NO. 2012-CA-00725

IN THE SUPREME COURT OF THE STATE OF MISSISSIPPI

STATE OF MISSISSIPPI,

Appellant,

vs.

NINA BUCKHALTER,

Appellee.

On Appeal From the Circuit Court of Lamar County

BRIEF OF *AMICUS CURIAE* THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN ACADEMY OF PEDIATRICS, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, THE NATIONAL PERINATAL ASSOCIATION, THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, THE NATIONAL ASSOCIATION OF SOCIAL WORKERS—MISSISSIPPI CHAPTER, THE NATIONAL WOMEN'S HEALTH NETWORK, IWOMANSHEALTH, THE INSTITUTE FOR HEALTH AND RECOVERY, AND THE BARON EDMOND DE ROTHSCHILD CHEMICAL DEPENDENCY INSTITUTE OF BETH ISRAEL MEDICAL CENTER

Oral Argument Not Requested

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Amici include Mississippi and national physicians, nurses, counselors, social workers, drug treatment specialists, public health practitioners, advocates for women and children's health, and their professional associations. These individuals and organizations have recognized expertise in the areas of maternal and neonatal health, and in understanding the effects of drugs and other substances on users, their families, and society.

At the outset, it must be noted that each *amicus curiae* is committed to reducing potential drug-related harms at every opportunity. Thus, *amici* do not endorse the non-medicinal use of drugs—including alcohol or tobacco—during pregnancy, by either parent. Nor do *amici* contend that there are no health risks associated with methamphetamine use during pregnancy. Nonetheless, it is entirely consistent with *amici's* public health and ethical mandates to bring to this Court's attention the relevant medical and scientific information—none of which supports the prosecution of Ms. Buckhalter for manslaughter.

Amici join this brief because Ms. Buckhalter's prosecution cannot be reconciled with evidence-based, peer-reviewed, medical and scientific research, or with the clear and explicit language of Mississippi law.

SUMMARY OF ARGUMENT

Nina Buckhalter experienced a stillbirth in approximately her 31st week of pregnancy. Ms. Buckhalter also had a drug problem. The decision to prosecute her for culpable negligent manslaughter because she attempted to continue her pregnancy to term is unsupported by law or public policy. Indeed, the lower court dismissed the indictment against Ms. Buckhalter on the ground that the Mississippi legislature did not intend to criminalize pregnant women whose drug use results in harm or injury to an unborn fetus. This Court should deny the State of Mississippi's Appeal of that order. To do otherwise would be contrary to the plain language and meaning of

the State's manslaughter statute, undermine legislative intent, usurp the legislative function, require the court to radically rewrite and expand the State's manslaughter law, and cause considerable fear and confusion among health professionals and their pregnant patients. This prosecution jeopardizes the well-being of women and their children.

Amici believe there is a strong societal interest in protecting the health of children. In the view of *amici*, however, such protective instincts are *undermined*, not advanced, by prosecuting pregnant women who experience pregnancy losses that may have been caused by a vast range of conditions, circumstances, and actions they may experience during pregnancy. Indeed, the policy of prosecuting pregnant women with drug dependency or other health problems is contrary to law, scientific research, and the consensus judgment of medical practitioners and their professional organizations.

This amicus brief underscores the fact that the prosecution of Ms. Buckhalter lacks any legal, medical, or scientific foundation. Interpreting Mississippi's manslaughter statute to apply to the context of pregnancy will lead to absurd and dangerous public health consequences. Moreover, treating an addiction as evidence of culpable negligence lacks foundation in medicine and science.

Such prosecutions deter pregnant women from seeking prenatal care and drug and alcohol treatment. And they create a disincentive for pregnant women who do seek medical care from disclosing important information about drug use to health care providers out of fear that the disclosure will lead to possible criminal sanctions.

Prosecuting women for continuing to term despite a drug addiction encourages them to terminate wanted pregnancies to avoid criminal penalties. The State could not have intended this result when it adopted the manslaughter statute.

Finally, this prosecution reflects a basic misunderstanding of the nature of drug dependency. The medical community has long recognized that addiction is not a crime but a medical condition that can respond successfully to treatment.

ARGUMENT

I. THIS PROSECUTION IS NOT SUBSTANTIATED BY SCIENCE.

The prosecution of women such as Ms. Buckhalter under the manslaughter statute is a threat to every pregnant woman and child in Mississippi. Science has yet to provide the tools to determine the cause of many stillbirths, and, in any event, those causes are likely beyond any woman's control, and should not be the basis for criminal prosecution. Moreover, science has failed to prove that in utero exposure to illegal drugs causes unique harms to a fetus distinguishable from those caused by other uncontrollable factors.

A. Stillbirths Are a Common Adverse Effect of Pregnancy and the Causes Are Not Fully Understood.

The causes of stillbirth are often entirely unknown. Stillbirths affect tens of thousands of women in the United States each year.[1] In Mississippi in 2011, there were as many as 402 *reported* cases of stillbirth.[2] A wide range of medical conditions and environmental factors are believed to contribute to stillbirth. Nevertheless, a small but significant number of pregnancies result in unexplained pregnancy loss. These inexplicable outcomes account for approximately ten to even fifty percent of all stillbirths.[3]

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[1] R.L. Goldenberg et al., *Stillbirth: A Review*, 16 Journal of Maternal-Fetal & Neonatal Medicine 79, 79 (2004) ("[S]tillbirth is one of the most common adverse outcomes of pregnancy . . . [I]n the year 2000, there were nearly 27,000 of these events.").

[2] Mississippi State Department of Health, *Mississippi Vital Statistics 2011*, at pg. 19, *available at* http://msdh.ms.gov/phs/2011/Bulletin/vr2011.pdf.

[3] F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 1073, 1075 (21st ed. 2001); *see also* M.A. Sims & K.A. Collins, *Fetal Death: A 10-Year Retrospective Study*, 22 Am. J. Forensic Med. & Pathology 261 (2001) ("Despite efforts to identify the etiologic factors contributing to fetal death, a substantial portion of fetal deaths are still classified as unexplained intrauterine fetal demise."); SHARE Pregnancy & Infant Loss Support, Inc., *Report on Stillbirth Workshop at the National Institute of Health* (April 2001), *available at* http://www.nationalshareoffice.com/about_research_sb_research.shtml (discussing the

Indeed, many people wrongly believe that women have a high degree of control over their pregnancy outcomes.[4] The longstanding and constant medical reality, however, is that as many as 20-30 percent of all pregnancies will end in miscarriage or stillbirth.[5] In fact, stillbirth is one of the most common adverse outcomes of pregnancy,[6] and it occurs despite the best intentions and precautions taken by women and their doctors.

The medical community agrees that the causes of stillbirth are not fully understood.[7] As a recent article states: "In many cases it is difficult to be certain of the etiology of stillbirth. First, many cases are unexplained, despite intensive investigation of potential causes. Second, more than one condition may contribute to stillbirth in an individual case."[8] Moreover, "it may not be possible to precisely determine which disorder was directly responsible for the loss. Indeed, it is likely that some cases of stillbirth are due to complications from multiple factors. Finally, conditions may be *associated* with stillbirth without directly *causing* them."[9]

Accordingly, experts warn that "the associations between exposures and stillbirth should be viewed with caution."[10] There are many alternative explanations for stillbirth, which include

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possibility that the cause of death for up to 50 percent of stillbirths is undetermined).

[4] *See, e.g.*, A. EISENBERG ET. AL., WHAT TO EXPECT WHEN YOU'RE EXPECTING 54-57 (2d ed. 1996) (popular pregnancy advice book warning women to avoid contact with anyone who is smoking, to avoid changing a cat litter box, consuming unpasteurized cheese or undercooked meat, gardening without gloves, inhaling when handling household cleaning products, and ingesting caffeine).

[5] C. Malacrida, *Complicating Mourning: The Social Economy of Perinatal Death*, 9(4) Qualitative Health Research 504, 505 (July 1999).

[6] Goldenberg et al., *supra* note 1, at 79.

[7] Laurie Barclay, *ACOG Issues Guidelines for Stillbirth Management*, 113 Obstetrics & Gynecology 748-761 (2009) ("... we have a long way to go before we have a clearer understanding of the causes of stillbirth . . . .") (quoting Ruth C. Fretts, MD, from Harvard Vanguard Medical Associates and Harvard Medical School in Boston, Massachusetts, who assisted in the development of ACOG's new practice bulletin).

[8] R.M. Silver et al., *Work-Up of Stillbirth: A Review of the Evidence*, 196(5) Am. J. of Obstetrics & Gynecology, 433-44 (2007).

[9] *Id.* (emphasis added); *see also* Cunningham, *supra* note 3, at 1073-75 (noting substantial percentage of perinatal deaths are unexplained).

[10] C. Stanton et al., *Stillbirth Rates: Delivering Estimates in 190 Countries*, 367 Lancet 1487-94 (2006) ("Data for the causes of stillbirth, especially largely preventable causes such as syphilis, are needed to prioritize action and reduce stillbirths. However, even in settings with the possibility of extensive investigation, the cause of death might not be established in a third of stillbirths.").

age, race, and socioeconomic factors,[11] hypertension, diabetes, thrombophilia, infections, maternal smoking,[12] paternal smoking, paternal workplace exposure to ionizing radiation, exposure to pain medications, and poverty.[13] Ultimately, Ms. Buckhalter is being prosecuted for *manslaughter* for an act that the State cannot prove caused the stillbirth.

B. Science Has Failed to Prove That In Utero Exposure to Illegal Drugs Causes Unique Harms to a Fetus.

In spite of myths and misconceptions, science has failed to prove that in utero exposure to illegal drugs, such as methamphetamine, causes unique harms distinguishable from those caused by other uncontrollable factors. In 2005, a national expert panel reviewed published studies about the developmental effects of prenatal exposure to methamphetamine and related drugs and concluded that, "the data regarding illicit methamphetamine are insufficient to draw conclusions concerning developmental toxicity in humans."[14] In that same year more than 90 leading medical

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[11] Barclay, *supra* note 7, at 748-761 ("Risk factors for stillbirth include non-Hispanic black race, with a stillbirth rate of 11.25 per 1000 births in this group, vs less than 6 per 1000 in Hispanic, Asian, American Indian, and white women. Greater prevalence of diabetes, hypertension, placental abruption, and premature rupture of membranes in black women may help explain this disparity . . . Non-Hispanic black race, nulliparity, advanced maternal age, and obesity are the risk factors most often associated with stillbirth.").

[12] Even among activities that are much more definitively linked to adverse pregnancy outcomes than methamphetamine/illegal drug use, such as cigarette smoking, the connection to stillbirths are complex and modest. *See* Center on Addiction and Substance Abuse, *Substance Abuse and the American Woman*, 50 (1996) (smoking during pregnancy increases infant mortality from 8.0 per 1,000 to 12.2 per 1,000); Helene M. Cole, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2666 (1990) ("Cigarette smoking may cause "spontaneous abortion, premature birth, increased infant perinatal mortality, low birth weight, and negative effects on later growth and development in infants.")

[13] *See Automobile Workers v. Johnson Controls*, 499 U.S. 187, 205 (1991) (noting that "[e]mployment late in pregnancy often imposes risks on the unborn child"); *see also Automobile Workers v. Johnson Controls*, 886 F.2d 877 (7th Cir. 1989) (Easterbrook, J., dissenting) (noting that an estimated 15 to 20 million jobs entail exposure to chemicals that pose fetal risk); P. Atkins, et al., *Drug Therapy for Hyperthyroidism in Pregnancy: Safety Issues for Mother and Fetus*, 23 Drug Safety 229 (2000); S. Khattak, et al., *Pregnancy Outcome Following Gestational Exposure to Organic Solvents: A Prospective Controlled Study*, 281 JAMA 1106-09 (1999); C. Stanton et al., *supra* note 10, at 1487-94; Silver, *supra* note 8, at 433-44; CYNTHIA DANIELS, EXPOSING MEN, THE SCIENCE AND POLITICS OF MALE REPRODUCTION 124 (Oxford University Press 2006).

[14] Center for the Evaluation of Risks to Human Reproduction, *Report of the NTP-CERHR Expert Panel on the Reproductive & Developmental Toxicity of Amphetamine and Methamphetamine*, II-189 (July 2005).

doctors, scientists, psychological researchers, and treatment specialists released an open letter warning that terms such as "meth babies" lack medical and scientific validity and should not be used.[15] The American College of Obstetricians and Gynecology's special information sheet about methamphetamine use in pregnancy notes that "the effects of maternal methamphetamine use cannot be separated from other factors" and that there "is no syndrome or disorder that can specifically be identified for babies who were exposed in utero to methamphetamine."[16]

This is not to say that prenatal exposure to illegal drugs is benign or that ongoing research may not reveal something as yet undiscovered. *Amici* recognize the State of Mississippi's interest in reducing drug-related harm. *Amici* bring the existing scientific research to the Court's attention, however, because this research contradicts many popular myths about the use of illegal drugs during pregnancy and does not support a ruling in favor of the State of Mississippi here.

II. THE PROSECUTION OF MS. BUCKHALTER UNDER THE STATE'S MANSLAUGHTER STATUTE WILL HARM THE HEALTH OF MOTHERS AND CHILDREN.

The prosecution of those who suffer stillbirths will undermine the quality and accessibility of health care for many pregnant women. Every leading medical organization and governmental body to consider this issue has concluded that responding to drug use during pregnancy through criminal sanction is likely to undermine the health of pregnant women and children.[17] This is true even if the unsupported claim of harm from exposure to drugs is true, because fear of prosecution operates as a deterrent to pursuing drug treatment, prenatal care, and

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[15] *See* David C. Lewis et al., *Meth Science Not Stigma: Open Letter to the Media*, July 25, 2005.
[16] Am. College of Obstetricians & Gynecologists, *Information about Methamphetamine Use in Pregnancy*, March 3, 2006.
[17] *See, e.g.*, Am. Med. Ass'n, *Legal Intervention During Pregnancy*, 264 JAMA 2663, 2670 (1990) (reporting AMA resolution that "[c]riminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate"); Am. Psychiatric Ass'n, *Care of Pregnant and Newly Delivered Women Addicts: Position Statement*, APA Document Reference No. 200101 (2001) (policies of prosecuting pregnant women "are likely to deter pregnant addicts from seeking either prenatal care or addiction treatment, because of fear of prosecution and/or civil commitment").

labor and delivery care, and discourages disclosure of critical medical information to health professionals.

A. This Prosecution Will Deter Drug-Dependent Pregnant Women From Seeking Health Care.

Pregnant women who face criminal sanctions will be deterred from seeking care that is critical to both their own health and the health of the fetus.[18] This prosecution could serve to deter some women from seeking prenatal care and drug and alcohol treatment altogether, by discouraging pregnant women who do seek medical treatment from disclosing critical information about their drug use to their health care providers, and by creating an incentive for women who cannot overcome their addictions in the short term of pregnancy to have abortions rather than carry the baby to term and face criminal charges.

State and national medical and public health organizations and experts unanimously condemn punitive state interventions during pregnancy because, as one public health expert observed two decades ago in the New England Journal of Medicine:

> [M]arriage of the state and medicine is likely to harm more fetuses than it helps, since many women will quite reasonably avoid physicians altogether during pregnancy if failure to follow medical advice can result in . . . involuntary confinement, or criminal charges. By protecting . . . the integrity of a voluntary doctor-patient relationship, we not only promote autonomy; we also promote the well-being of the vast majority of fetuses.[19] State law should not deter women from seeking care, whether it is prenatal care,[20] drug treatment,[21] or other general health care, all of which can help improve (but not guarantee) pregnancy outcomes.

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[18] *See, e.g.*, The Southern Legislative Conference, *Southern Reg'l Project on Infant Mortality, A Step Toward Recovery: Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women*, 6 (1993); *see also* A. Srinivasan & G. Blomquist, *Infant Mortality and Neonatal Rates: The Importance of Demographic Factors in Economic Analysis* (2002), *available at* http://gatton.uky.edu/GradStudents/srinivasan/InfantHealth.pdf (examining infant mortality in Kentucky); A. Racine et al., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 JAMA 1581, 1585-86 (1993) (finding that pregnant women who use cocaine but who have at least four prenatal care visits significantly reduce their chances of delivering low birth weight babies).

[19] G. Annas, *Protecting the Liberty of Pregnant Patients*, 316 New Eng. J. Med. 1213, 1214 (1987).

[20] Prenatal care has been found to be strongly associated with improved outcomes for children exposed to drugs in utero. *See, e.g.*, Racine et al., *supra* note 18; Edward F. Funai et al., *Compliance with Prenatal Care in Substance Abusers*, 14(5) J. Maternal Fetal Neonatal Med. 329, 329 (2003); Cynthia Chazotte et

As the American Medical Association has stated, "[p]regnant women will be likely to avoid seeking prenatal or open medical care for fear that their physician's knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment."[22] The even graver threat that a stillbirth could result in a manslaughter conviction greatly exacerbates such fears and will hinder access to vital medical care and substance abuse services for women in Mississippi.[23]

B. This Prosecution Will Deter Pregnant Women From Sharing Vital Information with Their Doctors.

If this Court allows the prosecution of Ms. Buckhalter, any pregnant Mississippian who confides in her health care provider that she has used drugs risks being charged with manslaughter if she suffers a stillbirth. Even for those women who are not deterred from seeking care, fear of prosecution is likely to discourage them from being truthful about drug use, corroding the formation of trust that is fundamental to any provider-patient relationship.

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al., *Cocaine Use During Pregnancy and Low Birth Weight: The Impact of Prenatal Care and Drug Treatment*, 19(4) Seminars in Perinatology 293, 293 (1995). Conversely, lack of prenatal care is associated with poor health outcomes for mothers and newborns. *See, e.g.*, Anthony M. Vintzileos et al., *The Impact of Prenatal Care on Neonatal Deaths in the Presence and Absence of Antenatal High-Risk Conditions*, 186(5) Am. J. of Obstetrics and Gynecology 1011, 1013 (2002); Vivian B. Faden et al., *The Relationship of Drinking and Birth Outcome in a U.S. National Sample of Expectant Mothers*, 11 Pediatric & Perinatal Epidemiology 167, 171 (1997) (finding "increased risk of adverse outcomes among mothers who had no prenatal care").

[21] The research also shows that drug treatment can be effective for pregnant women and can itself produce beneficial pregnancy outcomes. *See* Patrick J. Sweeney et al., *The Effect of Integrating Substance Abuse Treatment with Prenatal Care on Birth Outcomes*, 20(4) J. Perinatology 219, 219 (2000) (finding that neonatal outcome "is significantly improved for infants born to substance abusers who receive[d] drug treatment concurrent with prenatal care compared with those who received [prenatal care but] . . . treatment postpartum").

[22] American Medical Association Board, *Legal Intervention During Pregnancy*, *supra* note 17, at 2667; *see also* American Medical Association, *Treatment Versus Criminalization: Physician Role in Drug Addiction During Pregnancy*, Resolution 131 (1990) (resolving "that the AMA oppose[s] legislation which criminalizes maternal drug addiction").

[23] Studies of drug-dependent pregnant women have found that "fear and worry about loss of infant custody, arrest, prosecution, and incarceration for use of drugs during pregnancy" is "the[ir] primary emotional state." Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. Drug Issues 285 (2003); *see also* M.L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 Drug Alcohol Dependence 199 (1993).

A relationship of trust is critical for women because "[t]he promise of confidentiality encourages patients to disclose sensitive subjects to a physician."[24] Open communication between drug-dependent pregnant women and their doctors is especially critical.[25] The exceptionally high rates of depression among drug-dependent women mean that their prospects of successfully completing treatment depend on forming a strong "therapeutic alliance" with care providers.[26]

Courts have long viewed confidentiality as fundamental to the patient-care provider relationship. As the U.S. Supreme Court recognized, a "confidential relationship" is a necessary precondition for "successful [professional] treatment," and "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."[27] Allowing the prosecution of Ms. Buckhalter to move forward will erode this relationship, undermining maternal, fetal, and child health.

C. Prosecuting Drug-Dependent Women for Suffering a Stillbirth Discourages Women from Carrying Pregnancies to Term.

Prosecuting drug-addicted pregnant women will not only deter them from seeking treatment and confiding in their doctors, but it incentivizes abortion. The Mississippi legislature surely did not intend the manslaughter statute to have this consequence. Courts have recognized

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[24] R. Arnold et al., *Medical Ethics and Doctor/Patient Communication, in* THE MEDICAL INTERVIEW: CLINICAL CARE, EDUCATION AND RESEARCH 365 (M. Lipkin, Jr. et al. eds., 1995) (citing W. Winslade, *Confidentiality, in* ENCYCLOPEDIA OF BIOETHICS (W. T. Reich ed.)); *see also* S.H. Ebrahim & J. Gfroerer, *Pregnancy-Related Substances Use in the United States During 1996-1998*, 101(2) Obstetrics and Gynecology 374 (February 2003) ("Pregnancy-or childbirth-related contact of women with the health care system gives health care providers a unique opportunity to access women who use substances and possibly their partners to facilitate substance abuse treatment, the benefits of which extend to their infants and future pregnancies.").

[25] *See* R. Kelly et al., *The Detection & Treatment of Psychiatric Disorders and Substance Use Among Pregnant Women Cared For in Obstetrics*, 158 Am. J. Psych. 213-19 (2001).

[26] *See* Center on Addiction and Substance Abuse, *supra* note 12, at 64; C.E. Tracy & H.C. Williams, *Social Consequences of Substance Abuse Among Pregnant and Parenting Women*, 20 Pediatric Annals 548 (1991).

[27] *Jaffee v. Redmond*, 518 U.S. 1, 10, 12 (1997).

that this type of prosecution "may also unwittingly increase the incidence of abortion."[28] Although it is difficult to know how frequently abortions result from fear of prosecution, one study reported that "two-thirds of the women [surveyed] who reported using Cocaine during their pregnancies ... considered having an abortion."[29]

The adverse consequences stemming from the prosecution's interpretation of the law are severe; the criminal investigation and possible prosecution of women like Ms. Buckhalter sends a perilous message to pregnant addicts *not* to seek prenatal care or drug treatment, *not* to confide their addiction to health care professionals, and *not* to give birth with medical care—or not to carry the fetus to term. Accordingly, such prosecutions fail to serve any legitimate purpose, and undermine maternal and fetal health.

III. THIS PROSECUTION REFLECTS A MISUNDERSTANDING OF THE NATURE OF ADDICTION.

The assertion that Ms. Buckhalter's addiction is an act evincing culpable negligence is dangerously misinformed. Medical groups have long recognized "that addiction is not simply the product of a failure of individual willpower. Instead, dependency is the product of complex hereditary and environmental factors."[30] Addiction has pronounced physiological factors that heavily influence the user's behavior and affect his or her ability to cease use and seek

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[28] *See, e.g., Johnson v. State*, 602 So. 2d 1288, 1296 (Fla. 1992) ("Prosecution of pregnant women for engaging in activities harmful to their fetuses or newborns may also unwittingly increase the incidence of abortion.").

[29] *See* JEANNE FLAVIN, OUR BODIES, OUR CRIMES: THE POLICING OF WOMEN'S REPRODUCTION IN AMERICA 112 (New York University Press 2009).

[30] American Medical Association, *Proceedings of the House of Delegates: 137th Annual Meeting, Board of Trustees Report NNN* 236, 241, 247 (June 26-30, 1988); *see also* R. K. Portenoy & R. Payne, *Acute and Chronic Pain, in* SUBSTANCE ABUSE, A COMPREHENSIVE TEXTBOOK 563, 582-84 (J.H. Lowinson et al. eds., 1997) (citing AMA task force).

treatment.[31] Indeed, drug dependence has biological and genetic dimensions and cannot often be overcome without treatment.[32]

As a matter of law and medical science, addiction is marked by "compulsions not capable of management without outside help."[33] This is why the vast majority of drug-dependent people cannot simply "decide" to refrain from drug use or achieve long-term abstinence without appropriate treatment and support. Because of the compulsive nature of drug dependency, warnings or threats are unlikely to deter drug use among pregnant women; rather, such sanctions are likely to drive addicted women away from critical health care opportunities.

CONCLUSION

Because the prosecution of Nina Buckhalter for culpable negligent manslaughter is unsupported as a matter of science, is inappropriate as a matter of public health, and is unfounded as a matter of law, *amici curiae* respectfully request this Honorable Court to deny the State of Mississippi's Appeal.

Respectfully submitted:

Dated: November 13, 2012

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[31] Chaya G. Bhuvaneswar et al., *Cocaine and Opioid Use During Pregnancy: Prevalence and Management*, 10(1) Primary Care Companion Journal of Clinical Psychiatry 59–65 (2008).

[32] "Psychoactive Substance Dependence" is listed as a mental illness with specific diagnostic criteria by the American Psychiatric Association. *See* THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994); *see also Linder v. United States*, 268 U.S. 5, 18 (1925); *Robinson v. California*, 370 U.S. 660, 667 (1962).

[33] *Robinson*, 370 U.S. at 671; *see also* 42 U.S.C. § 201(q) ("'drug dependent person' means a person who is using a controlled substance . . . and who is in a state of psychic or physical dependence, or both.").

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