



# **Tennessee's Fetal Assault Law:** Understanding its impact on marginalized women

*"I just want pregnant women or people that just had kids into addictions to have the chance to make amends and make it right instead of taking our lives."*

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# Table of Contents

Executive Summary .....	4
Background.....	6
<b>The state of Tennessee</b> .....	6
<b>Drug use in the state</b> .....	6
<b>The Fetal Assault Law</b> .....	7
<b>The law in practice</b> .....	10
<b>Impact of the law</b> .....	11
<b>Advocates fight back</b> .....	11
Study aim and significance.....	13
Methods.....	14
<b>Ethics review</b> .....	15
<b>Recruitment</b> .....	15
<b>Data collection</b> .....	16
<b>Analysis</b> .....	17
Results .....	17
<b>Participant background</b> .....	17
<b>Aim one: Understand women’s experiences with the Fetal Assault Law and its impact on their lives and families</b> .....	18
Experience of women directly impacted by the Fetal Assault Law.....	19
Experience of women indirectly impacted by the Fetal Assault Law.....	23
<b>Aim two: Understand the social support services available to women struggling with drug dependency before, during, and after their encounter with the law</b> .....	24
Social support .....	25
Structural support .....	26
<b>Aim three: Generate recommendations to inform policy and practice guidelines for future treatment provision</b> .....	27
Recommendations, state/medical providers/community .....	27
Limitations.....	29
<b>Challenges recruiting directly impacted women</b> .....	29
<b>Challenges identifying and recruiting women who avoided arrest</b> .....	29
<b>Challenges collecting information</b> .....	29
Implications .....	30
Strengthening the evidence.....	30

New evidence.....	32
Recommendations.....	36
Conclusion.....	37
References.....	38
Appendix I: Screener, fetal assault listening session .....	43
Appendix II: Demographic table.....	45

## Executive Summary

In 2014, a bill (S.B. 1391) was passed that allowed the state of Tennessee to arrest pregnant women for the illegal use of narcotics during pregnancy if the child was born addicted to or harmed by the drug. Those arrested and charged under the Fetal Assault Law faced a penalty of up to 15 years in prison and loss of child custody. Prior to this legislation, and with the exception of a law penalizing inhalation of chemical fumes,<sup>1</sup> no one in Tennessee (pregnant or not) could be arrested or punished for using or being dependent on drugs. Therefore, this legislation made drug use (as opposed to possession) a special crime *only* for pregnant women.

Opponents of the legislation, including SisterReach, Healthy and Free Tennessee, Young Women United, and National Advocates for Pregnant Women rallied unprecedented local, national, and international support against the criminalization of pregnant women. More than 10,000 people signed a petition asking Tennessee Governor Bill Haslam to veto the law. Despite the extraordinary efforts of these groups, the law stayed in effect until July 1, 2016.

During the years the law was in effect, a reported 124 women were arrested statewide. More importantly, early assessments of the impact of the law showed that pregnant women were avoiding prenatal care, fleeing Tennessee to give birth in neighboring states, and giving birth at home rather than in hospitals. Additionally, the law seemed to disadvantage women who traditionally have poor access to health care services. In 2017, SisterReach launched a qualitative study to document the experiences of marginalized women, defined as women with limited financial, social, geographical, and legal assets or living in rural areas of the state, directly and indirectly impacted by the Fetal Assault Law. Through listening sessions with 41 women, we gained a better understanding of the factors that placed these women at increased risk for drug use, increased the harms from criminalization, and made them unlikely to benefit from mandated treatment initiatives as operationalized under the Fetal Assault Law.

Eighty percent of the women in our listening sessions were raised in households where substance use was common. More than two-thirds of the women were unemployed at the time of the discussion and reported having had sex in exchange for money, drugs, or other basic needs over the course of their life. The stress of limited finances was compounded by a history of domestic and sexual abuse for almost all participants—highlighting the impact of adverse childhood and adult life experiences and the vulnerability of substance using women.

Twenty-eight of the 41 women in the listening sessions reported being arrested and charged under the Fetal Assault Law. From their stories, we corroborate early findings that charges under the law varied, with some women arrested and charged based on a diagnosis of neonatal abstinence syndrome (NAS) in the child and others on positive screens of their own blood/urine for drugs. Further, we confirm that women delayed and, in some cases, avoided prenatal care altogether—a key finding for advocates working to better understand social and behavioral conditions affecting high maternal morbidity rates currently experienced by Tennessee mothers. We add to the knowledge base by showing the indelible impact of custody loss on women’s well-being and the insufficiency of a 28-day detoxification program as a treatment option. The loss of a child was upsetting and resulted in some women resuming drug activity to cope with the stress of loss. Challenges with child protective services, lack of structural

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<sup>1</sup> Only one Tennessee law criminalizes ingestion of a substance (as opposed to possession of an illegal substance), and that provision only applies to improper inhaling of chemical fumes. T.C.A. § 39-17-422.

supports, and personal challenges made it impossible for many women in the study to regain custody of their children. Women able to avoid arrest under the law did so by delivering across state lines, electing to have an abortion, attempting to detox, and avoiding prenatal care. Women report being triggered to take action based on reports of the law via media, by the experiences of other substance using women who were arrested, and medical providers during prenatal care visits.

The ability of marginalized women to navigate the court system once charged, to regain custody of their children, to successfully complete the treatment program, and to avoid relapse was dependent on the strength of their support system. From women’s stories, we learn that a lack of family and partner support, as well as finances, made it difficult to retain custody of their children once charged. Limited availability and/or access to support groups and parenting classes reduced their abilities to meet some of the criteria to regain custody and having a felony charge reduced their chances of finding stable housing and employment. In sum, these women—already at a higher risk for drug use relapse—needed more than detoxification, they needed environments that reduce barriers to care before and during drug use, and post drug rehabilitation.

According to lawmakers, the objective of the Fetal Assault Law was to reduce the use of opioids during pregnancy and the number of infants born with NAS. However, an increase in NAS diagnoses during the enactment period reveals that the law was ineffective. Our conversations with women show that the law was widely applied to substance-using pregnant women residing in Tennessee and that the use of criminal penalties was counterproductive to the well-being of women and their families. In particular, the law endangered the lives of substance-using pregnant women and their infants, as many women delayed or went without prenatal care due to fear of arrest and custody loss. Based on our findings we recommend that lawmakers, law enforcers, and the medical community apply a reproductive justice analyses before crafting, passing, or enforcing policy that bears the greatest impact for already vulnerable women. Further, we recommend 1) expanding behavioral health and treatment programs that include housing specifically for low-income women who are pregnant and women who already have children to decrease the rate of recidivism in rehabilitation programs and to keep families together, 2) providing counseling and social supports to impacted children and families while mothers participate in rehabilitation programs, and 3) providing transitional housing and other wrap-around service support to women who remain homeless due to the economic impact of participating in rehabilitation treatment.

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

Cherisse A. Scott, Founder & CEO,  
SisterReach, Memphis

## Background

### **The state of Tennessee**

Tennessee ranks in the top 20 for most densely populated states, with an estimated population size of 6.72 million.<sup>1</sup> The state has the tenth largest percentage of African American residents at 17.1% but smaller percentages of other ethnic and minority groups such as Hispanic or Latino (5.5%), Asian (1.9%), and Native Hawaiian and Other Pacific Islander (0.1%).<sup>1</sup>

In relation to quality of life and general health measures, Tennessee performs slightly better than its neighbors to the north (Kentucky, Indiana, and Ohio) and south (Alabama, Mississippi, and Arkansas), but ranks below its neighbors to the east (North Carolina, South Carolina, Georgia, and Virginia).<sup>2</sup> According to the US Census Bureau, the median household income for Tennessee in 2016 was \$46,574, and approximately 15% of residents had incomes below the poverty threshold.<sup>1</sup> Insufficient financial resources limit many Tennesseans from accessing necessities, such as food and housing. Seventeen percent of households in Tennessee experienced food insecurity in 2014,<sup>3</sup> and 11% of homeowners and 23% of renters spent greater than 50% of their income on housing in 2015.<sup>4</sup> Limited finances also prevent many Tennesseans from furthering their education, which could provide opportunities to increase their income and improve their standard of living. In 2016, only 23% of adults over the age of 25 had a two- or four-year college degree,<sup>5</sup> and graduation rates for African Americans were significantly lower than the rate for Whites for both two- or four-year institutions between 2005-2009.<sup>6</sup> In addition, the income poverty rate for African Americans was double that of Whites in 2017.<sup>7</sup>

Low household incomes, low levels of education, and insufficient access to health insurance contribute to poor health outcomes for many Tennesseans. Life expectancy, averaged across sex and race for Tennesseans born between 2009 and 2011, is 76.4 years, 2.1 years shorter than the national average.<sup>8</sup> This lower life expectancy correlates with a high prevalence of risk factors for non-communicable chronic diseases, such as obesity and diabetes.<sup>9</sup> Racial and ethnic minority populations in Tennessee have poorer child and adult health outcomes than their White counterparts.<sup>9</sup> As an illustration, the infant mortality rate from 2011 to 2013 was two times higher for African American infants compared with White infants in the state.<sup>10</sup> Similarly, mortality rates for heart disease in 2004 and cancer between the years of 2010-2014 were significantly higher for African Americans than their White counterparts.<sup>11,12</sup>

Limited finances, a lack of basic necessities, environmental violence, housing instability, and insufficient access to health care and other social services—a theme for many living in Tennessee—can lead to chronic stress and result in drug use and abuse as a coping strategy.<sup>13</sup> African Americans, immigrants, and other racial/ethnic minority populations may be especially at risk for chronic stress and alcohol and drug abuse due to racism and discrimination. Experience of racism and discrimination has been linked with higher levels of chronic stress and diminished well-being.<sup>14-16</sup> Further, racism has been shown to play a role in unhealthy behaviors, such as alcohol and drug abuse.<sup>17</sup>

### **Drug use in the state**

Alcohol is the most commonly used addictive substance among adults in Tennessee.<sup>18</sup> Alcohol is attributed to 20% of all fatal motor vehicle accidents occurring in Tennessee yearly and to 640 deaths in the state in 2014.<sup>18</sup> Marijuana was the most prevalent illicit substance used in the state in 2016, with 5.2% of adults aged 18 or older using marijuana.<sup>18</sup> Similar rates of use were observed for prescription

medications with approximately 4.1% of adults (18 years and older) misusing prescription medications in 2012-2014. Deaths in Tennessee due to drug overdose increased between 2013-2016, and the proportion of these deaths involving any type of opioid increased from 64.7% to 72.7%.<sup>19</sup> Of the criminal offenses statewide in 2015 that involved drug seizures, approximately two-thirds (6,775 criminal offenses) involved opioid and opioid related drugs.<sup>18</sup> Possession of a controlled substance such as opioids carries heavy penalties in Tennessee, including suspension of a driver's license, forfeiture of property, jail and/or prison time, fines, and/or probation.<sup>20</sup> People living in rural areas and having low income are a high-risk group for opioid use disorder.<sup>21</sup>

### **The Fetal Assault Law**

The prescription drug epidemic in the state coincided with a rising incidence of neonatal abstinence syndrome (NAS), a temporary non-fatal condition experienced by infants exposed to opiates or other narcotics while in utero.<sup>22</sup> To address the increase in NAS, a subcabinet working group was created in 2012,<sup>23</sup> and a year later the Tennessee Department of Health added NAS to the department's list of "reportable diseases and events,"<sup>24</sup> making Tennessee the first state to implement a mandatory statewide NAS monitoring system.<sup>25</sup> That same year, the section of the Tennessee Code pertaining to criminal offenses was amended so that the definition of a person included an embryo or fetus at any gestational age. The code was also amended to clarify that the law should not be used to prosecute individuals with respect to their pregnancies.<sup>26</sup>

Further, the General Assembly of Tennessee enacted the Safe Harbor Act of 2013, which prioritized pregnant women referred for drug treatment if they received public funding and were no more than 20 weeks pregnant.<sup>27</sup> The act provided "safe harbor" from civil child abuse actions by Tennessee's Department of Children's Services (DCS) if the pregnant woman initiated and complied with treatment throughout the rest of her pregnancy. While the Safe Harbor Act intended to protect the health and welfare of newborns and encouraged women to seek treatment, the legislation had no enforcement mechanism to ensure pregnant women were given priority for treatment. In addition, there were no other supportive programs in place through the state's health program that would facilitate entry into a drug treatment program, such as Medicaid expansion<sup>28</sup> or covered methadone treatment<sup>29,30</sup>—the gold standard of care for people dependent on opioids.<sup>31</sup>

Some legislators and groups did not believe the Safe Harbor Act would sufficiently protect newborns and pushed for the passage of more punitive measures. For example, District Attorney of Memphis Amy Weirich argued that the threat of jail was needed as a "velvet hammer" to force mothers into court-supervised drug treatment.<sup>32</sup> In 2014, a bill (S.B. 1391) was passed that allowed the state to arrest pregnant women for the illegal use of narcotics during pregnancy if the child was born exposed to or harmed by the drug.<sup>33</sup> Notably, a sunset date of July 1, 2016 was added to the bill. The sunset clause meant the law would only remain in effect for two years unless the legislature specifically voted to reenact the law.



SB 1391 added the following language in *italics* to the already existing “Fetus as Victim” provisions of the State’s criminal code:

T.C.A. § 39-13-107. Fetus as victim.

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

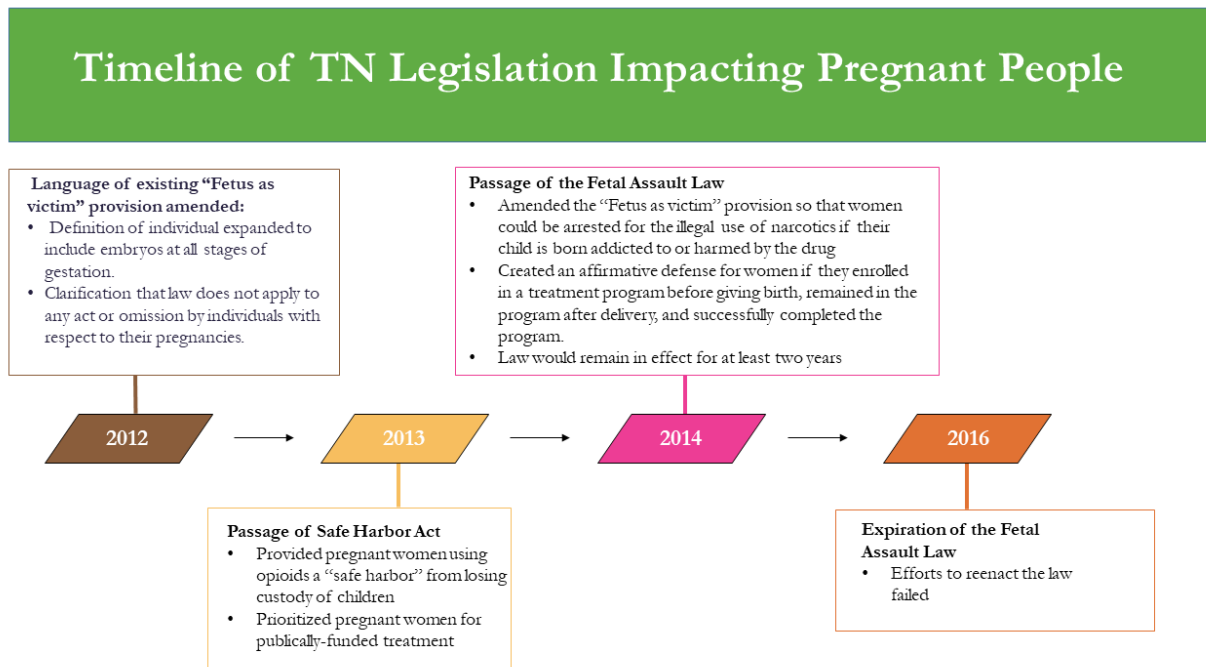
(b) Nothing in this section shall be construed to amend the provisions of § 39-15-201, or §§ 39-15-203 -- 39-15-205 and 39-15-207. [Provisions related to abortion.]

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

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

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

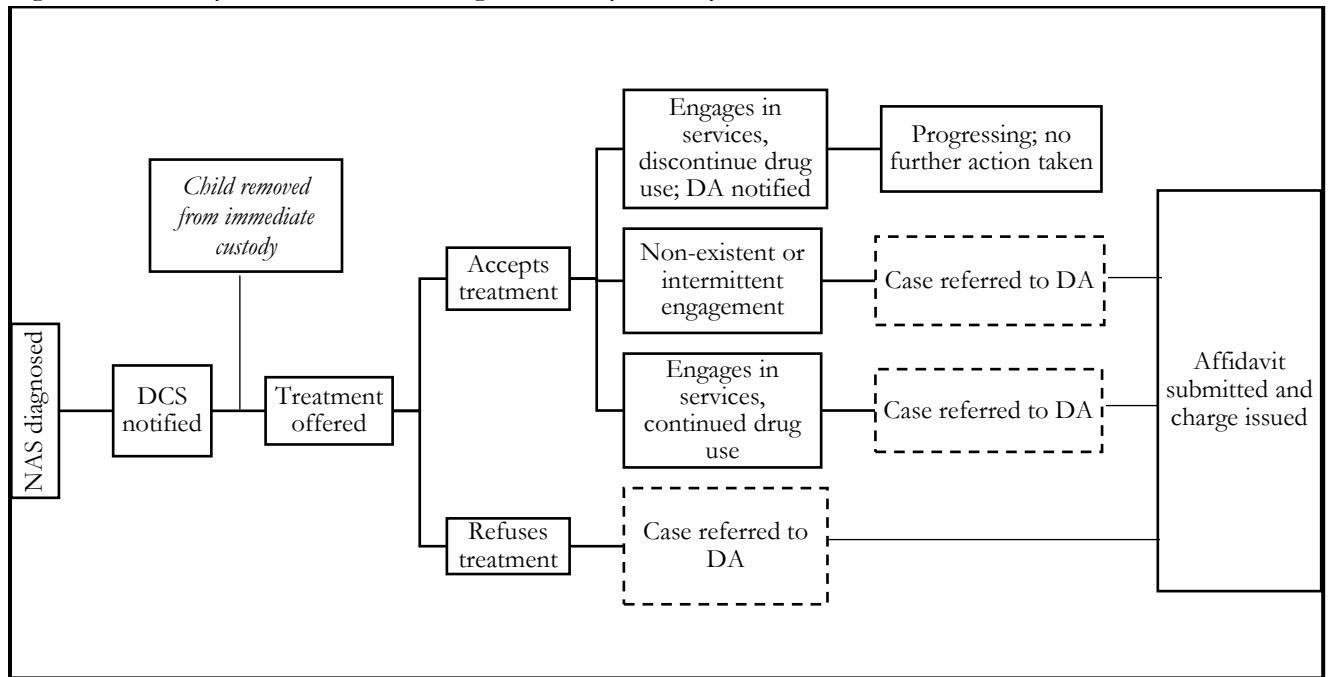
The timeline below displays the laws passed between 2012 and 2016 that impact pregnant individuals in Tennessee:



Thus, between July 1, 2014 and July 1, 2016, women living in Tennessee could be charged with fetal assault if the infant she carried was born drug-dependent due to the use of illegal narcotics during pregnancy under SB 1391, also known as the Fetal Assault Law or the Fetal Homicide Law. The stated rationale for the law was to reduce the use of opioids during pregnancy and the number of infants born with NAS. Those arrested and charged under the Fetal Assault Law faced a penalty of up to 15 years in prison and loss of child custody.<sup>34</sup>

The pathway to a fetal assault charge varied across the state. However, the steps taken in Shelby County (Memphis, Tennessee)—the county with the highest documented rates of arrested women under the law—<sup>35</sup>were as follows: at the instance of a birth, an infant exhibiting signs of or suspected of having NAS was tested and a diagnosis determined. If the infant tested positive for a narcotic or a non-narcotic drug, the Department of Children’s Services (DCS) was notified and the child was removed from the immediate custody of the woman. A treatment program was then offered to the woman facing charges. If the program was accepted, the woman would be linked to services and monitored. If the woman refused the program or failed to complete the program, the case was referred to the District Attorney’s (DA’s) office, which determined what charges would be filed. The DA’s office was also alerted when the woman accepted the program to verify the woman’s compliance with the program post-partum. If the woman was complying with the treatment program and progressing, no further action was taken. However, if participation was non-existent, intermittent, or there was continued drug use, an affidavit was submitted and the woman could be charged with fetal assault.<sup>36</sup> If charged, the Child Protective Services unit was then brought into the case usually to remove children under the age of 18 from the woman.<sup>36</sup> Children were either brought into state custody and placed in foster care, or placed in the custody of a suitable relative.<sup>36</sup>

Figure 1: Pathway to fetal assault charge in Shelby County



*Dashed lines = intermediary step that could but doesn't always occur*

### The law in practice

In practice, the Fetal Assault Law was applied beyond its singular target: women who used narcotics illegally while pregnant and whose child was born addicted to or harmed by the narcotic drug or addiction as a result of drug use while pregnant. The 2014 law added broad and undefined language (e.g. no definitions for addicted or harmed) that gave the state the authority to punish women if they intentionally, unknowingly, or recklessly (no intent needed) risked or caused bodily injury to fertilized eggs, embryos, or fetuses as a result of *any* unlawful act or unlawful omission. Additionally, the law seemed to disadvantage women who traditionally have poor access to health care services. Of the women arrested, the majority were low-income women, women in poorly-resourced areas, and women of color.<sup>30</sup> Charges for these women included: 1) giving birth to a child who tested positive for a non-narcotic drug;<sup>37</sup> 2) giving birth to a child who tested positive for a narcotic or other kind of drug but who was not determined to be “addicted” to or “harmed” by exposure;<sup>38</sup> 3) risking harm to a fetus by driving while pregnant without a seat belt and for fleeing from the police while pregnant;<sup>39</sup> and 4) attempting to self-abort a pregnancy.<sup>40</sup>

The law provided an “affirmative defense” for women charged with fetal assault, which allowed women to introduce evidence that could potentially negate their criminal liability for the crime allegedly committed.<sup>41</sup> According to the law, a woman who was arrested could argue that she should not be convicted and punished because she had “actively enrolled in an addiction recovery program before the child [was] born, remained in the program after delivery, and successfully completed the program.”<sup>33</sup> However, in practice, exercising this affirmative defense was difficult because it could take years for someone to “complete” treatment;<sup>42</sup> as previously mentioned, the gold standard of care for pregnant opioid users is ongoing medication treatment with methadone or buprenorphine.<sup>31</sup> In addition, the legislation provided no exception or defense for women who sought treatment but were turned away, could not find treatment, or could not afford treatment.

Moreover, the law did nothing to make treatment more widely available to the women who needed and wanted treatment throughout the state of Tennessee. This is particularly important to consider for pregnant women living in rural counties in the state. At the time it was passed, there were significant barriers to accessing comprehensive and affordable health care in Tennessee, including all forms of drug treatment. In 2010, an estimated 106,000 adults in the state needed, but had not received, treatment for a drug dependency problem.<sup>43</sup> Of the 177 treatment facilities throughout Tennessee, only 19 in the entire state listed themselves as serving pregnant women.<sup>44</sup> Even if there were an adequate number of treatment facilities, such programs were often not accessible because of transportation barriers, cost, waiting lists, and a lack of child care and mental health services, all of which made it extremely difficult for many people to access treatment—particularly in the short time frame of pregnancy. The statute contained no provisions for additional funding allocated for treatment, nor did it remove any of the existing barriers to treatment in the state.

### **Impact of the law**

The lack of a centralized database to track arrests makes it difficult to quantify the impact of the Fetal Assault Law. A desk review from Attorney Wendy Bach at the University of Tennessee College of Law reported that 124 women were arrested statewide. Women were charged with a combination of charges under the law.<sup>45</sup> Discrepancies in the number charged depended on what charges were filed at the time of arrest versus the actual charge and conviction. One article by Eliza Duggan states, “These assaultive offenses included simple assault, aggravated assault, reckless endangerment, vehicular assault, and criminal exposure of another to HIV, among others.”<sup>46</sup> A survey of District Attorney Generals conducted after the first six months the law was in effect revealed that 28 cases had been initiated for prosecution throughout ten judicial districts, with a greater number of cases in the western part of the state.<sup>47</sup> No cases of affirmative defense were raised in these first six months, although one office declined to prosecute cases where the woman had already sought drug treatment.<sup>47</sup>

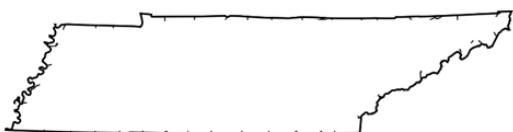
Initial findings six months after the law was enacted found that prosecutions resulted in more women choosing treatment than up-front jail time.<sup>47</sup> However, an investigative report documented that the 2014 law also had a profound effect on pregnant women who feared arrest. Pregnant women reported avoiding prenatal care, fleeing Tennessee to give birth in neighboring states, and giving birth at home rather than hospitals.<sup>48</sup> In other cases, fear of incarceration prompted substance-using pregnant women to seek an unwanted abortion.<sup>49,50</sup> These observations align with findings from the National Advocates for Pregnant Women (NAPW) study that showed that fear of arrest and forced intervention deterred pregnant women from seeking help for themselves and, in some cases, their infants.<sup>51</sup> Of note, analyses of the state’s NAS monitoring system showed **no decrease** in NAS diagnoses during the period of time when the law was in effect.<sup>22</sup> Although the law went out of effect on July 1, 2016 and no other women were charged under the Fetal Assault Law, women charged during the effective time period still faced prosecution years following its sunset.

### **Advocates fight back**

A multipronged advocacy effort was launched to block the passage of the fetal assault law. SisterReach in consultation with Young Women United, a New Mexico-based reproductive justice organization with experience defending women throughout their state, led a reproductive justice-informed strategy around messaging. This strategy involved SisterReach penning a letter to former Governor Haslam asking him to consider not signing the bill into law, NAPW drafting two open letters, one addressed to the media and Tennessee legislators,<sup>52</sup> and the other to the Tennessee Medical Association,<sup>53</sup> the

state's lone medical association supporting the law. The open letter to legislators corrected misconceptions propagated by many media outlets about NAS, and highlighted how such misinformation stigmatized women and their children.<sup>52</sup> In their open letter to the Tennessee Medical Association, NAPW reprimanded the association for a commentary written by the association's president, arguing that it failed to address physicians' role in the increase of opiate usage, revealed a lack of knowledge about NAS and its treatment, and showed a disregard for the dignity of patients and their families."<sup>53</sup>

## Advocates at the state and national levels



### State-based partners

- American Civil Liberties Union-Tennessee
- Healthy and Free Tennessee
- Nashville CARES
- SisterReach
- Tennessee Association of Alcohol, Drugs & Other Addiction Services




### National partners

- National Advocates for Pregnant Women
- RH Reality Check (now Rewire)
- SisterSong
- WV Free
- Young Women United

National partners provided legal, communications, and grassroots advocacy expertise to complement state-based efforts. Together, these advocacy efforts rallied local, national, and international media opposition to the use of criminal law to address pregnancy outcomes and drug usage. They also secured support from medical associations as well as from drug policy reform groups such as Law Enforcement Against Prohibition, and from the acting director of the White House Office of National Drug Control Policy under the Obama Administration. Healthy & Free Tennessee and their partners obtained more than 10,000 signatures on a petition asking the Governor to veto the law.

# Medical associations & organizations against the Fetal Assault Law

- 
- American Academy of Pediatrics
  - American College of Obstetricians and Gynecologists
  - American Medical Association
  - American Nurses Association
  - American Psychiatric Association
  - American Psychological Association
  - American Public Health Association
  - American Society of Addiction Medicine
  - Association of Family and Conciliation Courts
  - Association of Maternal and Child Health Programs
  - Center for the Future of Children
  - Coalition of Alcohol and Drug Dependent Women and Their Children
  - March of Dimes
  - National Association for Perinatal Addiction Research & Education
  - National Association of Public Child Welfare Administrators.
  - National Council on Alcoholism and Drug Dependence
  - National Organization on Fetal Alcohol Syndrome
  - National Perinatal Association
  - Southern Legislative Summit on Healthy Infants and Families

To garner support and raise awareness at the international level, SisterReach and Healthy and Free Tennessee presented to the United Nations Working Group on the Issue of Discrimination against Women in Law and Practice (UNWGDAW), detailing the conditions vulnerable women and families experienced in the state due to the implementation of the Fetal Assault Law.<sup>54</sup>

## Study aim and significance

Efforts to repeal the Fetal Assault Law were met with limited success due in part to the small evidence base on the impact of the law on substance-using women before, during, and after imprisonment or participation in a mandated treatment program. A more systematic documentation of the lived experience of this community was needed to center the voices and experiences of those most impacted to help inform state and medical communities on the best ways to honor and implement patient centered and patient led care to produce optimal health outcomes. Further, research in this area would 1) inform lawmakers, medical providers, and the public about the implementation and repercussions of this law; 2) highlight other areas of oppression that intersect with the law's impact; and 3) bolster advocacy efforts to improve policy and practice guidelines for substance-using pregnant women in Tennessee, as well as in the growing number of states considering pregnancy criminalization legislation.

Therefore, SisterReach launched a study to explore the perspectives of marginalized women, defined as women with limited financial assets or living in rural areas of the state, regarding the Tennessee Fetal Assault Law and its impact on their lives. This study uses the reproductive justice framework to better understand the experiences of women impacted by a law that violated these fundamental rights. The reproductive justice framework is a human rights framework coined in 1994 by twelve African American women attending a conference sponsored by the Illinois Pro-Choice Alliance and the Ms. Foundation for Women. Over the last 25 years, the framework has evolved to center these six core principles:

Every woman and individual has the human right to:

1. Decide if and when they will have a baby and the conditions under which they will give birth, adopt or parent
2. Decide if they will not have a baby and their options for preventing or ending a pregnancy
3. Parent the children they already have with the necessary social supports in safe environments and healthy communities, and without fear of violence from individuals or the government
4. Bodily autonomy free from all forms of Reproductive Oppression
5. The right to express sexuality and spirituality without violence or shame
6. A quality of life and sustainability before and beyond the ability to give birth or parent

The group applied black feminist theory as the foundational lens to inform what is now understood today as the reproductive justice framework. It is important to note that their work offered a unique race, class, and gender lens that centered the unique experiences of African American women—a model that is sure not to leave any marginalized woman or individual on the margins.

**The specific objectives of this study were to:**

1. Understand marginalized women’s perspectives on and experiences with the Fetal Assault Law and its impact on their lives and families
2. Understand the social support services available to women struggling with drug dependency before, during, and after their encounter with the law
3. Receive and offer recommendations to inform policy and practice guidelines for future treatment provision regarding pregnant women struggling with drug dependency in Tennessee and other states

## Methods

The study used a qualitative design to collect information through focus group discussions, hereafter referred to as listening sessions, from women who were directly impacted (defined as arrested and charged under the Fetal Assault Law), as well as women who were indirectly impacted (defined as able to avoid arrest due to obtaining treatment, having abortion, or crossing state lines to give birth) and in-depth interviews (IDIs) with a smaller number of directly impacted women.

To ensure the study design, implementation, and analysis of the data collected accurately captured and contextualized the experiences of women living in Tennessee that were affected by the law, we applied a stakeholder engagement approach combined with a reproductive justice lens (human rights approach) to the study. The stakeholder engagement approach is one where key stakeholders actively engaged in providing service or analysis about the communities’ health and social well-being, have the opportunity to participate in all stages of the research process, from the conception and design of the research study to the analysis and dissemination of results. Stakeholders for this study included key community informants, substance treatment providers, drug court advocates, community-based providers, faith leaders, community navigators (non-agency employed or affiliated community leaders or gatekeepers who are known and trusted by the target population for their expertise), people directly impacted by the law, and the community at large. This approach ensures that the most comprehensive, culturally sensitive lens is applied when considering those directly impacted. The main objective of the study was to hear directly from women most impacted and to take their recommendations as the most critical informing source, thereby strengthening the study’s ability to elucidate what services would best respond to the needs and priorities of substance-using women residing in Tennessee.

Interviews were conducted using a semi-structured interview guide. The guide was developed using an inquiry exercise called “101 Questions.” In this exercise, initial questions for the guides and screening process were sourced via a day-long strategy session with staff at SisterReach and shared with a variety of stakeholders, including a mix of local, regional, and national organizations that do research, programmatic, or advocacy work with marginalized communities including, but not limited to Healthy and Free Tennessee Reproductive Freedom Coalition, National Advocates for Pregnant Women, Amnesty International, University of Tennessee School of Law, Ibis Reproductive Health, and staff from Shelby County Drug court in Memphis. Stakeholders also included women directly affected by the law, such as women arrested and women who avoided arrest under the Fetal Assault Law. Feedback generated from the conference calls with stakeholders and via a listserv hosted by the advocacy group Healthcare Not Handcuffs were used to refine the interview guides and screening form. Final versions of both documents were reviewed with community stakeholders.

### **Ethics review**

The research protocol, instruments, consent forms, and flyers to advertise the study were submitted to two ethical review boards for approval: Union Institute and University located in Cincinnati, Ohio as well as through Allendale, an independent ethical review board. As part of the informed consent process, participants were given information about the study and their rights. Potential participants were informed of: (1) the purpose and components of the study, 2) procedures to protect confidentiality, 3) their right to withdraw from the study at any time and/or skip questions they did not want to answer, 4) the fact that participation or non-participation will not affect any relationship they may have with SisterReach or other organizations, and (5) persons to contact if they have any questions about the study or their rights as a research participant. If they agreed to participate, they were asked to sign an informed consent form. To assure participants that personal information would remain confidential, they were required to provide and use pseudonyms throughout the listening sessions, and all were instructed not to discuss anything shared during the session with any external party.

All personal identifying information was collected and stored securely within a locked cabinet at SisterReach’s office. Forms for recording socio-demographic characteristics of participants were stripped of the participant’s name or other identifying information. All information collected or transcribed electronically was stored on password-protected computers only accessible by core members of the study team.

### **Recruitment**

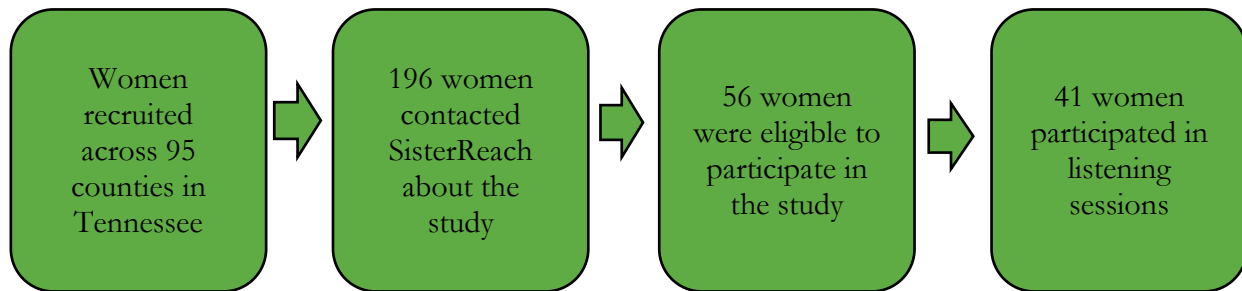
Between May 2017 and April 2018, women with diverse backgrounds and life experiences were recruited by SisterReach staff across the 95 counties of Tennessee to participate in a listening session and share their experiences with the Fetal Assault Law. Women were recruited through peer-to-peer networking, substance use providers, flyer dissemination, substance treatment programs, online outreach, print media advertisement, radio advertisements, public speaking engagements, and community events.

To participate in a listening session, interested women had to speak English, be aged 18 or older, and have been pregnant substance users residing in Tennessee between July 2014 and July 2016. All women participating in a listening session had a household income between 100-250% of the federal poverty level or lived in a more rural part of the state. A screening questionnaire (Appendix I) was used to assess eligibility to participate in the study, and eligible women filled out a short demographic survey.



Eligible participants also provided their first name and last initial or pseudonym, as well as a phone number or email address to be used by study staff to contact them. Listening session participants received compensation of \$75 for their participation in the form of a Visa gift card. A total of 196 women contacted SisterReach about the study, of which 56 were eligible to participate.

**Number of women recruited, screened, eligible, and able to participate in listening sessions**



**Data collection**

A total of 41 women participated in eight listening sessions and two IDIs between May 2017 and April 2018. The IDIs were conducted with two individuals that were arrested and charged with fetal assault. Research staff aimed to group women based on a similarity of experience; women who were arrested and charged with fetal assault are categorized as “directly impacted” (a total of two listening sessions) and women who managed to avoid arrest are categorized as “indirectly impacted” (a total of two listening sessions). However, many women were still actively attending drug treatment initiatives and were required to be under constant supervision; directly impacted women could not be physically separated from indirectly impacted women. Therefore, a third group of participants called “mixed impact groups” emerged (a total of four listening sessions).

A semi-structured interview guide was used to guide discussions during each listening session with different questions posed to women who were arrested versus women who avoided arrest.

**Women who were arrested:**



- asked about their:*
- 1) Experience with the judicial system
  - 2) Experience in the treatment program
  - 3) Experience following their release

**Women who avoided arrest:**

- asked about their:*
- 1) Pregnancy experience
  - 2) Experience with law enforcement
  - 3) Experience with treatment programs



Listening sessions averaged two and a half hours and IDIs averaged an hour. At least two study representatives were present at each listening session discussion; one as a moderator, and the other as note-taker to safeguard against potential problems with the digital recorder. The moderator utilized a set discussion guide to ensure that topics covered were similar across discussion groups. Participants were asked to use their pseudonym each time before speaking so they could be identified in the transcript.

## **Analysis**

All interviews were audio recorded and transcribed verbatim. Transcripts were then coded with Dedoose by staff from both SisterReach and Ibis Reproductive Health. A codebook was developed using themes from the listening session guide, and research staff independently read and coded one transcript from a listening session to ensure intercoder reliability. Discrepancies were discussed and addressed, and codes were updated to better reflect participant responses. Coding continued to be an iterative process, whereby research staff were free to create and add codes as new concepts emerged. After coding was complete, transcripts were analyzed by groups of women (arrested, not arrested, mixed group) to identify themes. Themes were then grouped under the three main aims of the study. Information from the demographic surveys were aggregated and presented as contextual information for the qualitative findings. The two IDIs were coded separate from the listening sessions. Illustrative quotes from the IDIs were incorporated under relevant themes.

## **Results**

### **Participant background**

Forty-one women participated in the study. Most lived in and around Memphis, Tennessee (n=32), while the remainder lived in Nashville (n=5) and Knoxville (n=4). About half (n=20) of the women participating in the listening sessions identified as White, and the other half (n=18) as African American. More than half of the participants (n=24) identified themselves as single and the majority had two or more children (n=27). Sixty-three percent of participants reported a high school diploma/general education diploma as their highest degree of education. The median age was 33 and 71% percent reported they were unemployed at the time of the session (see Appendix II for a participant demographic table). A little over half of participants (n=23) reported having health insurance. When asked if they had experienced financial hardship in the last 12 months, 44% of participants reported they had not been able to meet their basic needs like paying utilities or telephone bills, 61% had requested financial assistance, and 73% were forced to go without basic necessities.

A significant proportion of women (80%) reported a history of addiction in their family, with 67% of these women listing parents (mother or father) as the family member who abused substances and 84% listing alcohol as ‘the’ or ‘one of the’ substances abused. Thirty-eight women answered questions about the type of drug used during their pregnancy. About half of these participants used only one drug during their pregnancy, and the other half used multiple drugs; cocaine/crack (40%) and opioids (40%) were the most frequently cited, followed by marijuana (32%), alcohol (24%), and methamphetamines (15%). Thirty-five participants responded to questions about recreational drugs, with fifty-one percent of these women reporting they had used recreational drugs at some point, but only 31% reported ever using prescription drugs. Finally, 90% of all participants had ever tried to stop using drugs and 80% had participated in a substance treatment program. In combination with reports of a history of substance abuse in their family, high unemployment, financial struggles within the past year, and a struggle to stop using drugs despite several attempts, 69% percent of all participants reported having had sex for money, drugs, or their basic needs at some point. A similar proportion of women (65%) reported ever experiencing sexual abuse or assault, and almost all women (95%) reported ever experiencing domestic violence. Three quarters of participants had visited a psychologist or psychiatrist, and of the 17 women who disclosed the reason for their visit, 41% suffered from depression and 29% were bipolar.

Twenty-eight women in the study reported being arrested and charged under the Fetal Assault Law. Approximately 47% (n=13) of the women arrested and charged under the law reported losing custody of their children because of the arrest. Of the women who were able to avoid arrest or a charge (n=13), two reported delivering their child in a neighboring state, namely Mississippi and Alabama, and one woman reported having an abortion.

### **Aim one: Understand women’s experiences with the Fetal Assault Law and its impact on their lives and families**

Of the 41 women who participated in the listening sessions, 16 (40%) disclosed that they were using opioids during pregnancy. In our qualitative sample, 28 women (68%) reported being arrested and charged under the Fetal Assault Law, ten (36%) of which reported using opioids. Additionally, some of these women reported being arrested based on the results of a blood/urine drug screen rather than on the child being diagnosed with NAS as indicated by the law.

The narratives of women directly impacted by the law focused on the judicial system as well as the drug court and treatment program. From their stories, we learned that the time of arrest after NAS diagnosis or blood/urine drug screen varied, which left many feeling confused and vulnerable. Women’s experiences of drug court and the treatment program were mixed, with some citing benefits to participation and others highlighting the inadequacies of the program. The Fetal Assault Law had an indelible impact on women’s family, health, and economic well-being. Under the law, a woman with a child exposed to narcotics would be charged and her child would be removed and placed under the custody of DCS, foster care, or the care of a relative. Regaining custody was dependent on successful completion of the treatment program and an ability to show that she was sufficiently able to care for the child. Custody loss was a common feature of the narratives of women impacted by the law. The loss of a child was upsetting and resulted in some women resuming drug activity to cope with the stress of loss. Few women in our qualitative sample were able to regain custody of their children. In conjunction with custody loss, women charged with fetal assault reported a delay or complete avoidance of prenatal care as well as diminished quality of life as measured by employment and housing prospects.

Women who were able to avoid being charged under the law reported several different strategies to avoid arrest—such as delivering across state lines, having an abortion, attempting to detox, and avoiding prenatal care. Women report learning about the Fetal Assault Law through different sources, including media, the experiences of other substance using women who were arrested, and medical providers during prenatal care visits. Learning of the consequences of the law spurred these women to take action to avoid arrest.

## Experience of women directly impacted by the Fetal Assault Law

“My most recent pregnancy I had a hard time carrying her because I was on heroin at the beginning of the pregnancy. And I didn’t want my baby to be born addicted (exposed), so I tried Suboxone. I found out I was allergic to or something – rejected it. I had to go to methadone. My baby didn’t have anything withdrawals, but I failed the [drug] test and they charged me.” (FGD, mixed impact group)

### **Judicial system**

The time of arrest varied greatly, with some women reporting arrest at the time of delivery and others reporting arrest several months later. For women arrested months after delivery, many did not know that a warrant had been issued for their arrest. As one participant whose daughter tested positive for cocaine and trace amounts of marijuana but was not diagnosed with NAS, described: *“I had my daughter in September. I had a warrant [in] November. They came to my house. I had a warrant for assault with bodily harm. I didn’t even know that I had a warrant. They – DCS – had issued a warrant on me for assault with bodily harm on my daughter. I went to jail”* (FGD, mixed impact group).

The reason for arrest also varied, with some women being arrested based on their child’s diagnosis of NAS and others based on screens of their own blood/urine for drugs. Further, substance-using women faced arrest regardless of the delivery outcome. Several women who had miscarriages, delivered children who were stillborn, or had their children die shortly after delivery were still charged under the Fetal Assault Law. While the circumstances around drug screening were not explicitly described during the listening sessions, prior interviews done by SisterReach suggests that in some cases, substance using women were screened for drugs without their knowledge or written consent.

Illustrative quotes include a participant who was charged prior to delivery and another who was charged following a miscarriage—the symptoms of which the participant had mistaken as related to her chronic condition, endometriosis.

*“I got arrested and – once, I was pregnant and I was on drugs and I went to jail. [...] And I went in labor while I was in jail. While I was in jail, I had my baby. My mother then went and got my baby. Then my baby died, and they buried my baby in the state cemetery, but they locked me up initially because I had drugs in my system while I was pregnant”* (FGD, mixed impact group). This participant was offered five years’ probation pending completion of a year in the Cocaine Alcohol Awareness Program (CAAP).

*“I didn’t know I was pregnant. I suffer from endometriosis, so I have breakthrough bleeding anyway, so I never stopped bleeding. So I was having pain and I went to the doctor. [...] when I went to the emergency room, I was in there and the doctor came in there and told me I was pregnant and that I had miscarried [...] So at that time, they had taken – I had – they had taken blood. I had did a urine screen or whatever, and they said I tested positive for marijuana and I had been drinking prior. [...] So after I saw the doctor and they got the bleeding to stop and all of that, then a(n) officer came in and they transported me to the east jail and said that I was under the influence of alcohol and it caused me to have a miscarriage and it was against the law”* (FGD, mixed impact group). This participant presented to drug court a few days later and was sent to a CAAP.

Participants described a sense of powerlessness and vulnerability during arrest and at sentencing. This was particularly evident in narratives of women who were arrested immediately after delivery, “[They]

*didn't give me a chance to even call my family, just took me to jail straight after having a C-section and wheel-chaired me out the hospital"* (FGD, directly impacted group). Women also highlighted feeling a lack of agency and a loss of dignity as a judge decided their fate—whether that would be serving a sentence or participating in a treatment program. These feelings were compounded by the long wait for a trial, with some women having to wait a month between each court date. Importantly, many women had a criminal history prior to being arrested/charged under the Fetal Assault Law and this history either facilitated arrest or lengthened the sentence for a previous charge. “[...] *I was on probation and I had already gotten a charge for possession of a controlled substance with the intent, so once I went to jail, it automatically violated my probation. [...] That was one of the reasons I stayed so long, because I was on probation and I also had went about having the alcohol and stuff in my system during the miscarriage, so that violated me*” (FGD, mixed impact group).

### ***Drug court and treatment programs***

“ “Access to treatment should be improved definitely. That's what's so annoying is you see people like, they should go to treatment. Well, if it was that easy they would be there if they wanted to. It's just hard. If you're not just dying from benzos and alcohol, you can get in fairly easier. But on opiates, they're — that's just like, you'll be fine in four or five days, you don't need it. And people don't understand that it's not — 28 days is not gonna cure somebody.”  
(IDI, directly impacted) ”

Although the structure of the drug court program varies by county, these programs aim to provide treatment to individuals addicted to substances, and are an alternative to jail time.<sup>55</sup> Drug court is designed and controlled by the court system, and the program is overseen by a judge and a team comprised of counselors, treatment providers, lawyers, and case managers.<sup>56,57</sup> Eligibility requirements and process of approval for the program are different in each county, but final decisions about admission into drug court and treatment programs are made by the drug court judge.<sup>56,57</sup> The listening sessions illustrated the variations in length of drug court programs; some women were only placed in a 28-day detox program while others were placed in extended programs ranging from three months to a full year. Extended programs offered more systemic support for women to access and additional benefits such as classes that teach life skills. It was unclear from our discussions with women what factors led to the placement of women into short versus longer-term treatment programs.

For some women, acceptance into the program took months and resulted in feelings of powerlessness. One participant who eventually entered a treatment program through drug court describes her feelings: “*But I would say I never want to feel that feeling that someone—to go before a judge and know that this judge, whether he has a good day or bad day could decide on your fate on whether or not, okay, well, I'm gonna give you the minimum, I'm gonna give you the maximum, I'm gonna get you some help, or I'm gonna lock you up. It is crazy that it depends on one man or woman's day, in my opinion*” (FGD, directly impacted group). In the few cases where women identified and attempted to enroll into a treatment program outside of a court mandate, costs were a significant barrier. A lack of health insurance or other financial resources to offset costs resulted in some women forgoing treatment and continuing drug use. Three women from the impacted listening sessions highlighted the importance of self-advocacy and/or having access to resources such as good legal assistance and finances to get into a treatment program. Their stories highlight the burden of advocating for treatment: “*I had to beg to get into rehab. They denied me. They wanted to send me to prison for ten years. I had to wait eight months and go to court three different times to beg to get into a treatment program. And they weren't trying to put me in treatment*” (FGD, directly impacted group).

Sixteen women were currently in a treatment program at the time of the listening sessions. Very few treatment programs were explicitly named during the listening session, but the most frequently named was the CAAP, which provides both residential and outpatient treatment services to individuals in the drug court program.<sup>58</sup> Women who participated in an extended program were more likely to report that the treatment program was beneficial. Quotes from two women illustrate this finding: “I learned a lot in [CAAP] and I learned how to get myself together” (FGD, directly impacted group). “They’re teaching me so many productive skills that I never took advantage of before. They’re teaching good structure as far as getting up for work every morning” (FGD, directly impacted group). However, there were some who felt that their treatment program was inadequate, requiring very little from the participant outside of sobriety. As one woman described: “I did the assessment for Innovative Counseling. And it was basically like a joke. Like they recommended me to do an 18-week class, [...] three classes a week for two-and-a-half hours each class. And basically the class is like this. You go in a group of people. Everybody discusses their certain situations and that’s that on that. It’s no rehabilitation. It’s no help” (FGD, mixed impact group).

For women who only had the option of a 28-day detox program, the drug court program was described as insufficient. There was an explicit desire for more time to help you get prepared to re-enter society. Given the varied drug use (cocaine, opioids, and marijuana) of the women entering the treatment program, it stands to reason that some women would benefit more than others from a short-term detox program. This variation may help to explain why some women were unable to successfully complete the treatment program or remain sober after completion.

After successfully completing drug court, eligible defendants could go through an additional process to remove criminal charges from their records. In this study, **only one** participant from the listening sessions reported completing this process and having her charges expunged. The resources, money, legal assistance, and knowledge required to navigate this additional process may have presented a barrier to many other women charged with fetal assault.

### ***Impact on health-seeking behaviors***

Narratives from “indirectly impacted” and “mixed” listening sessions highlighted how fear of arrest under the Fetal Assault Law, as well as fear of DCS, influenced their engagement with prenatal care. Specifically, we learned that some women elected to delay or forgo seeking prenatal care during their pregnancy. The choice to forgo prenatal care was not taken lightly by participants. Many felt guilty about jeopardizing the health of their child but were able to justify their actions because they felt it increased the chances of them maintaining their parental rights. One woman who had delivered other children had some knowledge of how much they should be growing, as well as signs of a progressing pregnancy to help her navigate pregnancy. She used this knowledge to delay her first prenatal visit to the third trimester (seven through nine months of pregnancy).

“I feel more ashamed about not getting prenatal care than I do about doing drugs. I didn’t do drugs the whole time. I tried to space it out. That doesn’t make it okay. But not going and not knowing what’s wrong or what’s good or what’s going on through pregnancy of your baby because of a fear of a law is not healthy in my opinion for babies” (FGD, mixed impact group).

For those who made it to prenatal care, the presence of the law and reports of feeling judged because of their drug use impacted the doctor-patient relationship, with participants reporting a hesitation to

have an open relationship with the doctor. *“When I was pregnant, I was scared to death to have that open relationship with my doctor because the laws in effect prevented me from – it being a care issue. It became a law – a liability issue. [...] The doctors could not openly talk with you anymore because they were contributing in some way, and I was freaking terrified”* (FGD, mixed impact group). Therefore, for some women the kinds of care received would be limited by the depth and accuracy of information shared during the visit. As an example, we heard from one respondent using methadone or buprenorphine (brand name: Subutex)—drugs used to treat addiction to opioids— during pregnancy that she delayed revealing her attempts to detox via use of these medications during prenatal care. Using such treatment medications during pregnancy is not guaranteed to be safe, and women are recommended to alert their prenatal health care provider of its use to ensure the medication is the best option for them during pregnancy. On the other hand, detoxing without medication assistance while pregnant can also be dangerous, and can lead to respiratory depression (which can cause the child to not get adequate amounts of oxygen) and maternal anxiety and depression.<sup>59</sup>

### ***Impact on family life***

Custody loss was a significant feature of the narratives shared by women in the “impacted” and “mixed impact” listening sessions. The timeline for loss varied, with

“*When they took my kids, instead of stop getting high it stressed me out more to get high, because I was upset about my kids being gone, took from me.*” (FGD, mixed impact group)

some women reporting that the child was removed by DCS shortly after birth and others reporting removal a few months later. Women with multiple children also reported losing custody of other children in the household either before or after their experience with the Fetal Assault Law. As one woman described: *“They took her from the hospital from me. They didn’t take my other kids right away. They waited till like a month later and came and got the other children”* (FGD, mixed impact group). Custody took many forms, with children either being placed in the care of the state, with a family member or co-parent, or in some cases adopted into other families. For women with multiple children, custody type could vary for each child. The act of having a child(ren) removed was traumatizing for women. Many reported that it led to more stress and/or negative emotions, which triggered drug use.

Two participants reported feeling pressured by a DCS representative to sign away their parental rights while they awaited sentencing. In these stories, women report being told that they would lose their parental rights if they failed to have contact with the child for four consecutive months. In all cases, the women reported being approached by a DCS representative without a lawyer being present. This specific feature of the story highlights women’s distrust of the system as well as their fears that the state was more interested in separating rather than reuniting their families.

While some women were given a plan to be reunited with their child(ren)—typically completing drug court, remaining drug free/sober (as evidenced by clean drug screens) and completing parenting classes—many were unable to complete this plan. Temporary custody loss became a permanent loss for many of the women in our study. Women cited several challenges to regaining custody, but the most frequently cited was working with their assigned DCS caseworker. Several women remarked that calls to their caseworker went unanswered—making it impossible to set up visitations, make plans to remain in contact with their children, or complete drug screens or other drug court requirements. Other threats to regaining custody included continued drug use and having a prison sentence that extended beyond a year.

In a few cases, women made the decision to give up the child(ren) because of feelings of guilt, or a perception that she and/or the co-parent was unable to sufficiently take care of the child(ren). One woman's story provides a good illustration of the guilt experienced by some women: *"I did get my kids back, except for the baby that was drug-exposed. [...] I decided to sign my rights away for her. I let her stay with her foster parents because they had her since she was born. And she was a year old. And I felt like I traumatized her enough. I didn't want to traumatize her taking her from an environment that she been in for a whole year and bringing her to another one. So I let them keep her"* (FGD, mixed impact group).

### ***Impact on quality of life***

The impact of being charged and/or arrested under the Fetal Assault Law had far reaching consequences. Most notably, women described an inability to achieve and maintain good quality of life. Having a charge on their record negatively impacted their abilities to gain employment and secure housing. As one woman described: *"I've called 21, literally 21 different apartment complexes in Shelby County. They will not rent to me because I'm a convicted felon, not because of my credit but because I'm a convicted felon"* (FGD, directly impacted group). For women faced with temporary loss of their child(ren), employment and stable housing are key to reunification, as they signify an ability to provide sufficient care. Limited opportunities to earn money made it more difficult for women to pay fines such as reinstating a suspended driver's license, a frequently cited concern by women in our sample because it diminished their ability to complete visitations and made it more challenging to seek and travel to work. Incarceration has deleterious effects on an individual's finances due to the high and compound costs of courts and fines. Many women, once released, start with little to no finances and are therefore delayed in putting goals, such as such as getting a car or house, into action. A failure to achieve basic life goals such as gainful employment had a negative effect on women's mental state and was frequently described as stressful, which led some to return to criminal activities and resume drug use: *"I was having problems gaining employment and such and I went out there and I started selling drugs in order to make money" [...] it's a lot easier to run in the other direction and continue to do felonies, make – sell drugs, use drugs, and do all that so you can support yourself. And then – or to break the law driving a car without a driver's license because you need to get back and forth to work and you can't afford to pay the fines"* (FGD, directly impacted group).

### **Experience of women indirectly impacted by the Fetal Assault Law**

Narratives from our listening sessions confirm prior findings<sup>48</sup> that fear of arrest or drug testing drove some substance-using women to use different strategies to avoid arrest, including delivering outside of the state. Two of the 13 women in our sample who avoided arrest under the Fetal Assault Law elected to deliver in Alabama and Mississippi. Other strategies to avoid arrest included having an abortion, avoiding prenatal care, and attempting to detox. Two women in our sample were able to avoid arrest because they miscarried early in the pregnancy and therefore had no contact with the medical system. Maintaining custody of their child(ren) was the main concern for women attempting to avoid arrest under the law.

“I moved to Alabama with some of my friends to deliver my baby so that my doctor wouldn't test me again for drugs or anything like that” (FGD, indirectly impacted group)

Women learned about the Fetal Assault Law through media reports, the experiences of other substance-using women, and through their engagements with medical professionals. One woman reported being told by her doctor, following a positive screen for marijuana, that she could be arrested. This experience prompted the respondent to start planning how she could either treat herself or avoid arrest to ensure she could keep her child.



In the case of the woman who reported having an abortion, a publicized arrest of a friend who delivered a drug-addicted baby compelled her to avoid prenatal care and seek an abortion. While not explicitly stated, it is likely that her friend was arrested under the Fetal Assault Law and that the fear of delivering a child with NAS and being charged played a role in her decision to have an abortion.

*“[...] before I got pregnant, I was real heavy on alcohol and I started doing crack cocaine. And so, when I got pregnant, I had an incident with one of my friends. I had saw she was on the news for delivering a baby that was addicted (exposed) to drugs. So I just made the hard decision that since I was having a hard time shaking my habit that I was to stumble ahead and have an abortion to avoid being a risk for possibly bringing a baby addicted (exposed) to drugs”* (FGD, indirectly impacted group).

Stories about avoiding prenatal care were similar between women in the “indirectly impacted” and “directly impacted” listening sessions. These stories centered child custody as the motivation for their actions. Maintaining child custody was also cited as the motivation for attempting to detox while pregnant. While strategies, outside of abortion, resulted in women successfully keeping their children, one woman reported an unintended outcome because of her fear of arrest. In this story, the woman’s fear of arrest led her to avoid bonding with her newborn—an action she believes negatively affects her current relationship with her child.

*“And even though there wasn’t a trail of evidence because of my neglect of prenatal care that is enough to cause suspicion – to raise flags [...] I kept the baby in the room with me. I never slept. I watched that door waiting for the cops, waiting for DCS. I didn’t spend those vital hours that a mother should holding her child and feeding the child [...] And my daughter who’s three – Camilla – is still a very distant person. And I believe it is because of when she was born, there wasn’t – I wrapped her in her thing and she set in her bed because I was scared to death they were going to take her and I couldn’t be attached to her. I had done lost my other kids, and so that bond that’s created at birth is where the bond goes for mother and child. That’s my belief. And I didn’t want to have that with her and it be taken away, not only from me, but from her”* (FGD, indirectly impacted group).

### **Aim two: Understand the social support services available to women struggling with drug dependency before, during, and after their encounter with the law**

Findings from the demographic survey reveal that a large proportion (80%) of women in our listening sessions were raised in households where addiction was present. While the age at which drug use was started is unknown within our sample, findings from the literature show a higher risk of substance abuse for children growing up in homes where substance abuse takes place.<sup>60,61</sup> Women reported using a wide variety of drugs including methamphetamine, cocaine, and Lortab pills. Many used the drugs in tandem with alcohol and marijuana, as well as tobacco. Further, drug use was often used to escape difficult circumstances they faced in their personal lives. Seventy-one percent of our respondents reported that they were unemployed and close to 70% reported having had sex in exchange for money, drugs, or other basic needs over the course of their life. The stress of limited finances is compounded by the experience of domestic violence, experienced by 95% of our respondents, and highlights the extreme vulnerability of some substance-using women. Support is crucial to improving quality of life and helps buffer against adverse life events. To better understand the complexities of substance-using women’s lives, women were asked to describe the various types of support received over a wider period of time: before, during, and after their encounter with the Fetal Assault Law. Two distinct types of support were highlighted in the narratives: social and structural support. The social networks of women in our study included family and intimate partners, friends, counselors, and others such as

staff from the treatment program. The church and community were not mentioned as part of the social support network. Importantly, some women reported receiving **no** support at all.

## Social support

In terms of social support, we found two types mentioned in the narratives—emotional and instrumental support. Family members were the most commonly cited source of support and were named as being instrumental to providing care for the child born while the law was in effect as well as children born prior. Family care was preferable for some women over foster and/or state-based care but was largely dependent on the relationship the woman had with her family members. Support in the form of child care was a feature before, during, and following an encounter with the law. Similarly, some women reported receiving financial assistance from family members before, during, and after their encounter with the law. Some family members provided both child care and financial assistance while others provided one or the other. Unfortunately, women did not provide details about the scope and/or uses for the financial support provided by family members.

“ [...] my mother is a support system but she’s no longer an enabler. I have to fend for my own self. Thank God she has my children right now and they’re well taken care of. Thank God. But as far as me, as helping me, she will not help me financially nor when I was in treatment.” (FGD, directly impacted group)

Partners were less commonly cited as sources of support. However, when mentioned, the support focused on child care and/or finances. Other mentions of partners in the narrative indicated that some were using drugs, were abusive, or had been in trouble with the law—making them unsuitable and/or unavailable to care for the child.

While financial and child care support are very helpful, research has also demonstrated that women’s perceptions of emotional support from family and friends impact treatment completion.<sup>62</sup> However, very few women in our sample reported receiving emotional support from family members. As one participant reported: “as far as mentally though and emotionally, they [my family members] don’t have an understanding about the disease of addiction and there’s a stigma on m(e)” (FGD, directly impacted group). Participants’ stories provided some insight into why emotional support may have been absent. Women suggested that the burden of addiction may have taken a toll on the support received from family and that some family members eventually transitioned to a “tough love” type of support. This type of support is meant to encourage the woman to take charge of her addiction and recovery process. The feeling of despair stemming from the lack of recovery from addiction may have also led to waning support by family members. Finally, women suggested many family members believe care-taking and finances are the most important forms of support and place little value on non-tangible forms of support such as visiting them in the treatment center.

## Structural support

Women varied in their perceptions of whether there were sufficient or insufficient structural supports available to assist individuals struggling with substance use. Their narratives focused on support needed in the period prior to arrest/charge and following participation in the treatment program. Some women reported a dissatisfaction with the support offered by structures such as the church and community, reporting either no support or support that was limited in scope and reach. Others were satisfied with the resources available and faulted the individual for not availing themselves of the resources/supports that were available within the community. This dissonance in perception of resources may reflect the different expectations individual women had of their personal role and responsibilities versus the role society (churches, communities, etc.) could play in addiction recovery. Inequitable access to resources based on race emerged from the discussions with marginalized women. One participant of color implied that the society's response to women struggling with addiction, as well as the rate at which support was offered, differed by race, with her White counterparts being at an advantage.

“Yes, there are programs out there. But sometimes they don't hit the right people and the right people don't get the right help when they need it. They're too busy condemning and trying to snatch away our kids and it seems like it's not fair. Like we don't get the same treatment as somebody that was a different race than us. White people. . . .they will be quick to help them go back into society, help them get housing, food and everything, and then we have our kids taken away and their rights taken away from both parents without the other parent even knowing what's really going on. And it's just hard. We don't get the same treatment.” (FGD, indirectly impacted group)

“They wanna tell you what you need to do and then judge you because you're not doing it. But then there's no resources, no nothing to do.” (FGD, directly impacted group)

Those who were dissatisfied identified three areas for increased support. First, women felt the community could make more programs available and/or strengthen the existing programs for recovering addicts. As an example, one woman reported that the Alcoholics Anonymous (AA) program was only available in one location in her county and only on one night of the week. More meetings, both in terms of location and times, would allow more women to benefit from the program. Places

like churches and courthouses were suggested as additional locations for AA and other recovery meetings.

Second, several women indicated that the church could serve as a body that connects those coming out of jail or treatment centers with services or provide some services directly. Direct services, including parenting classes and marriage counseling, could assist women in regaining custody of their children. The church was also seen as a potential vehicle for reducing the public stigma surrounding drug addiction, as the religious institution could indicate that addicts are welcome and accepted into their space.

Third, women desired greater support for reunification with their children. Specifically, they wanted the community to provide resources that could lessen the burden of court costs such as legal assistance, help them remain compliant with probation with services such as public transportation or assistance reinstating driver's licenses to facilitate travel to recovery meetings and parenting classes, and implement systems that could help them support the child once reunited. These systems include setting up a payment plan for child support that women could pay off over time and providing housing and job assistance. Housing and job attainment were highlighted as particularly challenging for women with a criminal record. One woman suggested having a list of vetted housing options to make it easier to secure housing, while another suggested increasing job placement options.

When asked what factors might play a role in the church and community providing limited or insufficient resources, women highlighted poor knowledge about the disease as well as a perception of judgment. Research has demonstrated that stigma experienced by opioid users from health care providers and the general public negatively impacts health care delivery and prevents the treatment of opioid addiction with effective medications.<sup>63,64</sup> Such research is consistent with our findings, which reveal that the perception of judgment from the community made some women feel isolated and in one case, more hesitant to ask for assistance. Increasing knowledge of the disease was seen as the solution to improving the church's and community's perception of addicts, as well as the amount and type of assistance they provide.

### **Aim three: Generate recommendations to inform policy and practice guidelines for future treatment provision**

At the end of the listening sessions, women in all three groups (directly impacted, mixed, and indirectly impacted) were asked to provide recommendations to guide better policy and practice related to treatment and recovery.

#### **Recommendations, state/medical providers/community**

Women in the directly impacted and mixed-impacted listening sessions shared several recommendations aimed at improving the support systems available to women completing the treatment program. Women wanted more resources post treatment to help them:

- Maintain their sobriety, whether that was in the form of groups or motivational programming
- Gain access to innovative addiction recovery programs such as the moral reconnection therapy (MRT), a form of treatment that aims to decrease recidivism among criminal offenders by increasing moral reasoning
- Gain life skills. Specific suggestions included classes on parenting, domestic violence, and financial management, educational courses, etc.
- Regain custody of their children by connecting them with free legal aid, assisting them with employment (through job fairs, donated work clothes, etc.), and connecting them with fair housing options

“Yes, there are programs out there. But sometimes they don't hit the right people and the right people don't get the right help when they need it. They're too busy condemning and trying to snatch away our kids and it seems like it's not fair. Like we don't get the same treatment as somebody that was a different race than us. White people. ...they will be quick to help them go back into society, help them get housing, food and everything, and then we have our kids taken away and their rights taken away from both parents without the other parent even knowing what's really going on. And it's just hard. We don't get the same treatment.” (FGD, indirectly impacted group)

This final quote from an in-depth interview with a woman charged with fetal assault summarizes women’s desires to make amends within themselves and society without losing their children. The quote also highlights a practice that medical providers suggest—to keep families intact through treatment.

“

*“I just want pregnant women or people that just had kids into addictions to have the chance to make amends and make it right instead of taking our lives. Because, I mean, regret – we do do wrong things, and what we done – it was wrong. But, to take a mamma’s baby away from her, it’s hard. Because in all honesty, we do care but them drugs take us. It takes us far, but to just – it takes us really far away from them. But taking them away from us is like we done lost the world and there ain’t nothing left worth fighting for. But taking them and holding the process and helping us is all we need. Not to just take them”*

(IDI, directly impacted).

”

## Limitations

### **Challenges recruiting directly impacted women**

On average it took 30-60 days to complete recruitment and screening for each listening session. There were several challenges that hindered the recruitment efforts and hence limit our ability to speak fully to the impact of the Fetal Assault Law in Tennessee. First, race played a role in recruiting White women arrested and charged with fetal assault outside of Memphis. Some White women were explicit in their distrust of the African American researchers and in some cases refused to discuss the issue. Second, some providers in Knoxville, Tennessee refused to share the recruitment flyers citing that the “law had sunset” and “no women were arrested for fetal assault anymore.” Finally, some expressed fear around participating in a listening session on fetal assault. The “small town effect”—which is the perception that everyone in town would find out—contributed to some women not attending scheduled listening sessions in the rural areas. Despite using various recruitment strategies such as word of mouth, flyers, online advertisements, social media, and direct referrals, participation in the listening sessions was inconsistent.

### **Challenges identifying and recruiting women who avoided arrest**

Recruitment of women who avoided arrest under the Fetal Assault Law by choosing alternative birthing options (e.g. home birth, crossing state lines, abortion, etc.) proved to be much harder than anticipated. Most of the women who identified with the definition were recruited by word of mouth. Concerns about judgment and stigma related to having had an abortion to avoid arrest or fear for themselves and their children if they delivered in another state or alone were the greatest barriers to participation. Almost always these women stated that they “almost changed their mind about participating.” When asked why, often they cited a fear of discussing their experience before others or a desire to put the experience behind them.

### **Challenges collecting information**

There were limits on the amount of time that arrested women attending drug treatment programs could meet with the interviewer. Additionally, because these women were technically considered to be in state custody, they had to be under the direct supervision of a facility staff member during the listening sessions. These constraints could have hindered the ability of the participants to be candid as they shared their stories and feelings about the treatment program. Another limitation relates to the inconsistency of drug court programs across counties, with each operating under different policies. This made it difficult to compare women’s experiences with drug court and treatment centers.

For women who were both arrested and not arrested, literacy and reading comprehension were significant challenges. These issues presented as difficulty understanding the consent forms and eligibility criteria and/or eligibility processes related to the study and completing the demographic survey. This contributed, in part, to missing survey data on some demographic and/or lifestyle questions. To combat this challenge, the research staff spent a significant amount of time explaining the survey and were vigilant in their efforts to verify participant information for accuracy. It is important to note that missing data is also attributable to the fact the participants had the option to skip demographic or lifestyle questions they did not wish to answer.

## Implications

The stated objective of the Fetal Assault Law was to reduce the use of opioids during pregnancy and the number of infants born with NAS. The evidence shows that the law was ineffective as there was no decrease in NAS diagnoses during the enactment period.<sup>22</sup> Instead there is evidence to show that the law was widely applied,<sup>38</sup> endangered the lives of women and their infants as many substance using pregnant women delayed or went without prenatal care,<sup>48</sup> and forced women to elect alternate delivery options.<sup>48</sup>

Currently, 38 states have some version of a Fetal Assault Law,<sup>65</sup> and while the specific details of these laws vary greatly from state to state, the results of this study strengthen arguments against enacting laws that criminalize pregnant women. Qualitative stories from women who were arrested/charged under the Fetal Assault Law and women who were able to avoid arrest provide evidence for some of the original arguments made by SisterReach against the enactment of the law in Tennessee. Below is an answer to these initial arguments:

<p><b>Criminalizing pregnant women is a threat to the health and well-being of Tennessee children, women, and families</b></p>	<p><b>Pregnant women struggling with addiction need access to prenatal care, treatment, and resources—not jail time</b></p>	<p><b>Criminalizing pregnant women is a cost burden to tax payers</b></p>
<ul style="list-style-type: none"><li>• The majority of women in the study were unemployed and reported experiencing financial hardship within the last year. Few women had the resources necessary to navigate the courts and/or to keep their families together</li><li>• Some women reported losing custody of their children against their desires</li><li>• Custody loss was correlated with poor mental health</li><li>• Women reported that having a charge on their record negatively impacted their ability to gain employment and housing</li></ul>	<ul style="list-style-type: none"><li>• Eighty percent of women reported a history of addiction in their family</li><li>• Sixty-nine percent of women reported having sex for drugs, money, or other basic needs</li><li>• Women report turning to drugs in response to an inability to access housing and/or employment</li><li>• Women reported crossing state lines to deliver in an effort to avoid arrest. One woman reported having an abortion</li></ul>	<ul style="list-style-type: none"><li>• Women report turning to drugs in response to custody loss while trying to complete drug court, making the treatment process more difficult for women and more costly for taxpayers</li><li>• Many program initiatives, as described by participants, were subpar, ineffective, or insufficient</li></ul>

## Strengthening the evidence

### *Charges under the Fetal Assault Law*

Our conversations with women impacted by the Fetal Assault Law support the finding that the law was widely applied to substance-using pregnant women residing in Tennessee, and not just to women using opioids. Twenty-eight women were charged with fetal assault, and among the 25 that disclosed the type of substance used during pregnancy, only ten women reported using opioids, one of which was using methadone—a treatment for opioid addiction. The remaining women charged with the law were using other drugs, including cocaine, alcohol, marijuana, and methamphetamines. From our study, it appears that substance-using pregnant women were made aware of this wide application of

the law through medical professionals who warned them of arrest based on the use of a substance (not confined to opioids) while pregnant, the media, and the experience of other women arrested under the law. No stories surfaced from this sample of women about seeking legal advice related to their substance use prior to arrest or advocating for legal assistance at the time of arrest. Only a few women reported advocating on their own behalf at the time of sentencing, but that advocacy was not related to challenging the charge or conditions of arrest but related to placement into a treatment program and for one woman getting her record expunged. When advocating for women who would be potentially impacted by the law, SisterReach and our partners noted that low-income mothers would face more difficulty navigating the court systems. This lack of financial and other resources placed these women at a disadvantage, making them more likely to face higher penalties.

Not all women charged with fetal assault qualified for the option of a drug court treatment program versus prison time. Moreover, of the women who qualified for the treatment program, some were only placed into a detox program while others had the benefit of a longer-term program with more services and therapeutic approaches to recovery. Access to affordable treatment programs outside of the court system was almost impossible for low-income women because of a lack of social supports such as public health insurance or covered methadone treatment in the state. It is unclear whether women were given a chance to select their drug treatment program or whether the drug court program was tailored to their needs. This would have been particularly helpful given that women using drugs other than opioids were being charged and mandated to drug treatment programs and the treatment regimen for opioids is different than the treatment regimen for other addictive drugs, such as cocaine,<sup>66</sup> marijuana,<sup>67</sup> tobacco,<sup>68</sup> and alcohol.<sup>68</sup> Successful treatment requires that the regimen be tailored to the individual's "drug use patterns as well as their drug related medical, mental, and social problems."<sup>69</sup> A large proportion (80%) of women in our study had tried to stop using drugs and participated in a substance treatment program at some time in their lives. Moreover, two women reported attempting to treat their addiction prior to arrest using medication-assisted treatment during pregnancy. Contrary to Shelby County District Attorney Amy Weirich's comment that "the threat of jail was needed as a "velvet hammer" to force mothers into court-supervised drug treatment," these findings suggest that substance-using pregnant women do seek and participate in treatment programs without the threat of imprisonment.

The diagnosis of NAS was not the only precursor to arrest. This is inconsistent with the qualifying guidelines of the law that specifies opioid usage as the reason for arrest and temporary loss of child custody. Women in our study were arrested while still pregnant based on screenings of their own blood/urine and irrespective of the birth outcome (i.e. whether the child was born alive). The circumstances around arrest were inconsistent in terms of timing—with some women arrested before giving birth, some at the hospital immediately after delivery, and others months later—and the processes that followed. The evidence related to women providing consent for testing is mixed. Only one woman in our study stated that she had provided consent for drug testing, however she was not confident that this had occurred. In discussions with others knowledgeable about the Fetal Assault Law, SisterReach was informed that there were cases where women were tested for drugs without their knowledge or written consent. The experience of being arrested was confusing and left some women feeling stripped of their autonomy as women and parents. This feeling of dis-empowerment was heightened when they appeared before a judge for sentencing, knowing that they had little to no recourse to alter the outcome.



### *Impact on maternal and infant care and delivery*

Our study supports the conclusions of various professional medical associations that the use of criminal penalties is inappropriate and counterproductive to maternal, fetal, and child health.<sup>70,71</sup> From our conversations with women, we learned that prenatal care was delayed by up to seven/eight months, that information relevant to their prenatal care such as the use of medication-assisted treatments during pregnancy was sometimes omitted, and that some went without prenatal care altogether.

Early and regular prenatal care is a proven step to increasing the chances of a healthy pregnancy. Prenatal care can reduce risks of pregnancy complications and promote fetal health and development.<sup>72</sup> In addition to monitoring pregnant women's existing health conditions, prenatal care can connect women to other supportive services. Women receiving prenatal care often have access to 1) services that can help them stop or cut down on the use of substances, 2) nutritionists and programs that provide healthy foods, and 3) social workers who can assist with applications for enrollment into Medicaid insurance coverage or into other welfare and social programs. Given that 44% of our sample went without basic necessities during the previous year, 40% had no health insurance, and almost all (95%) had experienced domestic violence in their lifetime—a lack of or late prenatal care because of a fear of arrest presents missed opportunities to connect these women to care and services.

Fear of arrest drove two women in our study to deliver in a neighboring state to maintain custody of their child, and one woman to have an abortion instead of delivering a possibly drug-addicted infant and facing arrest. The combined punitive measure of arrest and custody loss had the effect of pushing some women away from seeking treatment and instead to preserving their personal and parental autonomy. Findings from studies of women in treatment for substance use showed that fear of custody loss could act as a barrier to entering a treatment program.<sup>73</sup> This unintended outcome is a violation of a woman's reproductive rights as it deprives her of the ability to freely decide if and when she will have a child, and the conditions under which she will give birth. Delivery outside the state, while beneficial in keeping families together, has the potential to disrupt postnatal care, defined as the first six weeks following birth. Given that infant and maternal deaths occur most often within the first month of life, ensuring women and their newborns remain connected to health services during those first six weeks is key to survival and wellbeing. Through discussions with women affected by the law, we uncovered that there were other ways that women were able to avoid arrest, such as delaying prenatal care and attempting detoxification.

## **New evidence**

By speaking directly with women charged with fetal assault, we gain an insider's perspective on the shortcomings of the law, such as challenges with family reunification and inadequacies of the mandated drug court program, as well as the harmful impact of the law on women, such as diminished quality of life.

### *Challenges reuniting families*

As part of the process of being charged with fetal assault, DCS would remove children under the age of 18 from the woman.<sup>36</sup> Children were either brought into state custody and placed in foster care or placed in the custody of a suitable relative.<sup>36</sup> Custody loss was a source of distress for these women, triggering negative emotions such as anger and guilt. Given prior evidence in the literature that negative life events such as the loss of a child by death or removal and long-term exposure to stressful

experiences are associated with an increased risk of substance abuse and addiction,<sup>13</sup> we were not surprised to find that some women in our study returned to drug use as a way to cope with these negative emotions. Women report being informed that they could regain custody of their children if they completed one or more requirements: completing the mandated treatment program, maintaining sobriety (i.e. passing regular drug screens via a hair follicle test), maintaining contact with the children in custody (through in-person visits or phone calls), identifying a permanent place of residence, completing a permanency plan, and completing parenting classes. The requirements for regaining custody varied widely, with some women reporting needing to meet multiple requirements and others reporting only needing to complete the mandated drug treatment program.

A permanency plan is defined as a plan for where the child will live when they leave foster care, outlining whether they are reunited with family, or are placed for adoption. Under the permanency plan, women charged must complete certain requirements such as showing they can provide adequate care, for children to return home.

Approximately 13 of the women arrested/charged with the Fetal Assault Law, roughly 46%, reported experiencing permanent custody loss of one or more of their children. The most cited reason for loss or delay in reunification was an inability to get in contact with the assigned DCS caseworker. This challenge, in addition to stories that DCS approached women prior to sentencing to preemptively terminate parental rights, highlights a lack of acknowledgement of these women's parental rights and a broken system.

Women able to connect with a caseworker and get a plan for reunification faced another challenge. A lack of resources such as reliable transportation to get women to visits or parenting classes, stable housing, or support to facilitate successful completion of a treatment program made it impossible for many to be reunited with their children. Women able to retain child custody while in treatment are more likely to remain in treatment.<sup>74</sup> In 2015, only 19 of the 177 treatment facilities in Tennessee listed themselves as serving pregnant women, and only two were equipped to provide prenatal care on site or allow older children to stay with their mothers.<sup>30</sup> Findings from a study of mothers who abused drugs but were not incarcerated and received help found that these mothers had more favorable outcomes in retaining custody and improving overall life conditions for themselves and their children; 60% of the women who received social services and treatment were caring for their index child (the child they were carrying during the study) and had secured further stabilizations (remained clean, secured better housing, employment, support systems) for three years beyond initial contact.<sup>75</sup> Limited options for women to stay connected with their children or receive assistance diminishes the chance that treatment programs in Tennessee will be successful.

#### *Failings of the mandated drug treatment program*

Central to applying a reproductive justice lens is an understanding of the intersections of a person's life and how those intersections impact their ability to lead a healthy life, make healthy decisions, and raise a healthy family. A significant proportion of women in our study (over 70%) had experienced either sexual and/or physical abuse and had a family history of substance-use. Moreover, participants in our study were navigating financial hardship, unemployment, and domestic violence. The combination of these experiences prompted actions like transactional sex to support themselves and their families. Exposure to stressful experiences, such as abuse and substance use in the home and financial crisis, place these women at higher risk for substance use and addiction and require additional support for them to overcome these personal challenges.

Addiction is a debilitating disease and can lead to substance users feeling isolated and unsupported. In our study, reports of support varied from some to none. Importantly, emotional support appeared to be lacking for many. This lack of emotional support from family and friends at baseline because of their drug use may have influenced some women's abilities to successfully complete the treatment program as well as their abilities to achieve and sustain sobriety once they left the program. Similarly, low-income women who had no support system (i.e. family and/or partners) to provide finances or take care of their child(ren) while they completed the treatment program would have found it more difficult to navigate the court system or avoid losing custody of their older and newborn children. Finally, stories from women suggest that the perception that they were being judged because of their drug use (past or present) made some women hesitant to engage with traditionally supportive groups such as the church and larger community, as well as medical professionals. This hesitancy placed their health, and the health of their child, at risk, and limited their opportunities to be connected with needed services.

While several women in our study found participation in the mandated treatment program beneficial, there were others who felt that the program failed on two counts: embedding resources to facilitate women remaining drug free and providing resources to help re-integrate them into society. In the case of maintaining sobriety, women in this study point to an unavailability of innovative treatment programs as well as limited options for participation in support groups like AA once their time with the program was completed. Reviews of the literature suggests that participation in peer support groups improves rates of abstinence in substance-abusing populations,<sup>76</sup> significantly reduces relapse rates and return to homelessness,<sup>77</sup> and improves an individual's self-efficacy.<sup>78</sup> Detox alone without subsequent treatment or follow up is insufficient to help a person recover and generally leads to resumption of drug use. Therefore, extending the mandated treatment program beyond detox may have resulted in fewer women resuming drug use. Moreover, access to programs that help women maintain sobriety is particularly crucial for this population, because sobriety was a criteria for regaining custody of the child(ren) lost at the time of arrest/charge.

While a few women reported being able to take classes with their treatment program, many more reported that they would have benefited from access to classes that taught them "life skills." Similarly, only a handful of women were connected with services, most often housing, but few connected women with multiple services (housing and employment) once the program was completed. Studies of substance-using pregnant women in states other than Tennessee show that engagement with community social services as well as access to resources for intimate partner violence, education, employment, and other support systems contribute to the success or failure of a drug treatment program.<sup>79</sup> The stress associated with limited access to employment and housing post-release from the program resulted in many resuming drug use and/or re-engaging with criminal activity.

To combat the inadequacies of the treatment program, women suggested that the church and community could help fill gaps in services, e.g. churches and court houses could host AA meetings or serve as a connector between women recently released from jail or a program and social welfare programs.

### *Diminished quality of life*

The Fetal Assault Law had a negative impact on two quality of life indicators: employment and housing. From our listening sessions we learned that the road to re-integration into society was especially challenging for women who were charged. Low-income women were placed at further disadvantage because of the added court fees and fines and other debt that they found themselves with upon release. This starting debt extends the time needed for these women to achieve a healthy economic well-being and prove they are financially capable to support their child(ren).

Additionally, women expressed how difficult it was to find employment and stable housing because of their felony charge. The listening sessions were rife with stories of being denied housing, failure to secure employment, and the resulting stress of not being able to achieve these goals. Employment and housing were high priorities for women aiming to get their children back, as establishing a permanent residence and showing they were able to support the child were some of the criteria they had to meet for reunification. Similarly, transportation (such as access to a car or bus pass) was a priority for women because it helped improve their chances of securing employment by increasing the geographic perimeter within which they could search for job opportunities and helping them to get to the place of employment. Transportation also helped them to stay connected with drug recovery classes. This impact was compounded by the fact that many women in our study were already acquainted with the judicial system for reasons other than substance use during pregnancy. In a few cases, we found that having a prior criminal record resulted in a previous sentence being lengthened. More time imprisoned is less time spent earning to help lower debts and greater difficulty finding a job that pays more than minimum wage. Women in our listening sessions expressed a strong desire to contribute to society, but the added debt and weight of a felony charge made it extremely difficult for some to successfully re-integrate into society.

The reproductive justice framework's intent is to demonstrate that people's ability to control their bodies is directly related to their ability to maintain their lives and communities. However, the crafting and execution of the Fetal Assault Law overlooked these important factors and instead attempted to curb drug addiction through fear and criminalization rather than compassion and access to services. Our observation in this report supports the argument that women charged with fetal assault could have experienced alternate positive outcomes if social supports and comprehensive and culturally-sensitive health care and education were available and accessible to them before the passing of the law. Access to comprehensive reproductive and sexual health education at an early age could prevent not only drug use, but also ensure that women identify potentially harmful social encounters and deter them from participating in potentially harmful sexual practices. Similarly, if the aim of the law was to treat and re-integrate these women into society, then treatment programs must take into consideration the mental, social, and financial background of the women entering these programs to ensure that there are appropriate and sufficient social and structural supports to facilitate successful completion of the program.

## **SisterReach Recommendations**

Based on the results and implications, there are a few recommendations we can offer to states that have or are considering the passage of a Fetal Assault Law:

- Lawmakers, law enforcers, and the medical community (both maternal and behavioral health) should adopt and apply a reproductive justice lens to analyses before crafting, passing, or enforcing policy.
- The medical community should provide patient-centered and patient-informed treatment. We recommend that behavioral health and maternal health providers incorporate patients' voices, as experts of their lives and circumstances, to inform treatment and recovery needs and concerns.
- Include a comprehensive reproductive and sexual health education component to treatment and counseling that includes: information on the full range of birth control options (with no specific focus on one particular method's effect over another); education about risky behavior practices during pregnancy and the side effects of NAS on newborns; information on healthy and unhealthy relationships, including the potential of sexual assault while under the influence of drugs and alcohol; and information on local resources for reproductive and maternal health care.
- Drug courts and elected officials should cease attempts to regulate the behavior of people navigating drug addiction via punitive or incentivized programs around jail time or child custody.
- Churches, community resource agencies, and medical professionals should provide non-judgmental, safe, and affirming space for mothers navigating addiction. Additionally, they should connect mothers to evidence-based, human rights informed resources for reproductive and sexual health education, needs-specific community support, and care continuum resources.
- Expand behavioral health and treatment programs that include housing specifically for low-income women who are pregnant and women who already have children to decrease the rate of recidivism in rehabilitation programs and to keep families together.
- Provide counseling and social support to impacted children and families while mothers participate in rehabilitation programs.

## **Specific recommendations from women impacted by the law**

Women in our study suggested several actions the community can take to help individuals struggling with drug addiction, including:

- Making more programs available and/or strengthening existing programs for recovering addicts. For example, churches and courthouses could serve as additional locations for recovery meetings.
- Directly provide and/or connect women recently released from jail or who have recently finished a treatment program with support services, including parenting classes and marriage counseling.
- Increasing public knowledge about addiction as a disease to reduce stigma. Churches can also make an effort to welcome individuals struggling with addiction to decrease stigma.
- Providing more resources or programs that could lessen the economic burden of legal fees, transportation costs, and expenses associated with child support.

## Conclusion

SisterReach's main objective with this research study was to use a reproductive justice framework to center and uplift the voices, leadership, trauma, and experiences of those most impacted by the Fetal Assault Law. It is our hope that this report will spark research around the country to pinpoint specific needs of marginalized mothers, children, and families, as well as support the drafting of policies that will provide the necessary support and services to help women undergo successful addiction treatment and raise healthy families.

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Appendix I: Screener, fetal assault listening session

**FETAL ASSAULT FOCUS GROUP PARTICIPANT SCREENING QUESTIONNAIRE**

**SCREENING SHEET**

Procedure: To be eligible an individual must give a “yes” answer to the following questions and meet the federal poverty income guidelines as outlined below.

<i>Step One</i>	<i>Step Two</i>	<i>Step Three</i>	<i>Step Four</i>
<p>What is your age? _____</p> <p>Is participant 18 or older?  ____ Yes ____ No <b>no: ineligible</b></p>	<p>Were you living in TN between July, 1, 2014 and July 1, 2016?  ____ Yes ____ No <b>no: ineligible</b></p>	<p>Do you live in or around:  ____ Memphis ____ Nashville ____ Knoxville</p>	<p>Were you arrested/charged as a result of the Fetal Assault Law?  ____ Yes ____ No  <b>Yes = impacted</b> <i>(if yes to steps 1, 2, 3, &amp; 4)</i>  <b>No = potentially impacted</b> <i>(if yes to steps 1, 2, and 3)</i></p>
<p>Were you pregnant between July, 1, 2014 and July 1, 2016?  ____ Yes ____ No <b>no: ineligible</b></p>	<p>Were you using substances during your pregnancy?  ____ Yes ____ No <b>no: ineligible</b></p>	<p>How many people live in your household? (Please include yourself in this count) _____</p> <p>What is your estimated total household income (per month/week?)  _____ <i>(to be eligible, participant must fall within one of the categories based on family size, see chart)</i></p>	

2017 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add \$4,180 for each additional person.	
1	\$12,060
2	\$16,240
3	\$20,420
4	\$24,600
5	\$28,780
6	\$32,960
7	\$37,140
8	\$41,320

***If Eligible,***

1. What kind of substances were you using during your pregnancy?

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2. Did you deliver a baby \_\_\_\_yes \_\_\_\_no (if no- skip question)
  - a) Did you deliver in Tennessee? \_\_\_\_yes \_\_\_\_no (if no- ask question b)
  - b) Did you deliver in a different state? \_\_\_\_yes \_\_\_\_no ( if yes, please list state: \_\_\_\_\_)

*-If **not** Eligible, Thank you for your interest in our listening session. Unfortunately, you did not meet one or more of our criteria for participation.*

## Appendix II: Demographic table

**TABLE 1: PARTICIPANT DEMOGRAPHICS (n=41)**

<b>Age</b>	<b>n</b>	<b>%</b>
18-29	13	32%
30-39	15	37%
40-49	9	22%
50+	2	5%
No response	2	5%
<b>City of Residence</b>		
Memphis	32	78%
Nashville	5	12%
Knoxville	4	10%
<b>Children</b>		
No children	4	10%
One child or more	36	88%
No response	1	2%
<b>Educational Attainment</b>		
Did not complete high school	8	20%
Diploma/General education degree	26	63%
Bachelor's degree	4	10%
Master's degree	1	2%
Doctorate degree	0	0%
No response	2	5%
<b>Employment Status</b>		
Employed	9	22%
Self	1	2%
Unemployed	29	71%
No response	2	5%
<b>Marital Status*</b>		
Married	3	7%
Single	24	59%
Divorced	4	10%
Separated	5	12%
Co-Habiting*	6	15%
<b>Race</b>		
Caucasian/White	20	49%
African American/Black	18	44%
Mixed race	2	5%
No response	1	2%

\*One participant selected both single and co-habiting