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NOTE

Control, Not Care: The Conflict Between Minnesota's Prenatal Substance Use Statutes and Reproductive Rights

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ABSTRACT

This Note argues that Minnesota's prenatal substance use statutes, enacted in response to the racialized "crack baby" panic of the late 1980s, violate the state constitutional protections for reproductive rights affirmed in Doe v. Gomez *and codified in the 2023 Protect Reproductive Options (PRO) Act. By classifying prenatal substance use as child abuse, these laws embed the logic of fetal personhood into the child welfare framework and create a separate, unequal system of compelled treatment for pregnant individuals who use substances. Although treatment is framed as voluntary, noncompliance triggers involuntary civil commitment under a vague and discriminatory standard that bypasses due process protections and permits compelled treatment without informed consent.*

These statutes disproportionately target Black and Native pregnant individuals, deter prenatal care, and rest on outdated, scientifically discredited assumptions about substance use and fetal harm. Therefore, they cannot withstand strict scrutiny and are fundamentally incompatible with Minnesota's constitutional and statutory protections of reproductive freedom and should be repealed.

*While based on Minnesota law, the article has broader significance. Twenty-four states and Washington, D.C., classify substance use during pregnancy as child abuse or neglect. At least four others—Oklahoma, North Dakota, South Dakota, and Wisconsin—permit involuntary commitment and compel treatment for prenatal substance use. In the post-*Dobbs *era, punitive laws targeting perceived risks to fetal health—often grounded in the logic of fetal personhood—threaten reproductive rights even in states that have codified protections.*

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INTRODUCTION

Following the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* (2022), which overturned *Roe v. Wade* (1973) and ended federal constitutional protections for abortion, Minnesota moved quickly to protect reproductive rights at the state level.[1] On January 31, 2023, Governor Tim Walz signed the Protect Reproductive Options (PRO) Act into Minnesota law, codifying the right to abortion and other reproductive health care. The legislation advanced swiftly through committee and ultimately passed, likely made possible by unified Democratic control of state government.

With the passage of the PRO Act, Minnesota became the first state to enact statutory protections for abortion access following *Dobbs*.[2] Before signing the bill into law, Governor Walz stated, "[t]o Minnesotans, know that your access to reproductive health and your right to make your own healthcare decisions are preserved and protected."[3] At the time, Minnesota was surrounded by states with strict abortion bans poised to take effect or be enforced if *Roe v. Wade* was overturned, including North Dakota, South Dakota, and Wisconsin.[4] The Center for Reproductive Rights began tracking abortion laws by state and developed a color-coded system to reflect the level of legal protection for abortion visually.[5] On that map, Minnesota appears as a lone green state (expanded abortion access) amid a region dominated by maroon (illegal) and red (hostile), including one state attempting to enforce a criminal abortion statute from the 19th century.

While Minnesota expanded access to abortion through the PRO Act's recognition of a statutory right to reproductive freedom, its neighboring states regressed. However, as legal scholar Michele Goodwin cautions, centering abortion as the sole focus of reproductive rights risks obscuring the broader set of choices and protections essential to women's health, autonomy, privacy, and equality.[6] This broader framing may explain the PRO Act's expansive language. However, when viewed through a more holistic reproductive justice lens, Minnesota's statutory landscape becomes more complex and possibly less favorable than the map indicates.[7]

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1. Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022); Roe v. Wade, 410 U.S. 113 (1973), *modified by* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

2. Jennifer Calfas, *Minnesota Enacts Rights to Abortion*, WALL ST. J. (Feb. 1, 2023) https://www.wsj.com/articles/minnesota-with-new-democratic-control-enacts-state-abortion-rights-11675190873 [https://perma.cc/5PJT-45JV].

3. *Id.*

4. *See* Act of Apr. 26, 2007, ch. 132, 2007 N.D. Laws 617, *invalidated by* Wrigley v. Romanick, 988 N.W.2d 231, 244 (N.D. 2023) (felony prohibition with life and rape/incest exceptions); S.D. CODIFIED LAWS § 22-17-5.1 (2025) (trigger ban with only life-of-mother exception); WIS. STAT. ANN. § 940.04 (West 2025) (post-*Dobbs* uncertainty over enforceability of 1849 criminal abortion ban; held impliedly repealed by Kaul v. Urmanski, 22 N.W.3d 740 (Wis. 2025)).

5. *After Roe Fell: Abortion Laws by State*, CTR. FOR REPROD. RTS., https://reproductiverights.org/maps/abortion-laws-by-state/ [https://perma.cc/VD9H-DRBD] (last visited May 2, 2025).

6. MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD 13 (2020).

7. The term "reproductive justice" was coined in 1994 by Black feminists as a human rights framework that includes not only the right to not have a child but also the right to have children and to

Governor Walz's promise that the PRO Act protects the right to make one's own health care decisions appears not to extend to individuals who use substances during pregnancy. As the Task Force on Pregnancy Health and Substance Use Disorders reported, Minnesota has some of the most punitive laws in the country for substance use during pregnancy. The state is one of 24 that designate prenatal substance exposure or substance use as child abuse or neglect, and one of only 5 that permit the involuntary commitment of pregnant individuals to treatment programs.[8] Part of what was known at the time as the "Cocaine Baby" Bill, these statutes trace their origin to the "crack baby" panic of the late 1980s. Fueled by sensationalized media coverage and exaggerated data, the panic was used to justify a legal response that equated substance use during pregnancy with child abuse at a time when fetal rights were being expanded without careful legal scrutiny or sufficient attention to their far-reaching implications for reproductive autonomy.[9]

Minnesota's prenatal substance use statutes are fundamentally incompatible with the state's constitutional and statutory guarantees of reproductive freedom. The Minnesota Supreme Court's decision in *Doe v. Gomez* recognizes a state constitutional right of privacy that protects an individual's reproductive decision-making autonomy, free from government interference, at least until fetal viability.[10] The PRO Act codifies and expands this principle, affirming that the right to make autonomous decisions about reproductive health, including the right to refuse care, is not suspended due to pregnancy status.[11] However, provisions regarding prenatal substance use establish a pregnancy-related exception to these protections.

Through mandatory reporting provisions in the child welfare statutes and a separate, lower standard for involuntary commitment, the state compels chemical dependency treatment for pregnant individuals suspected of substance use based on vague and undefined criteria. These statutes elevate fetal interests above those of the pregnant person, embedding the logic of fetal personhood into the statutory framework and undermining the bodily autonomy that the Minnesota Constitution, as interpreted in *Doe v. Gomez*, and the PRO Act are meant to protect.

This Note argues that Minnesota's prenatal substance use statutes are not only outdated and scientifically unsound, but also constitutionally infirm and should be repealed. Part II reviews the contradiction between the reproductive rights protections affirmed in *Doe v. Gomez* and the PRO Act and the prenatal substance exposure statutes. Part III situates the statutes within their historical context, tracing their origins to the "crack cocaine" scare and revealing how the racialized panic over the "crack baby" influenced legislative responses. Part IV

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raise them with dignity in safe, healthy, and supportive environments. DOROTHY ROBERTS, KILLING THE BLACK BODY xix (Vintage Books 2017) (1997).

8. TASK FORCE ON PREGNANCY HEALTH AND SUBSTANCE USE DISORDERS, MINN. DEP'T OF HEALTH, RECOMMENDATIONS TO THE MINNESOTA LEGISLATURE 11 (2024).

9. Dawn E. Johnsen, *Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L. J. 599, 600 (1986).

10. Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17, 31 (Minn. 1995).

11. *See* MINN. STAT. § 145.409, subdiv. 3 (2025).

presents the core legal argument: the prenatal substance exposure statutes expand the child welfare and civil commitment frameworks in ways that implicitly promote a fetal personhood agenda, impose vague and unequal standards on pregnant individuals, and violate due process and the right to refuse reproductive health care, disproportionately harming marginalized groups. Together, these provisions not only conflict with existing constitutional protections but also normalize the treatment of pregnancy as a condition that warrants the suspension of civil rights.[12]

I. Minnesota's Reproductive Freedom Protections

The Minnesota Supreme Court's 1995 decision in *Doe v. Gomez* interpreted the state constitution to provide broader protections for reproductive freedom than the Federal Constitution, grounding the right to choose abortions in the fundamental right of privacy.[13] The 2023 codification of its core holding in the PRO Act, passed in the wake of *Dobbs*, was ostensibly a "continued" commitment to safeguarding individual autonomy in reproductive decision-making, as Governor Walz claimed.[14] But this commitment has never been consistent. Five years before *Gomez*, Minnesota enacted punitive laws targeting substance use during pregnancy, laws passed under the guise of public health but rooted in the racialized panic over so-called "crack babies" in the late 1980s. By labeling prenatal exposure as child abuse and lowering the standard for involuntary commitment and chemical dependency treatment, these laws create a parallel system of compelled treatment for pregnant individuals who use substances and undermine bodily autonomy by embedding the logic of fetal personhood into the child protection and civil commitment frameworks.

A. Doe v. Gomez *and the Right to Make Reproductive Health Decisions*

The Minnesota Supreme Court's ruling in *Doe v. Gomez* is understood to have established a fundamental right to abortion under the Minnesota Constitution.[15] At the time, Minnesota's medical assistance program (MA) covered comprehensive pregnancy-related services and prenatal care.[16] However, the legislature enacted several statutes to restrict the use of those same funds to cover abortion-related services in three narrow circumstances due to the State's policy of encouraging childbirth

12. Note on language: The term "pregnant woman" is used when referring to statutes from the 1980s to 1990s that specifically targeted women's bodies. For contemporary frameworks, more inclusive terms like "pregnant person" or "pregnant individual" are also employed. In line with guidelines from the National Institute on Drug Abuse, this paper uses person-first and non-stigmatizing language, such as "substance" instead of "drug," "use" instead of "abuse," and "substance use disorder" instead of "addiction," except when citing sources or referencing historical language. *Your Words Matter—Language Showing Compassion and Care for Women, Infants, Families, and Communities Impacted by Substance Use Disorder*, Nat'l Inst. on Drug Abuse (Nov. 17, 2023), https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-language-showing-compassion-care-women-infants-families-communities-impacted-substance-use-disorder [https://perma.cc/7CVL-6BSG].

13. *Gomez*, 542 N.W.2d at 30–31.

14. *See* Minn. Stat. § 145.409 (2025); Calfas, *supra* note 2.

15. *Gomez*, 542 N.W.2d at 27 (finding that the fundamental right of privacy under the Minnesota Constitution encompasses a woman's right to decide to terminate her pregnancy).

16. *Id.* at 23.

over abortion.[17] The issue before the court was whether the State's exclusion of otherwise eligible individuals from MA, because it disagreed with their reproductive health care decision, infringed on a woman's fundamental right of privacy under the state constitution.[18] The court held that it did, reasoning that by so severely limiting the circumstances under which MA would cover abortion, the State impermissibly burdened the fundamental right to choose abortions for women needing financial assistance for such services.[19] The court's holding resulted in broader protection for abortion rights under the Minnesota Constitution than under the U.S. Constitution by affirming that the fundamental right of privacy protects not only the right to have an abortion but also the right to decide whether to have one: "any legislation infringing on the decision-making process . . . violates this fundamental right [of privacy]."[20]

B. The PRO Act: Codifying Reproductive Freedom

The PRO Act codifies the holding in *Doe v. Gomez*, tying the right to reproductive health care decisions to principles it describes as recognized in the Minnesota Constitution: individual liberty, personal privacy, and equality.[21] According to the Act, these principles "ensure," though do not independently guarantee, reproductive freedom.[22] In this way, the Act seeks to clarify what *Gomez* implied but did not explicitly define. It refers to "reproductive health care" and related rights as fundamental rights no less than six times, thereby signaling that they are entitled to the same level of protection as other constitutionally protected rights and that any state policy burdening them must withstand strict scrutiny.[23] However, because the PRO Act is statutory rather than constitutional, its protections are only as durable as the statute itself unless its principles are enshrined through constitutional amendment.

Under the PRO Act, reproductive freedom includes "the fundamental right to use or refuse reproductive health care," which is broadly defined as health care offered, arranged, or furnished to improve maternal or birth outcomes.[24] According to this definition, treatment for pregnant individuals who use substances, whether provided voluntarily or compelled, falls within the scope of reproductive health care. When that treatment is coerced—such as under Minnesota's current civil commitment framework—the individual is effectively denied the right to refuse reproductive health care. Consequently, the existing statutory

17. *Id.* at 19.

18. *Id.* at 28.

19. *Id.* at 29–31 (citing favorably Justice Brennan's dissent in Harris v. McRae, 448 U.S. 297, 333–34 (1980) criticizing the majority's decision to uphold the constitutionality of the Hyde Amendment, a federal provision restricting the use of Medicaid funds for abortions).

20. *Id.* at 31.

21. MINN. STAT. § 145.409, subdiv. 4 (2025).

22. *Id.*

23. *Id.* § 145.409, subdiv. 3–5.

24. *Id.* § 145.409, subdiv. 2–3.

scheme contradicts the protections outlined in the PRO Act and undermines the autonomy the Act claims to uphold.

C. State Laws on Prenatal Substance Use

Minnesota's laws concerning prenatal substance exposure are codified in the state's statutes on reporting maltreatment of minors, which has the express policy goal of "protect[ing] children and promot[ing] child safety,"[25] and civil commitment.[26] Passed in 1989 as part of the so-called "Cocaine Baby" Bill, these laws were a legislative response to the perceived crisis of substance use among pregnant women, particularly low-income Black women, and the alleged long-term societal costs of their so-called "crack babies." Though framed as public health measures, these provisions function as systems of surveillance and control. They subordinate the bodily autonomy of pregnant persons to the interests of the fetus, embedding the logic of fetal personhood into both the child welfare and civil commitment frameworks. In doing so, they create a parallel legal system that prevents pregnant people from refusing care, directly conflicting with the reproductive freedom protections ostensibly guaranteed under *Gomez* and the PRO Act.

1. Prenatal Substance Exposure or Substance Use as Child Abuse or Neglect

Within Minnesota law, the definition of neglect includes "prenatal exposure to a controlled substance," determined through a newborn's symptoms or toxicology tests performed on the mother or child at birth.[27] Under Minnesota Statutes section 260E.31, a medical professional is required to report suspected prenatal substance exposure to a local welfare agency unless they are currently providing care to the pregnant individual or the infant.[28] In addition, anyone may make a voluntary report.[29]

Toxicology testing is also a core component of this framework. If a pregnant woman presents with "obstetrical complications that are a medical indication" of substance use, a toxicology test must be administered within eight hours of delivery.[30] A positive toxicology result must be reported to a welfare agency under section 260E.31, subdivision 1.[31] A negative test result does not relieve medical professionals of the obligation to report if there is other evidence of substance use.[32] Similarly, a toxicology test of the newborn is required if the physician has

25. *Id.* § 260E.01.
26. *Id.* § 253B.01.
27. *Id.* § 260E.03, subdiv. 15(a)(5).
28. *Id.* § 260E.31, subdiv. 1(a)–(b).
29. *Id.* § 260E.31, subdiv. 1(c).
30. *Id.* § 260E.32, subdiv. 2.
31. *Id.* §§ 260E.31–32. Other relevant indications of substance use include refusal of drug testing, altered mental state, physical indicators such as intravenous track marks, prior infant exposure to substances, history of child abuse, incarceration, or unexplained premature birth before 37 weeks. *See* CRESTA JONES, LEGAL IMPLICATIONS OF PERINATAL SUBSTANCE USE 36 (unpublished presentation materials) (on file with author).
32. MINN. STAT. § 260E.32, subdiv. 1 (2025).

reason to believe, based on a medical assessment, that there was prenatal exposure.[33] The same reporting requirements under section 260E.32, subdivision 1 apply.[34]

2. Involuntary Commitment to a Treatment Program for Prenatal Substance Use

The civil commitment chapter defines a "chemically dependent person" for emergency admission under section 253B.051 as someone who: 1) is incapable of self-management due to habitual and excessive use of controlled substances; and 2) whose recent conduct, resulting from that use, poses a substantial likelihood of harm to self or others, as demonstrated by threats or harm to self or others, or a severe deterioration in condition.[35] However, the statute provides a distinct and broader definition for pregnant individuals: "'Chemically dependent person' also means a pregnant woman who has engaged during the pregnancy in habitual or excessive use" of controlled substances, including alcohol, without requiring evidence of incapacity to self-manage or substantial likelihood of harm.[36] This chapter also includes a section on the rights of patients during civil commitment, stating that patients must provide prior consent to medical or surgical treatment—*except* for treatment related to chemical dependency.[37] As a result, pregnant women involuntarily committed for substance use cannot withhold consent to that treatment.

II. Background: From the "Crack Baby" Panic to Civil Commitment

The prenatal substance use statutes, enacted in 1989 as part of the so-called "Cocaine Baby" Bill, were a product of the moral panic surrounding prenatal substance use, particularly involving crack cocaine. The following section examines the historical and cultural forces that fueled this panic, particularly the racialized "crack baby" myth, and how they shaped Minnesota's legislative response, ultimately resulting in the punitive use of civil commitment and the subordination of pregnant women's rights in the name of fetal protection.

A. The "Crack Baby" Panic and Its Legacy

The emergence of crack cocaine—a smokable form of cocaine named for the crackling sound it makes when burned—in the mid-1980s led to what historians identify as the most intense drug scare of the 20th century.[38] Drug scares are not rooted in the actual dangers of a substance but in efforts to link social anxieties with a demonized substance and a scapegoated group, often racial or ethnic

33. *Id.* § 260E.32, subdiv. 2.
34. *Id.* § 260E.32, subdiv. 2(b).
35. *Id.* §§ 253B.02, subdiv. 2, 253B.051.
36. *Id.* § 253B.02, subdiv. 2.
37. *Id.* § 253B.03, subdiv. 6.
38. Craig Reinarman & Harry G. Levine, *Crack in Context: America's Latest Demon Drug, in* Crack in America: Demon Drugs and Social Justice 1, 2–3 (Craig Reinarman & Harry G. Levine eds., 1997) [hereinafter Reinarman & Levine, *Crack in Context*].

minorities.[39] One of the most damaging legacies of the crack cocaine scare was the myth of the "crack baby," which cast pregnant women who used substances, particularly Black women, as unfit mothers who created dangerous threats to fetal health, ostensibly justifying punitive state intervention in the name of child welfare.

1. The War on Drugs

Crack cocaine became a racialized symbol of societal collapse. Fears about its use fueled harsh state responses that gained widespread legitimacy and broad public support.[40] Between the early 1970s and 1992, federal anti-drug spending surged from $200 million to $13 billion, with more than two-thirds devoted to policing and incarceration, and very little to prevention or treatment.[41] The U.S. prison population more than doubled from 330,000 in 1981 to 804,000 in 1991.[42] During that same period, federal drug offense convictions rose by 213%.[43] In 1989 alone, 35% of all Black males aged 16 to 35 were arrested.[44]

Although the media and politicians warned of a nationwide crack epidemic in the late 1980s, crack cocaine use was never as widespread as it was portrayed.[45] Its use was concentrated in impoverished inner-city neighborhoods, where its low cost, ease of manufacture, and instantaneous and intense high made it a form of escape for many facing the daily indignities of living in poverty.[46]

2. The "Crack Baby" Myth

The "crack baby" myth originated from sensationalized media coverage of a 1985 *New England Journal of Medicine* study by Dr. Ira Chasnoff, which suggested that prenatal cocaine exposure might negatively affect infant neurological behavior.[47] Although the study emphasized that its findings were preliminary and required further research, media outlets reported the results as conclusive proof

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39. *Id.* at 1.

40. *Id.*

41. LAURA E. GÓMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE 2 (1997) (breaking down federal anti-drug spending); Beverly Xaviera Watkins & Mindy Thompson Fullilove, *The Crack Epidemic and the Failure of Epidemic Response*, 10 TEMP. POL. & CIV. RTS. L. REV. 371, 380 (2001) (critiquing the public health response).

42. MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS 59 (2010) (linking drug policy to the mass incarceration of people of color).

43. Troy Duster, *Pattern, Purpose, and Race in the Drug War: The Crisis of Credibility in Criminal Justice, in* CRACK IN AMERICA, at 263–64 (explaining that Black males are twice as likely to be arrested as white males due to harsher sentencing for crack cocaine compared to powder cocaine).

44. *Id.*

45. Craig Reinarman & Harry G. Levine, *The Crack Attack: Politics and Media in the Crack Scare, in* CRACK IN AMERICA, at 33–34 (challenging the notion that crack use was spreading rapidly and widely enough among the general population to qualify as an epidemic in the strict sense) [hereinafter Reinarman & Levine, *The Crack Attack*].

46. Reinarman & Levine, *Crack in Context*, *supra* note 38, at 2 (acknowledging that the rapid spread of crack use among African American and Latino youth in impoverished urban neighborhoods during the mid- to late-1980s may have met that threshold).

47. Ira Chasnoff et al., *Cocaine Use in Pregnancy*, 313 NEW ENG. J. MED. 666 (1985).

of irreversible harm.[48] Thirteen years later, Chasnoff published a follow-up study that found no cognitive impairment resulting from prenatal cocaine use.[49] Nevertheless, the panic that had already taken hold—reflected in punitive fetal protection policies such as Minnesota's "Cocaine Baby" law—persisted. These policies were driven by exaggerated interpretations of early data and sustained by the broader cultural climate of the crack cocaine scare, not by subsequent scientific evidence.

In 1988, the National Association for Perinatal Addiction Research and Education (NAPARE) estimated that 375,000 infants were born annually with prenatal substance exposure.[50] Though the figure referred only to exposure, the media frequently mischaracterized it as evidence of widespread fetal harm.[51] These inflated estimates, combined with the false belief that the chemical properties of crack cocaine "stripped" women of maternal instinct, fueled a broader panic regarding not just individual children, but also about the economic and social burden their care would impose on public systems.[52]

Concerns were raised about a so-called "bio-underclass" unable to care for themselves.[53] This notion blended biological determinism, stemming from distorted interpretations of Chasnoff's findings, with racialized stereotypes of the urban underclass as a product of criminality, drug use, and the extreme poverty presumed to be endemic to inner cities.[54] The term itself implied a hierarchy of human worth, suggesting that infants exposed to crack cocaine were not only disadvantaged but also less deserving, destined to become the next generation of inner-city "burdens."[55]

Public anxiety about the economic cost of caring for these children was reinforced by classist and racist assumptions. The belief that the "poor choose to be poor"[56] and that Black Americans in particular preferred to live on welfare[57] intensified the narrative of social breakdown. Representative George Miller, Chair of the U.S. House Select Committee on Children, Youth, and Families, warned that "[t]hese children, who are the most expensive babies ever born in

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48. *Id.* at 666.

49. Ira Chasnoff et al., *Prenatal Exposure to Cocaine and Other Drugs: Outcome at Four to Six Years*, 846 ANNALS N.Y. ACAD. SCI. 314 (1998).

50. ROBERTS, *supra* note 7, at 156.

51. *Id.*

52. *See, e.g.*, Paul McEnroe, *Violence, Despair Tarnish Hope for New Generation*, STAR TRIB., Feb. 11, 1990, at 1A ("This crack—nothing like it ever, I tell you. . . . It removes the maternal instinct from a mother and then the children don't matter. It removes your humanity."); Michael DeCourcy Hinds, *The Instincts of Parenthood Become Part of Crack's Toll*, N.Y. TIMES, Mar. 17, 1990 ("The maternal instinct gets blocked out because the only thing that matters is the addiction.").

53. *See* Charles Krauthammer, *Children of Cocaine*, WASH. POST, Jul. 30, 1989 ("The inner-city crack epidemic is now giving birth to the newest horror: a bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth.").

54. *See* Erika Derkas, *"Don't Let Your Pregnancy Get in the Way of Your Drug Addiction": CRACK and the Ideological Construction of Addicted Women*, 38 SOC. JUST. 115, 129–30 (2012) (deconstructing the gendered, class-based, and racialized rhetorical strategies used by the media to represent pregnant women who used substances).

55. *Id.*

56. *Id.*

57. ROBERTS, *supra* note 7, at 17.

America, are going to overwhelm every social service delivery system that they come in contact with throughout the rest of their lives."[58] A bleak future was anticipated for the child.[59]

By centering crack cocaine, the "crack baby" myth not only vilified pregnant women who used substances, but poor Black women in particular. Although usage patterns did show a racial gap, with Black Americans nearly twice as likely as white Americans to report using crack cocaine, the media overrepresented Black people in coverage about the so-called epidemic.[60] This racialized framing laid the foundation for punitive state interventions, legitimizing the suspension of pregnant women's constitutional rights in the name of fetal protection and state interest.

3. "Bad Moms," Black Moms

The moral panic surrounding prenatal drug use and the punitive legal responses it provoked cannot be separated from the intersecting dynamics of gender, race, and class. Sociologists James Inciardi, Dorothy Lockwood, and Anne Pottieger were among the first to document how crack cocaine use was perceived differently based on gender.[61] While substance use among men was often excused or minimized ("boys will be boys"), women were judged more harshly.[62] Their behavior transgressed gender norms, casting them not only as irresponsible but as categorically unfit for motherhood.[63]

The archetypal opposite of the "good mother" became the pregnant woman who used substances.[64] This figure was quickly racialized as Black due to the intense focus on crack cocaine use.[65] Legal scholar Dorothy Roberts has argued that associating prenatal substance use with Black women reflects a longer history of devaluing Black motherhood that dates back to slavery and has been perpetuated through successive tropes of the "bad Black mother," such as the welfare queen.[66] Because the imagined harm occurred in the historically degraded and policed body of a Black woman, these women became uncontroversial targets for the state's fetal protection efforts.[67]

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58. RETRO REPORT, *From Crack Babies to Oxytots: Lessons Not Learned*, at 00:44-00:53 (YouTube, July 22, 2015), https://retroreport.org/video/from-crack-babies-to-oxytots-lessons-not-learned/ [https://perma.cc/28FH-3P24].

59. WENDY A. BACH, PROSECUTING POVERTY, CRIMINALIZING CARE 51 (2022) (describing "a life of certain suffering, of probable deviance, of permanent inferiority").

60. GÓMEZ, *supra* note 41, at 15.

61. JAMES A. INCIARDI ET AL., WOMEN AND CRACK-COCAINE 22–24 (1993).

62. *Id.* at 22.

63. *Id.* at 23.

64. *Id.*

65. ROBERTS, *supra* note 7, at 156–57.

66. *Id.*

67. *Id.* at 154.

B. Minnesota's Civil Response to the "Crack Baby" Panic

Minnesota's conscience was shocked by the state's own "cocaine baby" case in the summer of 1989, at the height of the national crack cocaine scare, when a nurse discovered Gayle Turenne injecting cocaine into her wrist in a hospital delivery room.[68] Turenne was charged with simple possession of cocaine, a felony punishable by up to five years in prison.[69] When the story broke, WCCO Radio, "Minnesota's good neighbor," asked its listeners, "[w]ould you support more government funding to battle cocaine addiction among pregnant women?"[70] Eighty-nine percent of the 164 callers said no.[71] While the poll was not scientific, the radio station's listenership and the responses to its morning question likely reflected prevailing public opinion in Minnesota at the time.[72] Although informal, the poll results suggest that public sentiment favored punitive responses over treatment for pregnant women who used substances, reflecting a broader tendency to view them as people who make trouble rather than as people in trouble.[73]

1. "Distributing Cocaine in a Schoolyard"

Ramsey County District Judge James Campbell was known as a "liberal" judge who favored treatment over incarceration for drug offenses.[74] However, Turenne's behavior tested his empathy and reason. He sentenced her to 26 months in prison, more than double the probationary term recommended by state guidelines for simple possession.[75] He was "mad as hell" because, as he put it, "[u]nlike most cocaine offenses, there was a victim in this case."[76] Her crime, he argued, was "roughly akin to distributing cocaine in a schoolyard."[77] Invoking the image of distributing controlled substances to an innocent child in a schoolyard—a crime associated with heightened penalties and moral outrage—Judge Campbell recharacterized Turenne's actions as criminal child endangerment, despite her only being charged with possession. This notion that prenatal substance use caused the fetus to experience the same "high" as the pregnant individual also reflected common public misunderstandings about how prenatal exposure impacted the fetus.[78]

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68. Conrad deFiebre, *Charges in Delivery-Room Drug Case: Police Say Mom Tried to Use Cocaine Before Giving Birth*, STAR TRIB., Aug. 10, 1989 [hereinafter deFiebre, *Charges*].

69. *Id.*

70. Doug Grow, *Turning Our Backs on Addiction Isn't Answer*, STAR TRIB., Aug. 10, 1989.

71. *Id.*

72. *Id.*

73. Katherine Beckett, *Fetal Rights and "Crack Moms": Pregnant Women in the War on Drugs*, 22 CONTEMP. DRUG PROBS. 587, 588 (1995).

74. Conrad deFiebre, *Woman Who Used Cocaine During Birth Gets Harsh Sentence*, STAR TRIB., Oct. 20, 1989 [hereinafter deFiebre, *Harsh Sentence*].

75. *Id.*

76. Conrad deFiebre, *Judge Turns from Anger, Hoping to Help Addicted Mother*, STAR TRIB., Nov. 10, 1989 [hereinafter deFiebre, *Turns from Anger*]; deFiebre, *Harsh Sentence*, *supra* note 74.

77. deFiebre, *Harsh Sentence*, *supra* note 74.

78. *See, e.g.*, ROYAL COLL. OF OBSTS. & GYNS., RCOG FETAL AWARENESS EVIDENCE REVIEW 9 (2022), https://www.rcog.org.uk/media/gdtnncdk/rcog-fetal-awareness-evidence-review-dec-2022.pdf

Ultimately, Judge Campbell reduced Turenne's sentence to five years of probation on the condition that she serve six months in the workhouse and attend Alcoholics or Narcotics Anonymous meetings throughout the probationary period.[79] He was swayed by the discovery that, months earlier, she had been convicted of a drug charge but had never received the court-ordered treatment.[80] Two counties had disputed who would pay for her rehabilitation, and as a result, she had been denied the help she needed.[81] In 1989, only about 11% of pregnant women in need of services were receiving treatment, as few programs accepted pregnant women, especially those who were low-income or publicly insured.[82] A 12-step program did not provide the level of support that women like Turenne needed.

While there was no criminal statute on which Judge Campbell could base his harsh sentence, a newly enacted civil statute, prompted by public outrage over prenatal substance exposure, treated substance use during pregnancy as equivalent to harm to a child.

2. Legislative Origins and Fetal-Centered Framing

Minnesota's so-called "cocaine babies" law was publicly framed as a compassionate measure to ensure that pregnant women with substance use disorders received treatment.[83] In practice, however, it functioned as a child protection statute—one that re-centered the fetus as the primary patient and recast the pregnant woman as a source of harm. This legal shift enabled the state to subordinate the pregnant woman's rights in the name of fetal protection.

Dr. Virginia Lupo, then director of maternal-fetal medicine and high-risk obstetrics at Hennepin County Medical Center, played a key role in advancing the law. In a 1989 study, she found evidence of cocaine in the urine of 2.9% of women in labor and delivery, and cannabis in 7%.[84] Although the sample was limited and the findings not contextualized by social determinants of health, Lupo described the findings in apocalyptic terms, likening the crisis of substance-exposed infants to "the plagues of the Middle Ages."[85] The Hennepin County Attorney's Office

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[https://perma.cc/JV49-XAWZ] (suggesting that a fetus's central nervous system function is not developed enough to experience pain until at least 28 weeks).

79. deFiebre, *Turns from Anger*, *supra* note 76.

80. *Id.*

81. *Id.*

82. JANINE M. BREYEL & IAN T. HILL, NAT'L GOVERNORS' ASS'N, CREATING SYSTEMS OF CARE FOR SUBSTANCE-USING PREGNANT WOMEN AND THEIR CHILDREN 16 (1993).

83. Randy Furst, *Pregnant Drug Users Are Focus of New Law*, STAR TRIB., Aug. 3, 1989.

84. Judith M. Nyhus Johnson, *Minnesota's Crack Baby Law: Weapon of War or Link in a Chain*, 8 LAW & INEQ. 485, 488 (1990). The study was conducted on 200 blinded urine samples from 1,800 women in nine Minneapolis and St. Paul hospitals. *Id.* The 1988 NAPARE study found that at least 11% of women in the hospitals studied had used controlled substances during pregnancy. *See* Jane E. Brody, *Widespread Abuse of Drugs by Pregnant Women Is Found*, N.Y. TIMES, Aug. 30, 1988, at A1. The most recent data from the Substance Abuse and Mental Health Services Administration (SAMHSA) report marijuana use among pregnant women at 9.6% and cocaine use at 0.0% in 2022. CTR. FOR BEHAV. HEALTH STAT. & QUALITY, NATIONAL SURVEY ON DRUG USE AND HEALTH: 2021 AND 2022 tbl. 8.27B (2023).

85. McEnroe, *supra* note 52, at 18A.

used this data to lobby for the "Cocaine Baby" reporting statute, which the state legislature passed as part of the 1989 Omnibus Crime Bill.[86]

The law amended the definition of "neglect" in Minnesota's child protection statute to include "prenatal exposure to a controlled substance," effectively collapsing the distinction between fetus and child.[87] Although presented to the public as a public health intervention, with $900,000 appropriated over two years for treatment programs for pregnant women,[88] the bill originated in the Judiciary Committees of both chambers[89] and was passed as part of a package of criminal laws including provisions on criminal sexual conduct and sentencing departures.[90]

The original bill also granted immunity to medical personnel who conducted toxicology tests without patient consent, shielding them from liability for violating informed consent.[91] While intended to address physicians' fears of lawsuits, such immunity provisions tend to encourage overreporting, disproportionately impacting poor women and women of color due to disparities in toxicology testing.[92] Enacted just one year after *Jarvis v. Levine*, in which the Minnesota Supreme Court reaffirmed that even individuals with mental disabilities have the right to refuse intrusive medical treatment, the "Cocaine Baby" Bill permitted pregnant women to be tested, reported, and referred for treatment without their consent solely to protect the fetus.[93]

C. From Fetal Protection to Fetal Rights

The fetal rights movement, which seeks to define the fetus as a legally separate person with rights and to hold the pregnant woman liable for its well-being, emerged in the early 1970s alongside advances in fetal medicine and gained traction during the War on Drugs.[94] Fetology, the study of the development and health of the fetus in utero, which was formally recognized as a specialty by the American College of Obstetricians and Gynecologists in 1973, contributed to a fundamental reimagining of the maternal-fetal relationship as involving two individuated patients.[95] As the fetus could be identified as a "second patient," it became possible to conceive of the interests of the fetus as separate from, and even in conflict with, those of the pregnant individual.[96] This shift fetishized the

86. MINN. HOUSE RSCH. DEP'T, ACT SUMMARY, H.F. 2390, ch. 542, 74th Leg., 1990 Sess., at 3 (Minn. 1990) (internally referencing the bill as "the Cocaine Baby" reporting statute).

87. Nyhus Johnson, *supra* note 84, at 490.

88. Furst, *supra* note 83.

89. Nyhus Johnson, *supra* note 84 at 491.

90. H.F. No. 59, 73rd Leg., 1989 Sess. (Minn. 1989).

91. Nyhus Johnson, *supra* note 84, at 490. MINN. STAT. § 626.5562 has since been repealed by Act of 2020, 1st Spec. Sess., ch. 2, art. 7, § 39(a), 2020 Minn. Laws 234.

92. Amnesty Int'l, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA*, AI Index AMR 51/6203/2017, at 20 (May 2017), https://www.amnesty.org/ar/wp-content/uploads/2021/05/AMR5162032017ENGLISH.pdf [https://perma.cc/X3V4-TVHE].

93. 418 N.W.2d 139, 148 (Minn. 1988).

94. *See* Beckett, *supra* note 73, at 589.

95. SARA DUBOW, OURSELVES UNBORN: A HISTORY OF THE FETUS IN MODERN AMERICA 113 (2011).

96. *Id.* at 114.

fetus[97] while simultaneously objectifying the pregnant woman as a "maternal environment" whose interests were framed as potentially hostile or obstructive to fetal care.[98]

The state-level "crackdown" on prenatal substance use in the 1980s and 1990s, fueled by the "crack baby" myth, illustrates how the State could marshal the fetal rights framework advanced by abortion opponents to justify criminalizing pregnant women. Central to this framework was the idea that the fetus had legal rights that could override those of the pregnant woman.[99] As former South Carolina County Solicitor Charles Condon put it, "[y]ou have the right to an abortion. You have the right to have a baby. You don't have the right to have a baby deformed by cocaine."[100]

This legal and cultural shift led to a wave of prosecutions. Between 1977 and 1998, at least 200 women in 30 states were prosecuted for crimes of "fetal abuse."[101] Policymakers and prosecutors increasingly policed pregnant women's actions and held them civilly and criminally liable for conduct potentially harmful to the fetus, particularly substance use.[102] This shift occurred amid deep-seated cultural anxiety about the effects of the women's liberation movement on traditional gender roles. The "crack mom" became a politicized scapegoat, embodying fears of multiple social deviance—nonmarital sexuality, criminality, and aberrant maternal behavior.[103] The narrative allowed complex structural problems—unemployment, poverty, crime, urban decay, and racial inequality—to be blamed on individual moral choices, which the New Right exploited to advance its political agenda of shrinking the welfare state.[104]

Having examined the deeply problematic historical, legal, and racial context that gave rise to prenatal substance use laws, the following section analyzes why Minnesota's statutes are constitutionally and statutorily vulnerable and represent unsound public policy.

III. Legal Infirmities of Minnesota's Prenatal Substance Use Statutes

The prenatal substance use statutes contravene and undermine the state's constitutional and statutory protections of reproductive freedom. The statutes implicitly promote fetal personhood, subordinating the rights of pregnant individuals to

97. Laura Hermer, *Intentional Parenthood, Contingent Fetal Personhood, and the Right to Reproductive Self-Determination*, 57 U. Mich. J. L. Reform 259, 278 (2024).

98. Johnsen, *supra* note 9, at 599.

99. *See* Nyhus Johnson, *supra* note 84, at 511.

100. Richard Lacayo, *Do the Unborn Have Rights*, Time (Nov. 8, 1990), https://time.com/archive/6716342/do-the-unborn-have-rights/[https://perma.cc/Q8KN-886E].

101. Dubow, *supra* note 95, at 139.

102. Johnsen, *supra* note 9, at 606–07 (listing accidents resulting from material negligence, such as automobile or household accidents, failing to eat properly, using prescription and nonprescription drugs, smoking, drinking, exposing herself to infectious disease or workplace hazards, and engaging in immoderate exercise or sexual intercourse as among the activities for which a pregnant woman could be held liable).

103. Enid Logan, *The Wrong Race, Committing Crime, Doing Drugs, and Maladjusted for Motherhood*, 26 Soc. Just. 115, 115–16 (1999) (attributing the power of the "crack baby" iconography to "the multiple . . . social deviance perpetrated upon the most innocent, by the least innocent").

104. Reinarman & Levine, *The Crack Attack*, *supra* note 45, at 37.

those of the fetus, which conflicts with *Doe v. Gomez* and the PRO Act. They impose vague and unequal standards on pregnant individuals for involuntary commitment due to substance use, violating due process and compelling chemical dependency treatment—i.e., reproductive health care. Furthermore, these standards are enforced unevenly, disproportionately harming low-income communities and communities of color, exacerbating Minnesota's already stark racial disparities. Finally, in the post-*Dobbs* era, these statutes normalize the treatment of pregnancy as a condition that justifies the suspension of civil rights, posing a broader threat to reproductive autonomy and women's equality beyond the context of substance use.

A. Defining Prenatal Substance Use as Child Neglect Invites Fetal Personhood

Minnesota's "Cocaine Baby" law marked a significant shift toward the legal recognition of fetal personhood by redefining prenatal substance use as child neglect.[105] Although the amended child protection statute stops short of explicitly declaring the fetus a child, it effectively endorses that proposition by allowing prenatal conduct to trigger protection mechanisms traditionally reserved for children after birth. This statutory scheme collapses the legal boundary between fetus and child, inventing a category of "unborn child abuse" and enabling the State to treat the fetus as a rights-holding entity and the pregnant person as a potential perpetrator.[106]

1. Eroding Boundaries Between Fetus and Child

By creating a special class of chemically dependent persons—pregnant women—subject to a lower threshold for civil commitment, the law authorizes coercive measures to punish so-called fetal neglect and abuse while avoiding the constitutional challenges that have hindered criminal prosecutions under general child abuse laws.[107] The outcome, however, is no less punitive. A pregnant woman suspected of substance use in Minnesota may have fewer rights than a non-pregnant person committed with a severe mental illness, a criminal suspect, or even a cadaver.[108]

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105. *See* MINN. STAT. § 260E.03, subdiv. 15 (2025).

106. *See* Loertscher v. Anderson, 259 F. Supp. 3d 902, 908 (W.D. Wis. 2017), *vacated*, 893 F.3d 386 (7th Cir. 2018).

107. Drew Humphries et al., *Mothers and Children, Drugs and Crack: Reactions to Maternal Drug Dependency, in* THE CRIMINALIZATION OF A WOMAN'S BODY 203, 210 (Clarice Feinman, ed., 1992). *See, e.g.*, State v. Wade, 232 S.W.3d 663, 665 (Mo. Ct. App. 2007) (declining to extend a state's sweeping personhood language "as creating a cause of action against a woman for indirectly harming her fetus by failing to properly care for herself or by failing to follow any particular program of prenatal care"); Reinesto v. Superior Court, 894 P.2d 733, 735–36 (Ariz. Ct. App. 1995) (holding that Arizona's child abuse statute could not be used to prosecute prenatal drug use, as the statute did not encompass fetuses); State v. Dunn, 916 P.2d 952, 955 (Wash. Ct. App. 1996) (finding that a fetus is not a "child" under the criminal mistreatment statute). *But see* State v. Besabe, 271 P.3d 387, 390 (Wash App. 2012) (finding that individuals may be prosecuted for homicide based on conduct towards the fetus if later born alive, as the victim is defined at the time of death, not time of defendant's conduct).

108. DUBOW, *supra* note 95, at 118 (observing that pregnant women had fewer rights than: a person suspected of drug dealing, whose stomach could not be pumped if they swallowed evidence; a rapist, who could not be forced to undergo involuntary blood testing for AIDS; a parent, who could not

The law also conscripts medical professionals into a kind of "prenatal police force," requiring them to conduct toxicology tests when obstetrical complications suggest possible substance use and to report pregnant patients to welfare agencies based on suspicion alone.[109] Physicians thus become de facto agents of the state, tasked with determining probable cause to test and report, which is in direct conflict with the privacy protections articulated in *Doe v. Gomez* and reaffirmed by the PRO Act.[110] In *Gomez*, the Minnesota Supreme Court held that under the state constitution's right of privacy, medical decisions "will not be made by the government, but will be left to the woman and her doctor."[111] But when the law mandates physicians to act on behalf of the State's interest in fetal life, the decision is no longer private—it is made by the government. Further, it is a decision not just made for the pregnant individual, but for the fetus as well.[112] The reporting mandate, therefore, violates *Gomez*.

2. Fetal Personhood and the Curtailment of Constitutional Rights

A core feature of fetal personhood ideology is the belief that pregnancy suspends an individual's civil rights. This logic not only justifies coerced medical interventions but also reflects the patriarchal expectation that pregnant women must sacrifice themselves entirely for the fetus, permitting the state to police and regulate their conduct.[113] The transformation of the fetus into a separate legal subject whose interests can override those of the pregnant person has resulted in court rulings that prioritize fetal life over bodily autonomy.

Reproductive rights advocates such as Lynn Paltrow have long identified *In re A.C.* as an early test of the fetal personhood logic in judicial reasoning.[114] Decided just two years after *Jarvis v. Levine*, in which the Minnesota Supreme Court held that the denial of informed consent stripped individuals of "basic human dignity," the D.C. Court of Appeals' 1988 *Matter of A.C.* ruling denied that same dignity to Angela Carder, who was 26 weeks pregnant and dying of cancer.[115]

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be compelled to donate bone marrow to save a dying child; and even a cadaver, whose life-saving organs could not be harvested without prior consent).

109. Humphries et al., *supra* note 107, at 209.

110. Nyhus Johnson, *supra* note 84, at 492.

111. Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17, 32 (Minn. 1995).

112. *See* Cynthia Soohoo, *An Embryo is Not a Person: Rejecting Prenatal Personhood for a More Complex View of Prenatal Life*, 14 CONLAWNOW 81, 114 (2022) (arguing that recognizing personhood for zygotes, embryos, and fetuses provides an opportunity for the state to assert the right to life "*on behalf of prenatal life*").

113. *See, e.g.*, Sonja C. Davig, *Crack-Cocaine Babies: Protecting Society's Innocent Victims*, 15 HAMLINE J. PUB. L. & POL'Y 281, 284 (1994) ("Society does not want to exempt children from legal protection when their mothers choose not to meet even minimal reasonable community standards of safe conduct during pregnancy. If a woman elects to carry the baby to full term, she takes on an additional responsibility to *do everything she can to make sure the child will be born healthy.* The woman is not being asked by society to do anything excessive—just to act reasonably.") (emphasis added).

114. *In re* A.C., 533 A.2d 611, 612 (D.C. 1987), *reh'g granted, judgment vacated sub nom.*, Matter of A.C., 539 A.2d 203 (D.C. 1988), *and on reh'g*, 573 A.2d 1235 (D.C. 1990).

115. Jarvis v. Levine, 418 N.W.2d 139, 148 (Minn. 1988).

Over Carder's objections, a D.C. trial court ordered a Caesarean section to deliver her fetus.[116] When she withheld consent and appealed, the appellate court denied a stay, concluding that her right to bodily autonomy was subordinate to the interests of the fetus and the state.[117] The court reasoned that since Carder had, "at best, two days left of sedated life," the surgery would not significantly affect her, whereas the "unborn child" had a slim chance at survival.[118] The court's shift in terminology—from "fetus" in the procedural history to "unborn child" and "child" in the holding—reinforced the logic of fetal personhood and reframed the fetus as a rights-bearing individual.[119]

This reasoning exposes a fundamental tension in American law: the assumption that individuals are autonomous actors housed within separate, distinct bodies. The pregnant body defies this framework. As legal scholars Meghan M. Boone and Benjamin J. McMichael argue, the pregnant body is "legally unintelligible," making it vulnerable to dehumanization.[120] When the fetus is granted rights, the pregnant person's subjecthood and rights diminish.[121] Additionally, since pregnancy is temporary, making an exception to the rule of constitutional rights becomes easier to justify.[122]

In Carder's case, the legal norm that individuals cannot be forced to undergo medical treatment, even to save a life, was suspended.[123] The appellate court essentially treated her dying body as a vessel for the fetus, a mere container for a superseding rights-holder.[124] Although the decision was later vacated, and the court reaffirmed that the right to refuse medical treatment did not depend on competency or prognosis, the original ruling advanced a dangerous legal proposition: that a pregnant woman's right to life could be subordinated to the interests of the fetus and the state.[125] In his dissent, Judge Belson argued that a woman who "has undertaken to bear another human being . . . to viability" enters a "special class of persons," implicitly forfeiting full constitutional protections.[126]

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116. *In re A.C.*, 533 A.2d at 613.

117. *Id.*

118. *Id.*

119. *Id.*

120. Meghan M. Boone & Benjamin J. McMichael, *Reproductive Objectification*, 108 MINN. L. REV. 2493, 2496 (2024).

121. *Id.*

122. *See id.* at 2495 & n.3.

123. *In re* A.C., 533 A.2d at 616.

124. *See* Boone & McMichael, *supra* note 120, at 2493 (arguing that the absence of a legal framework for two rights-holders in one body meant that if the fetus gained rights and was considered a legal subject, then the pregnant person must be an object—"a reproductive vessel, merely the container for another individual rights-holder").

125. *In re* A.C., 573 A.2d 1235, 1247 (D.C. 1990) (finding that "it matters not what the quality of a patient's life may be; the right of bodily integrity is not extinguished simply because someone is ill, or even at death's door.").

126. *Id.* at 1256 (Belson, J., dissenting). Judge Belson was one of three appellate judges who denied the stay.

Belson's reasoning betrays a disregard for the realities of reproductive life and the importance of access to abortion care. It assumes that all pregnancies are planned, wanted, and voluntarily carried to term. However, if nearly 18% of pregnancies are unplanned or unwanted, then treating all pregnant individuals as having voluntarily placed themselves in this "special class" unjustly denies a significant portion of them the fundamental procedural protections to which they are constitutionally entitled.[127]

In *Doe v. Gomez*, the state supreme court extended the right to make medical decisions free from government interference, including the right to refuse intrusive medical treatment, guaranteed under the right of privacy by the Minnesota Constitution, as held in *Jarvis*, to a woman's right to decide to terminate her pregnancy.[128] The PRO Act codifies this protection, stating that an individual's pregnancy status does not suspend their fundamental right to make autonomous decisions about their reproductive health.[129] However, the logic of fetal personhood directly contradicts both *Gomez* and the PRO Act by enabling the state to override the pregnant person's rights in the name of fetal protection. Once the fetus is considered a separate legal entity, the autonomy of the pregnant individual is diminished, undermining their own personhood.

3. The Slippery Slope and Broader Implications Post-*Dobbs*

Before *Dobbs*, granting the embryo or fetus full legal personhood would have directly conflicted with the federal right to abortion recognized in *Roe v. Wade*.[130] To navigate around that conflict, legislators embedded fetal personhood in specific legal contexts, like the prenatal substance exposure statutes.[131] The long-term goal was to chip away at support for abortion by making the fetus a person in so many other legal settings that abortion would come to seem like a morally unacceptable exception.[132]

Minnesota's reproductive freedoms remain vulnerable to this incremental approach. In response to public outrage over the state supreme court's decision in *State v. Soto*, which held that an unborn, viable fetus was not a "human being" under the state's vehicular homicide statute, lawmakers enacted a fetal-homicide law.[133] It defines "unborn child" as "the unborn offspring of a human being conceived, but not yet born," a formulation broad enough to encompass embryos

127. Kathryn Kost, Mia Zolna & Rachel Murro, *Pregnancies in the United States by Desire for Pregnancy: Estimates for 2009, 2011, 2013, and 2015*, 60 DEMOGRAPHY 837, 844 (2023).

128. Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17, 27 (Minn. 1995).

129. MINN. STAT. § 145.409, subdiv. 3 (2025).

130. Roe v. Wade, 410 U.S. 113, 121 (1973) (recognizing a constitutional right to abortion based on substantive due process under the Fourteenth Amendment).

131. Caitlin E. Borgmann, *The Meaning of "Life": Belief and Reason in the Abortion Debate*, 18 COLUM. J. GENDER & L. 551, 560 (2009).

132. *Id.*

133. Sandra L. Smith, *Fetal Homicide: Woman or Fetus as Victim? A Survey of Current State Approaches and Recommendations for Future State Application*, 41 WM. & MARY L. REV. 1845, 1863 (2000) (discussing State v. Soto, 378 N.W.2d 625 (Minn. 1985)).

created through IVF.[134] Minnesota Statutes § 256B.055 extends MA coverage to "needy unborn children," a term left undefined in a system already used for state surveillance and reproductive control of poor women.[135]

In the post-*Dobbs* era, where no federal abortion rights remain, these fragmentary fetal personhood doctrines carry real risk. Any statute that elevates fetal interests above a pregnant person's autonomy pushes the legal system further down a slippery slope toward more invasive monitoring of prenatal behavior and increasing restrictions on reproductive technologies. As Lynn Paltrow warns, "prosecutions . . . cannot rationally be limited to illegal conduct because many legal behaviors cause damage to developing babies. Women who are diabetic or obese, women with cancer or epilepsy who need drugs that could harm the fetus, women who are too poor to eat adequately or to get prenatal care could all be categorized as fetal abusers."[136]

In the absence of federal safeguards, Minnesota's constitutional and statutory protections for reproductive freedom must not be undermined by the significant threat posed by the logic of fetal personhood embedded in its prenatal substance use statutes. Unless the legislature and courts expressly reject the notion that a fetus holds rights independent of the pregnant person, the state's reproductive freedoms will remain vulnerable to further erosion.

B. Vague and Unequal Standards for Pregnant Individuals

Minnesota's civil commitment statute includes a pregnancy-specific exception that omits the requirement to demonstrate inability to self-manage and substantial risk of harm. This exception imposes a lower level of protection on pregnant individuals, dilutes the "clear and convincing" standard, and circumvents the procedural safeguards guaranteed in civil commitment proceedings, violating due process and creating an unequal legal standard based on pregnancy status.

1. The Pregnancy Exception is Unconstitutionally Vague

The 1989 "Cocaine Baby" Bill introduced a separate definition for pregnant individuals engaged in "habitual or excessive use" of controlled substances in the civil commitment statute, omitting the key elements of being rendered incapable of self-management and recent conduct demonstrating a likelihood of harm.[137] The same vague standard appears in the child welfare statute, which requires reports from health care and social service professionals and authorizes voluntary reports by laypeople who suspect a pregnant woman has used a controlled substance "in any way that is habitual or excessive."[138] Minnesota Statutes section 253B.02,

134. MINN. STAT. §§ 609.2661–63 (2025).

135. *See* PREGNANCY JUST., UNPACKING FETAL PERSONHOOD: THE RADICAL TOOL THAT UNDERMINES REPRODUCTIVE JUSTICE 34 (2024), https://www.pregnancyjusticeus.org/wp-content/uploads/2024/09/Fetal-personhood.pdf [https://perma.cc/2ERR-PNT8].

136. Humphries et al., *supra* note 107, at 211.

137. H.F. No. 59, 76th Leg., 1989 Sess. (Minn. 1989).

138. MINN. STAT. § 260E.31, subdiv. 1 (2025).

subdivision 2 defines a "chemically dependent person" as someone incapable of managing their personal affairs "by reason of the habitual and excessive use of alcohol, drugs, or other mind-altering substances."[139] The statute also requires that this use must result in recent conduct posing a substantial likelihood of physical harm to self or others, "demonstrated by (i) a recent attempt or threat to physically harm themselves or others; (ii) evidence of recent serious physical problems; or (iii) a failure to obtain necessary food, clothing, shelter, or medical care."[140] These criteria provide essential context to determine whether substance use is sufficiently severe to warrant involuntary commitment for emergency treatment. By contrast, the pregnancy-specific exception omits these clarifying elements, creating a vague and undefined standard that invites subjective interpretation.[141] The standard is even broader because, rather than "habitual *and* excessive use" as for non-pregnant people, pregnant people only need to satisfy one: "habitual *or* excessive use."[142] Framed from the outset as a way to compel pregnant women who use substances into treatment to protect fetuses from harm, the exception has largely escaped controversy and constitutional scrutiny.

To date, no reported Minnesota cases have interpreted or applied the pregnancy-specific exception.[143] This silence does not diminish the due process concerns section 253B.02, subdivision 2 raises: under the void-for-vagueness doctrine, laws must provide fair notice of prohibited conduct and guard against arbitrary or discriminatory enforcement.[144] Without clear criteria, pregnant individuals may be civilly committed based on speculation or bias, particularly along lines of race and class, due to enduring stereotypes about prenatal substance use. Minnesota's Sex Offense Civil Commitment (SOCC) law illustrates how the state's civil commitment system has long raised due process concerns, particularly when vague standards are used punitively as a substitute for the criminal justice system.[145]

Minnesota's SOCC scheme, which authorizes the indefinite confinement of sexual offenders after completion of their criminal sentences, has been criticized

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139. *Id.* § 253B.02, subdiv. 2; *see In re* Heurung, 446 N.W.2d 694, 696 (Minn. App. 1989).

140. § 253B.02, subdiv. 2.

141. In 2020, the Treatment Advocacy Center ranked Minnesota highest in the nation for the quality of its civil commitment laws, awarding a near-perfect score based on statutory clarity and procedural safeguards. However, the Center's evaluation did not address the pregnancy-specific exception, which lacks the very protections that earned Minnesota its high rating. This silence reinforces the normalized legal view of pregnancy as an exception to civil rights. *See* LISA DAILEY ET AL., TREATMENT ADVOC. CTR., GRADING THE STATES: AN ANALYSIS OF INVOLUNTARY PSYCHIATRIC TREATMENT LAWS 15–16 (2020), https://www.tac.org/reports_publications/grading-the-states-an-analysis-of-involuntary-psychiatric-treatment-laws-2020/ [https://perma.cc/66S7-82LS].

142. § 253B.02, subdiv. 2.

143. Civil commitment records, because they contain information on the provision of health care to a patient, are not available to the public through the state's online system. MINN. STAT. §§ 144.291–98 (2025).

144. *See* State v. Enyeart, 676 N.W.2d 311, 319 (Minn. Ct. App. 2004) (explaining that the void-for-vagueness doctrine prohibits statutes that permit "arbitrary or discriminatory enforcement"); *see also* Grayned v. City of Rockford, 408 U.S. 104, 108–09 (1972) (requiring that laws give fair notice and include explicit standards to avoid arbitrary enforcement).

145. MINN. STAT. § 253D (2025).

nationally and internationally.[146] In 2015, a federal district court struck down the program as unconstitutional because individuals were detained beyond any necessary treatment period, and because it functioned as punishment rather than care.[147] The Eighth Circuit later reversed, holding that the wrong legal standard had been applied.[148] After nearly a decade of litigation, the Eighth Circuit affirmed the dismissal of the plaintiffs' conditions-of-confinement claims, and Minnesota's SOCC framework still remains unreformed.[149] Individuals continue to be detained under an amorphous standard.[150] Although the Minnesota Supreme Court has held that SOCC commitments require a finding that a future sexual offense is "highly likely,"[151] neither the legislature nor the courts have defined the term.[152] A recent report from the Sex Offense Litigation and Policy Resource Center (SOLPRC) at the Mitchell Hamline School of Law notes that this absence has led to subjective determinations based on judicial interpretation, expert testimony, and risk assessment tools that may be outdated and unreliable.[153] A number of cases demonstrate that this discretionary determination of likelihood has led to the commitment of individuals despite low to moderate risk assessment scores and expert testimony supporting treatment in a less restrictive environment.[154]

The legislature's elimination of specific criteria for the involuntary commitment of pregnant individuals who use substances is similarly problematic. It leaves the terms "habitual" and "excessive" open to subjective interpretation, since both depend on determining what is considered "usual, proper, necessary, or normal" in order to decide whether conduct is "regular or repeated" or "exceeds" that baseline.[155] A plain reading of section 253B.02, subdivision 2 could permit the commitment of a pregnant person for drinking a glass of wine

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146. *See* SEX OFFENSE LITIG. & POL'Y RES. CTR. (SOLPRC), MITCHELL HAMLINE SCH. OF L., SEX OFFENSE CIVIL COMMITMENT 30 (2024), https://mitchellhamline.edu/sex-offense-litigation-policy/2024/04/16/sex-offense-civil-commitment-minnesotas-failed-investment-and-the-100-million-opportunity-to-stop-sexual-violence/[https://perma.cc/TW8W-RBHV] (noting that the High Court of Justice in the United Kingdom refused to extradite a person accused of rape to Minnesota, holding that the state's SOCC law constituted a "flagrant violation" of the European Convention on Human Rights).

147. Karsjens v. Jesson, 109 F. Supp. 3d 1139, 1144 (D. Minn. 2015), *rev'd and remanded sub nom.*, Karsjens v. Piper, 845 F.3d 394 (8th Cir. 2017).

148. *See Karsjens*, 845 F.3d at 407–08.

149. Karsjens v. Harpstead, 74 F.4th 561, 572 (8th Cir. 2023), *cert. denied*, 144 S. Ct. 814 (2024).

150. SEX OFFENSE LITIG. & POL'Y RES. CTR., *supra* note 146, at 18–19.

151. Matter of Linehan, 557 N.W.2d 171, 179–80 (Minn. 1996), *cert. granted, judgment vacated sub nom.*, Linehan v. Minnesota, 522 U.S. 1011 (1997).

152. *See* SEX OFFENSE LITIG. & POL'Y RES. CTR., *supra* note 146, at 18.

153. *Id.*

154. *See, e.g.*, Rick v. Harpstead, 678 F. Supp. 3d 1068, 1076 (D. Minn. 2023), *rev'd and remanded*, 110 F.4th 1055 (8th Cir. 2024), *cert. denied*, 145 S. Ct. 1055, 220 (2025) (indefinitely committing Harpstead to the Minnesota Sex Offender Program even though the court-appointed expert psychologists concluded that less restrictive alternatives would be sufficient); *see also* SEX OFFENSE LITIG. & POL'Y RES. CTR., *supra* note 146, at 39 n.164.

155. *See Habitual*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/habitual [https://perma.cc/DJX2-DR94] (last visited Nov. 21, 2025); *Excessive*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/excessive [https://perma.cc/P56V-ZDSD] (last visited Nov. 21, 2025).

several nights a week if a decisionmaker deemed such use "habitual or excessive" without any showing that the person is incapable of self-management or poses a risk of harm to herself or her fetus.[156]

This risk is not hypothetical. In *Loertscher v. Anderson*, a federal court struck down a similar Wisconsin statute as unconstitutionally vague.[157] The law allowed the detention of a pregnant woman who "severely and habitually lacks self-control" in substance use and whose use poses a "substantial risk" to fetal health.[158] The court found both phrases unconstitutionally vague, lacking sufficient specificity to guide legal enforcement or provide notice.[159] Minnesota's statutory language suffers from the same defect: it enables state intervention based on ambiguous and subjective notions of "habitual or excessive use" without requiring evidence of inability to self-manage or substantial risk of harm.

Loertscher can be distinguished from the recent Massachusetts case *Matter of J.P.*, in which the state supreme court upheld the constitutionality of its civil commitment statute.[160] The plaintiffs in *J.P.* argued that the terms "chronic" and "habitual" were unconstitutionally vague because they were not defined by statute.[161] The court disagreed, reasoning that the legislature had tied those terms to specific statutory metrics.[162] Under Massachusetts law, "substance use disorder" is defined as the "chronic or habitual consumption" of controlled substances to the extent that: (i) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning; or (ii) the person has lost the power of self-control over the use of controlled substances.[163] These concrete factual findings of harm and loss of control provide judges with standards for determining whether consumption is "chronic or habitual," thereby avoiding unconstitutional vagueness. Minnesota's legislature, by contrast, eliminated those limiting criteria and defined a "chemically dependent person" simply as "a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose."[164]

Taken together, these examples illustrate the dangers of vague standards in civil commitment and the essential role of concrete statutory metrics in preventing arbitrary enforcement. By authorizing detention on ambiguous and subjective terms, section 253B.02, subdivision 2 fails to provide fair notice and risks imposing severe deprivations of liberty without due process.

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156. Boone & McMichael, *supra* note 120, at 2518.
157. Loertscher v. Anderson, 259 F. Supp. 3d 902, 906 (W.D. Wis. 2017).
158. *Id*.
159. *Id.*
160. Matter of J.P., 241 N.E.3d 687 (Mass. 2024).
161. *Id.* at 695.
162. *Id.* at 700.
163. *Id.* at 695.
164. MINN. STAT. § 253B.02, subdiv. 2 (2025).

2. Dilution of the "Clear and Convincing" Standard

Under Minnesota Statutes section 253B.09, subdivision 1(a), a pregnant person may be involuntarily committed for emergency treatment based on a finding of chemical dependency "by clear and convincing evidence."[165] This standard requires the truth of the facts asserted to be highly probable.[166] This heightened standard serves as a constitutional safeguard due to the significant liberty interests at stake. As the U.S. Supreme Court held in *Addington v. Texas*, "the individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity" that due process requires proof by clear and convincing evidence.[167]

The Minnesota Appellate Court's analysis in *In re Heurung* demonstrates the importance of this higher evidentiary standard and the kinds of factual findings that satisfy it. There, because the respondent was a non-pregnant person, the trial court considered concrete evidence of inability to self-manage and substantial risk of harm to self or others: the physical injuries suffered by his girlfriend, his failure to eat properly, and his inability to stop drinking before reaching a dangerous blood alcohol concentration of .32.[168] These findings were necessary to meet the clear and convincing standard.[169]

By contrast, eliminating the elements of incapacity for self-management and recent conduct indicating a substantial likelihood of harm lowers the evidentiary standard. The Court noted in *Addington* that this increases the risk of wrongfully committing individuals.[170] Under section 260E.03, subdivision 15, "prenatal exposure to a controlled substance" may be determined in several ways: through a newborn's withdrawal symptoms, toxicology tests performed on the mother or child at birth, the presence of fetal alcohol spectrum disorder, or, perhaps most intrusively, monitoring the child for up to one year for physical or developmental effects that indicate prenatal exposure to a controlled substance.[171]

Clinical researchers, including Chasnoff, were aware of the limitations of toxicology testing when the "Cocaine Baby" law was enacted.[172] The tests only detect very recent substance use.[173] They provide no information about quantity, frequency, or actual harm to the fetus, and they carry a substantial risk of false positives.[174] Nonetheless, toxicology tests quickly became the default tool for

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165. *See In re* Heurung, 446 N.W.2d 694, 696 (Minn. Ct. App. 1989).
166. State v. Heller, 12 N.W.3d 452, 475 (Minn. 2024) (citations omitted).
167. Addington v. Texas, 441 U.S. 418, 427 (1979).
168. *In re Heurung*, 446 N.W.2d at 696.
169. *Id.*
170. *Addington*, 441 U.S. at 426.
171. MINN. STAT. § 260E.03, subdiv. 15 (2025).
172. Ira Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1205. Further research is needed to determine whether this research on the limitations of toxicology testing circulated beyond the academic community into the public health context, to what extent, and whether it was being ignored.
173. Humphries et al., *supra* note 107, at 212.
174. *Id.*

policing prenatal substance use because they were inexpensive, could be completed in or out of a laboratory setting, and substituted nuance with a single supposedly "neutral" or "objective" result.[175] They remain unreliable.[176] On their own, toxicology results cannot satisfy the clear and convincing evidence standard required for civil commitment because they fail to establish either the extent of substance use or a substantial likelihood of harm to the pregnant individual or the fetus. Moreover, because toxicology testing of the pregnant or birthing person serves as the basis for determining potential harm to the fetus in the name of protecting fetal interests, section 260E.03, subdivision 15 directly contravenes *Gomez* and the PRO Act. Finally, the vagueness of what level of use qualifies as "habitual or excessive" makes it impossible to meet the clear and convincing evidence standard of proof.

The consequences of a chemical dependency finding under the pregnancy exception are profound. Under Minnesota Statutes § 253B.09, subdivision 5, courts may order an initial commitment period of up to 6 months upon a finding of chemical dependency. If, after a review hearing, the court determines that the individual "continue[s] to have . . . chemical dependency," it may extend the commitment for up to 12 months.[177] In theory, a pregnant person may be involuntarily committed to an inpatient facility for the duration of their pregnancy and compelled to undergo treatment.

3. The Pregnancy Exception is Not Narrowly Tailored to Meet a Compelling State Interest

In *Doe v. Gomez*, the Minnesota Supreme Court held that the state constitutional right of privacy protects "the right to decide whether to carry a pregnancy to term."[178] The PRO Act builds on that protection by affirming that an individual's "fundamental right to make autonomous decisions about [their] own reproductive health, including the fundamental right to use or refuse reproductive health care" is not suspended due to pregnancy status.[179] Because Minnesota's prenatal substance use statutes burden this fundamental right, they are subject to strict scrutiny.[180] The State bears a "heavy burden of justification" and must show that the challenged statutory scheme is narrowly tailored to serve a compelling government interest using the least restrictive means.[181] The law must not be overinclusive or underinclusive.[182]

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175. *See* Marc Canellas, *Abolish and Reimagine: The Pseudoscience and Mythology of Substance Use in the Family Regulation System*, 30 GEO. J. ON POVERTY L. & POL'Y 169, 191 (arguing that these shortcuts are the function of the carceral technology).

176. *See generally* D. Adam Algren & Michael R. Christian, *Buyer Beware: Pitfalls in Toxicology Laboratory Testing*, 112 MO. MED. 206 (stating that urine drug screens (UDS) are prone to false positive and negative results, and that given the important implications in child abuse and neglect cases, interpretation must factor in these shortcomings).

177. *See* MINN. STAT. § 253B.13, subdiv. 1 (2025).

178. *See* Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17, 31 (Minn. 1995).

179. *See* MINN. STAT. § 145.409, subdiv. 3 (2025).

180. *In re* Welfare of Child of R.D.L., 853 N.W.2d 127, 133 (Minn. 2014).

181. *Id.* (citations omitted).

182. *Id.* at 135.

The State may argue that its interest in protecting fetal life is compelling and justifies early intervention through chemical dependency treatment for pregnant individuals. However, *Gomez* expressly held that privacy protections extend until fetal viability.[183] While the State may have a compelling interest in potential life after viability, *Gomez* reaffirmed that this interest did not override the pregnant individual's autonomy before that point.[184] Yet Minnesota's prenatal exposure statutes apply throughout the entire duration of pregnancy, including the pre-viability period, making them overbroad in design and application.[185]

Moreover, the statutory scheme authorizes civil commitment based merely on suspicion of "habitual or excessive use" without evidence of incapacity to self-manage or substantial risk of harm to the pregnant individual or fetus. Given the unreliability of toxicology testing, a pregnant person who does not meet the clinical or statutory threshold for chemical dependency may nonetheless be detained and compelled into treatment. A statute that authorizes such a deprivation of liberty without requiring clear and convincing evidence of imminent harm is not narrowly tailored.[186]

The State's means are also not the least restrictive. The State could advance fetal and maternal health by expanding access to voluntary treatment options during pregnancy and removing barriers to prenatal care. Dr. Andy Hsi, a clinician whose comprehensive practice focuses on treating pregnant and parenting women with substance use disorder and trauma, has consistently found that his patients are motivated by love and a desire to improve their children's lives. As he explains, "[O]ur job is to make it so easy to get care for themselves and their babies that it makes sense. . . . [W]e have to . . . be willing to create systems that allow people to act on their best intentions."[187] The issue is not a lack of will on the part of pregnant individuals to seek treatment, but rather the existence of a system designed without their input or regard for their actual needs.[188]

Finally, these statutes rest on outdated science and an exaggerated perception of risk rooted in the "crack baby" myth. They presume that prenatal substance use directly causes fetal harm, despite extensive research showing that fetal outcomes are shaped by a complex interplay of social, economic, and environmental

183. *Gomez*, 542 N.W.2d at 31.

184. *Id.* at 31 (citing State v. Merrill, 450 N.W.2d 318, 322 (Minn.1990)).

185. *See id.* at 32 (invalidating the challenged provisions on the same grounds).

186. Strict scrutiny tailoring requires proof of actual or imminent harm rather than the mere possibility of harm. *See, e.g.*, J. F. Quest Foundry Co. v. Int'l Molders & Foundry Workers Union, 13 N.W.2d 32, 35 (1944) (holding that in the tort context, injunctive relief requires showing "some irremediable damage"; "a mere assumption of a possible result is insufficient.").

187. BACH, *supra* note 59, at 34.

188. MONICA IDZELIS ROTHE, WILDER RSCH., WOMEN'S RECOVERY SERVICES IN MINNESOTA: KEY FINDINGS FROM YEAR 1 (2022–23), 26–27 (2024) (finding that working with a Peer Recovery Support Specialist—a person with lived experience of alcohol or substance use that helps women on their recovery journey—was an important contributor to achieving recovery goals), https://www.wilder.org/wilder-research/research-library/womens-recovery-services-minnesota-key-findings-year-1-2022-23 [https://perma.cc/9H8N-MC4K].

factors, often more significant than substance use alone.[189] Poverty is one of the most consequential determinants of maternal and fetal health, influencing access to prenatal care, treatment, and stable housing.[190] Intimate partner violence, which can contribute to or co-occur with substance use, poses a more substantial risk to fetal development than substance use alone.[191] The statutes also wholly ignore the role of paternal exposure to substances in influencing fetal brain and neurobehavioral development through epigenetic mechanisms.[192]

By treating maternal substance use as uniquely dangerous and singling it out as the only fetal harm subject to coercive intervention, the statutes are both over-inclusive—capturing individuals who pose no real risk—and underinclusive—ignoring other significant risks to fetal health. Laws based on outdated science and exaggerated risks cannot satisfy strict scrutiny.[193] Minnesota's prenatal substance use statutes, therefore, fail constitutional review.

C. Compelled Treatment Violates the Right to Reproductive Freedom

Minnesota's statutory framework does more than create vague and unequal standards—it compels treatment. What initially appears on paper as voluntary participation is coercive in practice: civil commitment becomes a mandatory remedy for noncompliance. This approach violates the reproductive freedom protected under *Doe v. Gomez* and codified in the PRO Act by suspending a pregnant person's ability to make autonomous decisions about their health. It also undermines the very outcomes it purports to advance. Rather than improve maternal and fetal health, compelled treatment deters prenatal care and disproportionately harms Black and Native women, deepening existing racial and health disparities.

1. The Statutory Scheme Compels Treatment

Minnesota's prenatal exposure reporting statutes appear to offer pregnant individuals the option to engage in voluntary services yet effectively compel treatment. Under Minnesota Statutes section 260E.31, subdivision 1(a), any health care or social service professional who "knows or has reason to believe" that a pregnant individual has used a controlled substance "in any way that is

189. SUSAN C. BOYD, FROM WITCHES TO CRACK MOMS: WOMEN, DRUG LAW, AND POLICY 81 (2d ed. 2015).

190. Laura M. Betancourt et al., *Adolescents with and without Gestational Cocaine Exposure: Longitudinal Analysis of Inhibitory Control, Memory and Receptive Language*, 33 NEUROTOXICOL. TERATOL. 36, 44 (2011) (suggesting that the overall effects of poverty are placing children with gestational cocaine exposure at a clinically significant disadvantage compared to other children their age due to limited access to resources needed to provide cognitively and emotionally stimulating experiences early in life).

191. GOODWIN, *supra* note 6, at 136–37.

192. Emily J. Ross et al., *Developmental Consequences of Fetal Exposure to Drugs: What We Know and What We Still Must Learn*, 40 NEUROPSYCHOPHARMACOL. REVS. 61, 62 (2015).

193. *See, e.g.*, Weir v. ACCRA Care, Inc., 828 N.W.2d 470, 474–75 (Minn. Ct. App. 2013) (holding that the distinction failed the first step of the Minnesota rational basis test because it was not based on studies or empirical evidence, but from "anecdotal evidence").

habitual or excessive" must immediately report to a welfare agency unless they are already providing the pregnant individual prenatal or postpartum care.[194] Once the welfare agency receives a report, it "may offer or refer the individual to appropriate services, including prenatal care and chemical dependency treatment." However, if the individual "refuses recommended voluntary services or fails recommended treatment," the agency "shall seek an emergency admission" under section 253B.051.[195]

Although section 260E.31 labels these services "voluntary," failure to participate triggers mandatory civil commitment proceedings.[196] Chemical dependency treatment is exempt from informed consent requirements under section 253B.03, so a refusal of "voluntary" services effectively compels treatment.[197] This statutory scheme violates the core holding of *Doe v. Gomez*, which protects a woman's decisions regarding pregnancy and reproductive health from government interference, and conflicts with the PRO Act's guarantee that pregnancy status does not suspend the right to refuse reproductive health care.[198]

2. The Statutory Scheme Deters Prenatal Care and Causes Harm

Punitive laws regulating prenatal substance use deter pregnant individuals from seeking care, negatively impacting both maternal and fetal health. Thus, rather than promoting fetal health, these policies undermine it, contradicting the compelling interest the State purports to serve. The 2004 Minneapolis case of Patricia L. Cavin is illustrative. Cavin, who had used crack cocaine during her pregnancy, panicked when she gave birth to a stillborn baby in the bathroom of her home and disposed of "the evidence" in a bin outside the back door of her building.[199] Approximately eight months pregnant when going into labor, Cavin explained that she did not seek medical care for fear of legal repercussions, even though she had tried to access substance use treatment and find stable housing after discovering she was pregnant.[200]

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194. Even if the health care or social service professional is working with the pregnant individual and therefore exempted from reporting under section 260E.31, subdiv. 1(a), they are required to report to a welfare agency if the pregnant individual "does not continue" the care and the professional "has made attempts to contact the woman." *See* MINN. STAT. § 260E.31, subdiv. 1(b) (2025).

195. MINN. STAT. § 260E.31, subdiv. 2 (2025).

196. *See* Skeen v. State, 505 N.W.2d 299, 313 (Minn. 1993) (referring to "shall" as mandatory language).

197. MINN. STAT. § 253B.03 (2025). That the legislature itself referred to the package as "the Cocaine Baby Bill" underscores that the reporting requirement was engineered as a punitive, fetal rights-driven intervention rather than a neutral public health measure. *See* MINN. HOUSE RSCH. DEP'T, *supra* note 86.

198. Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17, 25–26 (Minn. 1995); MINN. STAT. § 145.409, subdiv. 3 (2025).

199. Chao Xiong, *Woman Charged with Concealing a Birth*, STAR TRIB., June 10, 2004.

200. *Id.* Practitioners observe and research supports that:

> [O]verwhelmingly, mothers [who use substances] want to take care of their babies. And so, if a woman has a substance use disorder and she gets pregnant, you want to create the environment and the community that 1. [s]he automatically knows where she can go, and 2. [w]hen she gets there

Medical authorities have long warned against punitive approaches for prenatal substance use. As early as 1990, the American Academy of Pediatrics cautioned that such measures had no proven benefits for infant health due to their deterrent effect and endorsed voluntary treatment programs as the most desirable means of addressing substance use among pregnant women.[201] More recent studies confirm this chilling effect. Policies mandating the testing of suspected prenatal substance use are significantly associated with increases in the percentage of pregnant individuals not utilizing prenatal care and accessing care later than recommended.[202] Neonatal drug withdrawal syndrome is also more prevalent in states adopting a civil child abuse or civil commitment policy.[203] Because prenatal care is critical to maternal and fetal health, policies that discourage accessing it do not serve a compelling state interest and cannot be considered narrowly tailored under strict scrutiny.

3. Disproportionate Impact on Marginalized Communities

Punitive prenatal substance use laws not only violate principles of bodily autonomy and due process, but they also exacerbate entrenched racial and socioeconomic inequities. A 1990 Florida study found that although there was little difference in the prevalence of substance use among pregnant women across class and racial lines, women from poorer socioeconomic backgrounds were tested more often by medical providers than those from middle- and low-income backgrounds.[204] Black women were tested and reported to child welfare agencies by medical providers at ten times the rate of white women.[205] The researchers attributed this disparity to the reluctance of private physicians to offend affluent patients and to entrenched stereotypes about substance use held by doctors practicing in large urban area hospitals.[206]

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she's going to be received with compassion and open arms and following throughout her pregnancy with increased access to the resources that she does not have. We have to get them into treatment in a voluntary way as much as possible before you get to the delivery window.

See BACH, *supra* note 59, at 35.

201. Comm. on Substance Abuse, Am. Acad. of Pediatrics, *Drug-Exposed Infants*, 86 PEDIATRICS 639, 641 (1990) ("Punitive measures taken toward pregnant woman, such as criminal prosecution and incarceration, have no proven benefits for infant health; although sanctions imposed by civil court involvement may be of benefit. The American Academy of Pediatrics is concerned that such involuntary measures may discourage mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment.").

202. Chancey Herbolsheimer & Stephanie Burge, *Afraid to Seek Care? A Fixed Effects Analysis of State Fetal Protection Legislation and Prenatal Healthcare Utilization from 2002 to 2015*, 20 POPULATION HEALTH 1, 5 (2022).

203. Emilie Bruzelius et al., *Punitive Legal Responses to Prenatal Drug Use in the United States: A Survey of State Policies and Systematic Review of Their Public Health Impacts*, 126 INT'L J. DRUG POL'Y 1, 10–12 (2024). The authors qualify that additional research is needed to clarify whether the punitive policies engender overt health harm. *Id.* at 12.

204. Humphries et al., *supra* note 107, at 213.

205. *Id.*

206. *Id.*

The media reinforced these biases. In covering the Turenne case, the press treated the white mother in neutral terms, using a standard mug shot.[207] By contrast, a photo essay on the Minneapolis Police Department's raids of "crack houses" depicted a non-white mother face down on the floor, her hands zip-tied behind her back and her head covered by a blanket while her infant cried beside her—an image that sensationalized and dehumanized Black motherhood and criminalized substance use as a form of child neglect.[208]

Recent data confirm that these inequities persist and in some respects have worsened.[209] Black patients are more likely to have urine toxicology testing at any point during pregnancy compared with non-Black patients, regardless of whether they have a history of substance use.[210] In Minnesota, which ranks among the highest in racial disparities for both Native American and Black infants, Black infants are investigated for prenatal substance exposure at seven times the rate of white infants.[211] However, from 2011 to 2016, of the clients served by the welfare agencies contracted by the Minnesota Department of Human Services' (DHS) Alcohol and Drug Abuse Division to provide treatment support and recovery services to pregnant and parenting women who have substance use disorders, only 14% identified as Black, while 53% identified as white.[212] The program also reported significantly worse outcomes for Black women in both achieving sobriety and completing the program, factors that increase the likelihood of involuntary commitment following supposedly "voluntary" referrals.[213]

These disparities reveal a pattern of racially biased enforcement and outcomes. The statutes operate not through neutral or objective standards, but through discretionary judgments that reflect longstanding structural inequities in health care and the child welfare system. Laws that burden a fundamental right, produce demonstrable harm, and disproportionately impact historically marginalized groups cannot be considered narrowly tailored. Because Minnesota's prenatal substance use statutes rest on vague standards, cause racialized harm, and subject pregnancy to unequal due process, they fail strict scrutiny and violate both the state constitutional right of privacy and the statutory protections of reproductive freedom affirmed by the PRO Act.

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207. deFiebre, *Charges*, *supra* note 68, at 1B.

208. McEnroe, *supra* note 52. All of the "children of crack" pictured in the story are Black or Brown. *See id.* at 1A, 17A–19A.

209. Frank Edwards et al., *Medical Professional Reports and Child Welfare System Infant Investigations: An Analysis of National Child Abuse and Neglect Data System Data*, 7.1 HEALTH EQUITY 653, 659 (2023).

210. Marian Jarlenski et al., *Association of Race with Urine Toxicology Testing Among Pregnant Patients During Labor and Delivery*, 4 JAMA HEALTH F. 1, 3 (2023).

211. Edwards et al., *supra* note 209, at 658.

212. WILDER RSCH., WOMEN'S RECOVERY SERVICES IN MINNESOTA: CROSS-SITE FINDINGS EXECUTIVE SUMMARY 16 (2016), https://www.wilder.org/wp-content/pdf-file/WRS_Cumulative_EvaluationReport_Aggregate_10-16.pdf [https://perma.cc/6U54-CBPD]. DHS contracted with eight additional agencies for another five-year grant. *See* ROTHE, *supra* note 188, at 1. In the first year of the program, from 2022 to 2023, 57% of clients identified as white, and 14% identified as Black. *See id.*, at 3.

213. *See* ROTHE, *supra* note 188, at 34.

IV. Recommendations

Under Minnesota law, "[w]hen the provisions of two or more laws passed at different sessions of the legislature are irreconcilable, the law latest in date of final enactment shall prevail."[214] Because the prenatal substance use statutes are irreconcilable with both *Gomez* and the PRO Act, and because the PRO Act was enacted more recently, the prenatal substance use statutes must yield. Repeal is not only legislatively mandated; it is essential to affirm that pregnant people are entitled to equal protection, dignity, and autonomy under the law.

To bring Minnesota's laws into compliance with its constitutional and statutory commitments, the legislature should implement the recommendations of the Task Force on Pregnancy Health and Substance Use Disorders and repeal statutes that criminalize or define prenatal substance use as child maltreatment.[215] Specifically, this includes:

1) Repealing Minnesota Statutes section 260E.32, which mandates toxicology testing based on obstetrical complications, an approach that has proven scientifically flawed and disproportionately punitive;
2) Deleting Minnesota Statutes section 260E.03, subdivision 15(a)(5), which defines prenatal exposure as "neglect." Without this definition, Minnesota Statutes § 260E.31, which governs reporting requirements, would no longer have legal effect and should also be repealed; and
3) Replacing these provisions with a new statute that explicitly states that prenatal exposure notifications are not reports of child abuse or neglect, drawing from model legislation such as the *Model Substance Use During Pregnancy and Family Care Plans Act*.

In addition to the Task Force's recommendations, legislative action should include:

4) Eliminating the pregnancy-specific civil commitment standard in Minnesota Statutes section 253B.02, subdivision 2, to ensure a uniform threshold for civil commitment based on clearly defined and constitutionally sufficient standards of harm and incapacity; and
5) Amending the PRO Act to affirmatively reject fetal personhood by incorporating language such as that found in Colorado's Reproductive Health Equity Act: *"A fertilized egg, embryo, or fetus does not have independent or derivative rights under the laws of this state."*[216] In the alternative, the legislature should adopt a subjective approach to fetal legal status,

214. Minn. Stat. § 645.26, subdiv. 4 (2025).
215. Task Force on Pregnancy Health and Substance Use Disorders, *supra* note 8, at 17.
216. Colo. Rev. Stat. Ann. § 25-6-403 (West 2025) (emphasis added).

> recognizing the fetus as rights-bearing only when the pregnant person affirmatively confers such status.[217]

Taken together, these reforms would restore doctrinal coherence, prevent unconstitutional infringements on the rights of pregnant individuals, and ensure that Minnesota's legal system affirms reproductive autonomy, bodily integrity, and equal protection under law.

Conclusion

Minnesota's prenatal substance use statutes are constitutionally infirm and fundamentally incompatible with the rights protected by the Minnesota Constitution and codified in the PRO Act. They contravene the Minnesota Supreme Court's holding in *Doe v. Gomez* that the constitutional right of privacy encompasses the right to make decisions regarding pregnancy. They also violate the PRO Act's reaffirmation of that holding, which guarantees that the right to make autonomous decisions about reproductive health, including the right to refuse care, is not suspended due to pregnancy status.

By embedding the logic of fetal personhood into Minnesota's child welfare and civil commitment frameworks, these statutes subordinate the rights of the pregnant person to those of the fetus, directly conflicting with the state's commitments to bodily autonomy. They rest on vague and undefined terms—particularly "habitual or excessive use"—that lack objective criteria and enable arbitrary, discriminatory enforcement, especially against low-income persons and persons of color. Under the guise of voluntariness, they effectively compel chemical dependency treatment, bypassing informed consent and circumventing due process protections.

These laws cannot withstand strict scrutiny. They are overinclusive, capturing individuals who pose no real risk; underinclusive, ignoring other significant threats to fetal health; and grounded in outdated, scientifically discredited assumptions about substance use and fetal harm. Minnesota's prenatal substance use statutes fail to meet constitutional and statutory standards and should be repealed.

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217. *See, e.g.*, Hermer, *supra* note 97, at 295 ("If the pregnant person wants to bring the fetus to term, then all legal protections for the fetus in utero should flow from that intent alone."); *see also* Soohoo, *supra* note 112, at 109 ("[T]he one who 'calls the fetus into personhood' must be the pregnant person because they most likely have the strongest attachment and are growing the zygote-embryo-fetus in their body.").