



AMERICAN  
CONSTITUTION  
SOCIETY FOR  
LAW AND POLICY

Issue Brief

March 2018

## The Detention and Forced Medical Treatment of Pregnant Women: A Human Rights Perspective

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On October 26, 2017, the Seventh Circuit heard oral argument in *Loertscher v. Anderson*,<sup>1</sup> a case that asks how far a state can go in restricting a woman’s constitutional rights under the guise of protecting the fetus that she carries. The case challenges a Wisconsin law that allows the state to take a pregnant woman into the custody of child protective services in order to protect her “unborn child,”<sup>2</sup> from “the time of fertilization to the time of birth,” based on a concern that the threat of the woman’s future use of alcohol or controlled substances poses a “substantial risk” to the physical health of the “unborn child.”<sup>3</sup> Wisconsin’s law is unique in that it places a woman in the custody of child protective services. Several other states allow or promote similar use of their civil commitment laws to detain pregnant women.<sup>4</sup> And a county prosecutor in Montana recently announced a “crackdown policy,” pledging civil prosecution and incarceration of pregnant women suspected of non-medically proscribed use of drugs or alcohol.<sup>5</sup>

The *Loertscher* case came to the Seventh Circuit after the District Court granted summary judgment to plaintiff Tamara Loertscher, finding the Wisconsin statute void on vagueness grounds, and

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\* This Issue Brief is based on an amicus brief filed with the Seventh Circuit in *Loertscher v. Anderson*, authored by Cynthia Soohoo, Amanda Dysart, and Katherine Jack. The brief was joined by the Center for Reproductive Rights, Amnesty International, and the Human Rights and Gender Justice Clinic at City University of New York Law School. The authors are grateful for the research assistance of Johanna Segal, Jennifer Ringewald, Naomi Young and for the comments of Farah Diaz-Tello and Zoe Levine.

<sup>1</sup> *Loertscher v. Anderson*, 259 F. Supp.3d 902 (D. Wis. 2017).

<sup>2</sup> See WIS. STAT. ANN. § 48.133 (2016) (granting the court jurisdiction over “unborn children” allegedly in need of protection or services); see also *Loertscher v. Anderson*, 2017 U.S. Dist. WEST. 1613654, at \*1-\*19, \*3 (D. Wis. Apr. 28, 2017) (explaining that the Wisconsin Act 292 extended existing child welfare law to allow a county social services department to determine that unborn fetuses are children need of protective services).

<sup>3</sup> See WIS. STAT. ANN. § 48.133 (2016), *supra* note 2; see also *Loertscher*, *supra* note 2, at \*12 (interpreting Wisconsin’s Act 292 to include a jurisdictional standard for ordering protective services for unborn child which consists of a two-prong test of whether 1) the expectant mother severely and habitually lacks self-control in the use of controlled substances, and 2) whether the lack of self-control poses a substantial risk to the physical health of the child).

<sup>4</sup> In addition to Wisconsin, there are four other U.S. states with explicit statutory provisions that target pregnant women suspected of alcohol or substance for unique treatment under civil detention schemes. See *infra* notes 18 and 19 and accompanying text (describing other commitment schemes).

<sup>5</sup> Briana Monte, *Big Horn County Attorney Cracking Down on Pregnant Drug, Alcohol Users*, KULR (Jan. 12, 2018, 11:14 AM), <http://www.kulr8.com/story/37253594/big-horn-county-attorney-cracking-down-on-pregnant-drug-alcohol-users>.

enjoined enforcement of the law.<sup>6</sup> In addition to vagueness, Loertscher raised substantive and procedural due process, First and Fourth Amendment, and equal protection claims. The District Court recognized that the statute implicated the constitutional rights to be free from physical restraint and coerced medical treatment,<sup>7</sup> but rested its holding solely on vagueness grounds and did not reach “the other difficult constitutional questions.”<sup>8</sup> The District Court denied a motion to stay the injunction pending appeal,<sup>9</sup> but in July 2017, the U.S. Supreme Court granted Wisconsin’s application to stay enforcement of the injunction pending the Seventh Circuit’s review.<sup>10</sup>

Although the Seventh Circuit also may not reach the constitutional questions raised in *Loertscher v. Anderson*, because of the human rights concerns raised by the Wisconsin law, this Issue Brief provides an overview of relevant international human rights law and standards that should inform the Seventh Circuit’s consideration of the constitutional issues as well as other courts and legislatures considering the wisdom of similar civil commitment schemes. In particular, this Brief discusses the rights to be free from arbitrary detention and forced medical treatment and to privacy in personal medical information, which are universally recognized and protected by human rights law.

## I. Civil Detention Laws Targeting Pregnant Women

1997 Wisconsin Act 292 (“Act 292”), the statute at issue in *Loertscher*, authorizes Wisconsin’s juvenile courts to treat a fertilized egg, embryo, or fetus at any gestational stage as a child in need of protection or services if a pregnant woman:

habitually lacks self-control in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, to the extent that there is a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered unless the expectant mother receives prompt and adequate treatment for that habitual lack of self-control.<sup>11</sup>

The true practical scope of the law is not immediately clear from its language. The descriptors used in the statute, though numerous, provide little guidance as to the circumstances that trigger jurisdiction.<sup>12</sup> Once a court has asserted jurisdiction, it may order that a pregnant woman be detained in an inpatient drug treatment center, forcing her to leave her home and family and undergo

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<sup>6</sup> *Loertscher*, *supra* note 2 at 906. Tammy Loertscher is represented by National Advocates for Pregnant Women, the NYU Reproductive Justice Clinic, and the law firm Perkins Coie.

<sup>7</sup> *Loertscher*, *supra* note 2 at 915.

<sup>8</sup> *Loertscher*, *supra* note 2 at 906.

<sup>9</sup> *Loertscher v. Anderson*, 2017 WL 2198193 (May 18, 2017).

<sup>10</sup> *Anderson v. Loertscher*, 137 S.Ct. 2328 (July 7, 2017).

<sup>11</sup> WIS. STAT. ANN. § 48.133 (2016).

<sup>12</sup> The District Court ruled that Act 292’s language is unconstitutionally vague because it lacks a reasonably comprehensible standard that would put women on notice of the law, and the terms “substantial risk,” “habitual lack of self-control,” and “danger to the unborn child” are ambiguous and undefined. *Loertscher*, *supra* note 2 at 918-20, 921 (“An expectant mother who does not maintain complete sobriety simply cannot know when she would be subject to the Act. There is no way for her to know what type of behavior demonstrates a habitual lack of self-control to a severe degree in the eye of the enforcer, much less whether behavior *prior to pregnancy* may end up being sufficient to trigger the Act’s control over her once she conceives...”).

unwanted and potentially unnecessary medical treatment.<sup>13</sup> The Act also allows the state to obtain confidential medical information without the woman’s consent.<sup>14</sup> Further, the Wisconsin law authorizes the court to appoint a guardian ad litem for the fetus to “advocate for” and “[m]ake clear and specific recommendations to the court concerning the best interests of the . . . unborn child at every stage of the proceeding.”<sup>15</sup> In contrast, a woman who qualifies for appointed counsel is not entitled to representation at the initial plea hearing and may be held in custody for up to 30 days before counsel is appointed.<sup>16</sup> And even though the law is a part of the civil child welfare scheme rather than a criminal law, if the woman fails to comply with the court’s order, she may be held in contempt and incarcerated.<sup>17</sup>

In addition to Wisconsin, there are four other U.S. states—Minnesota, North Dakota, Oklahoma and South Dakota—with explicit statutory provisions that target pregnant women suspected of alcohol or substance for unique treatment under civil detention schemes. Rather than giving the juvenile court jurisdiction over pregnant women under their child protection laws, some states have added a special provision concerning pregnant women within the definition of persons who can be detained under their civil commitment schemes.<sup>18</sup> Others have provisions that allow authorities to trigger an involuntary commitment proceeding for a pregnant woman to protect an “unborn child.”<sup>19</sup>

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<sup>13</sup> Under § 48.347 of Act 292, if a judge finds that a pregnant woman is in need of treatment, then that judge must order a treatment plan including counseling, supervision, and placements. The statute ostensibly limits a court’s authority to order pregnant women to involuntary treatments to situations in which “the court finds that the adult expectant mother is refusing or has refused to accept any alcohol or other drug abuse services offered to her or is not making or has not made a good faith effort to participate in any alcohol or other drug abuse services offered to her.” WIS. STAT. ANN. § 48.347 (2016) (authorizing court to order inpatient alcohol or drug treatment); *see also* WIS. STAT. ANN. § 48.193 (2016) (enumerating the circumstances under which a pregnant woman may be taken into physical custody); WIS. STAT. ANN. § 48.205(1m) (2016) (providing criteria for holding a pregnant woman in physical custody, including the requirement that intake workers have “probable cause” for believing that the pregnant woman poses a “substantial risk of physical harm to her unborn child due to her habitual lack of self-control and refusal of services”). However, because the statute is vague as to when treatment is needed and how the appropriate level of treatment is ascertained, such a limitation provides little protection to women who may have a variety of reasons to “refuse” care, including that it is not appropriate or acceptable, or that they have other concerns such as employment or childcare that the recommended treatment fails to accommodate.

<sup>14</sup> WIS. STAT. ANN. § 48.981(2)(d) (2016) (“Any person, including an attorney, who has reason to suspect that an unborn child has been abused or who has reason to believe that an unborn child is at substantial risk of abuse may report . . .”); WIS. STAT. ANN. § 905.04(4)(e)(3) (2016) (stating that information regarding child abuse or neglect is not protected under the general rule of privilege for communications and information used in the diagnosis and treatment of a patient); *see also* Wis. Stat. Ann. § 48.981(4) (2016) (providing immunity from liability for any person or institution who makes a “good faith” report that an expectant mother is abusing her unborn child); WIS. STAT. ANN. § 48.981(2) (2016) (healthcare providers are mandated reporters of child abuse).

<sup>15</sup> WIS. STAT. ANN. § 48.235(3)(b) (2016).

<sup>16</sup> WIS. STAT. ANN. §§ 48.30 (1) & (2), 48.305 (2016).

<sup>17</sup> Under WIS. STAT. ANN. § 785.04, imprisonment is a permissible remedy for contempt of court as defined in § 785.01(1) (b, bm, br, c, d); *see also* WIS. STAT. ANN. § 785.01(1)(b) (defining contempt of court as certain intentional acts, including disobedience or resistance to a court order, authority, or process).

<sup>18</sup> MINN. STAT. § 253B.02 Subd. 2 (2016) (separate definition for pregnant women under chemically dependent person). *See also* S.D. CODIFIED LAWS § 34-20A-63 (2016) (amended the state’s Treatment and Prevention of Alcohol and Drug Abuse scheme in 1998 by adding “is pregnant and abusing alcohol or drugs” to grounds for emergency commitment).

<sup>19</sup> OKLA. STAT. tit. 63, § 1-546.5 (2016). *See also* N.D. CENT. CODE § 50-25.1-18 (2016) [Prenatal Exposure to Alcohol Abuse] and § 50-25.1-16 (2016) [Prenatal Exposure to Controlled Substances].

The impact of these laws on women’s lives is real and substantial, as the facts of the *Loertscher* case illustrate. In 2014, Tammy Loertscher suspected that she was pregnant and sought health care through the local county health department.<sup>20</sup> The department referred Loertscher to the Mayo Clinic Hospital emergency room, where she explained that she wanted to find out if she was pregnant, that she needed medical and psychiatric care for a severe untreated thyroid condition, and that she wanted to make sure her baby was healthy.<sup>21</sup> Loertscher was asked to provide a urine sample, which confirmed her pregnancy and revealed “unconfirmed positives” for methamphetamine, amphetamine, and THC. Ms. Loertscher was voluntarily admitted for overnight treatment in the Mayo Clinic Behavioral Health Unit.<sup>22</sup> The next morning, she was diagnosed with dangerously low thyroid levels that threatened her pregnancy and given medication to stabilize her hormone levels.<sup>23</sup>

In interviews with several physicians, Loertscher stated that, due to lethargy associated with her thyroid condition, she had been self-medicating with marijuana and methamphetamine and had used small amounts of alcohol before she knew she was pregnant.<sup>24</sup> While the fetus appeared to be healthy in an ultrasound, Loertscher was concerned about its health and told emergency room doctors that she wanted to stop using drugs and obtain treatment for her thyroid dysfunction.<sup>25</sup> A social worker reported her to Taylor County Human Services for using controlled substances and alcohol during her pregnancy.<sup>26</sup> Loertscher was prohibited from leaving the hospital, and a guardian ad litem was appointed to represent her fetus.<sup>27</sup>

In the days following, Loertscher was summoned to a telephonic Temporary Physical Custody hearing in a hospital conference room where she was presented with legal documents that she did not understand and stated that she did not want to take part in the proceeding without legal representation.<sup>28</sup> She left the room, but the hearing continued; in her absence, the court ordered that she be placed in an inpatient drug facility.<sup>29</sup>

Loertscher did not want inpatient treatment, preferring instead to continue the medications for depression and hypothyroidism and seek care on an outpatient basis.<sup>30</sup> Her treating physician determined that she was not “an imminent danger to herself or others” and discharged her, noting that the fact that she had “used in [t]he past does not mean she will again.”<sup>31</sup>

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<sup>20</sup> *Loertscher*, *supra* note 2 at 909.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> *Id.* Loertscher was unable to afford thyroid medication because she lost her job and health insurance several months prior to her pregnancy. *Id.* at 908.

<sup>25</sup> *Id.* at 909.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 910.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at 911.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

Despite the discharge by her treating physician, the guardian ad litem and Taylor County Human Services brought contempt proceedings against Loertscher for failing to report to the inpatient facility.<sup>32</sup> At a subsequent contempt hearing where Loertscher again did not have legal representation, the court ordered that she submit to inpatient treatment or serve 30 days in jail.<sup>33</sup> Loertscher spent 18 days in jail where she was denied prenatal care and placed in solitary confinement.<sup>34</sup> While in jail, she finally found a list of Taylor County public defense attorneys.<sup>35</sup> She called the number listed and was appointed a public defender.<sup>36</sup> Pursuant to her attorney's advice, Loertscher signed a consent decree mandating that she submit to weekly drug testing at her own expense and release her medical records to Taylor County Human Services, after which she was released.<sup>37</sup> For the next several months, with no help from the social services authorities, she tested negative for all controlled substances.<sup>38</sup> In January of 2015, she gave birth to a healthy baby boy.<sup>39</sup>

## II. The Relevance of International Human Rights Law to Civil Commitment Schemes

The United States is a party to human rights treaties that impose international legal obligations requiring it to protect individuals from arbitrary detention and forced medical treatment and to respect the right to confidential medical information.<sup>40</sup> These obligations require that the U.S. respect and ensure that women enjoy these fundamental rights on an equal basis with men.<sup>41</sup> Core human rights treaties ratified by the U.S., including the International Covenant on Civil and Political Rights (ICCPR)<sup>42</sup> and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT),<sup>43</sup> contain specific provisions implicated by civil laws designed to detain and involuntarily treat pregnant women based on a perceived threat of future substance abuse. In addition, the U.S. has signed but not ratified other treaties that safeguard these rights, including the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)<sup>44</sup> and the International Covenant on Economic, Social and Cultural Rights (ICESCR),<sup>45</sup>

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<sup>32</sup> *Id.* (recounting that, on August 11, 2014, the guardian ad litem for Loertscher's fetus "filed a motion for remedial contempt against Loertscher in the Circuit Court for Taylor County, requesting that the court hold Loertscher in contempt pursuant to Wis. Stat. § 785.04 if she did not comply with the terms of the temporary physical custody order (i.e., inpatient drug treatment).")

<sup>33</sup> *Id.* at 912.

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* at 913.

<sup>40</sup> See e.g., International Covenant on Civil and Political Rights, arts. 7, 9, 17, *opened for signature* Dec. 19, 1966, S. Treaty Doc. 95-20, 999 U.N.T.S. 171 [hereinafter the ICCPR]; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *opened for signature* Dec. 10, 1984, S. Treaty Doc. 100-20, 1465 U.N.T.S. 85 [hereinafter CAT].

<sup>41</sup> *Id.*, at arts. 2 and 3.

<sup>42</sup> ICCPR, *opened for signature* Dec. 19, 1966, S. Treaty Doc. 95-20, 999 U.N.T.S. 171

<sup>43</sup> CAT, *opened for signature* Dec. 10, 1984, S. Treaty Doc. 100-20, 1465 U.N.T.S. 85.

<sup>44</sup> Convention on the Elimination of all Forms of Discrimination Against Women, *opened for signature* Dec. 18, 1979, 1249 U.N.T.S. 13.

<sup>45</sup> International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3.



as well as the American Convention on Human Rights (American Convention on Human Rights).<sup>46</sup> Under international law, the United States has an obligation not to act in ways that would defeat the object and purpose of treaties it has signed, even if not yet ratified.<sup>47</sup>

U.S. courts often look to international human rights norms for guidance in analyzing constitutional claims. International law and the reasoning of international and regional human rights bodies and experts can provide a useful perspective for courts to consider, particularly when dealing with novel legal issues. For example, in *Graham v. Florida*, a case challenging the practice of sentencing juveniles to life in prison without the possibility of parole, the Supreme Court continued its “longstanding practice” of looking “beyond our Nation’s borders for support for its independent conclusion that a particular punishment is cruel and unusual.”<sup>48</sup> As Justice Breyer has stated, the experience of respected international bodies and courts can “cast an empirical light on the consequences of different solutions to a common legal problem.”<sup>49</sup> Policymakers, too, increasingly look to international human rights standards in assessing policy and practice.<sup>50</sup>

### III. Human Rights Standards on the Detention and Involuntary Treatment of Pregnant Women

State civil commitment laws authorizing states to detain pregnant women to prevent future substance abuse violate core human rights principles. Specifically, these laws violate universally recognized and protected rights to be free from arbitrary detention and forced medical treatment and the right to privacy in personal medical information. In considering the scope and content of these rights, human rights bodies have emphasized the importance of incorporating a gender perspective to ensure that physical differences between women and men, such as the capacity to be pregnant, as well as stereotypical attitudes about women’s ability and right to make their own health care decisions, do not undermine women’s equal enjoyment of human rights. Human rights bodies have explicitly rejected the idea that fetal interests can be considered separately from, or promoted

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<sup>46</sup> American Convention on Human Rights, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123.

<sup>47</sup> See Vienna Convention on the Law of Treaties, art. 18(a), *opened for signature* May 23, 1969, 1155 U.N.T.S. 331 [hereinafter Vienna Convention].

<sup>48</sup> *Graham v. Florida*, 560 U.S. 48, 80 (2010). See also *Lawrence v. Texas*, 539 U.S. 558, 572–73 (2003) (citing a European Court of Human Rights decision and a special committee report to the British Parliament in holding that Texas law criminalizing consensual sexual conduct between same-sex partners was at odds with norms of Western civilization); *Atkins v. Virginia*, 536 U.S. 304, 316 n.21 (2002) (citing to international disapproval of the practice of executing developmentally disabled individuals, as detailed in the filing of amicus European Union).

<sup>49</sup> *Printz v. United States*, 521 U.S. 898, 977 (1997) (Breyer, J., dissenting) (supporting Justice Stevens’ dissent by arguing that looking to the federalist systems of other countries might provide insight into the question of whether U.S. Constitutional law permits Congress to impose an obligation on state governments). See also Sarah H. Cleveland, *Our International Constitution*, 31 YALE J. INT’L L. 1, 11–88 (2006) (cataloging the ways in which the Supreme Court has drawn on foreign and international law in cases throughout its history).

<sup>50</sup> See, e.g., Martha F. Davis, *Thinking Globally, Acting Locally: States, Municipalities, and International Human Rights*, in 2 BRINGING HUMAN RIGHTS HOME 127 (Cynthia Soohoo et al. eds., 2008); BARBARA M. OOMEN, MARTHA F. DAVIS & MICHELE GRIGOLO, GLOBAL URBAN JUSTICE: THE RISE OF HUMAN RIGHTS CITIES (2016); Columbia Law School Human Rights Institute, *Bringing Human Rights Home: How State and Local Governments Can Use Human Rights to Advance Local Policy* (Dec. 2012), <http://web.law.columbia.edu/sites/default/files/microsites/human-rights-institute/files/Bringing%20Human%20Rights%20Home.pdf>.

to the detriment of, pregnant women.<sup>51</sup> And human rights standards emphasize that pregnant women must be treated with dignity and respect.<sup>52</sup>

## A. Prohibitions on Arbitrary Detention

### I. Applicable Human Rights Law

In *Loertscher*, the District Court recognized that involuntarily detaining a pregnant woman for drug treatment implicates her constitutional right to be free from physical restraint.<sup>53</sup> International law also unequivocally prohibits arbitrary detention because it violates an individual's right to liberty and freedom from physical restraint.

The International Covenant on Civil and Political Rights, a core human rights treaty ratified by the United States, protects against arbitrary arrest or detention by ensuring that “[n]o one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.”<sup>54</sup> The right to be free from arbitrary detention is so universally recognized that it rises to the level of customary international law<sup>55</sup> and has been recognized in some contexts as a *jus cogens* norm.<sup>56</sup>

International treaties and human rights bodies and experts have emphasized that any detention, whether civil or criminal, must be reasonable and proportionate and ensure full due process protections. The U.N. Human Rights Committee, which monitors implementation of the ICCPR,

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<sup>51</sup> International human rights law recognizes the right to life as a fundamental right, which does not accrue until birth, and international and regional human rights bodies and domestic courts have established that any state-imposed prenatal protections must be consistent with woman's human rights. *See* CTR. FOR REPRODUCTIVE RIGHTS, WHOSE RIGHT TO LIFE? WOMEN'S RIGHTS AND PRENATAL PROTECTIONS UNDER HUMAN RIGHTS AND COMPARATIVE LAW (2014), [https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/GLP\\_RTL\\_ENG\\_Updated\\_8%2014\\_Web.pdf](https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/GLP_RTL_ENG_Updated_8%2014_Web.pdf); *see also* AMNESTY INTERNATIONAL, *CRIMINALIZING PREGNANCY: POLICING PREGNANT WOMEN WHO USE DRUGS IN THE USA* (May 2017), <https://www.amnesty.org/en/documents/amr51/6203/2017/en/>. (“No international human rights body has ever recognized a fetus as a subject of protection under the right to life . . .”).

<sup>52</sup> HRC, GC 28, Human Rights Committee, *General Comment No 28: Article 3 (The equality of rights between men and women)*, ¶ 15, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (Mar. 29, 2000) [hereinafter HRC, GC 28].

<sup>53</sup> *See Loertscher*, *supra* note 2, at \*10; *see also*, *Reno v. Flores*, 507 U.S. 292, 315-16 (1993) (O'Connor, J., concurring) (recognizing that a person's “core liberty interest” is not limited to the criminal context and includes confinement in other custodial institutions).

<sup>54</sup> ICCPR, *supra* note 42, at art. 9(1).

<sup>55</sup> Customary international law “results from a general and consistent practice of states followed by them from a sense of legal obligation.” AMERICAN LAW INSTITUTE, *RESTATEMENT OF THE LAW (THIRD): FOREIGN RELATIONS LAW OF THE UNITED STATES* § 102(c)(2) (1987) [hereinafter *Restatement (Third): Foreign Relations Law*]; *see, e.g.*, *Ma v. Ashcroft*, 257 F.3d 1095, 1114 (9th Cir. 2001) (stating that a “clear international prohibition” exists against prolonged and arbitrary detentions); *De Sanchez v. Blanco Central de Nicaragua*, 770 F.2d 1385, 1397 (5th Cir. 1985) (listing “the right not to be arbitrarily detained” among the small group of “basic rights” that have been “generally accepted”); *Rodriguez-Fernandez v. Wilkinson*, 654 F.2d 1382, 1388 (10th Cir. 1981) (“No principle of international law is more fundamental than the concept that human beings should be free from arbitrary imprisonment.”).

<sup>56</sup> U.N. Working Group on Arbitrary Detention, *Report of the Working Group on Arbitrary Detention*, ¶ 51, U.N. Doc. A/HRC/22/44 (Dec. 24, 2012) [hereinafter *WGAD*, *Deliberation No. 9*]. *See* *Restatement (Third): Foreign Relations Law* § 702 (listing the prohibition on “arbitrary detention” as a customary international law norm) (emphasis added). A *jus cogens* norm is “a norm accepted and recognized by the international community of States as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character.” Vienna Convention, *supra* note 47 art. 53; *see also* *Siderman de Blake v. Republic of Argentina*, 965 F.2d 699, 714 (9th Cir. 1992).

has explained that a detention authorized by law may still be arbitrary if it is inappropriate, unjust, lacks predictability, or fails to provide due process as well as lacks essential elements of reasonableness, necessity, and proportionality.<sup>57</sup> Further, human rights law emphasizes that the state should make less restrictive alternatives available before involuntarily detaining someone.<sup>58</sup> Involuntary detention should always be a last resort and used for the shortest appropriate period.<sup>59</sup>

The Human Rights Committee has recognized that involuntary hospitalization, in particular, may constitute arbitrary detention. In the context of involuntary hospitalization, “deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others.”<sup>60</sup> According to the U.N. Working Group on Arbitrary Detention,<sup>61</sup> compulsory detention for the purpose of drug rehabilitation is “contrary to scientific evidence and inherently arbitrary,” and drug use or dependence alone “is not sufficient justification for detention.”<sup>62</sup> An involuntary hospitalization scheme also must be predictable and provide due process protections to ensure that it is fairly applied to a specific individual.<sup>63</sup> Predictability requires that the statute cannot be so vague that it fails to provide notice of what is prohibited.<sup>64</sup>

Human rights law requires that basic due process protections be provided when the state seeks to deprive individuals of their liberty. It provides that anyone deprived of liberty “shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his detention.”<sup>65</sup> Where the consequences of a nominally civil statute are nearly equivalent to criminal sanctions, human rights law recognizes a right to counsel.<sup>66</sup> Indeed, the U.N. Basic Principles and Guidelines on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court provide that access to legal counsel shall be provided “immediately after the moment of deprivation of liberty.”<sup>67</sup> Further, “any determination with respect to the need for treatment [should] be carried out by qualified professionals.”<sup>68</sup>

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<sup>57</sup> U.N. Human Rights Committee, *General Comment No. 35: art. 9, ¶ 12*. U.N. Doc. CCPR/C/GC/35 (Dec. 16, 2014) [hereinafter “HRC, GC 35”]; *see also*, U.N. Human Rights Committee, *Womah Mukong v. Cameroon*, ¶ 9.8, U.N. Doc. CCPR/C/51/d/458/1991 (July 21, 1994) (stating that the ICCPR’s drafting history “confirms that ‘arbitrariness is to be equated with ‘against the law,’ but must be interpreted more broadly to include elements of inappropriateness, injustice, lack of predictability and due process of law”).

<sup>58</sup> HRC, GC 35, *supra* note 57, at ¶ 19.

<sup>59</sup> HRC, GC 35, *supra* note 57, at ¶ 19.

<sup>60</sup> HRC, GC 35, *supra* note 57, at ¶ 19.

<sup>61</sup> The U.N. Working Group on Arbitrary Detention is composed of independent human rights experts who investigate alleged instances of arbitrary deprivation of liberty.

<sup>62</sup> U.N. Working Group on Arbitrary Detention, *Report of the Working Group on Arbitrary Detention*, ¶ 59-60, U.N. Doc. A/HRC/30/36 (July 10, 2015) [hereinafter *WGAD Report on Drug Control*].

<sup>63</sup> HRC, GC 35, *supra* note 57, at 12.

<sup>64</sup> *Loertscher*, *supra* note 2, at \*9 (“Due process requires that a law clearly define its prohibitions”).

<sup>65</sup> ICCPR Art. 9(4).

<sup>66</sup> U.N. Human Rights Committee, *General Comment No 32: Article 14: Right to equality before courts and tribunals to a fair trial*, ¶¶ 9-10, U.N. Doc. CCPR/C/GC/32 (Aug. 23, 2007).

<sup>67</sup> U.N. Working Group on Arbitrary Detention, *Report of the Working Group on Arbitrary Detention*, Guideline 8, U.N. Doc. A/HRC/30/37 (July 6, 2015).

<sup>68</sup> U.N. Working Group on Arbitrary Detention, *Preliminary Findings from its visit to the United States of America* (Oct. 11-24, 2016) [hereinafter *WGAD, Preliminary Findings on U.S.*].



## 2. Wisconsin’s Act 292 Violates Human Rights Standards on Arbitrary Detention

Civil confinement laws such as Act 292 are not reasonable or proportionate under human rights law and do not provide the adequate procedural safeguards outlined above. Human rights law provides that involuntary detention for medical reasons is only permitted to protect an individual from harm or to prevent immediate injury to others, and a woman’s drug use, or even drug dependence, does not justify involuntary detention for drug treatment.<sup>69</sup>

First, civil confinement laws which authorize the detention of pregnant women to prevent future substance use are not reasonable because they do not further their purported goals of maternal and fetal health.<sup>70</sup> As established by experts in public health, forced treatment undermines health goals because it actually dissuades pregnant women from seeking prenatal care and drug treatment in the first place.<sup>71</sup> The American College of Obstetricians and Gynecologists has stated that “drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.”<sup>72</sup> As a result, these statutory schemes fail to promote a healthy pregnancy.<sup>73</sup>

Moreover, civil confinement laws which allow for the confinement of pregnant women suspected of substance abuse are not proportionate because they encompass a pregnant woman’s use of a wide range of substances without proof that all, or any of them, actually pose a danger to a developing fertilized egg, embryo, or fetus, or a determination of what level of use is dangerous.<sup>74</sup> As the District Court in *Loertscher* noted, “all agree that medical science can draw no reasonably precise line where consumption levels transition from benign to seriously risky.”<sup>75</sup>

Furthermore, civil commitment statutes such as Act 292 violate due process because they are written in a vague manner that fails to provide women with adequate notice of what behavior is prohibited.<sup>76</sup> The statutes’ vagueness and breadth allow arbitrary and unreasonable enforcement by non-medical

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<sup>69</sup> See WGAD, *Report on Drug Control*, *supra* note 62, ¶ 59-60.

<sup>70</sup> As discussed *supra*, human rights experts have rejected the notion that fetal interests can be considered separately from, or promoted to the detriment of, pregnant women. See notes 121 - 123, *supra*.

<sup>71</sup> American Medical Association, *Legal Intervention During Pregnancy*, 264 JAMA 2663, 2667 (1990); Loertscher, *supra* note 2, at \*8 (noting that some experts find that women may be dissuaded from seeking prenatal care by reporting of substance abuse during pregnancy).

<sup>72</sup> ACOG Comm. on Health Care for Underserved Women, *Opinion 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (Jan. 2011), <http://bit.ly/2dBttBo>.

<sup>73</sup> Regardless of any possible intentions by government officials to promote maternal and infant health through pregnancy criminalization laws, the women interviewed by Amnesty International reported that the effect of such laws was to deter them from seeking healthcare, prenatal care, and drug treatment. See AMNESTY INTERNATIONAL, *supra* note 51 at 9.

<sup>74</sup> Center for the Evaluation of Risks to Human Reproduction, *Report of the NTP-DEHR Expert Panel on the Reproductive & Developmental Toxicity of Amphetamine and Methamphetamine* 163, 174 (2005); Loertscher, *supra* note 2, at \*8.

<sup>75</sup> Loertscher, *supra* note 2, at 914.

<sup>76</sup> See *supra* note 12. Similarly, civil commitment schemes in other states also contain vague and ambiguous terms. See, e.g., MINN. STAT. § 253B.02(2) (2016) (defining a chemically dependent person as “also mean[ing] a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following substances or their derivatives: opium, cocaine, heroin, phencyclidine, methamphetamine, amphetamine, tetrahydrocannabinol, or alcohol”). In South Dakota, being “pregnant and abusing alcohol or drugs” is grounds for involuntary commitment, but the term “abuse” is undefined. S.D. CODIFIED LAWS § 34-20A-70 (2016).

professionals.<sup>77</sup> For example, in Wisconsin, intake workers, without medical expertise or credentials, may initiate enforcement proceedings.<sup>78</sup> In *Loertscher*'s case, this resulted in the state issuing an order of temporary custody and mandating treatment, even though her treating physician determined that she was not in imminent danger to herself or others and she did not have a substance use disorder.<sup>79</sup> *Loertscher* was never offered non-coercive medical treatment and services as an alternative.<sup>80</sup>

In addition, these civil confinement laws often fail to provide the procedural safeguards required under international law, including immediate appointment of counsel and state-appointed experts to examine the individual and provide reliable scientific testimony. For example, under Wisconsin Act 292, a pregnant woman is only entitled to counsel if she is placed outside the home, even if the court order substantially infringes upon her liberty and medical decision-making.<sup>81</sup> A woman who qualifies for appointed counsel is not entitled to representation at the initial plea hearing and may be held in custody for up to 30 days before counsel is appointed.<sup>82</sup> Expert testimony is not required to prove that a woman “habitually lacks self-control” in the use of alcohol or controlled substances or that there is a substantial risk to the health of the fetus. Even if there were such a requirement, an expert would be able to provide little insight into whether an individual’s drug use is “habitual” or lacking in self-control. In *Loertscher*, the District Court noted that Act 292 does not define these terms<sup>83</sup> and there was “no support for the notion that a qualified medical expert would understand and be able to apply the concept of ‘habitual lack of self-control.’”

Indeed, international human rights experts have expressed explicit concern that civil statutes that allow detention of pregnant women in order to prevent future substance use may result in arbitrary detention. In October 2016, at the conclusion of its official fact-finding visit to the United States, the U.N. Working Group on Arbitrary Detention highlighted the increasing use of civil laws that allow for the confinement and forced medical treatment of pregnant women suspected of substance

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<sup>77</sup> The statutory scheme under Wisconsin Act 292 authorizes both law enforcement offices and others to take pregnant women into custody if, in that individual’s judgment, the unborn child is at substantial risk of significant physical harm at birth because of the mother’s habitual lack of self-control. *See, e.g.*, WIS. STAT. § 48.08(3) (authorizing anybody designated by the court to provide intake or dispositional services to act as a police officer or sheriff for the purpose of taking a pregnant woman into custody); *see also* WIS. STAT. § 48.193(1)(d)(2) (authorizing a law enforcement officers to take a pregnant woman into physical custody if they believe on reasonable grounds that this action is necessary to prevent an unborn child from being substantially physically harmed at birth). Other states mandate that certain professionals report pregnant women who are using substances and also allow any person to make voluntary reports. MINN. STAT. § 626.5561(1)(a) and (c) (2016) (mandating reports from certain professionals and allowing “[a]ny person may make a voluntary report” where the professional or the person “knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy”); N.D. CENT. CODE ANN. § 50-25.1-16(1) and (2) (West 2016) (authorizing mandatory and voluntary reporting of where there is knowledge or reasonable cause to suspect a woman is pregnant and “using controlled substances for a non-medical purpose during pregnancy.”); N.D. CENT. CODE ANN. § 50-25.1-18 (West 2016) (stating that a woman may be subjected to reporting if she has “abused alcohol after [she] knows of a pregnancy”).

<sup>78</sup> WIS. STAT. § 48.205(1m) (2016).

<sup>79</sup> *Loertscher*, *supra* note 2, at 911.

<sup>80</sup> *Loertscher* was not even present at the hearing at which temporary physical custody was ordered. *Id.* at 910-11.

<sup>81</sup> WIS. STAT. § 48.23(2m) (2016).

<sup>82</sup> WIS. STAT. §§ 48.30 (1) & (2), 48.305 (2016).

<sup>83</sup> *Loertscher*, *supra* note 2, at 919.

abuse, including Wisconsin Act 292.<sup>84</sup> It specifically expressed concern about key aspects of laws like Act 292, including the fact that the laws remove women “from their homes, families and employment” pursuant to procedures that “lack meaningful standards and provide few procedural protections” and “may take place without the mother having legal representation.”<sup>85</sup> The Working Group emphasized that statutory schemes such as Act 292 “should be replaced with alternative measures that protect women without jeopardizing their liberty.”<sup>86</sup> At the conclusion of its visit, the Working Group recommended that the U.S. ensure that any confinement of pregnant women takes place voluntarily and provides essential due process guarantees.<sup>87</sup>

## B. Prohibitions on Forced Medical Treatment

The *Loertscher* District Court found that coerced medical treatment implicates constitutionally protected liberty interests in privacy and bodily autonomy.<sup>88</sup> International human rights standards also recognize that forced medical treatment violates an individual’s liberty interests in privacy and bodily integrity.

The right to personal integrity is a key concept of human rights law that is protected both by explicit provisions in human rights treaties and underlying principles of human rights, closely linked with human dignity.<sup>89</sup> Bodily autonomy and personal integrity, including informed consent for medical treatment, are protected under multiple provisions of human rights treaties, including the right to privacy, the right to health, and the right to be free from torture and cruel, inhuman and degrading treatment (“CIDT”).<sup>90</sup> In particular, the right to privacy and the right to be free from torture and CIDT are protected by Articles 7 and 17(1) of the ICCPR and Article 16 of CAT. Regional human rights treaties also specifically guarantee these rights.<sup>91</sup>

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<sup>84</sup> U.N. Working Group on Arbitrary Detention, *Report of the Working Group on Arbitrary Detention on its visit to the United States of America*, ¶ 72, U.N. Doc. A/HRC/36/37/Add.2 (July 17, 2017).

<sup>85</sup> *Id.* ¶¶ 73, 74.

<sup>86</sup> WGAD, *Preliminary Findings on U.S.*, *supra* note 68.

<sup>87</sup> U.N. Working Group on Arbitrary Detention, *Report of the Working Group on Arbitrary Detention on its visit to the United States of America*, ¶ 94(b), U.N. Doc. A/HRC/36/37/Add.2 (July 17, 2017). Similarly, a recent report by Amnesty International examining the unique forms of regulation imposed on pregnant women suspected of substance abuse in the U.S. concluded that, rather than promoting the health and rights of pregnant women, forced state intervention violates women’s human rights and are a mistaken legal response to address individual and public health issues. AMNESTY INTERNATIONAL, *supra* note 51.

<sup>88</sup> *Loertscher*, *supra* note 2, at \*10. *See also* *United States v. Husband*, 226 F.3d 626, 632 (7th Cir. 2000) (noting that “[b]ecause any medical procedure implicates an individual’s liberty interests in personal privacy and bodily integrity, the Supreme Court has indicated that there is a “general liberty interest in refusing medical treatment”) (quoting *Cruzan v. Dir., Mi. Dep’t of Health*, 497 U.S. 261, 278 (1990)).

<sup>89</sup> For instance, the European Court of Human Rights describes “respect for human dignity and human freedom and the notions of self-determination and personal autonomy” as the “very essence” of the European Convention on Human Rights. *Jehovah’s Witnesses of Moscow v. Russia*, App. No. 302/02 Eur. Ct. H.R. at ¶ 135 (2010).

<sup>90</sup> Because of the relationship between physical integrity and torture and CIDT, the American Convention on Human Rights contains provisions on physical integrity and torture and CIDT in the same article:

Art. 5(1): “Every person has the right to have his physical, mental or moral integrity respected.”

Art. 5(2): “No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment.”

American Convention on Human Rights, *supra* note 51, at art. 5.

<sup>91</sup> *See* European Convention for the Protection of Human Rights and Fundamental Freedoms, arts. 3, 8, *as amended by* Protocols Nos. 11 and 14, Nov. 4, 1950, ETS 5 [hereinafter European Convention on Human Rights] (prohibiting

Because the right to decide whether to undergo medical treatment goes to the heart of privacy and bodily integrity,<sup>92</sup> human rights law prohibits forced medical interventions and requires informed consent for medical treatment, with very narrow exceptions. Thus, ICCPR, Art. 7 explicitly prohibits nonconsensual medical experimentation, and the U.N. Human Rights Committee has repeatedly recognized that nonconsensual medical treatment violates the ICCPR.<sup>93</sup> Cases decided by the European Court of Human Rights and the Inter-American Court of Human Rights have also held that forced medical treatment violates the right to privacy and to be free from torture and CIDT,<sup>94</sup> and that informed consent is essential to respect a patient’s autonomy and dignity.<sup>95</sup> International

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torture and CIDT in Article 3, addressing privacy and family life in Article 8); *see also* American Convention on Human Rights, *supra* note 46, at arts. 5, 11 (addressing personal integrity in Article 5 and granting a right to privacy in Article 11)). The U.S. has signed (though not yet ratified) the ICESCR and CEDAW, two human rights treaties that recognize the right to health, including a right to autonomous health care decisions. ICESCR, *supra* note 45, at art. 12; CEDAW, *supra* note 44, at art. 12; *see also* U.N. Comm. on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, ¶ 8, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, GC 14] (stating that right to health includes “the right to control one’s health and body . . . and the right to be free from interference, such as the right to be free from . . . non-consensual medical treatment . . .”); U.N. Comm. on Economic, Social and Cultural Rights, *General Comment 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 10, U.N. Doc. E/C.12/GC/22 (May 2, 2016); U.N. Comm. on the Elimination of Discrimination Against Women, *General Recommendation 24: Article 12 of the Convention (Women and Health)*, ¶ 31(e), U.N. Doc. A/54/38/Rev.1 (1999) [hereinafter CEDAW, GR 24] (stating that women’s health services must respect the “rights to autonomy, privacy, confidentiality, informed consent and choice”).

<sup>92</sup> The U.N. Special Rapporteur on Health has explained that “guaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity.” Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, ¶ 18, U.N. Doc. A/64/272 (Aug. 10, 2009) [hereinafter SR on Health, Informed Consent Report], *see also* Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 28, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) [hereinafter SR on Torture Health Care Settings Report] (“Guaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services. . .”).

<sup>93</sup> U.N. Human Rights Comm., *Concluding Observations of the Fourth Periodic Report of France*, ¶ 20, U.N. Doc. CCPR/C/FRA/CO/4 (Aug. 17, 2015) (stating that DNA testing should be subject to informed consent); U.N. Human Rights Committee, *Concluding Observations on the Third Periodic Report of Latvia*, ¶ 16, U.N. Doc. CCPR/C/LVA/CO/3 (Apr. 11, 2014) (expressing concern about forced medication in high dosages for adults with mental disabilities); Human Rights Comm., *Concluding Observations on the Fourth Periodic Report of Ireland*, ¶ 11, U.N. Doc. CCPR/C/IRL/CO/4 (Aug. 19, 2014) (expressing concern about performance of symphysiotomy on women without their free and informed consent); Human Rights Committee, *Concluding Observations on the Sixth Periodic Report of Spain*, ¶ 10, U.N. Doc. CCPR/C/ESP/CO/6 (Aug. 14, 2015) (expressing concern about forced sterilization of persons with disabilities).

<sup>94</sup> *See, e.g.*, *I.V. v. Bolivia*, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (ser. A) No. 329 ¶¶ 256, 270 (Nov. 30, 2016) (holding forced sterilization violates the right to personal integrity, privacy and to be free from torture or cruel, human and degrading treatment under American Convention on Human Rights, Arts. 5.1, 5.2 and 1); *V.C. v. Slovakia*, App. No. 18968/07, Eur. Ct. H.R. ¶¶ 120, 155 (Feb. 8, 2012) (holding forced sterilization violates European Convention on Human Rights, Arts. 3 and 8); *G.B. v. Moldova*, App. No. 16761/09, Eur. Ct. H.R. ¶ 29 (1999) (administering medical treatment against patient’s will interferes with rights under European Convention on Human Rights, Art. 8).

<sup>95</sup> *I.V. v. Bolivia*, *supra* note 94, ¶ 159; *Jehovah’s Witnesses of Moscow v. Russia*, *supra* note 89, at ¶ 136 (stating that “The freedom to accept or refuse specific medical treatment, or to select an alternative form of treatment, is vital to principles of self-determination and personal autonomy”).

treaties and consensus documents on bioethics similarly recognize that human dignity, integrity, and personal autonomy require informed consent for any medical intervention.<sup>96</sup>

Human rights bodies and international health experts have also explicitly found that forced drug treatment violates human rights. The U.N. Special Rapporteur on Torture has stated that “subjecting persons to [drug] treatment or testing without their consent may constitute a violation of the right to physical integrity.”<sup>97</sup> World Health Organization (WHO) guidelines require that drug treatment should not be compulsory and should only be undertaken with informed consent.<sup>98</sup> The U.N. Special Rapporteur on Health has emphasized that compulsory testing for purposes of drug treatment is counter-productive and that drug dependence should be treated like other health care conditions.<sup>99</sup> Pregnancy does not change or diminish a woman’s right to be free from forced drug treatment. Indeed, the WHO’s guidelines on the identification and management of substance use in pregnancy requires prioritizing prevention, ensuring access to affordable prevention and treatment services, respecting patient autonomy, and safeguarding against discrimination and stigmatization.<sup>100</sup>

Given the importance of the right to bodily integrity and privacy, forced medical interventions are only justified under human rights law in very limited circumstances. ICCPR, Art. 17 protects against “arbitrary or unlawful interference” with the right to privacy. The Human Rights Committee has emphasized that any state interference with an individual’s privacy must be consistent with the “aims and objectives” of the ICCPR and “reasonable in the particular circumstances.”<sup>101</sup> Similarly, Art. 8 of the European Convention on Human Rights provides that interference with the right to privacy is only justified if it is “in accordance with the law” and “necessary in a democratic society [including] for the protection of health or morals.”<sup>102</sup> According to the European Court of Human Rights, necessity implies “interference that corresponds to a pressing social need and . . . is proportionate to the legitimate aim pursued.”<sup>103</sup> In addition, because of the importance of personal integrity and

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<sup>96</sup> The Universal Declaration on Bioethics and Human Rights, Article 6 provides that “Any preventative, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information.” UNESCO, *Universal Declaration on Bioethics and Human Rights* arts. 2(c), 3, 5 (2005). Similarly, the Convention on Human Rights, Biology and Medicine, Art. 5 states that “Any intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.” Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, art. 1, 4 ETS 164 (Jan. 12, 1999) [hereinafter Convention on Human Rights, Biology and Medicine].

<sup>97</sup> Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/HRC/10/44, ¶ 71 (Jan. 14, 2009) [hereinafter SR on Torture Drug Treatment Report].

<sup>98</sup> World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, pp. 9, 15. (2009)

<sup>99</sup> See SR on Health, Informed Consent Report, *supra* note 92, at ¶ 32.

<sup>100</sup> World Health Organization, *Guidelines for the identification and management of substance use and substance use disorders in pregnancy* (2014), <http://bit.ly/2ejmU2A>.

<sup>101</sup> U.N. Human Rights Committee, *General Comment No 16: Article 17 “The Right to Privacy”*, ¶ 4, U.N. Doc. INT/CCPR/CEC/662.E (1988) [hereinafter HRC, GC 16].

<sup>102</sup> European Convention on Human Rights and Fundamental Freedoms, art. 8, *as amended by protocols Nos. 11 and 14*, Nov. 4, 1950, ETS 5.

<sup>103</sup> *Pretty v. United Kingdom*, App. No. 2346/02, ¶ 70, Eur. Ct. H.R. (Apr. 29, 2002); *V.C. v. Slovakia*, *supra* note 94 at ¶ 139.



bodily autonomy, the European Court of Human Rights has made clear that due process protections must be provided.<sup>104</sup>

Medical treatment without consent cannot be justified even if authorities view treatment as being in the patient's best interests. In *Jehovah's Witnesses of Moscow v. Russia*, the European Court of Human Rights rejected an argument that a ban on the activities of Jehovah's Witnesses was justified because of the group's adherence to religious beliefs that prohibited blood transfusions. The court emphasized that for freedom to make one's medical decisions to be meaningful, "patients must have the right to make choices that accord with their own views and values, regardless of how irrational, unwise or imprudent such choices may appear to others."<sup>105</sup> The court stated that:

In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably lead to a fatal outcome, yet the imposition of medical treatment, with the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging [the right to privacy].<sup>106</sup>

To the extent that a state claims an interest in the health of an "unborn child" separate from the pregnant woman, civil confinement laws such as Wisconsin Act 292 are neither reasonable nor proportionate measures to protect that interest and do not provide adequate due process protection. As a threshold matter, and as explained more fully, *infra*, from both a rights and public health perspective, fetal interests cannot be separated from the interests of the women who carry them.<sup>107</sup> Moreover, the U.N. Special Rapporteur on Health has stated that in the public health context, "[a]ny limitations of informed consent must be substantiated by scientific evidence and implemented with participation, transparency and accountability to the principles of gradualism and proportionality."<sup>108</sup> As discussed in the prior section, Wisconsin, Act 292 is not a reasonable or proportionate approach to further the state's purported goals of promoting maternal and fetal health. The Act is not substantiated by scientific evidence and does not require expert testimony in specific cases. The statute creates a presumption that all women who use drugs have a substance use disorder, and that inpatient treatment is the most effective means of addressing it. Further, the Act is not reasonable because rather than promoting healthy pregnancies it is likely to have the opposite effect since women will be deterred from seeking prenatal care and drug treatment and because it fails to provide alternative, less coercive means to promote its objectives.

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<sup>104</sup> V.C. v. Slovakia, *supra* note 94 at ¶141.

<sup>105</sup> *Jehovah's Witnesses v. Russia*, *supra* note 89 at ¶ 135. Although this case only involved evidence of adults' refusal of blood transfusions, a state law designed to protect a minor's health would be distinguishable from the instant situation for a number of reasons, including: 1) it would involve a separate person (as opposed to a fetus) and 2) overriding a mother's choice not to consent to treatment for a minor does not infringe upon her own bodily integrity. *See also* V.C. v. Slovakia, *supra* note 94 at ¶ 105.

<sup>106</sup> *Jehovah's Witnesses v. Russia*, *supra* note 89 at ¶ 135.

<sup>107</sup> *See* CTR. FOR REPRODUCTIVE RIGHTS, *supra* note 51; *see also* text and accompanying notes 121-123, *infra*.

<sup>108</sup> SR on Health, Informed Consent Report, *supra* note 92 at ¶ 31.

### C. Right to Confidentiality of Medical Records

Women have a reasonable expectation of privacy in their medical information, and the Fourth Amendment protects the right to be free from nonconsensual searches without a valid warrant.<sup>109</sup> Human rights law and international standards, too, support a patient's right to maintain the confidentiality of medical information.

The World Medical Association's Declaration of Lisbon on the Rights of the Patient requires that "all identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death."<sup>110</sup> The right to confidential personal information is protected by the right to privacy under ICCPR Art. 17(1).<sup>111</sup> The Human Rights Committee has specifically criticized laws that require doctors to report medical information about women, such as information regarding whether they have undergone abortions.<sup>112</sup>

In addition to privacy concerns, human rights norms recognize that medical confidentiality is an important component of the right to health because failure to protect patient confidentiality adversely affects patient health and well-being.<sup>113</sup> The Special Rapporteur on Health has noted that "lack of confidentiality may deter individuals from seeking advice and treatment, thereby jeopardizing their health and well-being."<sup>114</sup>

Civil confinement laws allowing for the detention of pregnant women suspected of substance abuse violate these core human rights protections. Again, the facts of the *Loertscher* case are instructive. When Loertscher was sent to the Mayo Clinic hospital by the county health service to confirm her pregnancy and receive medical care, unbeknownst to her, the medical staff also conducted a drug test. Subsequently, without Loertscher's consent, hospital staff informed the authorities of her pregnancy and positive test for controlled substances, which was used as evidence against her to obtain a court order to detain her and force her into a drug treatment program.<sup>115</sup> The county health service then obtained medical records from the clinic, and an obstetrician testified about Loertscher's confidential health information without her consent.<sup>116</sup> These facts illustrate the ways in which confidentiality is violated by the civil confinement laws targeting pregnant women suspected of substance abuse.

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<sup>109</sup> *Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001); *Denius v. Dunlap*, 209 F.3d 944, 956 (7th Cir. 2000).

<sup>110</sup> World Medical Association, *Declaration of Lisbon on the Rights of the Patient, as revised in 2005 and reaffirmed in 2015*, ¶ 8.

<sup>111</sup> HRC, GC 16, *supra* note 101 at ¶ 7.

<sup>112</sup> HRC, GC 28, *supra* note 52 at ¶ 20.

<sup>113</sup> *See* CESCR, GC 14, *supra* note 91 at ¶ 12(c) ("All health facilities, goods and services must be . . . designed to respect confidentiality.").

<sup>114</sup> SR on Health, Informed Consent Report, *supra* note 92 at ¶ 40.

<sup>115</sup> *Loertscher*, *supra* note 2 at 909.

<sup>116</sup> *Id.* at 911.

## D. Women’s Rights to Equal Enjoyment of Fundamental Rights and Non-Discrimination

Rather than respecting the dignity, liberty, privacy, and rights to personal integrity of women, civil confinement laws such as Act 292 impose a unique burden on these rights because of women’s capacity to become pregnant and because of stereotypical ideas surrounding women’s ability to make their own health care decisions. These discriminatory attitudes result in state laws and policies that violate women’s fundamental rights to liberty, privacy, and personal integrity and may also give rise to equal protection violations based on gender discrimination.

The U.N. Working Group on Arbitrary Detention has described civil laws that detain pregnant women as a “form of deprivation of liberty [that] is gendered and discriminatory . . . , as pregnancy combined with the presumption of drug or other substance abuse, is the determining factor for involuntary treatment.”<sup>117</sup> U.N. human rights bodies and experts have repeatedly warned that gender discrimination—and in particular stereotyped views about women—can lead to violations of a woman’s rights to make autonomous health decisions and to have the confidentiality of her health information respected.<sup>118</sup> They have cautioned that this is particularly the case in reproductive health contexts<sup>119</sup> and emphasized that a woman seeking health care “is entitled to be treated as an individual in her own right, the sole beneficiary of the service provided by the health-care practitioner and fully competent to make decisions concerning her own health.”<sup>120</sup>

The likelihood of rights violations increases when states adopt the view that fetal interests can be separated from the interests of the women who carry them. This view is flawed from both a rights and public health perspective.<sup>121</sup> The Special Rapporteur on Health has expressed concern that pregnant women can be improperly denied full autonomy in health care settings when states purport to be acting in “the best interests of the unborn child.”<sup>122</sup> Rather than assuming a conflict between a pregnant woman and her fetus, the Special Rapporteur recommends that health care initiatives

<sup>117</sup> Report of the Working Group on Arbitrary Detention on its visit to the United States of America, U.N. Doc. A/HRC/36/37/Add.2 (July 17, 2017), ¶ 74.

<sup>118</sup> Committee on the Elimination of Discrimination Against Women, *General Recommendation 34: On the Rights of Rural Women*, ¶¶ 22, 31(e), U.N. Doc. CEDAW/C/GC/32 (Mar. 4, 2016); see also HRC, GC 28, *supra* note 52 at ¶ 20; see also SR on Health, Informed Consent Report, *supra* note 92 at ¶ 54 (“Gender inequities reinforced by political, economic and social structures result in women being routinely coerced and denied information and autonomy in the health-setting”).

<sup>119</sup> HRC, GC 28, *supra* note 52 at ¶20 (expressing concern about spousal authorization laws, requirements that women have a certain number of children before sterilization, and laws requiring doctors to report abortions).

<sup>120</sup> U.N. Working Group on the issue of discrimination against women in law and practice, *Rep. of the Working Group on the issue of discrimination against women in law and practice*, U.N. Doc. A/HRC/32/44, ¶ 86 (Apr. 8, 2016).

<sup>121</sup> See American College of Obstetricians & Gynecologists, *Refusal of Medically Recommended Treatment During Pregnancy*, ACOG Comm. Op., No. 664 (June 2016) (citing H. Minkoff & M.F. Marshal, *Fetal Risks, Relative Risks, and Relatives’ Risks*, 16 AM. J. BIOETHICS 3 (2016) (stating that “questions of how to care for [a] fetus cannot be viewed as a simple ratio of maternal and fetal risks but should account for the need to respects fundamental values, such as the pregnant woman’s autonomy and control over her body”); Lisa H. Harris, *Rethinking Maternal-Fetal Conflict: Gender and Equality in Perinatal Ethics*, 96 OBSTETRICS & GYNECOLOGY 786 (2000) (stating that “clinically sound medical practices focus on the mutual interests of pregnant women and their fetuses”).

<sup>122</sup> SR on Health, Informed Consent Report, *supra* note 92 at ¶ 54.

designed to protect fetal health emphasize counseling and support services to “mitigate restrictions of autonomous decision-making of the woman and any potential harmful effects to the child.”<sup>123</sup>

Human rights law also emphasizes that pregnant women must have appropriate health care services and be treated with dignity.<sup>124</sup> For example, human rights bodies prohibit solitary confinement of pregnant women.<sup>125</sup> Yet, rather than promoting pregnant women’s access to health care, civil commitment laws undermine women’s access to prenatal care, by creating a strong disincentive for pregnant women who have used alcohol or controlled substances to seek medical care, and result in punitive and coercive treatment that violates pregnant women’s right to be treated with dignity and respect for their humanity. The *Loertscher* case illustrates how such laws are counter-productive and are implemented in a manner that imposes real harm on women and their pregnancies. Rather than supporting Loertscher’s efforts to have a healthy pregnancy by offering access to appropriate non-coercive, out-patient services, Wisconsin ordered her into the most restrictive treatment option, an inpatient drug treatment facility which would have required her to leave her home and family during her pregnancy. When Loertscher refused to report to the inpatient facility, a court ordered that she serve 30 days in jail. While in jail she was placed in solitary confinement and denied access to prenatal care.

## Conclusion

Civil commitment laws authorizing states to detain pregnant women to prevent future substance use improperly and unconstitutionally restrict a woman’s right to liberty, privacy, personal autonomy, and non-discrimination. Detention and forced treatment have real world consequences on pregnant women who are forced to leave their homes, families, and jobs, and thus are also deprived of family and community support and the ability to earn a livelihood.

Under human rights law, any involuntary detention and forced medical treatment scheme must be necessary, reasonable, proportionate, imposed as a last resort, and satisfy due process. Because involuntary detention and forced treatment are inconsistent with the stated goal of promoting maternal and fetal health, statutes such as Wisconsin Act 292 are *per se* unnecessary and unreasonable. To the extent that a state claims it seeks to promote maternal and fetal health, human rights law emphasizes that the state must provide pregnant women with adequate opportunities and resources to obtain appropriate voluntary treatment prior to considering coercive methods.<sup>126</sup>

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<sup>123</sup> *Id.* at ¶ 60.

<sup>124</sup> CEDAW, *supra* note 44 at art. 12; *see also* HRC, GC 28, *supra* note 52 at ¶15.

<sup>125</sup> Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016).

<sup>126</sup> In the U.S., there is a shortage of substance abuse programs, especially outside of large urban areas. Liz Szabo, *Addiction Treatment Hard to Find, Even as Overdose Deaths Soar*, USA TODAY (May 24, 2015, 2:16 PM), <https://www.usatoday.com/story/news/2015/05/24/addiction-treatment-shortage/27181773/>. Fewer than 2,000 of the 11,000 treatment facilities listed by the Substance Abuse and Mental Health Services Administration include services for pregnant women. NAT’L COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, *Shortage of Drug Treatment for Pregnant Women Can Endanger Fetuses* (July 14, 2015), <https://www.ncadd.org/blogs/in-the-news/shortage-of-drug-treatment-for-pregnant-women-can-endanger-fetuses>.

Further, human rights standards require that pregnant women be treated with dignity and respect, and not subjected to discrimination. Rather than considering fetal interests separately from the women who carry them, human rights bodies emphasize that states seeking to promote healthy pregnancies should adopt measures that maximize maternal well-being and support autonomous health care decision-making by providing meaningful access to health care, including prenatal care and voluntary, non-coercive drug treatment and counseling. Thus, a human rights lens illuminates the fundamental rights violations resulting from Wisconsin Act 292 and other state civil confinement laws targeting pregnant women suspected of substance use.



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