See* Laurie Nsiah-Jefferson, *Reproductive Laws, Women of Color, and Low-Income Women, in* REPRODUCTIVE LAWS FOR THE 1990S 23, 46 (Sherrill Cohen & Nadine Taub eds., 1989); *see generally* STEPHEN TROMBLEY, THE RIGHT TO REPRODUCE 175–213 (1998) (reviewing the "sterilization explosion" and development of sterilization guidelines).

financial assistance.[240] In order to receive federal funds, health care providers must meet federally established informed consent requirements when performing sterilizations.[241] Any additional state or local consent requirements (with the exception of spousal consent) must also be met.[242]

Federal informed consent requirements are particularly relevant here. For the C.R.A.C.K. financial incentive to be profitable or persuasive to the woman, she would have to obtain a free sterilization or one at a reduced rate. Most likely, C.R.A.C.K. participants will use a federally funded or subsidized program or clinic to receive their counseling and birth control.[243] Reliance on subsidized clinics will subject the women to the informed consent requirements and provide some level of assurance that the procedure is voluntarily undertaken.

Concerns arise when the participants are not subject to the federal regulations, such as those women using an unsubsidized health care provider for a sterilization or those that opt for long-term birth control. Granted, the states may have regulations of their own for sterilizations, but they may also have shorter waiting periods from the time consent is given to the time of sterilization.[244]

The safeguards must be sufficient to overcome the persuasiveness of a financial incentive so that truly voluntary choices are ensured. C.R.A.C.K.'s critics claim that waiting periods may not offer enough protection in this situation.[245] In reality, there are other factors that influence and pressure particular groups of

240. *See* 42 C.F.R. §§ 50.201 (1999), 441.250 (2000). Sterilization services are provided by the states through Medicaid. The federal government reimburses the states for 90% of the cost. *See* Nsiah-Jefferson, *supra* note 239, at 47.

241. The individual to be sterilized must be at least 21 years old, mentally competent, and must give informed consent. *See* 42 C.F.R. § 50.203(a)-(c) (1999). At least thirty days, but not more than 180, must have passed between the date of informed consent and the date of sterilization. *See id.* § 50.203(d). Informed consent requires that the individual receive information on alternative methods of birth control, be advised that the procedure is irreversible, receive notice of the thirty-day waiting period, and receive a full description of the benefits and risks involved. *See id.* §§ 50.204(a), 441.257(a). Informed consent may not be obtained when the individual is "[u]nder the influence of alcohol or other substances that affect the individual's state of awareness." *Id.* §§ 441.257(b)(3), 50.204(e)(3).

242. *See id.* §§ 50.204(f), 441.257(a)(6). For examples of state requirements see CAL. CODE REGS. tit. 22, § 51305.1(a)(6) (2000) (requiring a waiting period of at least thirty days but no more than 180 days); FLA. STAT. ANN. § 766.103 (West 2000) (outlining the "Florida Medical Consent Law"); KY. REV. STAT. ANN. § 212.347 (Banks-Baldwin 2000) (setting forth waiting period requirements).

243. The program also offers referrals to Planned Parenthood or free clinics. *See* Smith, *supra* note 162, at A10. Some states may directly provide free services. *See, e.g.*, WASH. REV. CODE ANN. § 74.09.320, 74.09.310 (West 2000) (providing pharmaceutical birth control services and free tubal ligations for qualified persons admitted to chemical dependency treatment).

244. *See, e.g.*, KY. REV. STAT. ANN. § 212.347 (Banks-Baldwin 2000) ("No physician shall perform a nontherapeutic sterilization on any person before twenty-four (24) hours following the giving of written informed consent by the person requesting such sterilization.").

245. *See* Hornblower, *supra* note 164, at 47.

women to make certain choices regarding birth control. For example, the reproductive choices of minority and low-income women can be influenced by factors such as lack of access to prenatal care; lack of gynecological services; unnecessary reproductive surgery; lack of information about sex, birth control, and health; and domestic violence.[246] While these influences are not limited to minority and low-income women, the lack of publicly funded social and medical services may have a more noticeable effect on those populations.[247]

Although C.R.A.C.K. relies on independent health care providers to counsel women regarding the best form of contraception, physicians actually may detract from the voluntariness of the woman's choice.[248] Some physicians, unaware of a patient's preferences and cultural attitudes towards family size, regard excessive childbearing by poor and minority women as inappropriate.[249] They may urge sterilization or long-term birth control under the belief that some women are incapable of using other methods effectively.[250] Participants in C.R.A.C.K. can be especially susceptible to these pressures, because women with a history of substance abuse may be viewed as especially irresponsible and incapable of using short-term birth control contraception methods successfully. The physician's attitudes, albeit unconscious, are conveyed to the women, subtly leading them into accepting unwanted or inappropriate birth control.[251]

Another question is whether an individual in these circumstances can even give fully informed consent. Federal regulations state that consent to sterilization is invalid if given while under the influence of drugs or other substances that affect the person's state of awareness.[252] Although the regulations do not apply to other forms of birth control, in theory physicians should not prescribe long-term contraceptives to a woman under the influence of drugs either.

Aside from the direct physical influence of drugs, a woman with a drug addiction may be under a more subtle psychological influence that would cloud

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246. *See* Nsiah-Jefferson, *supra* note 239, at 45.

247. *See id.* at 45–47.

248. *See id.* at 47.

249. *See id.*

250. *See id.* This belief is not necessarily unfounded in the C.R.A.C.K. context. In one study of drug addicted women, researchers found that most of the women in the study did not practice birth control or long-range family planning techniques. *See* Murphy & Rosenbaum, *supra* note 12, at 49–53. The researchers cite a variety of reasons for the lack of birth control use including: the women's lack of sense of control over their own bodies and futures, high levels of exploitation and violent relationships, and the physical impact of drug use on their menstrual cycle. *See id.* Other women involved in "commercial sexual activities with strangers feared that insisting on a condom might cause them to lose a customer." *See id.* at 52.

251. *See* Nsiah-Jefferson, *supra* note 239, at 47–48 (commenting that physicians "convey these attitudes to their patients, who come to believe that they will not be accepted as patients unless they conform to the medical profession's analysis of their behavior and problems").

252. *See* 42 C.F.R. §§ 441.257(b)(3), 50.204(c)(3) (1999).

her judgment.[253] In a cash-for-contraception situation, a woman's contraceptive decisions may not be based on balancing the risks and benefits of each contraceptive option, but only on her impulsive desire for money to purchase her next drug "fix." She may be blind to the long-term consequences of her actions. It is entirely possible that in a few years a woman may be drug free and in a position to support a child and will regret her decision to be sterilized.

C.R.A.C.K. has several defenses available to the charge that the $200 offer is coercing women into contraception they would not choose voluntarily. Most important, a majority of the participants are subject to federal thirty-day waiting periods and medical counseling before they can be sterilized, which is the most drastic, and only permanent, option under the program. In fact, all but a handful of the C.R.A.C.K. participants qualified for free birth control through county clinics, Medicaid, or Planned Parenthood.[254] Even after giving consent for the sterilization, there is no requirement to undergo the procedure, and at no point in the process are the women under any obligation to begin the use of any form of birth control. The waiting periods insulate against hasty decisions and provide the woman sufficient time to consider her decision.

As discussed previously,[255] C.R.A.C.K. has also distanced itself from the woman's decision. First, participants choose an independent health care provider for counseling and selecting the appropriate contraception.[256] The physician should provide information regarding all forms of birth control, not just the methods eligible for the C.R.A.C.K. incentive. The potential for the personal biases of the physicians[257] to affect the women's' decision-making may be a legitimate concern, but it is not C.R.A.C.K. that is providing the biased counseling. Second, C.R.A.C.K. does not advocate sterilization over the use of long-term birth control.[258] The program offers several contraception options and pays equally for each.[259]

If money were truly the motivating factor behind the decision, logic suggests women would opt for the quickest and easiest way to satisfy C.R.A.C.K.'s requirements—this certainly would not be a tubal ligation, an

253. Leaders from Planned Parenthood and the American Civil Liberties Union have expressed concern that the cash offer will "coerce" poor drug users into making a decision they may regret later. *See* Smith, *supra* note 162, at A10.

254. Email from Barbara Harris, C.R.A.C.K. founder, to Jennifer Johnson (April 20, 2000) (on file with Author). As of April 2000, all but two of the participants qualified for free birth control. *See id.*

255. *See* discussion *supra* Part IV.A.

256. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

257. *See* notes 248–251 and accompanying text.

258. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>; *see also* Dixon, *supra* note 143, at A3.

259. The use of Depo-Provera, IUD, and Norplant all qualify for the $200 award. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/prevention/>.

invasive procedure requiring repeat appointments. In light of what the women are giving up, their reproductive ability, the amount of the monetary incentive, $200, seems quite small. It may be just enough to do what one was already inclined to do; for some women, pregnancy is truly an inconvenience, and they may have contemplated birth control beforehand. A Berkeley study suggests that a financial incentive or inducement for reproductive decisions is generally not the sole reason a program succeeds or fails.[260]

B. Constitutional Protection of Reproductive Rights

Broadly speaking, freedom of personal choice in matters of marriage and family life has found constitutional protection in the Due Process Clause of the Fourteenth Amendment,[261] the Equal Protection Clause of the Fourteenth Amendment,[262] and the Ninth Amendment.[263] The "rights to conceive and to raise one's children have been deemed 'essential, basic civil rights of man,' and 'rights far more precious than property rights.'"[264] There is a right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[265] A review of Supreme Court precedent makes it clear: "A woman has a constitutional privacy right to control her reproductive functions."[266]

A fundamental right should not be infringed upon without a compelling state interest and a showing that the interference is necessary because the state's interest cannot be protected in a less burdensome manner.[267] Under this theory, a woman has a constitutionally protected right to use birth control or be sterilized. Any attempts by the states to regulate the cash-for-contraception agreements may face strict scrutiny.

The first issue would be to determine what sort of interest the state has in the cash-for-contraception contract situation. It lacks two commonly recognized

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260. *See* Jeff Stryker, *Under the Influence of Gifts, Coupons and Cash*, NEW YORK TIMES ABSTRACTS, July 23, 2000 at § 4.

261. *See* Meyer v. Nebraska, 262 U.S. 390 (1923) (finding that parents have a right, protected by the Fourteenth Amendment, to give their children a suitable education through the study of the German language in a private school); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639–40 (1974) (citing several supporting Supreme Court decisions).

262. *See* Skinner v. Oklahoma, 316 U.S. 535 (1942) (protecting an individual's right to procreate by invalidating a sterilization law as violating the Equal Protection Clause).

263. *See* Griswold v. Connecticut, 381 U.S. 479 (1965) (striking down a statute prohibiting the use of contraceptives by referencing a right of privacy derived from several constitutional sources, including the Ninth Amendment).

264. Stanley v. Illinois, 405 U.S. 645, 651 (1972) (internal citations and quotations omitted).

265. Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

266. Cameron v. Board of Educ. of Hillsboro, 795 F. Supp. 228, 237 (S.D. Ohio 1991) (finding that a woman possesses the right to become pregnant by artificial insemination).

267. *See* Roe v. Wade, 410 U.S. 113 (1973).

interests; there is no viable fetus[268] and the health of the mother is not directly implicated.[269] One possible interest may be to prevent groups from motivating decisions about fundamental rights through the use of money. However, whether or not a woman is being paid by another private party regarding her basic reproductive rights may not rise to the level of a compelling state interest. The states may even have an interest that would support contraception—preventing the birth of children to parents who cannot afford to care for them.[270]

Another problem in attempting to regulate cash-for-contraception agreements would be in drafting legislation that was narrowly drawn so as not to infringe on a woman's exercise of her rights, but at the same time stop others, i.e. those offering cash, from interfering as well.[271] Odds are, there are other plausible and less burdensome ways to guard against financial coercion through means that do not involve direct regulation of, or a ban on, cash-for-contraception programs. For example, mandatory waiting periods for all sterilizations and long-term birth control, or requiring physicians to provide information on a range of alternate birth control methods, may protect against hasty decision-making without depriving a woman of her rights. An indirect benefit of these less intrusive options is that persons with drug addictions would not be impermissibly singled out, and the protections would extend to the public at large.

Part of the reason criminalization, fetal abuse statutes, and surrogacy raise such complex issues is because another batch of rights is implicated–those of the developing fetus. States have a compelling interest in protecting a viable fetus,[272] and in essence, balance the mother's rights against those of the fetus. Remove concerns over fetal rights, and the balancing weighs heavily in favor of a woman's right to make a decision regarding her reproductive ability. The lack of fetal rights to consider is one major advantage of a preventative cash-for-contraception agreement.

C. Other Considerations

The moral and ethical arguments for and against cash payments for sterilization are as volatile as they are varied. They touch upon topics beyond the

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268. *See id.* at 163–64 (noting the state's legitimate interest in fetal life after viability).

269. *See, e.g., id.* at 162 (discussing that states have an important and legitimate interest in protecting the health of a pregnant woman).

270. See CLARK, supra note 9, at 386 (suggesting, in the context of involuntary sterilization, that states may have an interest in preventing the "transmission of inheritable mental defects" and preventing "the birth of children to parents who are incapable of caring for them").

271. If a court or legislature tries to interfere with a woman's choice to participate in a cash-for-contraception agreement and "rules directly affect 'one of the basic civil rights of man,' the Due Process Clause of the Fourteenth Amendment requires that such rules must not needlessly, arbitrarily, or capriciously impinge upon this vital area of...constitutional liberty." Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639 (1974) (internal citations omitted).

272. *See Roe*, 410 U.S. at 163–64.

scope of this Note but are important to mention because they can shape and influence public policy, which is relevant in this context.

A frequent complaint is that C.R.A.C.K. is racist because it targets minorities and poor women.[273] The billboard campaign has placed billboards in almost exclusively urban minority neighborhoods,[274] and other advertising has been placed near welfare offices.[275] The short name of the program, C.R.A.C.K., is a drug that has historically been abused by poor, African American populations.[276]

C.R.A.C.K.'s response to the charges of racism is that the client base is racially mixed and that the group's founder is not personally racist, implying that the goals of her organization are not racially motivated either.[277] The racial breakdown of the participants includes 150 African American, 158 white, 34 Hispanic, and 13 participants of other backgrounds.[278]

A 1992 NIDA study illustrates the incidence of illegal drug use during pregnancy by racial and ethnic groups on a national level.[279] The survey estimates that 11.3% of African American women, 4.4% of white women, and 4.5% of Hispanic women use illicit drugs during pregnancy.[280] Although African American women had a higher proportion of drug use, white women represented the highest total number of pregnant drug users.[281]

The relative proportion of minorities in the communities and neighborhoods where C.R.A.C.K. is being promoted, however, may not be as diverse as the nationally representative NIDA study. If drug use during pregnancy is more prevalent among a particular ethnic group, and that ethnic group makes up a large portion of the population, then it would not be surprising to find more members of that group participating in C.R.A.C.K. Even if C.R.A.C.K.'s motives are strictly non-racist, it should not be overlooked that in practice, C.R.A.C.K. might draw more participants from a certain ethnic group.

Another aspect of C.R.A.C.K. that may affect public policy is what the women do with the $200; namely, whether they are buying drugs with it. One could question whether C.R.A.C.K. was indirectly supporting the woman's drug habit.

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273. *See, e.g.*, Cottle, *supra* note 20 at 16; Hornblower, *supra* note 164, at 47; Haynes, *supra* note 20, at 3.

274. *See* Boyer, *supra* note 19, at 21; Cottle, *supra* note 20, at 16.

275. *See* Smith, *supra* note 162, at A10.

276. *See* Cottle, *supra* note 20, at 16.

277. The founder is a white woman married to an African American man; they have adopted four African American children abandoned by the same drug addicted mother. *See* Haynes, *supra* note 20, at 3.

278. *See C.R.A.C.K. Children Requiring A Caring Kommunity* (visited Jan. 7, 2001) <http://www.cracksterilization.com/stats/stats.html>.

279. *See NIDA Survey*, *supra* note 26.

280. *See id.* The survey found that marijuana and cocaine are the most frequently used illicit drugs and found there was also a high incidence of legal drug use, mainly alcohol (18.8%) and cigarettes (20.4%). *See id.*

281. *See id.*

VI. CONCLUSION

The problem of fetal exposure to drugs and maternal substance abuse is a serious and costly one with rippling effects on the infants, mothers, and society at large. Yet, current state methods and legislative approaches are not effective in dealing with the problem. In many circumstances, such as criminal prosecutions, these state approaches may actually increase the risk of harm to the developing fetus and infringe on women's constitutional rights.[282]

C.R.A.C.K. has devised a privately funded, cost-effective, and most notably, preventative alternative to state action–a cash-for-contraception contract. The participants are able to choose from a list of contraception options and are counseled by an independent physician before making their decisions regarding birth control.[283]

Yet, public policy or the unsavory idea of reproductive ability being a commodity to be bought and sold on the marketplace, may demand precautions similar to those in surrogacy agreements or the sale of human organs.[284] An analogy to these similar types of private contracts implicates public policies that could discourage courts from enforcing a cash-for-contraception contract. Similarly, private contracts requiring a woman to limit her reproductive capacity could exist, but be unenforceable due to the substantive unconscionability of the terms.[285]

Additionally, in a cash-for-contraception agreement there is a potential concern over abuse, coercion, and exploitation.[286] Pregnant women possess a right to personal privacy and autonomy with regard to reproductive choices. For women to give up this right it should be clear that they are choosing to do so of their own free will. Federal informed consent and waiting period requirements do offer some measure of protection and time for reflection when participants opt for permanent birth control and almost all of C.R.A.C.K.'s participants that chose sterilization were covered by these federal protections.[287] However, these safeguards may be lacking in the private sector or with the use of long-term birth control methods. Unless states have legislation that mandates protections similar to those of the federal government, it would be prudent to include safeguards that distance the party offering cash from direct involvement with the other party's contraception choice.

That is not to say that all cash-for-contraception agreements should be allowed to operate unchecked. Aside from the moral and ethical arguments, there are still unanswered questions with regard to C.R.A.C.K.'s potentially discriminatory effect on minority and low-income women, however, the

282. *See* discussion *supra* Part II.B.1.
283. *See* discussion *supra* Part III.
284. *See* discussion *supra* Part IV.
285. *See* discussion *supra* Part IV.A.
286. *See generally* discussion *supra* Part IV.
287. *See* discussion *supra* Part V.A.

disproportionate effect on minority groups may be explained by the prevalence of drug use in particular ethnic groups.[288]

This comes down to a balancing act between the different facets of the maternal substance abuse picture—maternal rights, ineffective and misguided state alternatives, cost-effectiveness, risk of harm to fetuses in utero, fetal rights generally, preventive as opposed to reactive measures, a woman's freedom to contract, and her fundamental right to control her reproductive decisions. C.R.A.C.K. appears to have devised a private cash-for-contraception agreement that avoids many of the issues that arise when a fetus enters the equation. As the program continues to grow, it chips away at the number of babies that are exposed to drugs because of their mothers' behavior while pregnant. While this Note is not a wholesale approval of a cash-for-contraception agreements, and without passing on the moral or ethical implications, C.R.A.C.K.'s specific agreement structure (and the way it plays out in practice)[289] provides an alternative—one focused on *prevention.*

288. *See* discussion *supra* Part V.C.

289. With a majority of the participants seeking sterilization subject to federal informed consent requirements.