THE HYPERREGULATION OF THE POOR

Wendy A. Bach[*]

INTRODUCTION[1]

Feminist theory has long been criticized for centering the experiences of white, citizen, middle class women and for eliding the experiences of women who differs along the lines of class, race, citizenship or other identity axis. Historically, by centering the experiences of white women of privilege, streams within feminist discourse have given rise to social policy that at best fails to meet the needs of poor women and women of color and at worst contributes to their continued subordination. The critique waged by Kimberle Crenshaw in 1991 that the domestic violence and anti-rape movements, by centering the experiences of white citizen women, at best erased and at worst undermined the safety and needs of women of color is among the most trenchant of these many critiques.[2] This article suggests that, in a vital area of feminist political and legal theory, in subtle but crucial ways, we are in danger of making the same mistake.

A significant branch of current feminist political theory seeks to reconceptualize the very subject of law and the role of the state. These theorists posit, in contrast to the current constrained notion of liberal autonomous subject, a subject who possesses a shared human vulnerability. They critique the current state as largely absent – as one that is fundamentally uninvolved in helping women meet dependency needs. They then draw a compelling path from those vulnerable interdependent subjects and the absent nature of the current state to a vision of a responsive or supportive state. This article endorses the idea that the state envisioned by these theorists may well be significantly better for women across race and class. But it also challenges us collectively to ask how conceptions of vulnerability, state absence and state responsiveness might be altered if we more squarely center the analysis around key aspects of the relationship between legal institutions and the poor, disproportionately women

[*] Associate Professor of Law, University of Tennessee College of Law.

[1] Note to Law Review Editors: For the purposes of facilitating the editing process, , in this version of the article I have left sources fully cited throughout rather than doing short form and cross reference citations.

[2] Kimberle Crenshaw, *Mapping The Margins: Intersectionality, Identity Politics, and Violence Against Women of Color,* 43 STAN L. REV. 1241 (1991). For foundational pieces on this topic *see e..g* bell hooks, AIN'T I A WOMAN: BLACK WOMEN AND FEMINISM (1981); ALL THE WOMEN ARE WHITE, ALL THE BLACKS ARE MEN, BUT SOME OF US ARE BRAVE: BLACK WOMEN'S STUDIES (Gloria T. Hull et al. eds., 1982); THIS BRIDGE CALLED MY BACK: WRITINGS BY RADICAL WOMEN OF COLOR (Cherríe Moraga & Gloria Anzaldúa eds., 2d ed. 1983). For relevant readings specific to some of the social welfare policy that is discussed in Section III of this article, *see e.g.* Jill Quadagno, THE COLOR OF WELFARE: HOW RACISM UNDERMINED THE WAR ON POVERTY (1994).

and families of color who have no choice but to avail themselves of what remains of a shredded social safety net. This shift in perspective gives rise perhaps, not to a fundamentally different vision of where we might be moving, but to a different path to get there.

For women who have no choice but to avail themselves of the safety net (think welfare or public housing) or who by their sheer geographic exposure to the mechanisms of government systems (think overpolicing of poor communities, public hospitals and public schools) find themselves subject to government intrusion (think child welfare agencies and the criminalization of poverty) the state is anything but absent. Instead it is highly intrusive, stripping women of their privacy and subjecting them to extraordinary scrutiny, surveillance and punishment. More specifically, crucial interactions between poor women and the state are characterized by a phenomena that this article terms regulatory intersectionality, defined as the means by which regulatory systems interlock to share information and heighten the adverse consequences of unlawful or noncompliant conduct.

Drawing together the formal and informal structures of legal regulatory institutions and research documenting the disproportionate impact of these policies on poor women and poor communities of color, this article describes the functioning of regulatory intersectionality in two key institutions of the safety net. The article highlights first the exposure of poor pregnant women to child welfare intervention and criminal prosecution as a result of drug testing in public hospitals; and second the referral of individuals to child protective agencies when welfare applicants test positive for drugs or refuse drug tests. In each of these cases, the poor women, who are disproportionately African American, and who seek support from the state, through health care facilities and welfare programs, find themselves, as a price of their vulnerability, subject not only to extraordinary surveillance but to a far reaching interconnected set of civil and criminal regulatory systems designed to impose escalating punitive consequences for their behavior.

The article concludes by arguing that centering the phenomena of regulatory intersectionality would revise vulnerability theory in two crucial and related ways. First, it serves as a practical warning. If the current social safety net is so profoundly characterized by mechanisms that interlock to impose escalating punishment, the road to a supportive state that does not function in this way is likely to be long and complicated. The second observation is suggested by the first. In attempting to realize the vision of the supportive or responsive state, the next step may not be continuing to envision a set of policies that provide support or a set of claims that lead to responsiveness but instead joining together to dismantle the state mechanisms revealed by regulatory intersectionality analysis. If we fail to center and prioritize those realities and those tasks, then this particular, and crucial part of political theory is again in danger of leaving behind those who are, by virtue or race, gender, class and place, among the most

vulnerable.

The article proceeds as follows. Section I provides an overview of the feminist political theory referenced above with a particular emphasis on its description of the functioning of the social welfare state. Section II then contextualizes the concept of regulatory intersectionality within current discussions of social welfare history, sociology and critical race theory. Section III then offers a description of the regulatory intersectionality as it plays out in public health and welfare settings. Finally Section IV lays out the implications of regulatory intersectionality for theorizing a path towards a more supportive and responsive state and suggests areas for further research and analysis.

I. The Failures of Liberal Theory and the Idea of the Supportive State

The recent work of Martha Fineman and Maxine Eichner[3] challenges us to reconceptualize the very subject of law and the role of the state.[4] As to the subject, Fineman and Eichner call the fundamental bluff of liberalism. They remind us that, much as liberal political theory is built around the assumption that we are all autonomous and able, if simply left alone, to realize our full potential, in lived experience this is very far from true. They remind us that, while we are sometimes autonomous, we are frequently not. We are instead dependent and vulnerable. In addition, and crucially, some subjects are tremendously privileged while others "are caught in systems of disadvantage that are almost impossible to transcend." [56][5] As to the current operations of state in the domestic context,

[3] When referencing the work of Fineman I am referring primarily to Fineman's work on Vulnerability and Dependency: Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 257 (2010); Martha Albertson Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition* 20 YALE J.L. & FEMINISM 1 (2008) and Martha Albertson Fineman, THE AUTONOMY MYTH: A THEORY OF DEPENDENCY (2004). When referencing Eichner, I am referring primarily to MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS (2010). In these texts, Fineman and Eichner differ both as a matter of the methodology of how one might reach the vision of a supportive (in Eichner's term) or responsive (in Fineman's) state, and these differences matter a great deal. They also differ significantly in what the end goal looks like, particularly on issues of how care work should be compensated. Throughout this section I will highlight, in footnotes, some of these differences. However, for the purposes of this portion of the article, I highlight the ways in which their work complements and builds upon each other's.

[4] Fineman and Eichner's work focuses on U.S. social policy in the domestic context, as do references to the "state" in this paper.

[5] Eichner's critique of liberal theory begins not in current political discourse and its manifestations in social policy but in a fundamental critique of Rawlsian political theory as exemplified by his work in A THEORY OF JUSTICE. See. e.g. MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 17-26 (2010)(critiquing the failure of Rawls to incorporate the role of the family in meeting dependency needs). In this article, however, I focus not on Eichner's critique of Rawls

Fineman and Eicher offer a searing indictment. Each posits that the result of liberal rhetoric is fundamentally an absent and unresponsive state. Vulnerable and dependent subjects are left alone to succeed or fail and the profound impacts of privilege and prejudice remain undisturbed. When people fail to live up to the ideal notions of autonomy and privacy, they are blamed,[7] and either deprived of support or, as Eichner vividly describes in her discussion of U.S. child welfare policy, severely punished.[8]

The positive vision of the state that Eichner and Fineman offer is markedly different and, this article maintains, far better than the current state of affairs. While Fineman and Eichner differ on crucial issues of policy, the focus of their critique and the results they envision,[9] they both call for a state that responds to vulnerability through the creation of policies and institutions that address dependency. In Eichner's terms, rather than structuring policy in a way that either leaves families alone to meet needs or punishes them for failing to meeting needs, the supportive state would,

> [a]t a minimum . . . arrange institutions in such a way that family members can, through exercising diligent but not Herculean efforts, meet the basic physical, mental and emotional needs of children and other dependents and promote human development while avoiding impoverishment or immiseration.[10]

Moreover, Fineman in particular believes that the focus on vulnerability on the one hand and responsiveness on the other provides a powerful mechanism to

per se but on her analysis of how the idea of autonomy profoundly limits the ability of American political discourse to justify government institutions that meet dependency needs.

[6] Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 257 (2010).

[7] Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 257 (2010).

[8] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 119-123 (2010).

[9] For discussion, by Eichner, of the differences between her vision of the mechanism of the supportive state and Fineman's *see e.g.* MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS, 75-77 (2010). Eichner identifies crucial differences between her vision and Fineman's particularly on the issue of whether parents should be compensated for care work. In addition, although their work is extraordinarily complementary, they do differ in significant ways in terms of emphasis. In particular Fineman frames her Vulnerability project around the profound failure of Equal Protection doctrine to support the conditions for substantive, as opposed to formal, inequality. Eichner's work in THE SUPPORTIVE STATE focuses primarily on how state policies and social mechanisms can be restructured to support the work of families in meeting dependency needs.

[10] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 78-79 (2010).

address the profound inequalities that exist in U.S. society. Vulnerability theory, in Fineman's analysis forms the basis of a claim that state institutions must provide not just formal equal access but the material conditions necessary to achieve substantive equality.[11] Fineman and Eichner provide an essential critique and a compelling vision, and this article largely endorses and attempts to build upon their essential work.

The article argues, however, that Fineman and Eichner's description of the existing mechanisms of the state as fundamentally as either absent or punitive fails to focus sufficiently on the way that the mechanisms of the state actually operates for those who are, by virtue of the intersecting implications of class, race, gender and geography, most vulnerable. The article argues, in Section III, that in institutions like public hospitals and welfare offices, poor people, and disproproportionately poor people of color, face something quite different from an absent state. Mechanisms of the state that purport to be in place to provide what remains of a shredded social safety net go far beyond failing to support. Instead, because of their position and because of their need, poor families face a pervasive, hyperregulatory state, one whose systems interlock, in a mechanism referred to here as regulatory intersectionality, to exact escalating punitive consequences on those who seek its support. Before describing those mechanisms, however, this Section lays out in more detail Fineman and Eichner's theory of the liberal subject, the current, largely absent state, and the responsive state they collectively envision.

A. The Autonomous Subject and the Vulnerable Subject

The theory of the Supportive State begins, fundamentally, with a critique the American ideal of the person to be governed. Liberal political theory, as manifested in dominant U.S. political discourse, is built, "on its conceptualization of individuals as autonomous and able."[12] We are, in this formulation, people who can, through the exercise of hard work, pull ourselves up by our proverbial bootstraps. The purpose of government then, is to make sure that nothing gets in our way. We need liberty to protect against incursions on the exercise of our autonomy, and we need formal equality, some sense not that we will all end up equal but that we perhaps start the race at the same point, so that we can all reach our ultimate potential. In popular discourse, this proverbial race is primarily an economic one. We are all, in theory, free participants in the market, and nothing is supposed to get in the way of realizing our economic potential.

---

[11] *See infra* notes ___ and accompanying text.

[12] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 17 (2010). Fineman makes clear that in her view notions of autonomy "defined in terms of expectations of self-sufficiency" dominates our political discourse. Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 259 (2010).

The problem with these ideas is, in short, that it "… seems to mistake this moral ideal for an account of the human condition."[13] It does so in two fundamental ways. First, it entirely fails to account for the fact that we are often dependent. We are young, old, sick and unable to meet our needs. We are dependent, and we are vulnerable. Second, the theory fails to acknowledge that, "[f]ar from having equal opportunity, many individuals are caught in systems of disadvantage that are almost impossible to transcend."[14] Moreover these critiques are not just issues of theory. These falacies are manifest in the state of American law and policy.

1. The Failure to Account For and Respond to Dependency

The first broad critique is that this political discourse, as manifest in U.S. policy, fails almost entirely to account for the way that families, broadly defined, meet the dependency needs of its members. Adults in families care for the young and old, and adult members care for each other in a myriad of ways. And, in a phenomena termed derivative dependency,[15] when the caretakers, who are almost always women, provide this care work they do so at the expense of their own ability to be those idealized economic actors.

A few examples make this point evident. In the last several decades we have experienced radical shifts in the nature of work and family. The conceptual ideal of the two parent family with one breadwinner barely exists and yet still forms the conceptual basis for many work related policies. Today, 70% percent of children live in households where all parents in the household, be there two or one, work. Despite these radical shifts in the nature of family and work, the workplace has barely shifted to accommodate these changes. In fact, as Eichner notes, "a comparison of policies in 173 countries found that when it came to parental leave protections in the workplace, the United States came in dead last, tied with only three other countries: Liberia, Papua New Guinea and Swaziland."[16] In addition to facing a workplace that is tremendously inflexible, American workers are consistently called on to work far more hours than those in

[13] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 21 (2010).

[14] Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 257 (2010).

[15] Martha Albertson Fineman, THE AUTONOMY MYTH: A THEORY OF DEPENDENCY 34-37 (2004).

[16] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 27 (2010)(citing Jody Heyman, Alison Earle, Jeffrey Hayes, *Project on Global Working Families, The Work, Family and Equity Index: How Does the United States Measure Up?* (2007), available at http://www.mcgill.ca/ihsp/sites/mcgill.ca.ihsp/files/WFEI2007FINAL.pdf (last visited December 29, 2012)).

other western countries.[17] Adding to the difficulties created by the lack of flexible workplace policies and long hours are the absence of high quality affordable care. Although children who receive high quality care tend to fare quite well, due in large part to the extraordinarily low compensation offered to those who engage in paid care work, the vast majority of available childcare is lightly regulated and of low quality.[18]

Women who both work and fulfill caregiving roles find themselves lagging behind on a variety of economic indicators. While women in couples struggle to maintain economic equality, single women raising children face harsher circumstances and harder choices. They generally must attempt to balance care work with employment, but the lower they are on the economic ladder, the more difficult this balance and the harsher the consequences should their carefully calibrated work and care plans fall apart. For the poorest women, who are disproportionately women of color, attempting to provide care for their own dependent children and family members, all these statistics and policies are significantly worse. Low wage workplaces tend to be less flexible and more precarious than those higher on the economic ladder. The extraordinary expense of childcare and the lack of any significant effort to subsidize that care force women into unstable and often unsuitable childcare arrangements and into a set of expenses that are nearly guaranteed to fail. And whereas prior to the 1996 welfare reform act, some women could rely on Aid to Families With Dependent Children to provide some level of support should they choose or be forced into unemployment, today the combined impact of work requirements, time limits, and the extraordinary push in many states to eliminate welfare, make the choices poor women face all the more difficult. Moreover, as wealthier women seek to meet the care needs of their families, they employ poor, disproportionately immigrant women, and provide them with generally low wages and even fewer benefits.

In short, despite the ideal of an autonomous adult actors and a family that is supposed to provide care work, the reality for the women who provide this care work and the adults and children who receive it, is that meeting these obligations is extraordinarily difficult. It is, for both Fineman and Eichner, our autonomy centered political rhetoric that allows the state to fail to intervene to provide additional support:

> [The] assumptions, that individual liberty and equality are appropriately recognized by law, that dependency is not a condition that law needs to recognize; that the state should be neutral on issues of family; and that

[17] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 39-40 (2010).

[18] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 40 (2010).

the state should not adulterate families internal dynamics – prevent policies that effectively support families.[19]

2. The Failure to Account for and Respond To Structural Inequality

The second both theoretical and quite practical critique of the way the autonomous subject drives policy focuses on structural inequality. As Fineman aptly puts it, in our society "[p]rofound inequalities are tolerated – even justified – by reference to individual responsibility and the working of an asserted meritocracy within a free market."[20] We are, in short, a nation characterized by profound economic inequality, inequalities that are again more starkly felt in communities of color.

Although an in depth discussion of the profound inequities woven into our current society is well beyond the scope of this article, a few statistics serve as a potent reminder of these phenomena. Since the 1970s, the income gap between those at the bottom and those at the top has continued to widen, with an ever smaller share going to those at the bottom and in the middle and more going to those at the top. According to the Congressional Research Service, "… the U.S. income distribution appears to be among the most unequal of all major industrialized countries and the United States appears to be among the nations experiencing the greatest increases in measure of income dispersion."[21] Looking in particular at African Americans, who are disproportionately affected by the social welfare policies examined in Section III of this article, reveals significant income disparities between blacks and whites. For example, sixty five percent of blacks studied in the most recent PEW Charitable Trust Economic Mobility Project report, "were raised at the bottom of the income ladder compared with only 11 percent of whites."[22]

[19] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 27 (2010).

[20] Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 251 (2010)(Fineman's critique is aimed squarely at the failures of Equal Protection doctrine. In this piece and in a prior piece on vulnerability, Martha Albertson Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition* 20 YALE J.L. & FEMINISM 1 (2008), Fineman indicts the doctrine for its utter failure to provide any means to realize substantive equality. This article draws on Fineman's work on vulnerability, however, not to engage in the important debates around how that theory might add to Equal Protection analysis but for its description of the theory and practice of the state as it operates in American society.

[21] Linda Levine, Congressional Research Services, The U.S. Income Distribution and Mobility: Trends and International Comparisons, summary (2012). Available at www.fas.org/sgp/crs/misc/R42400.pdf. (last visited February 12, 2013).

[22] The PEW Charitable Trusts, Economic Mobility Project, Pursuing the American Dream: Economic Mobility Across Generations, www.pewstates.org/uploadedFiles/PCS_Assets/2012/Pursuing_American_Dream.pdf. at 18.

In addition, although the popular rhetoric about autonomy might suggest that it is quite possible to, by hard work and effort, move up the economic ladder during one's lifetime, according to the Congressional Research Service, "… empirical analysis suggests that children born into low-income families have not become more likely and may have become less likely to surpass their parents position at the bottom of the income distribution."[23] In fact, according to recent data, only 4% of those raised in the bottom fifth of household earnings make it all the way to the top quintile. In contrast, 43% of Americans raised in the bottom fifth will remain there as adults.[24] Blacks are also significantly more likely to be stuck at the bottom than whites. "More than half of black adults (53% for family income and 50% for family wealth) raised at the bottom remain stuck there as adults, but only a third of white (33 percent for both) do."[25]

Despite these and other clear inequalities woven into our society along lines of gender, class and race, our social policy does little to nothing to address these inequalities. Instead, and this is the heart of the critique of what Fineman terms The Autonomy Myth,[26] American social policy is largely "unresponsive to those who are disadvantaged, blaming individual for their situations and ignoring the inequity woven into the systems in which we are all mired."[27]

B. From The Absent State to The Responsive State

The social policy and jurisprudence that results from this constricted view of autonomy justifies and gives rise, in Fineman and Eichner's view, to a non-responsive and largely absent state.[28] "… [T]he same problematic assumptions

---

[23] Levine at 14.

[24] The PEW Charitable Trusts, Economic Mobility Project, Pursuing the American Dream: Economic Mobility Across Generations, www.pewstates.org/uploadedFiles/PCS_Assets/2012/Pursuing_American_Dream.pdf. at 3.

[25] The PEW Charitable Trusts, Economic Mobility Project, Pursuing the American Dream: Economic Mobility Across Generationswww.pewstates.org/uploadedFiles/PCS_Assets/2012/Pursuing_American_Dream.pdf. at 20.

[26] Martha Albertson Fineman, THE AUTONOMY MYTH: A THEORY OF DEPENDENCY (2004).

[27] Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 257 (2010).

[28] By characterizing their collective description of the state as absent and unresponsive I do not mean to suggest that either author fails to acknowledge to means by which law and social policy constitute both the family and the overlapping means by which dependency needs are met or unmet. In fact, both authors clearly acknowledge the way that law shapes the very nature of the family. *See e.g* MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 55-

that are embodied in political theory are also present in US law."[29] If, rather than accepting this constrained view of autonomy and absent state the "primary objective [was instead] ensuring and enhancing a meaningful equality of opportunity and access, we may see a need for a more active and responsive state. . . ." This envisioned state would take as its primary mission not, "simply [to] protect citizens' individual rights from violation by others." Instead it would, "actively support the expanded list of liberal goods by creating institutions that facilitate caretaking and human development."[30] This envisioned state would also move past constrained notions of formal equality towards a much more robust and substantive demand on state institutions to create the possibility for real equality. The "primary objective [would be] ensuring and enhancing a meaningful equality of opportunity."[31]

The absent state manifests itself in two primary ways: first in its failure to regulate the workplace in way that allows families to balance employment and caretaking and second in the constricted and punitive ways in which it provides assistance to those in need. The envisioned state would provide be restructured to respond in both these areas.

1. The Failure to Regulate the Market and Regulation of the Market in the Supportive State

The state's failure to regulate the market is a central concern of the theory of

57(2010)("Just as there is no natural, pre-political family, there are no natural, pre-political ways in which families function. In today's complex society the ways in which families function are always deeply and inextricably intertwined with government policy." (citing Frances E. Olsen, *The Myth of State Intervention in the Family*, 18 MICH. J. L. REFORM 835, 836 (1985)). Martha Albertson Fineman, THE AUTONOMY MYTH 151 ("While the family may be viewed as private in our rhetoric, it is highly regulated and controlled by the state.").

[29] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 27 (2010).

[30] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 70 (2010). Although Fineman frames it differently, and again focuses more squarely on the failures of equality doctrine to meet the challenges of structural inequality, Fineman's framing is similar. In her terms,

> …. Consideration of vulnerability brings societal institutions, in addition to the state, and individual into discussion and under scrutiny. . . . The nature of human vulnerability forms the basis for a claim that the state must be more responsive to that vulnerability. It fulfills that responsibility primarily through the establishment and support of societal institutions."

Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 255 (2010).

[31] Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 260 (2010).

the Supportive State. With a few limited exceptions,[32] American law provides comparatively few restraints on the market designed to support families in meeting the care needs of their dependents. The Supportive State, in contrast, would "focus on limiting coercion by the market," and would enact policies to ". . . allow families the institutional space to make important decisions and to the accomplish important tasks without being completely beholden to the market."[33] For example, upper hour restrictions on work would be imposed, time off to meet caretaking needs would be expanded and compensated and workers would be allowed flexible work hours if needed to meet caretaking obligations.[34]

2. The Limited and Punitive Nature of the Safety Net and A Newly Envisioned Set of Supports

Current U.S. social policy provides a severely limited and highly punitive safety net for those in poverty. In order to receive the meager support offered by the state, poor women are stigmatized, forced to surrender their autonomy and subjected to an extraordinarily punitive system as a price for meager support.[35] Eichner's devastating description of the operation of the current child welfare system provides a vivid example of how current social policy assumes autonomy as a baseline and stigmatizes and punishes those who fail to meet their own needs. Poor families receive little to no support in parenting successfully while attempting to survive the harsh conditions of poor communities and the low wage labor market. The vast majority of interventions fall on the punitive and, for both the children and the families involved, devastating side. As a general matter, the state only enters when there is allegation of abuse or neglect. Once the state enters the vast majority of resources go not into supporting families to parent successfully but to moving children into foster care. Once in foster care, the vast majority of children fare very badly. And, as in the case in so many of these

[32] Eichner notes the existence of the Family and Medical Leave Act ("FMLA") as the only federal legislation specifically designed to address the ability of families to meet caretaking needs. Although tremendously important for what is does, it is limited in both the employees it covers and the support it provides. In short the Act guarantees up to twelve weeks of leave for certain caretaking activities for approximately 50% of the workforce. Because it is unpaid, however, according to at least one estimate 78% of workers eligible for leave under the Act cannot take advantage of it because the of the associated loss in wages. MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 36 (2010).

[33] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 64-65 (2010).

[34] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 64-65 (2010).

[35] Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 259 (2010)"(. . . those who must resort to certain forms of state assistance are asked to surrender their autonomy (and privacy) and are stigmatized as dependent and failures").

punitive systems, they focus these punitive resources overwhelmingly on communities of color. The consequences, as Dorothy Roberts has so thoroughly and persuasively demonstrated, is a concerted and often devastatingly effective attack on poor African American families.[36]

The supportive state would respond quite differently both for poor women and for women who are farther up on the economic ladder. In place of the current child welfare system the supportive state would be, "premised on the view that children's welfare is a concurrent rather than a residual responsibility of the state, and this responsibility [would be] best met through supporting families in the normal course of events."[37] The goal of such a state would be, "supporting the development of flourishing children."[38] The Supportive State then would seek to alleviate child poverty and would provide high quality early education and childcare,[39] sufficient access to low income housing[40] and "policies that ensure access to mental health services and drug-treatment programs."[41] More generally, the supportive and responsive state would provide significantly more access to support for all families in the form of universal health care, subsidized childcare, and in some iterations, compensation for care work.[42]

C. The Path Towards the Responsive State: A Cautionary Note

These feminist political theorists offer a tremendously productive reframing of the liberal subject and the role of the state and a comprehensive vision of what the supportive or responsive state might entail. The idea of vulnerability, as opposed to constrained notions of autonomy, as at the center of liberal theory creates a shift in the burden placed on the state. As Fineman frames it, "[t]he

---

[36] *See infra.*notes __ and accompanying text.

[37] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 123 (2010).

[38] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 123 (2010).

[39] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 123-24 (2010).

[40] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 124 (2010).

[41] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 124 (2010).

[42] Eichner and Fineman diverge to a certain extent on this issue. Fineman suggests, in THE AUTONOMY MYTH that care work should be publically compensated. Eichner rejects this proposal, largely on the grounds that it would be politically infeasible. It is important to note that Eichner and Fineman also both devote substantial parts of their analysis to the crucial questions of how the supportive state should support women's equality. For example, Eichner suggests policies that would encourage both men and women to provide care work by, for example, providing dependency care leaves that each worker with a dependent family member on a use or or lose it basis.

nature of human vulnerability forms the basis for a claim that the state must be more responsive to that vulnerability."[43] These theorists also clearly understand and acknowledge that poor women, and disproportionately communities of color, are stigmatized and punished in the current social welfare system. My concern is not that these theorists fail to pay attention to how poor women are treated. In fact to varying degrees these realities are in fact described in their work. Instead, this article raises a few related concerns. One is that while it is certainly true both that the state is absent with respect to facilitating a supportive workplace, and that, to the extent that it provides any sort of social welfare, it does so in a way that stigmatizes and punishes, such a description understates what is going on. First it fails to wrestle with the fundamental split in social welfare policies between those policies that are targeted toward the poor and those that are available without income restrictions. Second, it fails sufficiently to acknowledge the extraordinary hyperregulatory nature of the mechanisms that control poor communities colors in the U.S. Finally, it seems very possible, given the repeated marginalization of poor women of color within some of feminist theory, that unless these issues are foregrounded, the appeal of the narrative of the absent state for those not in poverty could easily dominate further inquiry.[44] This possibility would leave uninterrogated and untouched those wide swaths of policy that uniquely and disproportionately impact poor communities. In this scenario, the fundamental task of realizing a more supportive state could easily focus on creating legal structures to facilitate caretaking by those in the workplace at the expense of interrogating and dismantling the punitive and hyperregulatory mechanisms of the those parts of the state targeted at poor women generally and poor women and communities of color specifically.

II. Hyperregulation and Poverty

Before focusing on the legal and policy structures of the phenomena that this article terms regulatory intersectionality, it is important to provide some context, from history, sociology and critical race theory, within which to situate this analysis. In particular, it is important to briefly recount the history of social welfare policy in the United States which led us to a bifurcation of support

[43] Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State* 60 EMORY L.J. 251, 255-56 (2010).

[44] One example of this phenomena in popular culture was clear from the extraordinary focus, among professional women on the publication of Anne Marie Slaughter's *Why Women Still Can't Have It All*, THE ATLANTIC MONTHLY, July/August 2012, available at http://www.theatlantic.com/magazine/archive/2012/07/why-women-still-cant-have-it-all/309020)(last visited January 30, 3013). For some coverage on the response to the article, *see* links embedded in Anne Marie Slaughter, *The 'Having it All Debate Convinced Me To Stop Saying 'Having it All.',* THE ATLANTIC MONTHLY, July 2, 2012, available at http://www.theatlantic.com/business/archive/2012/07/the-having-it-all-debate-convinced-me-to-stop-saying-having-it-all/259284/)(last visited January 30, 2013).

systems: one for those in poverty and one for everyone else. It is also crucial to situate regulatory intersectionality analysis within a recent movement within both sociology and law, describing the means by which legal systems, both civil and criminal, interlock to control poor communities of color. This scholarship has entailed a reenvisioning of how we conceptualize the mechanisms of social control within the welfare state.

A. A Bit of Social Welfare History

As has been well told elsewhere, at the advent of the New Deal the United States made a crucial set of decisions about how to structure its welfare state. Very roughly speaking, the set of supports created in the 1930s and then significantly expanded and reconfigured during 1960s and the Great Society were split in two.[45] One set of supports was created for a group viewed as workers and therefore deserving of support. These programs, like Social Security and Medicare, did not have income cut offs. Although of course certain categories of workers were originally excluded,[46] this category of social supports were created and remain in place for those who, politically speaking, "paid into the system."[47]

During the same period (starting during the New Deal and continuing in the 1960s) another very different set of supports were created for some in poverty: those deemed worthy of support but still poor and in need not just of support but of behavioral control.[48] Originally Aid to Dependent Children was created primarily to enable poor white widows to remain in their homes and care for their children. This program was, like poverty programs that preceded it, focused strongly on controlling the behavior of its recipients. Later, during the War on Poverty and the Great Society, programs like Food Stamps and Medicaid were added to those programs exclusively for those in or near poverty. The poverty programs have been, since their very inception, focused on scrutinizing and controlling the behavior of recipients. Moreover, as AFDC was transformed, in the 1960s, as the result of extensive activism and litigation, from a program primarily for poor white widows to a program open to poor communities of color, the nature of extent of behavioral controls became inextricably linked to structures of racial subordination. As this article argues in Section IV, remembering this fundamental structural divide in U.S. Social Welfare Policy

---

[45] Michael B. Katz, IN THE SHADOW OF THE POORHOUSE: A HISTORY OF WELFARE IN AMERICA 238-39 (1986).

[46] Linda Gordon, PITIED BUT NOT ENTITLED: SINGLE MOTHERS AND THE HISTORY OF WELFARE 1890- 1935, 5 (1994).

[47] Michael B. Katz, IN THE SHADOW OF THE POORHOUSE: A HISTORY OF WELFARE IN AMERICA 238-39 (1986).

[48] For a discussion of the historical origins of this split in U.S. social welfare policy and their relationship to who was "deserving" *see* Michael B. Katz, IN THE SHADOW OF THE POORHOUSE: A HISTORY OF WELFARE IN AMERICA 238-39 (1986).

and its extricable ties to racial subordination is crucial to conceptualizing a path to the Supportive State that includes those in poverty.

B. From Less Eligibility to Hyperregulation

In 1971 Frances Fox Piven and Richard Cloward published REGULATING THE POOR, a groundbreaking treatise that would shift the way that left scholars talked about U.S. poverty policy. Piven and Cloward argued that, "relief programs are initiated to deal with dislocation in the work system that lead to mass disorder, and are then retained . . . to enforce work."[49] Highlighting current manifestations of the age old social welfare theory of *less eligibility*,[50] Piven and Cloward persuasively chronicled the systematic expansion and contraction of public aid as a mechanism to keep workers vulnerable and beholden to the vagaries of the low wage labor market. Loic Waquant has recently and persuasively argued, however, that it is no longer sufficient to analyze the working of the social welfare state in isolation. Instead Wacquant and others urge us to widen the frame and see how both social welfare and criminal justice mechanisms interweave to control poor communities. As Waquant frames it,

> . . . [T]his cyclical dynamic of expansion and contraction of public aid has been superseded by a *new division of the labor of nomination and domination of dependent populations* that couples welfare services and criminal justice administration under the aegis of the same behaviorist and punitive philosophy. The activation of disciplinary programs applied to the unemployed, the indigent, single mothers, and others 'on assistance' so as to push them onto the peripheral sectors of the employment market, on the one side, and the deployment of an extended police and penal net . . . on the other side, are the two components of a single apparatus for the management of poverty that aims at effecting the authoritarian rectification of the behaviors of populations recalcitrant to the emerging economic and symbolic order.[51]

Wacquant persuasively insists that the U.S. social welfare state, which he genders female, and the U.S. penal system, which he genders male,[52] are two interlocked

[49] Frances Fox Piven and Richard A. Cloward, REGULATING THE POOR: THE FUNCTIONS OF PUBLIC WELFARE xvii (1993).

[50] "Less Eligibility" describes the principle, long established within social welfare policy, that any means of support offered to the poor should leave them in circumstances less good than the circumstances they would face if participating in the market. For an historical description of this concept *see*, Frances Fox Piven and Richard A. Cloward, REGULATING THE POOR: THE FUNCTIONS OF PUBLIC WELFARE 35-36 (1993).

[51] Loic Wacquant PUNISHING THE POOR: THE NEOLIBERAL GOVERNMENT OF SOCIAL INSECURITY 74 (2009).

[52] Although this article does not focus on the question of the gender of the penal arm

mechanisms that work together to discipline those who threaten the neoliberal economic order. In his terms, "workfare" and "prisonfare" are inextricably linked.[53] And those disciplined are, of course, raced black, both actually and as a matter of symbolic ordering. As discussed in more detail below, there is absolutely no question both that the punitive policies of the U.S. social welfare state impact African American comnmunities disproportionately.[54]

Frank Rudy Cooper recently noted that Wacquant also offers valuable terminology for describing the targeted nature of these interlocking systems. Cooper, citing Waquant, recently argued that we should use the prefix "hyper" as opposed the descriptor "mass" to describe the phenomena of incarceration in poor, urban communities of color in the United States. Cooper notes that the use of the prefix "hyper"

> is not generalized, but targeted . . . .[H]yper-incarceration should be seen as a multidimensional attack on a specific group of people. Wacquant reveals that hyper-incarceration has 'been finely targeted, first by class, second by that disguised brand of ethnicity called race, and third by place.' The class targeted is, of course, the poor. The races targeted are, of course, blacks and then Latinos/as. The place targeted is the inner city.[55]

The titling of this article the "hyperregulation" of the poor thus invokes this

---

as Wacquant describes it, the gendering of the penal system as male is problematic in its elision of one of the fastest growing incarcerated populations, poor women of color. For a broad ranging discussion of the implications of this trend, *See* the symposium issue recently published by the Stanford Law Review. 59 STAN. L. REV 1418 (2012). The symposium was entitled *Overpoliced and Underprotected: Women, Race and Criminalization.* As described by Kimberle Crenshaw, whose article introduces the volume, "[m]ore than simply adding women of color into the mix, this symposium interrogates the terms by which women are situated both within the discourse of mass incarceration as well as within various systems that overlap and that contribute to the vulnerability of racially marginalized women." Kimberle Crenshaw, *From Private Violence to Mass Incarceration: Thinking Intersectionally About Women, Race and Social Control*. 59 UCLA L. REV 1418, 1422 (2012).

[53] Loic Wacquant PUNISHING THE POOR: THE NEOLIBERAL GOVERNMENT OF SOCIAL INSECURITY 79 (2009).

[54] Moreover with the publication of Michelle Alexander's THE NEW JIM CROW, it is clear that that the criminal justice system and its associated civil feeder and post incarceration classifications systems serve to strip black communities of their freedom and of the fundamental privileges of citizenship and to recreate, in Alexander's terms, a New Jim Crow. Michelle Alexander THE NEW JIM CROW: MASS INCARCERATION IN AN AGE OF COLORBLINDNESS (2010).

[55] Frank Rudy Cooper, *Hyper-Incarceration as a Multidimensional Attack: Replying to Angela Harris Through The Wire*, 37 WASH U. J. L & POLY. 67, 68-69 (2011)(citing Loic Wacquant, *Racial Stigma in the Making of America's Punitive State*, RACE, INCARCERATION, AND AMERICAN VALUES 57, 59 (2008)).

conception of targeted, interlocking and focused mechanisms of social control.

In addition to widening the frame and defining terms, however, we also need to focus sharply on the details of these "structural and institutional intersections."[56] As Dorothy Robert's work continually reminds us, understanding how systems interlock to, in the terms of this article, hyperregulate the poor and function to reinforce racial hierarchies requires investigating, ". . . particular systemic intersection[s] to help elucidate how state mechanisms of surveillance and punishment work to penalize the most marginalized women in our society . . . "[57] We must, in short, look at these intersections from the ground up.

The following section turns to one less explored but crucial piece of that task: outlining the mechanisms of regulatory intersectionality[58] as it manifests when poor people seek assistance from some of the most basic social support mechanisms that exist in the United States: public health and welfare. In each example, information that is deemed to indicate non-compliant and/or deviant conduct travels, from the original social welfare system into other even more punitive systems. It is in large part through the mechanisms of these processes that the systems work together to impose ever heightening penalties on the families that seek assistance.[59]

[56] Kimberle Crenshaw, *From Private Violence to Mass Incarceration: Thinking Intersectionally About Women, Race and Social Control*. 59 UCLA L. REV. 1418, 1427 (2012)(Crenshaw uses the term ""structural-dynamic discrimination" to describe, "intersections [that] are termed in reference to work describing, "a variety of social forces that situate women of color within contexts structured by various social hierarchies and that render them disproportionately available to certain punitive policies and discretionary judgment that dynamically reproduce these hierarchies." She uses the term, "intersectional subordination" as, "outcomes produced in the interface between private institutional configurations such as the housing market or neighborhood watches and the policing power of state actors.").

[57] Dorothy Roberts, Prison, Foster Care, and the Systemic Punishment of Black Mothers, 59 UCLA L. REV. 1474, 1476 (2012).

[58] Dorothy Roberts uses the term "system intersectionality" to describe her work examining how the policies of the child welfare and criminal justice system work together to perpetuate the subordination of poor African American women. Dorothy Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474 (2012). The focus here is slightly different. While Roberts' analysis looks at how a variety of policies, such as incarceration for low level drug offenses and the emphasis on adoption in the Adoption and Safe Families Act work together to lead to African American women losing their children, the analysis here looks at a particular kind of intersections whereby information travels from one regulatory system to another, resulting in heightened consequences for the person seeking support.

[59] It is important to note that each of these phenomena could be and in some cases has been studied in more detail than is presented here. For example, Kaaryn S. Gustafson's CHEATING WELFARE: PUBLIC ASSISTANCE AND THE CRIMINALIZATION OF

To understand the impact of regulatory intersectionality on the theory and path to realization of a more responsive or supportive state, it is important to understand both whom these policies impact and how those impacts shape the perception of the users of the U.S. social welfare system. In every system described below, be it the social welfare settings (public health and welfare) or the systems into which data is transmitted and further punishment imposed (child protection and criminal justice), these systems disproportionately serve and target poor communities which are, in turn disproportionately composed of African American families. Moreover, as other scholars have amply demonstrated, both the child welfare and the criminal justice systems have been fairly described as contributing to the destruction of poor Black communities and families and the recreation of a racial caste like system. This article takes those arguments to be true.[60] However, it is not necessary, for the purposes of this article, to reprove those well proven claims. Here two specific pieces of this larger argument are crucial. First, it is important simply to understand that the systems at issue effect and target poor, African American communities disproportionately. Second, it is important to understand both the validity and widespread existence of the perception within poor communities of the child welfare and criminal justice

POVERTY (2011) provides a detailed and extensive description of how welfare programs are characterized by both an assumptions of latent criminality among recipients and extensive interactions between the welfare and criminal justice systems. John Gilliom's OVERSEERS OF THE POOR: SURVEILLANCE, RESISTANCE AND THE LIMITS OF PRIVACY (2001) provides an astounding look at the mechanisms of surveillance and data sharing that dominate public assistance programs and fuel welfare fraud prosecutions. Similarly, Dorothy Roberts has for many years been tracing the means by which poor Black women, through the wieldling of racial tropes, the geography of race and poverty and the disproportionate targeting of their communities, face interlocked public health, child welfare and criminal systems that expose them to escalating punishments and reinforce the U.S. racial hierarchy. *See e..g* Dorothy Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy* 104 HARV. L. REV. 1419 (1991); Dorothy Roberts, SHATTERED BONDS: THE COLOR OF CHILD WELFARE (2002); Dorothy Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474 (2012). The point of this article is not to reproduce these descriptions and analysis but is rather to build on them and, more specifically, to begin to draw attention to the pervasive nature of intersectional regulation across social welfare settings and beyond.

[60] The literature on the topic of race and the criminal justice system is extensive. For a compelling description of the way that mass incarceration and its concomitant over policing, targeted prosecution and post conviction civil consequences operates to institute a system of racial cast in American *see* Michele Alexander, THE NEW JIM CROW (2010). For a devastating chronicle of the impact of punitive child welfare policies on poor African American children and families *see generally* Dorothy Roberts, SHATTERED BONDS: THE COLOR OF CHILD WELFARE (2002). For a discussion of the way that child welfare and criminal justice systems work together to devastate Black Families *see* Dorothy Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474 (2012).

systems as tools of racial subordination. It is justified perceptions like these and the mechanisms of heightening punishment described below that lend credence to those perceptions, and that make them important for realizing the supportive state. If we are, as this article proposes, to center the experiences of poor African American women in our analysis of how the state currently operates and how we might theorize a path from its current operation to a more responsive state, these perceptions and realities matter a great deal. Below is a brief summary of the data that underlies the claim of disproportionate representation and disproportionate negative impact.

C. Race, Gender and Poverty In Public Health and Welfare Settings

In both examples described in Section III, clients enter a particular social welfare setting: public health and welfare. As a result of that entrance, the original social welfare system comes to the conclusion that the person has broken some rule of the system or has engaged in what actors in the system or system policies define as deviant or dangerous conduct. In both systems, the conduct leads to some overt sanction within the social welfare setting: in the example of public health an overt deterrence to accessing prenatal care and in the welfare setting a denial of benefits.[61] The punishment, however, does not cease with the imposition of those penalties. The information about that person or that family then travels from that system to another, resulting in ever heightening negative consequences for some or all members of the family. In both examples the information flows from the social welfare setting to the child protection agency and, in some circumstances, to the criminal system. In each of these systems (social welfare, child protection, and criminal justice) poor African American people are disproportionately represented.

Of the two social welfare settings considered below, one, serves, by definition, only those in poverty.[62] Although, under the terms of the federal Temporary Assistance to Needy Families Program, states have broad discretion to design their programs, a central purpose of the program is ,"to provide assistance to needy families . . ."[63] In contrast although the health care facilities that serve pregnant women are by definition open to all, by virtue of geography

[61] In the public health setting the fact that a pregnant mother tests positive for drugs doesn't lead overtly to a sanction within the public health system. So for example, unlike in the welfare context, that mother is not subject to a rule that would deny her health benefits as a result of that test. Instead in that setting the punishment comes with the transmission of information from the public health to the child welfare and criminal systems.

[62] In using the term poverty, it is crucial to note that those who fall below the poverty line are very, very poor. The U.S. poverty measure has been widely criticized as the U.S. as inaccurate and outdated. *See generally* Wendy A. Bach, *Governance, Accountability and the New Poverty Agenda*, 2010 WIS. L. REV. 239, 278-79).

[63] 42 U.S.C.A. §601(a)(1).

and the race and class stratification of the health care system in the U.S., these setting serve, disproportionately, poor communities of color.[64]

D. Race, Gender and Poverty: Racial Subordination in the Child Welfare and Criminal Systems

Regulatory Intersectionality analysis reveals legal mechanisms that facilitate and in some cases mandate the transmission of information about poor clients from the social welfare setting into other even more intrusive and punitive regulatory systems. In particular both social welfare settings are structured to facilitate the transmission of purportedly negative information about clients from the social welfare setting into the agencies of the child welfare and criminal justice systems, thereby imposing escalating punitive consequences on those who seek support. Although the disproportionate representation of poor African American men, women and children in both child welfare[65] and criminal systems as well as the means by which these systems work to perpetuate the subordination of poor African American communities in the U.S. has been extensively and compellingly chronicled elsewhere, because of the way that regulatory intersectionality facilitates this subordination, it is important to review these arguments here.

As to the child welfare system, Dorothy Roberts' seminal work leaves little doubt that, "the child welfare system [is] a state-run program that disrupts, restructures and polices Black families."[66] Her work also leaves little doubt that, "[b]lack families are being systematically demolished"[67] by that system. A few statistics paint this picture clearly. Although the cause of overrepresentation is disputed, it is beyond dispute that African American children are far more likely to be subject child welfare intervention than white children[68] and that poor

[64] See generally CERD Working Group on Health and Environmental Health, Unequal Health Outcomes in the United States: Racial and Ethnic Disparities in Health Care Treatment and Access, The Role of Social and Environmental Determinants of Health, and the Responsibility of the State, (January 2008). Available at http://www.prrac.org/pdf/CERDhealthEnvironmentReport.pdf (last visited February 4, 2013.

[65] For a concise description of these phenomena as they impact African American women in particular *See e.g.* Geneva Brown, *The Intersectionality of Race, Gender and Reentry: Challenges for African American Women*, THE AMERICAN CONSTITUTIONAL SOCIETY FOR LAW AND POLICY ISSUE BRIEF (Nov. 2010) (available at http://www.acslaw.org/files/Brown%20issue%20brief%20-%20Intersectionality.pdf , last visited January 10, 2013).

[66] Dorothy Roberts, SHATTERED BONDS: THE COLOR OF CHILD WELFARE vii (2002).

[67] Dorothy Roberts, SHATTERED BONDS: THE COLOR OF CHILD WELFARE vii (2002).

[68] *Addressing Racial Disproportionately in Child Welfare*, Child Welfare Information Gateway, U.S Department of Health and Human Services (January 2011)(available at https://www.childwelfare.gov/pubs/issue_briefs/racial_disproportionality/) (last visited

children, who are, of course, disproportionately African American,[69] are also are far more likely to be subject to intervention than children who are not poor. For example, in 2008, while African American children were only 14% of the total population, they were 31% of the percentage of children in foster care.[70] It is also beyond dispute that African American children and African American families fare far worse than their white counterparts once they come to the attention of child welfare authorities. As Roberts systematically chronicles in SHATTERED BONDS, black children are more likely to be separated from their parents, spend more time in foster care, and are more likely to stay in foster care longer.[71] Although it is difficult to capture the extraordinary presence of child protection agencies in the lives of poor Black families today, the fact that, "[o]ne out of twenty two Black children in New York City is in foster care" and, "one out ten children [in the low income neighborhoods of Central Harlem is] . . . in foster care"[72] gives some sense of the incredible depth of this presence and its impact on these communities.

As to the criminal justice system, although many have long documented the extraordinary negative impact of the War on Drugs and hyper-incarceration on poor African American communities, Michelle Alexander's THE NEW JIM CROW has captured public imagination on this issue as perhaps no other work has before it. Paralleling Roberts' work on the way that the child welfare targets African American communities, Alexander persuasively argues that the criminal justice system writ large (in which she includes the full gamut of systems from over-policing in poor African American neighborhoods, through prosecution and plea bargaining, incarceration and post-conviction collateral consequences),

> creates and maintains racial hierarchy much as earlier system of control did. Like Jim Crow (and slavery), mass incarceration operates as a tightly networked system of laws, policies, customs, and institutions that operate collectively to ensure the subordinate status of a group defined largely by race.[73]

It is in part through the mechanisms of regulatory intersectionality that the social welfare systems described below feed negative information about poor women

---

January 10, 2013).

[69] *See infra* n. __ and accompanying text.

[70] *Addressing Racial Disproportionately in Child Welfare*, Child Welfare Information Gateway, U.S Department of Health and Human Services 3 (January 2011)(available at https://www.childwelfare.gov/pubs/issue_briefs/racial_disproportionality/) (last visited January 10, 2013).

[71] Dorothy Roberts, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 9 (2002).

[72] Dorothy Roberts, SHATTERED BONDS: THE COLOR OF CHILD WELFARE vii (2002).

[73] Michelle Alexander, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS 13 (2010).

and children out of the already punitive social welfare setting into these even more harmful and punitive systems.

III. Regulatory Intersectionality

A. Seeking Prenatal and Pregnancy Care in Public Health Facilities: Drug Testing, Child Protection Interventions and Criminal Prosecutions.

In 2001 the Supreme Court, in *Ferguson v. City of Charleston,*[74] addressed the constitutionality of a drug testing program established by a task force of police and public hospital employees in Charleston, South Carolina. Under the program, women who sought prenatal care and/or gave birth at a particular state hospital were drug tested without their knowledge or consent if they met one of nine specified criteria.[75] If a woman tested positive for cocaine she was subject to prosecution for crimes such as simple possession of a controlled substance, unlawful distribution to a minor, and endangering the welfare of a child.[76] Over the course of its implementation, the program took on various forms, sometimes offering the women a chance to avoid prosecution if they enrolled in treatment programs and sometimes not.[77] Ten women who received care at the public hospital, were subject to the drug tests and were subsequently prosecuted challenged the program on the basis that it violated their rights under the Fourth Amendment. The Court held that the tests were in fact searches under the Fourth Amendment,[78] and that they violated that, "general prohibition against nonconsensual, warrantless, and suspicionless searches."[79]

Although the program at issue in *Ferguson* was a product of the much hyped phenomena of "crack babies"[80] and was perhaps, in the overt and targeted nature of the collaboration between the police and hospital, perhaps sui generis, as detailed extensively below, across the country today, the statutory and regulatory frameworks that govern confidentiality of health information, child protection agencies, and criminal justice agencies provide ample opportunities to facilitate the gathering and transmission of data about drug use by pregnant women out of the public health setting and into child welfare and criminal systems. Moreover, despite some of the protections imbedded in the laws governing the conduct of health care providers, significant research indicates that information often flows from the public health setting into the child welfare and criminal justice setting despite the law. The information concerning any particular woman, like the drug testing data the arises in the welfare context, is originally collected in the public

[74] 532 U.S. 67 (2001).
[75] *Ferguson v. City of Charleston*, 532 U.S. 67, 72 (2001).
[76] *Ferguson v. City of Charleston*, 532 U.S. 67, 72-73 (2001).
[77] *Ferguson v. City of Charleston*, 532 U.S. 67, 72 (2001).
[78] *Ferguson v. City of Charleston*, 532 U.S. 67, 76 (2001).
[79] *Ferguson v. City of Charleston*, 532 U.S. 67, 86 (2001).
[80] *See infra* n. 106- 107 and accompanying text.

health setting, but it is then transmitted across regulatory systems, resulting in escalating punitive consequences for the women and children involved. These interlocked regulatory systems thus provide a clear example, in a quite generic social welfare setting, of regulatory intersectionality.

1. Drug Testing: The Basic Legal Framework

Although drug testing in a variety of contexts is becoming increasingly commonplace,[81] when looking particularly at the drug testing of pregnant women in a health care setting, it is crucial to remember that, except in a very narrow circumstances, information obtained by health professionals in the course of providing medical care must be kept confidential and can only be disclosed with the patient's consent.[82] In addition, as noted by the Supreme Court in *Ferguson*, "the reasonable expectation of privacy enjoyed by the typical patient undergoing diagnostic tests in a hospital is that the results of those tests will not be shared with nonmedical personnel without her consent."[83] Finally, as the Supreme Court noted in *Ferguson*, unlike in the welfare setting or in an employment setting, a pregnant woman seeking health care in a public health setting is not seeking some benefit a condition of which is passing a drug test.[84] The woman is

[81] *See e.g.* Craig M. Cornish & Donald B. Louria, *Mass Drug Testing: The Hidden Long-Term Costs*, 33 WM. & MARY L. REV. 95 (1991) ("Widespread drug testing in the American workplace began with President Ronald Reagan's enactment of Executive Order 12,564[.]"); Mary Pilon, *Drug-Testing Company Tied to N.C.A.A. Stirs Criticism*, N.Y. TIMES, Jan. 5, 2013, at SP1 (discussing the proliferation of drug testing in professional and collegiate sports); Mary Pilon, *Middle Schools Add a Team Rule: Get a Drug Test*, N.Y. TIMES, Sept. 22, 2012, at A1 (even some middle schools now test for drugs).

[82] *See e..g*. American Medical Association, Patient Confidentiality, http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/patient-confidentiality.page (last visited February 11, 2013).

[83] *Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001).

[84] In discussing the constitutionality of the search at issue in *Ferguson*, the Court distinguished the *Ferguson* facts from the four previous settings in which the Court had ruled on the issue of whether a drug test violated the Fourth Amendment. The four cases, involved ". . .drug tests for railway employees involved in train accidents, *Skinner v. Railway Labor Execut- ives' Assn.,* 489 U.S. 602, 109 S.Ct. 1402, 103 L.Ed.2d 639 (1989), for United States Customs Service employees seeking promotion to certain sensitive positions, *Treasury Employees v. Von Raab,* 489 U.S. 656, 109 S.Ct. 1384, 103 L.Ed.2d 685 (1989), and for high school students participating in interscholastic sports, *Vernonia School Dist. 47J v. Acton,* 515 U.S. 646, 115 S.Ct. 2386, 132 L.Ed.2d 564 (1995). . . [and] . . . for candidates for designated state offices as unreasonable. *Chandler v. Miller,* 520 U.S. 305, 117 S.Ct. 1295, 137 L.Ed.2d 513 (1997). As the Court explained, in those cases, "there was no misunderstanding about the purpose of the test or the potential use of the test results, and there were protections against the dissemination

seeking medical care, the quality of which has always depended on a relationship of trust between doctors and patients.[85]

In the context of drug testing pregnant women, these basic rules of law are complicated by a variety of factors. First, in the vast majority of circumstances, once a pregnant woman goes to a hospital to give birth and signs a generalized consent form, health care professionals can legally order virtually any medical test that they believe to be medically indicated to diagnose and treat the patient.[86] Second, in the context of pregnancy and childbirth, there are valid medical concerns for the health of both the mother and the fetus during pregnancy and the child after birth, and it is certainly possible that those interests may diverge during the course of treatment. Another complicating factors has to do with laws concerning the reporting of suspected child abuse. As is true in the welfare context described above, health professionals are in the vast majority of jurisdictions, mandatory reporters.[87] Although child abuse reporting laws vary significantly by state,[88] it is always true that health care professionals who see evidence of abuse or neglect have a duty to report that to child protection agencies.[89] Finally, in every state, child abuse is crime.[90]

These final two facts bear repeating and emphasis. In virtually every jurisdiction, health care professionals are under a duty to report suspected abuse. And in every jurisdiction people can be prosecuted for various crimes associated with child abuse. Given this long standing, pre existing legal background, arguably we need no other law or regulatory schema in place either to create a duty to report or for prosecutors to have the authority to prosecute. In light of

---

of the results to third parties. The use of an adverse test result to disqualify one from eligibility for a particular benefit, such as a promotion or an opportunity to participate in an extracurricular activity, involves a less serious intrusion on privacy than the unauthorized dissemination of such results to third parties." *Ferguson v. City of Charleston,* 532 U.S. 67, 77-78 (2001).

[85] For a discussion of the effect on patient trust of mandatory reporting laws, *see* Ellen M. Weber, *Child Welfare Interventions for Drug-Dependent Pregnant Women: Limitation of a Non-Public Health Response*, 75 UMKC L REV. 789, 805 (2006)

[86] *See infra* notes __ and accompanying text. Elizabeth A. Warner, MD, Robert M. Walker, MD, Peter D. Friedmann, MD, MPH, *Should Informed Consent be Required for Laboratory Testing for Drugs of Abuse in Medical Settings?*, 115-1 AM. J. OF MEDICINE, 55 (July 2003)("Currently, explicit informed consent is not required for clinical drug testing. In many cases, such as trauma or overdose, explicit consent is not possible. However, even when substance abuse is suspected and the patient is able to provide consent, clinicians often order drug testing without the patient's knowledge and consent.").

[87] *See supra* n. 195.

[88] *Id.*

[89] *Id.*

[90] Child Welfare Information Gateway, *Definitions of Child Abuse and Neglect*, available at www.childwelfare.gov/systemwide/laws_policies/statutes/define.pdf (last visited February 11, 2013).

this, the extensive elaborations of these duties as well as the remarkable legal contortions engaged in by prosecutors and some appellate courts to allow for criminal prosecution in these circumstances[91] constitute a set of legal mechanisms to put society's finger on the scale in favor of child protection and criminal interventions and against the traditional the health care and privacy interests of the women involved. Thus in this example, the mechanisms of regulatory intersectionality serve to facilitate the imposition of escalating punishment on the poor, disproportionately African American women who seek assistance and find themselves subject to these intersecting regulatory systems.

2. Drug Testing of Pregnant Women and Their Children: The Legal Framework and Hospital Practice

Despite the basic legal framework concerning patient autonomy and informed consent, a combination of legal rules and medical practices make it nearly impossible for some pregnant women to both obtain care and avoid drug testing. Moreover, as discussed extensively below, the discretionary framework established around drug testing leads to disproportionate punitive impacts on poor African American women.[92]

In three states, Iowa,[93] Kentucky,[94] and South Dakota, health care providers are authorized by statute to test women and/or infants for exposure to controlled substances without informed consent. The Iowa provision is fairly typical:

> If a health practitioner discovers in a child physical or behavioral symptoms of the effects of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or combinations or derivatives thereof, which were not prescribed by a health practitioner, or if the health practitioner has determined through examination of the natural mother of the child that the child was exposed *in utero*, the health practitioner *may* perform or cause to be performed a medically relevant test. . . on the child.[95]

Minnesota and Louisiana[96] go even further mandating, as opposed to authorizing, a test on certain newborns. The Minnesota statue provides that:

> [a] physician *shall* administer to each newborn infant born under the physician's care a toxicology test to determine whether there is evidence

---

[91] *See infra* notes ___ and accompanying text.
[92] *See infra* notes ___ and accompanying text.
[93] IOWA CODE ANN. §232.77(2).
[94] KY. REV. STAT. ANN §214.160(3-4).
[95] IOWA CODE ANN. §232.77(2) (emphasis on "may" added).
[96] LA. CHILD. CODE ANN §610(G).

> of prenatal exposure to a controlled substance if the physician has reason to believe, based on a medical assessment of the mother or the infant, that the mother used a controlled substance for a nonmedical purpose during the pregnancy.[97]

Although one might assume, from the lack of legislation authorizing testing without consent in the vast majority of states, that in most circumstances newborns are not tested without the mother's consent, in practice there is evidence to suggest that hospitals either routinely test without explicit consent or use the threat of child protective interventions as a means to pressure women to consent. When a pregnant woman goes to a hospital to give birth, she is generally asked to sign a generalized consent form giving health care providers authorization to treat both the mother and the eventual newborn child. Although best practices developed in the field of obstetrical care suggest that no test should be run on a pregnant woman without explicit consent to that test,[98] there is substantial evidence to suggest that hospitals routinely test pregnant women without their consent. In addition, although the law continues to require informed consent, protocols are set at the hospital level.[99] Crucial decisions, including for example whether a general consent to testing includes drug testing or requires specific consent to that test, are left to hospitals to determine.[100]

Despite legal mandates and best practice suggestions, it appears that both pregnant women and their newborn children are often tested without notice or

---

[97] MINN. STAT. ANN §626.5562 (emphasis added). Minnesota law mandates testing of pregnant women pursuant to similar rules. Pursuant to the same statutory provision, "A physician shall administer a toxicology test to a pregnant woman under the physician's care or to a woman under the physician's care within 8 hours after delivery to determine whether there is evidence that she has ingested a controlled substance, if the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose."

[98] *See e.g.* American College of Obstetricians and Gynecologists and American Academy of Pediatrics, *Model Informed Consent: Screening and Testing for Controlled or Addictive Substances in Pregnancy* (on file with author).

[99] Kathryn Wells, *Substance Abuse and Child Maltreatment*, 56 PEDIATRIC CLIN. N. AM 345, 356 (2009)(Stating, in a discussion of best practices protocols for using drug testing as a part screening newborns who may have been exposed to drugs, that, "[d]epending on a hospital's policy, consent may need to be obtained prior to testing the mother or infant."); Krista Drescher-Burke and Amy Price, *Identifying, Reporting and Responding to Substance Exposed Newborns: An Exploratory Study of Policies and Practices*, Berkeley, CA: The National Abandoned Infants Assistance Resource Center (2005). Available at: http://aia.berkeley.edu/media/pdf/rwj_report.pdf (last visited January 18, 2013).

[100] A 2009 guideline issued by the Dartmouth-Hitchcock Medical Center entitled *guidelines for Care of the Known or Suspected Drug (Illicit Substance) Exposed Newborn* provides an example of such a policy. Under this guideline, "[p]arental permission is not required for newborn drug screening, but is recommended. The care agreement signed on admission serves as consent to testing." (on file with author).

consent. A study funded by the Robert Wood Johnson Foundation as part of the Substance Abuse Policy Research Program and conducted at the National Abandoned Infants Assistance Resource Center at Berkeley[101] studied a variety of laws, policies and practices across eight large urban areas in 2005 gives a glimpse into these issues. The study authors, Krista Drescher-Burke and Amy Price, surveyed public and private hospital personnel in each of the eight cities and interviewed hospital personnel on a variety of topics.[102] Hospital staff were asked questions about notification and consent for drug testing of both mothers and newborns. As to informed consent for the testing of the mother, 87% of hospital respondents told the researchers that the mother would be informed about her own test and 83% told them that the mother would be informed about a test of her child. As, to consent, however the data was quite different.

> … [O]f the 34 hospital employees who responded, 41% stated that consent is not required for mothers to be tested, 41% reported that specific consent is required, and 18% reported that consent is included in the hospital's general admission consent. In contrast, a greater number reported that consent is not required for the newborn to be tested: 66% of the respondents indicated that consent is not required for the newborn to be tested; 23% reported that consent is not required for the newborn *if* the test is medically necessary, and 11% noted that the consent to test the newborn is included in the hospital's general consent. It is important to note that *no respondents* reported that a mother's consent is explicitly required to test a newborn.[103]

Moreover, while some hospitals clearly do discuss drug testing of both

[101] Krista Drescher-Burke and Amy Price, *Identifying, Reporting and Responding to Substance Exposed Newborns: An Exploratory Study of Policies and Practices*, Berkeley, CA: The National Abandoned Infants Assistance Resource Center (2005). Available at: http://aia.berkeley.edu/media/pdf/rwj_report.pdf (last visited January 18, 2013).

[102] The study authors were ultimately able to interview staff from 29 hospitals across the eight cities studied. These included 10 public and 4 private, for profit and 12 private non-profit hospitals. They conducted a total of 39 interviews of hospital staff. Krista Drescher-Burke and Amy Price, *Identifying, Reporting and Responding to Substance Exposed Newborns: An Exploratory Study of Policies and Practices*, Berkeley, CA: The National Abandoned Infants Assistance Resource Center (2005), 6. Available at: http://aia.berkeley.edu/media/pdf/rwj_report.pdf (last visited January 18, 2013). Presumably to preserve the anonymity of their research subjects the report does not reveal the names of the urban areas studied.

[103] Krista Drescher-Burke and Amy Price, *Identifying, Reporting and Responding to Substance Exposed Newborns: An Exploratory Study of Policies and Practices*, Berkeley, CA: The National Abandoned Infants Assistance Resource Center, 9 (2005). Available at: http://aia.berkeley.edu/media/pdf/rwj_report.pdf (last visited January 18, 2013).

mothers and newborns with their patients, in practice women face substantial risks for failing to consent. For example, internal guidelines issued by the Dartmouth-Hitchcock Medical Center in New Hampshire specify that, if a parent refuses drug screening for their infant the need for the test is documented in that mother's medical record and, "[t]he parent's refusal of drug screening is reported to the state Child Protective Service . . . as being *potentially* 'neglectful.' (emphasis and quotations in original)."[104] The American College of Obstetrics and Gynecology Model Informed Consent Form indicates concurrence with such policies. In this model form the pregnant woman, while clearly being given the right to refuse a drug test for herself, is told,

> If *you* do not agree to testing when it is recommend by *your* doctor or midwife, it may result in *your baby* being tested after birth if *the baby's medical provider* has reason to be medically concerned for the baby's health. If you newborn is tested and the test results are positive for addictive substances (drugs/alcohol), [Child Protective Services] will be notified.[105]

Thus for all intensive purposes, pregnant women who enter into a hospital setting at birth and who, for whatever reason, are determined to have potentially exposed their fetuses to controlled substances, have little means to avoid drug testing.

3. The consequence within the initial social welfare system that results from the information

A variety of researchers agree that the cultural hysteria around drug addicted newborns, both at the height of the "crack baby" scares in the mid 1980s and today misconstrue the complex relationship between drug use and the health of children exposed in utero to controlled substances.[106] For example, as Lynn Paltrow and Jeanne Flavin have noted, the U.S. Sentencing Commission concluded that, "'[t]he negative effects of prenatal cocaine exposure are significantly less severe than previous believed" and those negative effects, "do not differ from the effects of prenatal exposure to other drugs, both legal and illegal.'"[107] Nevertheless, it is certainly true, in some circumstances, that the

[104] Dartmouth-Hitchcock Medical Center, *Guidelines for Care of the Known or Suspected Drug (Illicit Substance) Exposed Newborn* (emphasis in original)(on file with author).

[105] American College of Obstetricians and Gynecologists and American Academy of Pediatrics, *Model Informed Consent: Screening and Testing for Controlled or Addictive Substances in Pregnancy* (on file with author).

[106] *See e.g.* Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine and Common Sense* 29 J. OF ADDICTIVE DISEASES 231, 232 (2010).

[107] Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine and Common Sense* 29 J. OF ADDICTIVE DISEASES 231, 233 (2010)(quoting U.S. Sentencing Commission, *Report to Congress: Cocaine and Federal*

mother's addiction so dominates her choices than it is appropriate to remove her child temporarily or permanently from her care. In addition it is certainly true that, were appropriate, comprehensive services available to support women in facing addiction and addressing the poverty related conditions that make it hard to parent when one is poor, referring women to treatment and support services might make a great deal of sense. As was the case in this article's discussion of welfare drug testing, however, the focus here is not on whether, in some ideal circumstance, we should be structuring aspects of our regulatory systems to interact in the way they do. Instead the focus here is on describing the mechanisms of those intersections particularly as they play out disproportionately in the lives of poor women of color and the consequences for the women and children subject to these interlocking, escalating systems.

There is no question that the possibility that a drug addicted pregnant woman will be tested and, as detailed below, face both intervention by child welfare agencies and prosecution, has significant negative consequences for both the woman and the child in terms of their access to quality health services.[108] First, and most importantly, punitive policies deter pregnant women from seeking care both for their addition and for their pregnancy. As detailed below, South Carolina has consistently wielded the mechanisms of the child welfare and criminal justice systems against pregnant women. The results for the utilization of drug treatment are disturbing. In the year following a decision by the South Carolina Supreme Court to treat a viable fetus as a "child" for the purposes South Carolina's child endangerment statute,[109] "drug treatment programs in the state experienced as much as an 80% decline in admission of pregnant women."[110]

In addition, as noted by Seema Mohaptra in her article advocating a public health as opposed to criminal responses to drug use during pregnancy, organizations as wide ranging and respected as the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Public Health Association

---

Sentencing Policy) 21-22 (2002)(available at http://www.ussc.gov/Legislative_and_Public_Affairs/Congressional_Testimony_and_Reports/Drug_Topics/200205_RtC_Cocaine_Sentencing_Policy/ch3.pdf) (last visited 1/22/13).

[108] This is not to suggest that there may not also be substantial positive consequences if the mother and child receive appropriate support and care to address the addiction as well as any underlying causes of the addiction. There is, however strong evidence to indicate that these services do not exist. For example there is a shocking lack of drug treatment program available to serve pregnant women. Julie B. Ehrlich, *Breaking the Law By Giving Birth* 32 NYU SOC. CHANGE 381, 383 (2008).

[109] *Whitner v. State*, 492 S.E.2d 777, 778 (1997).

[110] Cynthia Dailard and Elizabeth Nash, *State Responses to Substance abuse among Pregnant Women*, THE GUTMACHER INSTITUTE (2000), available at http://www.guttmacher.org/pubs/tgr/03/6/gr030603.html (last visited January 19, 2013).

have raised serious concerns that the emphasis on punitive responses to drug use during pregnancy results in less utilization of vital prenatal care. [111] This is of particular concern for poor women of color. Women in poverty already face substantial barriers to accessing comprehensive prenatal care.[112] For example, the Medicaid program, which provides health care coverage to poor pregnant women, varies significantly by State in terms of the income guidelines, excluding a significant portion of poor pregnant women.[113] In addition depending on the State, prenatal care can be limited. For example, in contravention of best practices in the field of obstetrical care, many states do not provide coverage until several weeks into a pregnancy. [114] Given the importance of prenatal care to maternal and child health, creating an additional substantial discincentive to access care has clear negative impacts on both women and children.

4. Pregnancy and Childbirth At The Intersections: Intervention by Child Protective Agencies

Despite the emphasis within the healthcare profession on patient confidentiality, a variety of state and federal statutes, as well as widespread practice, facilitate the transfer of information out of the public health system and into the child protection and criminal justice systems. On the federal level, the Child Abuse Prevention and Treatment Act ("CAPTA") provides a significant amount of funding to state child welfare programs.[115] In order to participate in the

[111] Seema Mohapatra, *Unshackling Addiction: A Public Health Approach to Drug Use During Pregnancy*, 26 WIS. J.L. GENDER & SOC'Y 241, 254-55 (2011)(citing Am. Med. Ass'n Bd. of Trustees, *Legal Interventions During Pregnancy*, 264 J. AM. MED. ASS'N 2663, 2667 (1990); Comm. on Substance Abuse, Am. Acad. of Pediatrics, *Drug Exposed Infants*, 86 PEDIATRICS 639, 641 (1990); Am. Pub. Health Ass'n, *Illicit Drug Use by Pregnant Women, Policy Statement No. 9020*, 8 AM. J. PUB. HEALTH 240 (1990); Comm. on Ethics, Am. College of Obstetrics & Gynecology, *Committee Opinion 321 Maternal Decision Making, Ethics and the Law*, 106 OBSTETRICS & GYNECOLOGY 1127 (2005)).

[112] *See e.g.* Barbara M. Aved, Mary M Irwin, Lesley S. Cummings and Nancy Findeisen, *Barriers to Prenatal Care for Low-Income Women*, 158(5) WESTERN J. OF MED. 493 (1993).

[113] Tara Culp-Ressler & Adam Peck, *Without Obamacare, Families Making Under $5,000 Aren't Poor Enough for Medicaid in Some States*, Think Progress (Aug. 15, 2012, 9:30 AM), http://thinkprogress.org/health/2012/08/15/690761/without-obamacare-families-making-under-5000-arent-poor-enough-for-medicaid-in-some-states/ ("In five states — Alabama, Arkansas, Indiana, Louisiana, and Texas — a family of three with an annual income over $5,000 makes too much money to receive any Medicaid assistance.").

[114] INSTITUTE OF MEDICINE, PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS 59 (1989).

[115] U.S. Dept' of Health and Human Services, Administration for Children and Families, *Child Abuse Prevention and Treatment Act State Grants*, available at www.acf.hhs.gov/programs/cb/resource/capta-state-grants (last visited February 11, 2013).

program and receive federal funds each state must submit a plan for the administration of its CAPTA program that complies with a variety of federal requirements.[116] Among other conditions, states must, in order to receive CAPTA funds, put in place policies and procedures to address the needs of infants, "born with and identified as being affected by illegal substance abuse . . . including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants."[117]

State law varies significantly both in how health care providers are to identify substance abuse[118] and the criteria they are to use in making a determination about whether to report suspected abuse. In addition, there is some evidence to suggest, as was the case for drug testing, that despite variations in state law, hospital practices leans strongly toward the reporting of women to child protection agencies whenever a drug test comes back positive.

i. State Statutory Standards for Reporting and Defining Abuse

State law varies significantly on the question of when a health care practitioner can and must make a report to a child protection agency. These reporting laws tend to vary along two basic questions: whether a positive test result itself is enough and whether the report is voluntary or mandatory. Three states (Missouri,[119] Illinois,[120] and Kentucky[121]) allow but do not require referral. Six states (Alaska,[122] Maine[123], Massachusetts,[124] Montana,[125] Nevada[126] and Pennsylvania[127]) require reporting upon evidence of something more than just a positive toxicology report. In those states providers must refer upon a determination that the child is in some way, "adversely affected by a controlled substance."[128] In seven states (Arizona,[129] Iowa,[130] Louisiana,[131] Michigan,[132]

[116] 42 USC §5106a(b)(1). This requirement was added to CAPTA in 2003 as a result of the Keeping Children and Families Safe Act of 2003.
[117] 42 USC §5106a(b)(2)(A)(ii).
[118] *See infra* notes ____ and accompanying text.
[119] MO. REV. STAT §191.737.
[120] ILL. COMP STAT. 325 Ch.5/7.3b.
[121] KY. REV STAT. ANN §214.160.
[122] ALASKA STAT ANN §47.17.024.
[123] ME. REV. STAT. TIT. 22 § 4011-B.
[124] MASS. GEN. LAWS ch. 119 §51A.
[125] MONT. CODE ANN. §41-3-201.
[126] NEV. REV. STA ANN. §432B.220.
[127] 23 PA. CONS. STAT. ANN. §6386.
[128] ALASKA STAT. §47.17.024.
[129] ARIZ. REV. STAT. ANN. §13-3620.
[130] IOWA CODE ANN. §232.77.
[131] LA. REV. STAT. ANN. §232.77.
[132] MICH. COM. LAWS § 722.623a.

Minnesota,[133] Oklahoma,[134] and South Carolina[135]) the referral is required based solely on the positive toxicology report. Is is important to keep in mind that, as is often the case with occasional alcohol use during pregnancy, a positive toxicology report does not necessarily mean any harm has occurred.[136] Despite this, in those states any positive toxicology screen leads to a referral to the child protection agency. Finally four states (South Carolina,[137] Colorado,[138] Maryland,[139] and Wisconsin[140]) legislate not just in the area of when a report should be made but in addition by defining certain acts as abuse per se and allowing for the detention of a child without a court order. For example, in Colorado, a child can be detained without a court order, "when a newborn child is identified . . . as being affected by substance abuse . . . . "[141] The South Carolina statute is without question the most aggressive. That statute creates a presumption, "that a newborn child is an abused or neglected child . . . and that the child cannot be protected from further harm without being removed from the custody of the mother" if the infant or mother tests positive for a non-prescribed controlled substance or if the mother or any child she gave birth to in the past tested positive for a controlled substance.[142]

ii. Reporting in Practice

Despite the significant variation in state law described above, and the clear suggestion in several states that reporting requires some evidence of abuse beyond just a positive toxicology report, in practice, it takes no more than that to result in a report of the child. As noted above, The Drescher-Burke and Price

[133] MINN. STAT. ANN. § 626.5561(1).
[134] OKLA STAT. ANN TIT. 10A, §1-2-101.
[135] S.C. CODE ANN. §63-7-1660(F)(1).
[136] *See infra* notes ___ and accompanying text.
[137] S.C. CODE ANN. §63-7-1660(F)(1).
[138] COLO. REV. STAT. §19-3-401(3)(b-c).
[139] MD. CODE ANN., CTS. & JUD. PROC. §3-818.
[140] WIS. STAT ANN §48.02(1).
[141] COLO. REV. STAT. §19-3-401(3)(b-c).
[142] S.C. CODE ANN. §63-7-1660(F)(1). In full the statutory provision provides that, "[i]t is presumed that a newborn child is an abused or neglected child as defined in Section 63-7-20 and that the child cannot be protected from further harm without being removed from the custody of the mother upon proof that:
(a) a blood or urine test of the child at birth or a blood or urine test of the mother at birth shows the presence of any amount of a controlled substance or a metabolite of a controlled substance unless the presence of the substance or the metabolite is the result of medical treatment administered to the mother of the infant or the infant, or
(b) the child has a medical diagnosis of fetal alcohol syndrome; and
(c) a blood or urine test of another child of the mother or a blood or urine test of the mother at the birth of another child showed the presence of any amount of a controlled substance or a metabolite of a controlled substance unless the presence of the substance or the metabolite was the result of medical treatment administered to the mother of the infant or the infant, or
(d) another child of the mother has the medical diagnosis of fetal alcohol syndrome."

study of policies and procedures concerning substance exposed newborns in eight urban centers revealed that, "[r]egardless of state's laws most (87%) of the 39 respondents indicated that all identified [substance exposed newborns] are reported to [child protective services]. A positive toxicology test alone appears to trigger a report in most cases."[143] This was true across jurisdictions and despite significant variations in state law.

5. Pregnancy and Childbirth At The Intersections: Intervention by the Criminal Justice System

The use of the criminal justice system to punish women for exposing their unborn children to controlled substances is among the most disturbing examples of the way regulatory intersectionality facilitates escalating punishment. The many issues that arise from these prosecutions have been extensively explored by other scholars who have documented the means by which prosecutors have attempted to contort their criminal laws to include drug use during pregnancy within the ambit of crimes such as felony endangerment, criminal child neglect, delivering drugs to a minor, assault, and homicide.[144] To date no state has successfully passed legislation explicitly criminalizing the transmission of drugs in utero. And, with the notable exception of South Carolina's decision in *Whitner v. State*,[145] until the Alabama Supreme Court's 2013 decision in *Ex Parte Ankrom*,[146] every appellate court to consider the issue has overturned these convictions as falling outside the conduct contemplated by these statutes.[147]

[143] Krista Drescher-Burke and Amy Price, *Identifying, Reporting and Responding to Substance Exposed Newborns: An Exploratory Study of Policies and Practices*, Berkeley, CA: The National Abandoned Infants Assistance Resource Center, 9 (2005). Available at: http://aia.berkeley.edu/media/pdf/rwj_report.pdf (last visited January 18, 2013).

[144] Seema Mohapatra, *Unshackling Addiction: A Public Health Approach to Drug Use During Pregnancy*, 26 WIS. J.L. GENDER & SOC'Y 241, 248-52 (2011); Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine and Common Sense* 29 J. OF ADDICTIVE DISEASES 231, 233 (2010).

[145] In *Whitner v. State*, 492 S.E.2d 777 (1997), the South Carolina Supreme Court upheld the prosecution of Cornelia Whitner for criminal child neglect. Ms. Whitner's soon was born in good health but tested positive for cocaine at birth. The Court held that the fetus is a viable "person" for the purposes of the criminal child neglect statute and upheld her conviction. To date this is the only case that has so held.

[146] 2013 WL 135748 (2013).

[147] *See, e.g.* Cochran v. Kentucky, 315 S.W.3d 325 (Ky. 2010) (holding that an indictment charging a woman for first-degree wanton endangerment based on her ingestion of illegal drugs during pregnancy was invalid on its face); State v. Aiwohi, 123 P.3d 1210 (Haw. 2005) (holding that a mother who smoked crystal meth, leading to the death of her as-of-then unborn son, could not be prosecuted for manslaughter); State v. Cervantes, 223 P.3d 425 (Or. App. 2009) (holding that ingesting drugs during pregnancy was not reckless endangerment); Ex Parte Perales, 215 S.W.3d 418 (Tx. App. 2007) (holding that a controlled substance entering a child through the umbilical cord is not the

Despite the lack of explicit legislation and the spate of negative court decisions, hundreds of women have been charged with criminal offenses arising from their drug use during pregnancy.

The most comprehensive study to date on state actions in which, "a woman's pregnancy was a necessary factor leading to attempted and actual deprivations of the woman's physical liberty" comes from Lynn M. Paltrow and Jeanne Flavin.[148] Paltrow and Flavin comprehensively reviewed 413 cases that took place between 1973 and 2005, 354 of which involved ". . efforts to deprive pregnant women of their liberty . . . through the use of existing criminal statutes intended for other purposes."[149]

i. The Mechanisms of Reporting

In January of 2013, the Alabama Supreme Court chose to follow the South Carolina reasoning when it held, in *Ex Parte Ankrom*[150] that the term "child" found within Alabama's child endangerment statute included a fetus. In so holding the court upheld the convictions of Hope Ankrom and Amanda Kimbrough based on their use of controlled substances during their pregnancies. The case is striking in the way that the facts in both prosecutions demonstrate the phenomena of regulatory intersectionality. In the *Ankrom* case the parties stipulated to the following facts:

On January 31, 2009, the defendant, Hope Ankrom, gave birth to a son,

"knowing delivery" of that substance to the child).

[148] Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications Women's Legal Status and Public Health* 39 JOURNAL OF HEALTH POLITICS, POLICY AND THE LAW, 299, 299 (2013). *See also* Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine and Common Sense* 29 J. OF ADDICTIVE DISEASES 231, 233 (2010) (Stating that, "National Advocates for Pregnant Women has … documented hundreds of known cases in at least 40 states where pregnant women who are identifed as drug users have been arrested.").

[149] Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications Women's Legal Status and Public Health* 39 JOURNAL OF HEALTH POLITICS, POLICY AND THE LAW, 299, 321 (2013). In addition to prosecutions, the 413 cases included other forms of forced detention including detentions in hospitals mental institutions and treatment programs and forced medical interventions such as surgery. *Id*. at 301. The study argues persuasively that, due to the extraordinary difficulty in obtaining data about these forced interventions and prosecutions, this figure represents a substantial undercount of those subject to prosecution for crimes involving their pregnancies. Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications Women's Legal Status and Public Health* 39 JOURNAL OF HEALTH POLITICS, POLICY AND THE LAW, 299, 303-05 (2013).

[150] 2011 WL 3781258 1.

> [B.W.], at Medical Center Enterprise. Medical records showed that the defendant tested positive for cocaine prior to giving birth and that the child tested positive for cocaine after birth. . . . Department of Human Resources worker Ashley Arnold became involved and developed a plan for the care of the child. During the investigation the defendant admitted to Ashley that she had used marijuana while she was pregnant but denied using cocaine. Medical records from her doctor show that he documented a substance abuse problem several times during her pregnancy and she had tested positive for cocaine and marijuana on more than one occasion during her pregnancy.[151]

Thus in this case the prosecution was facilitated first by the drug tests conducted by her health care providers both during and after the pregnancy, the referral to child protective services, the collection of information by health care and child protective service staff and the subsequent use of that information to facilitate the prosecution of Ms. Ankrom. The facts in Ms. Kimbrough's prosecution reveal the same set of intersecting regulatory mechanisms. As recited by the Alabama Supreme Court, in Ms. Kimbrough's case,

> The Colbert County Department of Human Resources ('DHR') was notified regarding Kimbrough's testing positive for methamphetamine and Timmy's death, and Kimbrough's other two children were temporarily removed from her home and placed with Kimbrough's mother. A DHR social worker spoke with Kimbrough regarding a safety plan for her children on two occasions. During one of those conversations, Kimbrough admitted that she had smoked methamphetamine with a friend three days before she had experienced labor pains. In July 2008, after having determined that the children would be safe in Kimbrough's home, DHR returned Kimbrough's children to her custody.[152]

Thus in Kimbrough's case too the information about the drug use started with the healthcare system, was transmitted to the child protection agency and was ultimately crucial to support the prosecution. Kimbrough's facts are particularly striking in the ostensibly benevolent purpose of the conversation between Kimbrough and the child protection worker. According to the court, the child protection agency held out that they were interviewing Kimbrough for the purpose of creating a "safety plan" for her family. It was during those conversations that she admitted to the drug use during her pregnancy. Moreover, the agency ultimately concluded that her home was safe for her two other children, and those children were returned to her care. Despite this, however, the admission of drug use by Kimbrough was ultimately utilized not to facilitate the

---

[151] 2011 WL 3781258 1.
[152] *Ex parte Anrkom*, 2013 WL 135748, 4 (Ala.).

safety of her children but to prosecute Ms. Kimbrough and sentence her to the mandatory statutory minimum penalty: ten years in prison.

Paltrow and Flavin's recent study confirms that the pattern revealed in the *In Re Anrkom* is characteristic of the mechanisms of regulatory intersectionality. Paltrow and Flavin traced the, "mechanisms by which the case came to the attention of police, prosecutors and courts."[153] In 112 of the 413 cases, disclosure came from "health care, drug treatment or social work professionals." In 47 cases, "health care and hospital-based social work professionals disclosed confidential information about pregnant women to child welfare or social service authorities, who in turn reported the case to the police.[154] As they describe it, "[f]ar from being a bulwark against outside intrusion and protecting patient privacy and confidentiality, we find that health care and other 'helping' professionals are sometimes the people gathering information from pregnant women and new mothers and disclosing it to police, prosecutors and court officials."[155]

6. The Disproportionate Impact on Poor Women of Color

There is little question that, at every step along the way, the intersectional and escalating punitive impact of drug testing of pregnant women falls disproportionately on poor African American woman. Several studies demonstrate this disproportionality.

As detailed above, the process of regulatory intersectionality begins with the decision to administer a drug test to the mother or infant. A recent study was designed to test whether race was used as a factor in deciding whether to test newborns in a context where detailed protocols were in place to guide the decision to test the newborn. After examining the records of 2,121 mother infant pairs, the researchers discovered that, despite the existence of detailed protocols dictating when testing should occur, 35.1 of infants born to Black mothers who met the screening critieria were tested. In contrast only 12.9% of children born to White women who met the screening criteria were tested. The researchers therefore concluded that, "race was used as a factor for determining whether

---

[153] Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications Women's Legal Status and Public Health* 39 JOURNAL OF HEALTH POLITICS, POLICY AND THE LAW, 299, 326 (2013).

[154] Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications Women's Legal Status and Public Health* 39 JOURNAL OF HEALTH POLITICS, POLICY AND THE LAW, 299, 326-27 (2013).

[155] Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications Women's Legal Status and Public Health* 39 JOURNAL OF HEALTH POLITICS, POLICY AND THE LAW, 299, 327 (2013).

infants should be screened for illicit drugs, even at an institution with a standard protocol that did not include race as a screening factor."[156]

Other researchers have focused on rate of referral of children to child protection agencies. In the medical field a study conducted in 2000 by Jeanne Chasnoff et. al. and a more recent 2012 study, conducted by Sarah Roberts and Amani Nuru-Jeter provide compelling data on the extent of disproportionality in the rate of referrals. Chasnoff et. al. sought to determine the rate of illicit drug use among pregnant women throughout public and private health care facilities and to explore whether the rates of drug test results reporting correlated with the rates of drug use. They conducted the study shortly after Florida adopted a statewide policy mandating, "the reporting [to the Department of Health] of births to mother who used drugs or alcohol during pregnancy."[157] Pursuant to state policy a positive toxicology screen from either the mother or the child was sufficient evidence to require such a report.[158]

During a one month period the researchers obtained a urine sample from, "every woman who enrolled for prenatal care … at each of the five Pinellas County Health Unit Clinics and from every woman who entered prenatal care . . . at the offices of each of 12 private obstetrical practices in the county." In total they obtained a sample from 715 women. The results across race and class were striking. Of the 715 women, 14.8% tested positive for alcohol, cannabinoids (marijuana), cocaine or opiates. A slightly higher percentage of white women (15.4%) than black women (14.1%) tested positive. As to socioeconomic status, which the researchers determined from the economic demographics of the zip code in which women lived, the researchers concluded that, "socioeconomic status . . . did not predict a positive result on toxicologic testing."[159] Despite essentially equivalent rates of positive toxicology screens across race and class, only 1.1% of white women were reported, whereas 10.7% of black women were reported. "Thus, a black woman was 9.6 times more likely than a white woman to be reported for substance abuse during pregnancy."[160]

---

[156] Marc A. Ellsworth, Timothy P. Stevens and Carl T. D'Angio, *Infant Race Affects Application of Clinical Guidelines When Screening for Drugs of Abuse in Newborns* 125 PEDIATRICS 6 (2010).

[157] Chasnoff, Landress & Barrett, *The Prevalence of Illicit-Drug and Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County Florida,* 322 NEW ENGL J. MED 1202 (1990).

[158] Chasnoff, Landress & Barrett, *The Prevalence of Illicit-Drug and Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County Florida,* 322 NEW ENGL J. MED 1202, 1203 (1990).

[159] Chasnoff, Landress & Barrett, *The Prevalence of Illicit-Drug and Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County Florida,* 322 NEW ENGL J. MED 1202, 1204 (1990).

[160] Chasnoff, Landress & Barrett, *The Prevalence of Illicit-Drug and Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County*

Roberts and Nuru-Jeter's study suggests similar findings. Relying on a variety of government data collected for administrative reasons, Roberts and Nuru-Jeter examined data from a set of providers in California that had implemented universal testing of pregnant women for drug and alcohol use. They sought to determine whether drug and alcohol use varied by race and whether there were disparities in reporting by race. They concluded that, "despite Black women having alcohol-drug use identified by prenatal providers at similar rates to White women and entering treatment more than expected, Black newborns were four times more likely than White newborns to be reported to CPS at delivery."[161] The study authors also note, however, that, due to some differences among the data sets that they drew on in order to reach their findings, it is likely that African American children were reported at even more disproportionate rates than their data suggests.[162]

It is also clearly true that the prosecutions of pregnant women for crimes arising from their pregnancies falls disproportionately on poor African American women. Of the 368 women in the Paltrow and Flavin study for which the race of the woman was available, 59% were women of color and 52% were African American.[163] African American women were particularly overrepresented in the South. African American women were also more likely to be more harshly prosecuted. Of the 354 cases involving prosecutions, 295 were felony prosecutions. While 71% of the White women were charged with felonies, 85% of the African American women were charged with felonies.[164] In addition, 71% of the women in the study qualified for indigent defense, a clear indication that these state interventions are targeted against poor women.

Florida, 322 NEW ENGL J. MED 1202, 1204 (1990).

[161] Sarah C.M. Roberts and Amani Nuru-Jeter, *Universal Screening for Alcohol and Durg Use and Racial Disparities in Child Protective Services Reporting*, 39 J OF BEHAVIORAL HEALTH SERVS. AND RESEARCH 3, 3 (2012).

[162] Sarah C.M. Roberts and Amani Nuru-Jeter, *Universal Screening for Alcohol and Durg Use and Racial Disparities in Child Protective Services Reporting*, 39 J OF BEHAVIORAL HEALTH SERVS. AND RESEARCH 3, 14-15 (2012)(Explaining that, due to some variations in information available in the multiple data sets they used to reach their conclusions, ". . . comparison of racial distributions of identification data (including the data from the private provider) and reporting data would be expected to show an even greater overrepresentation of Black women among those reported to CPS than among those identified through screening in prenatal care.").

[163] Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications Women's Legal Status and Public Health* 39 JOURNAL OF HEALTH POLITICS, POLICY AND THE LAW, 299, 311 (2013).

[164] Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications Women's Legal Status and Public Health* 39 JOURNAL OF HEALTH POLITICS, POLICY AND THE LAW, 299, 322 (2013).

B. Applying for Welfare: Drug Testing, Child Protection Interventions and Criminal Prosecutions

In recent years, legislatures across the country, as well as Congress, have considered and in seven states passed legislation to institute drug testing of applicants for and recipients of public benefits and to condition benefits on consenting to and passing a drug test. In comparison to the research on pregnant women and drug use discussed above, we know very little about how these programs actually operate, whom they effect and how, and the extent and mechanisms of transmission of information from the welfare system into the child welfare and criminal systems. Although we do know in general that punitive policies in the welfare context tend to be targeted disproportionately at recipients of color,[165] we do not have specific data to indicate that that this is occurring in welfare drug testing programs or at the intersections of those programs and other systems. This lack of information comes in part from the relative newness of these programs and in part from the lack of scholars from other disciplines who focus on these issues. Nevertheless, what information we do have from statutory and regulatory sources suggests that, as in the public health context, the phenomena of regulatory intersectionality is central to what's occuring.

1. Welfare Drug Testing: Federal Authority and A Trend on the Rise

This legislative trend finds its roots in the devolution of welfare policy embodied in the 1996 welfare reform law. In 1996 Congress enacted the Personal Responsibility and Work Opportunity Act (hereinafter PRA), legislation that fundamentally altered the domestic social safety net by eliminating the entitlement to cash assistance for needy families with dependant children, eliminated benefits for a wide range of lawful immigrants and, among other key elements, devolved significant authority for designing what was newly termed Temporary Assistance to Needy Families (hereinafter TANF) to the states. To guide states in exercising their newly devolved authority, the legislation included a series of provisions permitting the states to include various features in their TANF program. For example, although the PRA generally bars receipt of TANF benefits to adults after five years, states are authorized to and in fact have significantly shortened that period of time.[166] Similarly, the PRA included a provision authorizing states to condition receipt of benefits under the Temporary Assistance to Needy Families program to those who do not test positive for drugs. As the legislation details,

> [n]otwithstanding any other provision of law, States shall not be

[165] *See infra* n. ___
[166] 42 U.S.C. §608(a)(7).

> prohibited by the Federal Government from testing welfare recipients for use of controlled substances nor from sanctioning welfare recipients who test positive for use of controlled substances . . . .[167]

Although in the several years directly following welfare reform, the focus of state activity around drug abuse was on screening and referral to treatment and drug felony bans,[168] in the last several years, mirroring a significant trend in the private and other public sectors,[169] there has been an increasing focus on drug testing in both TANF and other public benefit programs and in denial of benefits to individuals who either fail to pass a drug test or who refuse to take that test.

The trend toward conditioning receipt of public benefits on passing drug tests began in earnest late in 2009 when over twenty states proposed legislation. Over the course of the next several years, despite an unfavorable court ruling holding that suspicionless drug testing programs cannot survive scrutiny under the Fourth Amendment,[170] states continued to try to enact this legislation.[171] In 2010 at least twelve states proposed legislation mandating drug testing of welfare recipients. In 2011 bills were introduced in 36 states.[172] In addition twelve legislatures

[167] 21 U.S.C. § 862(b).

[168] Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health and Human Services, *ASPE Issue Brief: Drug Testing Welfare REcipietns: Recent Proposals and Continuing Controversies*, available at http://aspe.hhs.gov/hsp/11/DrugTesting/ib.pdf (last visited February 5, 2013).

[169] *See infra* n. __.

[170] The state of Michigan was the first state to enact a suspicionless drug testing provision that led to denial of benefits. This program, which was enacted in 1999, was immediately challenged and enjoined by the District Court. The District Court held that Michigan's suspicionless drug testing program violated the Fourth Amendment. On appeal the Sixth Circuit initially reversed that opinion only to have the case accepted for hearing en banc. The en banc court split down the middle, with half of the justices voting for affirmance and half voting for reversal. The result in the case was therefore affirmative of the District Court's opinion. *Marchwinski v. Howard*, 113 F. Supp. 2d 1134 (E.D. Mich 2000); rev'd 309 F.3d 330 (6th Cir. 2002), reh'g en banc granted, judgment vacated, 319 F.3d 258 (6th Cir., 2003)(en banc), aff'd by an equally divided court, 60 F. App'x 601 (6th Cir. 2003)(en banc). Despite the fact that, for the purposes of the Michigan program the provisions are unconstitutional, the split between the judges and between the District and the original appellate bench that heard the case clearly indicate that the law in this area remains profoundly unsettled. More recently the District Court in the Middle District of Florida recently preliminarily enjoined Florida's suspicionless drug testing program. *Lebron v. Wilkins*, 820 F.Supp 2d 1273 (M.D. Fla 2011). The case is currently being appealed.

[171] National Conference of State Legislatures, *Drug Testing and Public Assistance*, November 2012, available at http://www.ncsl.org/issues-research/human-services/drug-testing-and-public-assistance.aspx ("In 2010 at least 12 states had similar proposals.").

[172] National Conference of State Legislatures, *Drug Testing and Public Assistance*, November 2012, available at http://www.ncsl.org/issues-research/human-services/drug-testing-and-public-assistance.aspx

proposed drug testing for unemployment and two cities, Chicago, Illinois and Flint, Michigan proposed a program to ban those who fail a drug test from public housing.[173] In 2012, at least 28 states proposed such legislation.[174] In addition, in 2012, Congress enacted a provision authorizing states to condition receipt of unemployment benefits, in some circumstances, on passing a drug test.[175] Since the 2012 presidential election legislators in at least four states have said they will introduce or have introduced bills.[176] Today seven states, Arizona, Florida, Missouri, Tennessee, Georgia, Ohio and Utah have enacted welfare drug testing programs that allow for partial or complete denial of benefits for refusing to take or failure to pass a drug test.[177]

Both the enacted and the vast swath of proposed legislation vary significantly on several key issues: the severity of the penalty imposed;[178] the emphasis on sanction versus treatment;[179] and crucially for the purposes of the Fourth Amendment, whether or not the state must have some reasonable suspicion before testing.[180] States law and legislative proposals also vary as to what public

[173] A.G. Sulzberger, *States Adding Drug Test as Hurdle for Welfare*, New York Times, October 10, 2011.

[174] National Conference of State Legislatures, Drug *Testing and Public Assistance*, November 2012, available at http://www.ncsl.org/issues-research/human-services/drug-testing-and-public-assistance.aspx ("At least 28 states put forth proposals in 2012 to require drug testing or screening for public assistance applicants or recipients.")

[175] MIDDLE CLASS TAX RELIEF AND JOB CREATION ACT OF 2012, PL 112-96, February 22, 2012, 126 Stat 156 (allowing states to condition receipt of unemployment benefits on passing a drug test for any applicant who, "(i) was terminated from employment with the applicant's most recent employer (as defined under the State law) because of the unlawful use of controlled substances; or (ii) is an individual for whom suitable work (as defined under the State law) is only available in an occupation that regularly conducts drug testing (as determined under regulations issued by the Secretary of Labor)").

[176] Morgan Whitaker, More States Consider Welfare Drug-Testing Bills, www.msnbc.com, Dec. 7, 2012, available at http://tv.msnbc.com/2012/12/07/more-states-consider-welfare-drug-testing-bills/ ("Ohio, Virginia, and Kansas are not the first states to take up the measure since Election Day. Lone Star State Gov. Rick Perry himself filed a bill in the Texas state legislature in mid-November").

[177] National Council of State Legislators, *Drug Testing and Public Assistance*, Nov. 2012, available at http://www.ncsl.org/issues-research/human-services/drug-testing-and-public-assistance.aspx (last visited February 5, 2013).

[178] *Compare* GA. CODE ANN. § 49-4-193(d)(imposing progressive sanctions based on the number of positive tests beginning with a one month sanction) *with* ARIZ. STAT. ANN. §46-201(29)(imposing one year sanction for testing positive).

[179] *Compare* ARIZ. STAT. ANN. §46-201(29)(imposing one year sanction for testing positive) *with* TN CODE ANN. 71-3-1202(h)(1)(allowing individuals who test positive to receive benefits for six months while in treatment).

[180] *Compare* MO. ANN. STAT § 208.027(a)(requiring that the Department of Social Services, "screen each applicant or recipient who is otherwise eligible for temporary

benefits are included, ranging from proposals that limit testing to TANF to proposals that include TANF, Supplemental Assistance to Needy Families (formerly termed Food Stamps), unemployment and Medicaid.

2. The Penalty for Failing a Drug Test Within the TANF Program

Although each statute imposes a penalty on the applicant and/or the applicant's dependent children for failing or refusing the drug test, the penalties do vary substantially. For example, in Arizona applicants who fail or refuse a drug screen are ineligible for benefits for one calendar year.[181] In other states the penalties are progressive, based on the number of times one fails or refuses a drug screen. For example, in Georgia the first time one fails the applicant loses one month of benefits, but subsequent failed tests lead to progressively longer sanctions. In addition, some states will allow applicants to receive benefits if they enroll in or once they have completed drug treatment. For example in Tennessee if one enrolls in drug treatment one can receive benefits for six months while in treatment. If the applicant refuses treatment or is positive at the end of treatment, benefits are denied for at least six months. Similarly, in Oklahoma, if one enters treatment, the penalty, which is otherwise twelve months without benefits, can be reduced to six. However, it is important to note that no state legislation creating drug testing mandates include provisions giving priority for drug treatment to welfare applicants nor are there any provisions within those statutes granting additional funding for drug treatment. Given the overall dearth of drug treatment programs for the poor,[182] the inclusion of provisions allowing individuals to get treatment and then get benefits, is somewhat disingenuous.

In looking at this program through the lens of regulatory intersectionality, it

---

assistance for needy families benefits under this chapter, and then test, using a urine dipstick five panel test, each one who the department has reasonable cause to believe, based on the screening, engages in illegal use of controlled substances . . . .) *with* GA. CODE ANN. § 49-4-193(c)(requiring a drug test for "each individual who applies for assistance") . For an extensive summary of proposed and enacted legislation as of 2011 see Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy – U.S. Department of Health and Human Services, *ASPE Issue Brief – Drug Testing Welfare Recipients: Recent Proposals and Continuing Controversies*, Appendix A (October 2011). Available at http://aspe.hhs.gov/hsp/11/DrugTesting/ib.shtml. http://www.ncsl.org/issues-research/human-services/drug-testing-and-public-assistance.aspx (last visited June 26, 2012)

[181] ARIZ. STAT. ANN. §46-201(29)(denying benefits for one year as a result of a positive drug test).

[182] Victor Capoccia, Dennis McCarty, Laura Schmidt, *Closing the Addiction Treatment Gap: A Priority for Health Care Reform*, Spotlight on Poverty and Opportunity, http://www.spotlightonpoverty.org/ExclusiveCommentary.aspx?id=049a9de2-a1fc-447e-b36d-3ac90e0bca10 (last visited February 11, 2013).

is important to understand the initial consequence to the family for what the program defines as sanctionable or deviant conduct, in this case, the failure of a drug screen. In evaluating the nature and severity of this consequence, it is helpful to keep a few facts in mind. First, in order to qualify for TANF benefits, you must, among other criteria be, to put it bluntly, extremely poor. Taking as an example a three person household with one adult, one pre-school age child and one school age child living in Phoenix, Arizona, that family would not qualify for benefits if they have countable income in excess of Arizona's defined standard of need for their family size. For this family of three, they could only qualify for TANF benefits if they have less than $964 in monthly income.[183] That same family, however, would not receive $964 in TANF benefits were they accepted into the program. Instead, if all three household members received benefits, they would receive a maximum of $278 per month or $3,336 per year.[184] If the adult in that family fails or refuses the drug screen, the family would receive, for an entire calendar year, benefits only for the two children.[185] Their TANF grant would then be reduced by 21% from $278 per month to a mere $220 per month or $2,640 per year.[186]

To understand just how low this cash grant is, it is helpful to compare it to two different measures. First, the federal poverty threshold, a measure that is nearly universally acknowledged as outdated and is regarded in many quarters as far too low.[187] The Arizona family of three would fall below the federal poverty line if they earned less than $19,090 in income per year.[188] So the reduced cash grant that results from the drug test sanction gives this family cash assistance at 18% of the federal poverty level.

Another useful way to look at these numbers is to compare the family's income under the sanction to what they actually need to meet basic needs. The Center for Women's Welfare at the University of Washington School of Social Work and its director Diana Pierce developed the Self Sufficiency Standard to assist in such analysis.[189] The standard provides a rigorous methodology for

---

[183] Arizona Department of Economic Security, *Cash Assistance A1 Needs Standards* (January 9, 2013), https://www.azdes.gov/popup.aspx?id=5422.

[184] Arizona Department of Economic Security, *Cash Assistance A1 Needs Standards* (January 9, 2013), https://www.azdes.gov/popup.aspx?id=5422.

[185] ARIZ. REV. STAT. ANN. § 46-201(29).

[186] Arizona Department of Economic Security, *Cash Assistance A1 Needs Standards* (January 9, 2013), https://www.azdes.gov/popup.aspx?id=5422.

[187] For an in depth discussion of the insufficiency of the current federal poverty measure *see* Wendy A. Bach, *Governance, Accountability and the New Poverty Agenda*, 2010 WISC. L. REV. 239, 278-281.

[188] United States Department of Health and Human Services, *2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia* (January 9, 2013), http://aspe.hhs.gov/poverty/12poverty.shtml.

[189] For additional information on the standard *see generally* The Center for Women's

calculating how much income particular families, in particular geographic locations, need to meet their basic needs[190] without public or private assistance. According to the 2012 Arizona Self Sufficiency Standard, for the same family, were they to receive no private or public assistance whatsoever, the adult would need to work full time and earn $24.20 per hour for a total of $51,115 in income per year to meet all the families' basic needs.[191] Even if one makes the optimistic assumption that this family is receiving other benefits, such as Supplemental Nutrition Assistance, Medicaid and, perhaps if they are very lucky, subsidized housing, losing $696 in annual income is a devastating blow.

3. Welfare Drug Testing At The Intersections: Intervention by Child Protective and Criminal Justice Systems.

The penalty to the family for the failed or refused drug screen does not stop at the drastic reduction in their already tremendously low level of assistance. The second aspect of regulatory intersectionality analysis describes what else might happen to this family as a result of the stigmatized conduct. As noted above, one variable along which various welfare drug testing statutes differ is the extent of privacy protections built into the legislation. Of particular interest, for the purposes of discussing regulatory intersectionality, are provisions concerning the sharing of this information among government agencies and in particular provisions that allow or mandate the sharing of results with child protective agencies, that require some level of child protective investigation and that raise the specter of data sharing with criminal justice agencies.

When looking at these intersecting system phenomena, it is crucial to keep in mind some basic background rules in the area. First, although the extent of privacy protections for drug tests has been eroding in a variety of contexts,[192] its remains true that requiring individuals to consent to a drug test which requires that person to urinate, likely in the presence of a government employee and then give that urine sample to the agency, invades a long protected and long recognized zone of bodily integrity and privacy. As the Court of Appeals for the Fifth Circuit has stated, that, "[t]here are few activities in our society more personal or private than the passing of urine. Most people describe it by euphemisms if they talk about it at all."[193] For this reason, the Supreme Court, in

---

Welfare, (January 9, 2013), http://www.selfsufficiencystandard.org.

[190] Under the standards methodology basic needs include geographically specific calculations of expenses in six categories: housing, childcare, food, transportation, healthcare and an addition 10% in miscellaneous expenses. The Center on Women's Welfare, *How is the Self Sufficiency Standard Calculated* (January 9, 2013), http://www.selfsufficiencystandard.org/standard.html#howis.

[191] Women's Foundation of Southern Arizona, *How Much Is Enough In Your County? The Self-Sufficiency Standard for Arizona 2012*, 59 (January 9, 2013), http://www.selfsufficiencystandard.org/docs/Arizona_2012.pdf.

[192] *See infra* n. 169.

[193] *National Treasury Employees Union v Von Raab*, 816 F.2d 170, 175 (1987).

Skinner v Oklahoma made clear that a mandatory urinalysis constitutes a search for the purposes of the Fourth Amendment.[194]

Moreover, even before the advent of this spate of legislation welfare officials across the nation,[195] and in all seven states that have enacted welfare drug testing programs, were already required to report suspected abuse to child protective agencies.[196] Thus, the mechanisms described below, to facilitate and in some cases mandate reporting and investigation in light of a positive drug test, seem at best superfluous and at worst, yet another mechanism to target, punish and criminalize poor, African American mothers.

Jurisdictions vary significantly in the use and strength of privacy protections. One jurisdiction appears to bar the use of test results in collateral investigations and proceedings; many are silent, and a few permit disclosure. In two jurisdictions, however, the programs go beyond permissive disclosure to mandate disclosure to and in some cases intervention by child protection agencies. In addition, in many jurisdictions results of welfare drug tests are available to police and prosecutors. In these cases, the program seems to be designed to snowball the possible detrimental effect of the positive test far beyond the sanction included in the statute and described above.

Of the seven states that have enacted welfare drug testing programs to date, the statute enacted in Georgia is the only one that appears to provide a comprehensive ban on the use of test results in other investigations and proceedings. The statute provides that,

> [t]he results of any drug testing done according to this Code section . . . shall not be used as a part of a criminal investigation or criminal prosecution. Such results shall not be used in a civil action nor otherwise disclosed to any person or entity without the express written consent of

---

[194] *Skinner v. Railway Labor Executives Association*, 489 U.S. 602, 617 (1989).

[195] *See e.g.* Child Welfare Information Gateway, *Mandatory Reporters of Chil d Abuse and Neglect* (August 2012) (Approximately 48 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands designate professions whose members are mandated by law to report child maltreatment. Individuals designated as mandatory reporters typically have frequent contact with children. Such individuals may include . . . Social workers, Teachers, principals, and other school personnel, Physicians, nurses, and other health-care workers, Counselors, therapists, and other mental health professionals, Child care providers, Medical examiners or coroners, Law enforcement officers."). Available at https://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.pdf (last visited February 5, 2013).

[196] *See* ARIZ. REV. STAT. ANN. § 13-3620; FLA. STAT. ANN. § 39.201; MO. ANN. STAT § 210.115; UTAH CODE ANN. §62A-4A-403; TENN. CODE ANN § 37-1-403; OKLA. STAT. ANN. TITL 10A, § 1-2-101.

the person tested or his or her heirs or legal representatives.[197]

In contrast to the Georgia provision, most of statutes enacted in the past several years allow disclosure of the drug test results to some or all government agencies. For example, while the Oklahoma and Arizona statutes are silent on the issue of privacy protection,[198] each state's general records access provision allow the sharing of data between government agencies.[199] Similarly, although the Utah statute bars public disclosure of the test results,[200] underlying records access provisions allow government agencies to provide data to any entity that, "enforces, litigates, or investigates civil, criminal, or administrative law, and the record is necessary to a proceeding or investigation."[201] Tennessee's statute is more restrictive, barring the use of all information received by the department in connection with the drug testing program, "in any public or private proceeding. . . ."[202] However an exception is carved out for any proceeding, "concerning the protection or permanency of children." In addition, although the ban clearly forbids the use of the drug test results in formal proceedings, there appears to be no ban on using them in investigations of any criminal or civil nature, thus leaving open the possibility that the results could be shared with child protection agencies and police.

Two states, Florida and Missouri, go beyond permissive sharing of data to mandate data transmission and investigation by the child protective agencies. The underlying statutes also clearly allow the use of positive drug tests in criminal prosecutions. Like some of the statutes discussed above, the Florida

[197] Georgia H.B. 861.

[198] The silence of the particular welfare drug testing statutes in these states could very well mean, as was the case in Florida, that in implementing the statute the agencies will enact policies that mandate reporting and action by other parts of the state administrative structure. For a discussion of how this occurred in Florida, *see infra* notes ____ and accompanying text.

[199] *See e.g.* ARIZ. REV. STAT. ANN. § 8-807 (requiring disclosure of child protection records to a to various government entities to enable such entities, "to meet its duties to provide for the safety, permanency and well-being of a child, provide services to a parent, guardian or custodian or provide services to family members to strengthen the family pursuant to this chapter; . . . [t]o enforce or prosecute any violation involving child abuse or neglect. . . . [and t]o provide information to a defendant after a criminal charge has been filed as required by an order of the criminal court.); OKLA. STAT. ANN. TIT. 10A § 1-6-103 (allowing inspections without a court order of Juvenile and Department of Human Services records by offices of the Attorney General, and law enforcement personnel).

[200] U.C.A. 1953 § 35A-3-304.5(5)("The result of a drug test given under this section is a private record in accordance with Section 63G-2-302 and disclosure to a third party is prohibited except as provider under Title 63G, Chapter 2, Government Records Access and Management Act.").

[201] U.C.A. 1953 § 63G-2-206(1)(b).

[202] Tenn SB 2580.

statute that implemented the drug testing program was silent as to the issue of privacy and data sharing.[203] Nevertheless when designing the procedures to be used in implementing the program, the Florida Department of Children and Families instituted procedures which included the sharing of positive drug tests with the Florida Abuse Hotline.[204] As described by the District Court in its decision enjoining the Florida program,

> DCF shares all positive drug tests for controlled substances with the Florida Abuse Hotline. . . . After receiving a positive drug test, a hotline counselor enters a Parent Needs Assistance referral into a child welfare database known as the Florida Safe Families Network. . . A referral is then prepared . . . so that 'other appropriate response to the referral in the particular county of residence of the applicant' may be taken. . . . The statute governing the Florida Abuse Hotline authorizes the disclosure of records from the abuse hotline to, '[c]riminal justice agencies of the appropriate jurisdiction,' as well as '[t]he state attorney of the judicial circuit in which the child resides or in which the alleged abuse occurred.' Law enforcement officials may access the Florida Safe Families Network and make such use of the data as they see fit.[205]

The Missouri statute is explicit and, unlike any of the other statutes, mandates reporting not only for those who test positive for drugs but for all those who refuse to take a drug test. The statute provides that "[c]aseworkers [who have knowledge that an applicant has either failed or refused a drug test] shall be required to report or cause a report to be made to the children's division . . . for suspected child abuse as a result of drug abuse."[206]

4. Disproportionality

As noted above, in contrast to the health settings, there are no studies looking specifically at the question of whether welfare drug testing policies are administered in ways that vary by the race of the welfare recipient or that disproportionately negative impact African American clients of the system. There is, however, a good deal of information to merit worry that these policies will, like the drug testing policies in the healthcare setting, have these impacts. A

---

[203] FL. CH. 2011-81 §414.0652.

[204] Lebron v. Wilkins, Verified Complaint: Class Action, Exhibit D (available at http://www.clearinghouse.net/chDocs/public/PB-FL-0006-0001.pdf)(applicants are required to sign a "Drug Testing Information Acknowledgement and Consent Release" which includes, among other provisions applicants to consent that "[i]nformation on a failed test will be shared with the Florida Abuse Hotline for review to initiate an assessment or an offer of services.")(last visited February 5, 2013).

[205] *LeBron v. Wilkins* 820 F. Supp. 2d 1273 (M.D. Fla. 2011) at 5 (citations omitted).

[206] MO. ANN. STATE §208.027(2).

few bodies of research justify this concern.

First, as to the question of disproportionate impact in the initial welfare system, while this particular policy has not been studied, researchers have looked at the impact of punitive welfare policies by race and have concluded that punitive policies are targeted disproportionately at clients of color.[207] In addition, for those programs that involve the use of discretion, it is quite clear, as it was in the healthcare setting, that the existence of discretion correlates with disproportionate targeting of poor African American women. Moving beyond the initial welfare setting and to the intersections that arise from reporting out, we do know as a general matter that African American children are referred to child welfare agencies in numbers far outweighing their percentage of the population. Once there, as Dorothy Roberts and others have compellingly described, African American families suffer outcomes far worse than their white counterparts. Similarly, as discussed above, many scholars including Wacquant and Alexander, have demonstrated that the criminal justice system impacts and is in fact targeted at communities of color in general and at the African American community in particular. Given all this data and that fact that that the statutory and regulatory framework of welfare drug testing is structurally very similar to the structure in the health care setting, there is in fact very good reason to assume that this too will result in disproportionate punishment of African American families.

IV. Intersectional Regulation and the Supportive State: Implications and Theorizing a Path

Section III of this article described the specific means by which, in basic institutions of the U.S. safety net, poor women in general and poor African American women in particular find themselves subject to an escalating series of punishments meted out as a price of seeking support. In light of this analysis, one needn't speculate much in order to understand why many poor women view America's safety net with enormous distrust. It is no secret, in poor communities of color in the United States, that seeking support involves extraordinary risk. Listening to the voices of women interviewed by Dorothy Roberts in her study of the child welfare system is a strong reminder of this very basic reality. As part of her study, Roberts interviewed an African American woman from Chicago who descried her own needs and punitive the role of child welfare agencies in her community:

> '[T]he advertisement [for the child abuse hotline], it just says abuse. If you being abused, this is the number you call, this is the only way you gonna get help. It doesn't say if I'm in need of counseling, or if . . . my

[207] For a detailed discussion of the literature on disproportionate negative treatment of non White welfare recipients, *see* Sanford F. Schram, *Contextualizing Racial Disparties in American Welfare Reform: Toward a New Poverty Research*, PERPSECTIVES ON POLITICS, 3, 2, 253 (2005).

> children don't have shoes, if I just can't provide groceries even though I may have seven kids, but I only get a hundred something dollars food stamps. And my work check only goes to bills. I can't feed eight of us all off a hundred something dollar food stamps. . . . I don't want to lose my children, so I'm not going to call [Department of Children and Family Services] for help because I only see them take away children.[208]

If we center experiences like this one and like those revealed by regulatory intersectionality analysis, then the state looks quite different from the view of the state that arises if we were to center the experiences of more economically and racially privileged women.

To understand the implications here it is crucial to go back to where this article began, in the description of the current operation of the state. Although the theories of dependency, vulnerability, responsiveness and the supportive state clearly acknowledge that poor women are subject to a punitive state, centering the impact of the systems described in this article poses squarely the question of how one might theorize a road from the state as it currently operates towards a state that is truly supportive for those who are most vulnerable.

A. Regulatory Intersectionality and Vulnerability: Rendering Women More Vulnerable

The punitive nature of what remains of the United States safety net is not lost on either Fineman or Eicher. Both repeatedly note not only that there is very little actual safety net left post 1996 but also that what remains is highly punitive in nature. Focusing on how these hyperregulatory punitive systems work, however, refocuses the relationship between poor women and the state and changes both the way that we understand the state's current relationship to vulnerability and the mechanisms by which the state controls and punishes those who seek its assistance.

Women who enter the social welfare programs described in this article, are no doubt vulnerable, as Fineman posits and are, more than most, struggling mightily to meet dependency needs. Women subject to these particular hyperregulatory systems are in fact subjecting themselves to these systems to meet very basic human needs. In the examples above they are seeking economic support and healthcare.[209] And it is certainly true, as Fineman and Eichner discuss, that those systems are in fact punitive in the sense that they exact punishment as a price of support. In the examples described above, women who

---

[208] Dorothy E. Roberts, *The Racial Geography of Child Welfare: Toward a New Research Paradigm*, 87 CHILD WELFARE 125, 145-46 (2008) (internal quotation marks omitted).

[209] *See infra* notes ____ and accompanying text.

enter those systems and reveal evidence of behavior that the system deems deviant or non compliant (in both these examples drug use), are in fact punished within the social welfare program. The women seeking prenatal care are stripped of their rights to privacy and confidentiality and deterred from accessing essential health care.[210] Women seeking welfare face denial, reduction or termination of the already meager aid offered by the program.[211] But the system is not just punitive in the sense of imposing a punishment as a price of support. Instead, the above analysis reveals these systems as hyperregulatory in the sense that Cooper referenced in his discussion of hyper-incarceration. These systems, characterized by regulatory intersectionality, are interlocked with other regulatory systems and are structured to exact ever-escalating consequences for the woman's deviant conduct. They are also hyperregulatory in the sense that they are targeted. They exact these ever escalating interlocked punitive consequences disproportionately on poor African American women. Being emeshed in hyperregulatory systems in this specific sense, is thus the price of seeking support. To describe women entering that system as merely vulnerable and the state as either absent or punitive, then seems to understate what is really going on. These particular women certainly enter in a state of vulnerability, but once they enter the mechanisms of the state seem intentionally structured to render them more and more vulnerable, more and more exposed to punishment and social control.

B. Conceptualizing a Road to the Supportive State

This article has argued that regulatory intersectionality is imbedded within the structure of the current social welfare available to poor people in the United States. It has also sought to demonstrate that these hyperregulatory mechanisms are targeted at poor, disproportionately African American families. As is the case for many of the hyperregulatory mechanisms described by scholars such as Wacquant, Roberts, and Alexander, these mechanisms are part and parcel of a larger mechanisms of social control targeted at these communities. This ultimately results in a distinction, by economic status, by race and often by place, in how the state operates. Centering the experiences of those subject to these hyperregulatory institutions creates a set of challenges for building a road toward the Supportive State.

If one splits the vision of the Supportive State roughly into two categories – one focused on regulation of the workplace and one focused on building supportive institutions and programs, it becomes clear that that regulatory intersectionality analysis impacts primarily the latter set of policy revisions. To clarify this distinction, very roughly speaking realizing a supportive state would entail revisions of both how the market operates and the creation of programs and institutions to address vulnerability and dependency needs. In the first category, the supportive state would include policies regulating the market: "upper limit[s]

[210] *See infra* notes ____ and accompanying text.
[211] *See infra* notes ____ and accompanying text.

on mandatory working hours, … paid time off for caretaking, [prohibitions on the firing of] parents of young children … for refusing to work overtime, and … flexible hours [requirements]."[212] On the programmatic and institutional side the supportive state would include the provision of, for example, universal health care, subsidized high quality childcare and pre school education and high quality public schools. As to the first category, the goals for market regulation, if actually realized throughout the market, would no doubt be of assistance to low income women, and regulatory intersectionality analysis adds little to thinking about how one might build this part of the supportive state. This analysis, however, has significant implications for those components of the supportive state that focus on providing supportive programs and institutions.

Regulatory interesectionality analysis focuses on mechanisms imbedded within the current, however meager, safety net institutions in the United States. At this point it should be clear that, in key institutions of that existing safety net, mechanisms are in place to escalate the punitive consequences of behavior deemed deviant within those benefit systems. It is no wonder then, that women are deterred from accessing support. It is for this reason that, to realize the supportive state for those poor, disproportionately African American women and families who have no choice but to avail themselves of today's safety net and who, as a result of these needs are rendered more rather than less vulnerable, one must dismantle the mechanisms of regulatory intersectionality. This involves at least three tasks. First, we must attempt to describe how these mechanisms operate. Second, we must fully understand how hyperregulatory mechanisms like those described in this article impact the reenvisioning of the role of the state. Finally, we must forge a path toward their dismantling.

The purpose of this article has been primarily to begin the first two of these tasks, thus its focus on a few examples of the way these mechanisms operate and its two principle arguments: that the existence of these mechanisms renders women more rather than less vulnerable, and that a crucial task of building the supportive state involves dismantling the hyperregulatory mechanisms of regulatory intersectionality. The third task, laying out in detail how to begin to reconfigure social institutions so they are not interlocked and structured to heighten punitive consequences is an enormous task and is, in that sense, well beyond the scope of this article.[213] However, thinking briefly again about the details of the two programs described above gives some contour of the questions and challenges involved.

To begin to think about dismantling regulatory intersectionality we could

---

[212] MAXINE EICHNER, THE SUPPORTIVE STATE: FAMILIES, GOVERNMENT AND AMERICA'S POLITICAL IDEALS 65 (2010).

[213] Some scholars are already engaged in parts of this task. *See e.g.* Michele Estrin Gilman, *The Class Differential in Privacy Law,* 77 BROOKLYN L. REV. 1389 (2012).

begin by asking what it might mean for public health and welfare systems not to be characterized by these mechanisms. On a practical level, a woman seeking care would need to be guaranteed a far higher degree of privacy in public health settings. It should be true, as the Supreme Court noted in *Ferguson* that, "the reasonable expectation of privacy enjoyed by the typical patient undergoing diagnostic tests in a hospital is that the results of those tests will not be shared with nonmedical personnel without her consent."[214] But the above analysis reveals that, for poor disproportionately African American women, this is an assumption that does not comport with reality. Given how mechanisms of regulatory intersectionality actually function, it is far more reasonable for a poor African American woman to assume that she has no health privacy and that the cost of seeking prenatal or childbirth care may well be the investigation of her family, the loss of her children and her possible prosecution and incarceration. And this is true for her when her higher income white counterpart, who is just as likely to have used drugs during her pregnancy, is far less likely to face these escalating penalties.

In the welfare setting, it is certainly true that intrusions into the lives of poor women and the emphasis on behavioral control have since the very inception of the modern welfare state, characterized welfare programs.[215] One need only look at the practices involved in *King v. Smith*,[216] in which the state of Alabama inspected women's homes for signs that a man was there, to understand the deep and long standing nature of privacy intrusions in public welfare programs. It is also, true, as referenced in Section II of this article, that the institutions of the social welfare state in the United States have, since at least the New Deal, been bifurcated, with one set of programs, social security, Medicare and the like, going to one group of people and another set (Welfare, Medicaid, Food Stamps and the like) going to the poor. Although it has not been a focus of this article, other scholars have well documented the ways in which these poverty focused programs have been characterized by behavioral controls. They have also extensively documented the ways in which the entry in the late 1960s of substantial number of poor African American recipients in many ways gave rise to ever more punitive mechanisms within these social welfare programs. Given this history, one cannot, as perhaps one can in public health, invoke a longstanding precept that there is a reasonable expectation of privacy for women applying for welfare. In fact, if the history of public welfare in the U.S. is our guide, then poor disproportionately African American women have no reason to expect privacy. The question here, then, is if we are to conceptualize the supportive state, how might it be possible to change this long-standing reality? Although such a question is tremendously difficult to answer, this article argues that if we are to build a road toward a Supportive State, questions like this are central.

[214] *Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001).
[215] *See infra* notes ___ and accompanying text.
[216] 392 U.S. 309 (1968).

The problem does not stop, of course, with simply the lack of privacy. One would also need to ask whether the current regulatory finger on the scale strongly in favor of child protective investigations and criminal prosecutions both accomplishes the purposes of these social welfare programs as they are constituted and whether they could coexist with the creation of a supportive state. As argued above, in both the public health and the welfare setting, virtually every employee with which a woman might interact when seeking support is a mandatory reporter.[217] In addition, generally speaking, child welfare records are available to the police.[218] Thus the mechanisms described above are almost wholly added on to a preexisting legal framework allowing for investigation of these families. While one can, and scholars have, raised important questions about the structure of both reporting and prosecution in these contexts, what is described above goes well beyond just the existence of mandatory reporters and the ability to prosecute. What's described above constitutes an added set of laws, regulations, policies and practices that further erode privacy and augment the transmission of information about poor women between social welfare and other punitive agencies. What is also described above is a set of practices that exact punitive consequences disproportionately on African American women and their families. Although it is perhaps politically naïve to do so, one might well ask why we have chosen to add on this plethora of additional data sharing, punitive mechanisms and why we are content to have it exact punishment disproportionately on these families. Certainly to realize a supportive and responsive state, one would need to ask all these questions and design advocacy strategies and systemic changes to address these issues.

CONCLUSION

This article is in large part an attempt to suggest a next step in the direction of an essential conversation within feminist legal theory. There is no question that both current political theory and, more importantly, current state institutions fail to enable families to meet dependency needs and seem, in the name of autonomy, obscenely content to leave gross inequality in place. Together Fineman and Eichner lay out a potent critique, a clearly better vision of the state we need and a theory that holds great promise in getting us there. As we consider their vision, however, we must remember, as Kimberle Crenshaw and Dorothy Roberts among many others counsel, that, if we are to build institutions that are responsive to some of the most vulnerable among us, we must seek specificity. We must seek to understand the particular intersectional and institutional realities that constitute the relationship between poor disproportionately African American women and the state. This article, by focusing on one piece of that larger project, the pervasive existence of regulatory

[217] *See infra* notes ___ and accompanying text.
[218] *See infra* notes ___ and accompanying text.

intersectionality within the current social welfare state, attempts to do precisely that. Realizing the supportive state is an enormous and daunting task to which scholars and activists must devote their considerable energies and talents. Understanding and dismantling regulatory intersectionality is a crucial first step.