IN THE COURT OF APPEALS FOR HIGHLAND COUNTY, OHIO
FOURTH APPELLATE DISTRICT

Appeal from the Highland County Court of Common Pleas
Highland County, Ohio

STATE OF OHIO, Plaintiff-Appellee,	:	
	:	Case No. 12 CA 0009
vs.	:	
	:	Oral Argument Not Requested
ASTASIA CLEMONS, Defendant-Appellant.	:	

BRIEF OF AMICI CURIAE IN SUPPORT OF APPELLANT ASTASIA CLEMONS

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Table of Contents

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

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Andrew Racine et al., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 J. Am. Med. Ass'n 1581 (1993) 6, 8
Anja Huizink & Eduard Mulder, *Maternal Smoking, Drinking or Cannabis Use During Pregnancy and Neurobehavioral and Cognitive Functioning in Human Offspring*, 30 Neuroscience & Biobehavioral Revs. 1 (2005) 18
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 (2002) 8
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Brian J. Cleary et al., *Medication Use in Early Pregnancy: Prevalence and Determinants of Use in a Prospective Cohort of Women*, 19 Pharmacoepidemiology & Drug Safety 410 (2010) ... 12
Chaya G. Bhuvaneswar, MD, et al., Cocaine and Opioid Use During Pregnancy: Prevalence and Management, 10(1) Primary Care Companion J. Clinical Psychiatry 59 (2008) 21, 23
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Emmalee S. Bandstra et al., *Prenatal Drug Exposure: Infant and Toddler Outcomes*, 29 J. Addictive Diseases 245 (2010) 15
Erika Hyde Riley, et al. *Correlates of Prescription Drug Use During Pregnancy*, 14 J. Women's Health 401 (2005) 12, 13
Euni Lee et al., *National Patterns of Medication Use During Pregnancy*, 15 Pharmacoepidemiology & Drug Safety 537 (2006) 12
F. Gary Cunningham et al., *Williams Obstetrics* (22d ed. 2005) 13, 19
Gary D. Helmbrecht & Siva Thiagarajah, *Management of Addiction Disorders in Pregnancy*, 2 J. Addiction Med. 1 (2008). 16
Jeanne Flavin, *A Glass Half Full? Harm Reduction Among Pregnant Women Who Use Cocaine*, 32 J. Drug Issues 973 (2002) 9
Maria A. Morgan et al., *Management of Prescription and Nonprescription Drug Use During Pregnancy*, 23 J. Maternal-Fetal & Neonatal Med, 813 (2010), ... 11, 12
Marilyn L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 Drug Alcohol Dependence 199 (1993) 6, 7

INTERESTS OF AMICI

Amici curiae include national and international organizations and individuals[1] with recognized expertise in the areas of maternal, fetal and neonatal health, and in understanding the effects of improper drug use on users, their families, and society.

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 the use of controlled substances during pregnancy. Nonetheless, amici commitment to public health obligate them to bring to this Court's attention the relevant medical and scientific information—none of which supports the prosecution of Ms. Clemons for Corrupting Another with Drugs under O.R.C. § 2925.02(A)(1).

Amici join in this brief because Ms. Clemons's prosecution is contrary to Ohio law and cannot be reconciled with evidence-based, peer-reviewed, medical and scientific research. Amici respectfully request that this Court reverse the trial court's erroneous decision that is contrary to Ohio precedent and stop an unjustifiable expansion of the scope of the crime of Corrupting Another with Drugs, O.R.C. § 2925.02, to include women in relation to their own pregnancies, that endangers, rather than protects, pregnant women, fetuses, and children.

STATEMENT OF THE CASE

In 2011 Astasia Clemons became pregnant. She continued that pregnancy to term and gave birth to a healthy baby girl named Aniston on November 14, 2011. According to the Appellant's Brief, the baby's meconium tested positive for THC, morphine, and oxycodone (Appellant's Br. 1). While nurses allegedly observed that the baby exhibited rapid breathing and

[1] Statements of interest for each are included as an appendix. Amici will provide the Court with sources relied on in this brief upon the Court's request.

trembling upon being disturbed, no harm to the baby has ever been documented. (Appellant's Br. 1). Even so, Ms. Clemons was charged with two counts of a felony crime, Corrupting Another with Drugs, under O.R.C. § 2925.02(A)(1) and (A)(3). Ms. Clemons filed a motion to dismiss both counts: the trial court denied the motion as to the first count, O.R.C. § 2925.02(A)(1) ("By force, threat, or deception, administer to another or induce or cause another to use a controlled substance."), but dismissed the second, O.R.C. § 2925.02(A)(3) ("By any means, administer or furnish to another or induce or cause another to use a controlled substance, and thereby cause serious physical harm to the other person, or cause the other person to become drug dependent."). Ms. Clemons pleaded no contest to Corrupting Another with Drugs on April 9, 2012, and filed a notice of appeal on May 8, 2012.

SUMMARY OF THE ARGUMENT

This case presents a question of monumental importance to the health and well-being of Ohio women and their families. In essence, the trial court usurped the legislative function and judicially expanded O.R.C. § 2925.02—a provision by its terms enacted to punish drug dealers and people who coerce others to use drugs—so that it could reach any pregnant woman who uses any amount of a controlled substance, prescribed or unprescribed, legally or illegally, and carries her pregnancy to term. In so doing, the court below created new law that reaches well beyond the Legislature's clear intent evidenced in the plain language of the law and that violates Ohio Supreme Court precedent. *See State v. Gray,* 62 Ohio St.3d 514 (Ohio 1992) (holding that carrying a pregnancy to term after having ingested a controlled substance is not child endangerment under O.R.C. § 2919.22, and it is the purview of the Legislature, not the courts, to create such a crime). Indeed, Ohio has chosen to address the issue of drug use and pregnancy through its civil child welfare and public health laws. *See, e.g., In re Blackshear*, 90 Ohio St. 3d

197 (2000); O.R.C. § 3793.15 (programs concerning addicted pregnant women and their children). As a result of this judicial rewriting, the trial court has even made the law applicable to pregnant women who, under the care of a medical provider, are lawfully taking certain prescription medications. The court's decision extends the criminal law, for the first time in Ohio, to permit the prosecution and punishment of a pregnant woman in relation to her pregnancy. This has profound and detrimental implications for the health and welfare of women and their babies.

Amici seek to bring their medical and scientific expertise to this Court's analysis of the statute at issue in this case. Amici urge this Court to reverse the decision below as it is not supported by the plain language and intent of the Corrupting Another with Drugs statute. Further, the decision below is contradicted by scientific research that makes clear that controlled substances that have been criminalized cannot be singled out from innumerable other actions, inactions, and exposures that pose potential risks to a fetus or to a child once born. The decision below is contrary to the consensus judgment of medical practitioners and their professional organizations, and, finally, it would undermine individual and public health.

Amici recognize a strong societal interest in protecting the health of women, children, and families. In the view of amici, such interests are undermined, not advanced, by the judicial expansion of the Corrupting Another with Drugs law to apply to pregnant women who seek to continue their pregnancies to term despite using or being prescribe certain drugs, or having a drug problem.

The negative consequences of the expansion of the law endorsed by the trial court for pregnant women and their families are significant and far-reaching. There is no language in the Corrupting Another with Drugs statute suggesting that the Legislature intended to single out

women who are or may be pregnant for special criminal penalties related to their drug use or dependency problems. The statute makes no reference to pregnancy, pregnant women, or the unborn, *see* O.R.C. § 2925.02, nor does the definition of "person" applicable to the Drug Offenses chapter of the criminal code. *See* O.R.C. § 2925.01(A); O.R.C. § 3719.01(T). In the limited instance where the Legislature defined the term "person" to include the unborn within the criminal code, it specifically directed that the criminal code should not be used to punish pregnant women for the circumstances or outcomes of their pregnancies. *See* O.R.C. § 2901.01(B)(2)(b) (stating that the word "person" shall "in no case" be applied or construed in any section contained in Title XXIX (29) of the Revised Code—of which the crime of Corrupting Another with Drugs is a part—so as to apply to a "woman based on an act or omission of the woman that occurs while she is or was pregnant . . . .") This section necessarily informs the interpretation of O.R.C. § 2925.02 and reflects a recognition that criminally prosecuting women for the circumstances of their pregnancies—including the act of using a prescribed or unprescribed drug—leads to harmful and dangerous public health consequences.

As amici will explain in full below, public health research establishes that pregnant women are often deterred from pursuing drug treatment and prenatal care in circumstances where they fear arrest, prosecution, and possible imprisonment. The threat of criminal sanctions also creates a disincentive for pregnant women to disclose information about drug use to health care providers. Furthermore, prosecuting women for continuing their pregnancies to term despite a drug problem encourages them to terminate pregnancies to avoid criminal penalties.

Because this case presents issues critical to all pregnant women in Ohio and has broad implications for maternal, fetal, and child health, and for the proper role of courts in interpreting the law, this Court should find: (1) that O.R.C. § 2925.02, was not intended to apply to pregnant

women in relation to the fetuses they carry; and (2) that judicial interpretation of the law must be informed by evidence-based research rooted in current science.

ARGUMENT

I. The Trial Court's Decision Should Be Reversed Because it Creates Absurd and Foolish Results that Endanger Maternal, Fetal, and Child Health.

The Ohio Legislature has made plain its intent that women not be criminalized for the circumstances or outcomes of their pregnancies by passing O.R.C. § 2901.01(B)(2)(b), ensuring that the expansion of the term "person" to include the unborn would not be used to criminalize stillbirths, neonatal losses, or illness or impairment at birth.[2] This policy decision by the Legislature is consistent with the recommendations of medical and public health authorities, who warn against the negative public health consequences of applying a criminal law approach to the issue of drug use and pregnancy. And yet the prosecutor urged, and the trial court endorsed, an interpretation of the law not only contrary to the Legislature's admonition in O.R.C. §

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[2] O.R.C. § 2901.01(B)(2) provides as follows:
Notwithstanding division (B)(1)(a) of this section, in no case shall the portion of the definition of the term "person" that is set forth in division (B)(1)(a)(ii) of this section be applied or construed in any section contained in Title XXIX of the Revised Code that sets forth a criminal offense in any of the following manners:
[. . .]
(b) In a manner so that the offense is applied or is construed as applying to a woman based on an act or omission of the woman that occurs while she is or was pregnant and that results in any of the following:
(i) Her delivery of a stillborn baby;
(ii) Her causing, in any other manner, the death in utero of a viable, unborn human that she is carrying;
(iii) Her causing the death of her child who is born alive but who dies from one or more injuries that are sustained while the child is a viable, unborn human;
(iv) Her causing her child who is born alive to sustain one or more injuries while the child is a viable, unborn human;
(v) Her causing, threatening to cause, or attempting to cause, in any other manner, an injury, illness, or other physiological impairment, regardless of its duration or gravity, or a mental illness or condition, regardless of its duration or gravity, to a viable, unborn human that she is carrying.

2901.01(B)(2) that women should "in no case" be criminalized for the circumstances or outcomes of their pregnancies, but which contravenes Ohio precedent requiring that statutes be construed "to operate sensibly and not to accomplish foolish results." *State ex rel. Carna v. Teays Valley Local Sch. Dist. Bd. of Educ.*, 131 Ohio St. 3d 478, 484 (Ohio 2012) (*citing Saltsman v. Burton*, 154 Ohio St. 262, 268 (Ohio 1950)).

The trial court below ignored the plain language of the law and instead expansively rewrote state law in a way that creates a host of foolish and undesirable effects, including criminalizing use of even prescribed controlled substances, thus undermining rather than advancing fetal and maternal health.

A. Allowing the Decision Below to Stand Will Deter Drug-Dependent Pregnant Women from Seeking Health Care.

Comprehensive, early, and high-quality prenatal care is one of the most effective weapons against pregnancy complications and infant mortality, especially for women experiencing drug dependency.[3] Pregnant women who fear arrest will be deterred from seeking prenatal care.[4] The harm resulting from a mother's fear of being prosecuted is so apparent that the American College of Obstetricians and Gynecologists ("the College") Committee on Health Care for Underserved Women has called upon doctors to change policies that lead to punitive interventions.[5] As the College committee explains, "[s]eeking obstetric-gynecologic care should

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[3] Paul Moran et al., *Substance Misuse During Pregnancy: Its Effects and Treatment*, 20 Fetal & Maternal Med. Rev. 1, 16 (2009); Andrew Racine et al., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 J. Am. Med. Ass'n 1581, 1585-86 (1993) (finding that pregnant women who use cocaine but who have at least four prenatal visits significantly reduce their chances of delivering low birth weight babies).

[4] *See e.g.*, Marilyn L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 Drug Alcohol Dependence 199 (1993), *available at* ftp://senfiles.healthystartfv.org/Sort%20Literature%20Review%201990%20-%201999.Data/Poland-1993-Punishing%20pregnant%20d-2670163712/Poland-1993-Punishing%20pregnant%20d.pdf.

[5] Am. Coll. of Obstetricians & Gynecologists, Comm. On Health Care for Underserved Women,

not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing."[6] The committee also notes that "use of the legal system to address perinatal alcohol and substance abuse is inappropriate."[7]

The College committee makes clear that punitive approaches deter care and, where addiction is an issue, wrongly treat addiction as a failure of will. Instead, "[a]ddiction is a chronic, relapsing biological and behavioral disorder with genetic components [. . .] subject to medical and behavioral management in the same fashion as hypertension and diabetes."[8] If upheld, the interpretation of O.R.C. § 2925.02 adopted by the trial court will create an atmosphere of fear and uncertainty among women who have used a controlled substance, and drive women from needed drug treatment.[9]

The American Medical Association agrees that fear of prosecution is a deterrent to pursuing drug treatment and prenatal care:[10]

Committee Opinion 473 Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist, 117 Obstetrics & Gynecology 200 (2011), *available at* http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Substance_Abuse_Reporting_and_Pregnancy_The_Role_of_the_Obstetrician_Gynecologist.

[6] *Id*. at 200.

[7] *Id*. at 201.

[8] *Id*. at 200.

[9] *See e.g.*, Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. Drug Issues 285 (2003), *available at* http://www.nnvawi.org/pdfs/alo/Humphreys_barriers_substance_treatment.pdf; Poland et al., *supra* note 4; Mishka Terplan et al., *Methamphetamine Use Among Pregnant Women*, 113 Obstetrics & Gynecology 1290(2009)("Although the desire for behavioral change may be strong in pregnancy, substance-using women may be afraid to seek prenatal care out of fear of prosecution or child protection intervention. This is unfortunate, because prenatal care has shown improvement in birth outcomes, even given continued substance use."), *available at* http://journals.lww.com/greenjournal/Fulltext/2009/06000/Who_Will_be_There_When_Women_Deliver___Assuring.14.aspx.

[10] Am. Med. Ass'n Bd. of Trustees, *Legal Interventions During Pregnancy,* 264 J. Am. Med. Ass'n 2663, 2669 (1990); *See also* Am. Med. Ass'n, *Policy H-420.970: Treatment Versus Criminalization: Physician Role in Drug Addiction During Pregnancy*, 1990, *reaff'd* 2010

> Pregnant 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.[11]

Prenatal care,[12] drug treatment,[13] and other general health care have all been demonstrated to improve pregnancy outcomes whether or not a woman is able to achieve and maintain complete abstinence from her use during the short length of pregnancy.[14] The flight

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(resolving "that the AMA oppose[s] legislation which criminalizes maternal drug addiction"), *available at* http://www.ama-assn.org/resources/doc/PolicyFinder/policyfiles/HnE/H-420.970.HTM.

[11] Am. Med. Ass'n Bd. of Trustees, *supra* note 10, at 2667.

[12] Prenatal care is strongly associated with improved outcomes for children exposed to drugs in utero. Racine et al., *supra* note 3, at 1585-86 (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); 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 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); Sheri Della Grotto et al. *Patterns of Methamphetamine Use During Pregnancy: Results from the Infant Development, Environment, and Lifestyle (IDEAL) Study*, 14 Maternal Child Health J. 519 (2010), *available at* http://www.escholarship.org/uc/item/84j88256.pdf. Conversely, lack of prenatal care is associated with poor health outcomes for mothers and newborns. *See*, 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. Obstetrics & Gynecology 1011, 1013-14 (2002); Susan Hatters Friedman, Amy Heneghan & Miriam Rosenthal, *Disposition and Health Outcomes Among Infants Born to Mothers with No Prenatal Care*, 33 Child Abuse & Neglect 116 (2009).

[13] The research also shows that drug treatment can be effective for pregnant women and can produce beneficial pregnancy outcomes. *See e.g,* Patrick J. Sweeney et al., *The Effect of Integrating Substance Abuse Treatment with Prenatal Care on Birth Outcomes*, 20(4) J. Perinatology 219, 223 (2000) (finding that neonatal outcome "is significantly improved for infants born to substance abusers who receive[d] drug treatment concurrent with prenatal care.")

[14] *See* Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *Curriculum for Addiction Professionals (CAP): Level 1* ("Prenatal care is necessary for healthy pregnancies, particularly for women with alcohol or drug issues"); *see also*, Nancy C. Goler et al., *Substance Abuse Treatment Linked with Prenatal Visits Improves Perinatal Outcomes: A New Standard*, 28 J. Perinatology 597, 602 (2008) ("Women who admit to use might be more motivated to stay clean in pregnancy. However, they will only get better if they receive appropriate support that they can access without . . . stigmatization or fears of criminal investigation."), *available at* http://www.nature.com/jp/journal/v28/n9/pdf/jp200870a.pdf.

from care that would result from upholding the trial court's ruling would endanger maternal, fetal, and child health—a foolish result clearly not intended by the legislature.

B. The Expansion of the Corrupting with Drugs Law Would Operate Nonsensically by Discouraging Pregnant Women With Drug Problems from Carrying Pregnancies to Term.

When the trial court reinterpreted O.R.C. § 2925.02 to reach women who have used a controlled substance during pregnancy, it articulated no delineating principle that would limit its applicability to women who have already given birth. The threat of prosecution, whether during pregnancy or upon giving birth, will pressure pregnant women who have used a controlled substance or who are drug dependent to terminate wanted pregnancies. Courts have recognized that this type of prosecution may "unwittingly increase the incidence of abortion."[15] 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.[16] In at least one well-documented case, a North Dakota woman did obtain an abortion to avoid prosecution in circumstances similar to Ms. Clemons. *See State v. Greywind*, No. CR-92-447 (N.D. Cass County Ct. Apr. 10, 1992). In response to being charged with reckless endangerment (based on the claim that by inhaling the vapors of paint fumes, she was creating a substantial risk of serious bodily injury or death to her unborn child), Ms. Martina Greywind obtained an abortion. As a result, the prosecutor dropped the charge.[17] Nothing in O.R.C. § 2925.02 suggests that the Legislature intended to punish women for carrying their

[15] *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").

[16] *See* Jeanne Flavin, *A Glass Half Full? Harm Reduction Among Pregnant Women Who Use Cocaine*, 32 J. DRUG ISSUES 973, 985 tbl.2 (2002)

[17] *See* Motion to Dismiss With Prejudice, *State v. Greywind*, No. CR-92-447 (N.D. Cass County Ct. Apr. 10, 1992) (prosecutor sought and obtained dismissal of the endangerment charge because "[d]efendant has made it known to the State that she has terminated her pregnancy. Consequently, the controversial legal issues presented are no longer ripe for litigation.")

pregnancies to term, thereby creating incentives for abortion. Indeed, an interpretation of the law that encourages abortions would be at odds with established Ohio policy. O.R.C. § 9.041 ("It is the public policy of the state of Ohio to prefer childbirth over abortion to the extent that is constitutionally permissible.") The trial court erred in permitting this illogical and foolish result that was clearly not intended by the Legislature.

C. Allowing the Decision Below to Stand Will Lead to the Foolish Result of Deterring Pregnant Women from Sharing Vital Information with Health Care Professionals.

If this Court upholds Ms. Clemons's conviction, any pregnant woman in Ohio who confides in her health care provider that she has used drugs, risks being charged criminally, undermining the provider/patient relationship. A relationship of trust is critical for effective medical care because the promise of confidentiality encourages patients to disclose sensitive subjects to a physician.[18] Open communication between drug-dependent pregnant women and their health care providers is critical,[19] and courts have long viewed confidentiality as fundamental to this relationship.[20]

Allowing the ruling below to stand would prevent the sensible operation of the law and put Ohio criminal law directly at odds with the prevailing medical and public health recommendations regarding the treatment of pregnant drug-using women. As a result this Court should overturn the trial court's decision.

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[18] Am. Med. Ass'n, Patient Physician Relationship Topics: *Patient Confidentiality*, http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/patient-confidentiality.page# (last visited Mar. 12, 2012).

[19] *See* Rosemary H. Kelly et al., *The Detection & Treatment of Psychiatric Disorders and Substance Use Among Pregnant Women Cared for in Obstetrics*, 158 Am. J. Psych. 213 (2001), *available at* http://ajp.psychiatryonline.org/article.aspx?articleID=174591.

[20] As the United States Supreme Court recognized, a "confidential relationship" is necessary for "successful [professional] treatment," and "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment." *Jaffee v. Redmond*, 518 U.S. 1,10 (1996) (upholding confidentiality of mental health records).

D. Allowing the Decision Below to Stand Will Undermine the Sensible Operation of the Law by Making Pregnant Women Who Lawfully Take Prescribed Controlled Substances Criminals.

Judicial expansion of the Corrupting Another with Drugs law to apply to pregnant women would make women who fill certain lawful prescriptions subject to arrest. The Corrupting Another with Drugs statute criminalizes "caus[ing] another to use" *any* "controlled substance." O.R.C. § 2925.02. Many prescription medications, including drugs commonly used for pain relief during labor, are "controlled substances" under the law. *See* O.R.C. § 3719.41.

By its terms, the Corrupting Another with Drugs law does not apply to medical care providers and others who are authorized to prescribe drugs and who act in accordance with the law. *See* O.R.C. § 2925.02(B). However, the statute does not exempt pregnant women who take controlled substances, even if they are prescribed. In other words, the trial court's decision means that a pregnant woman who takes a prescribed controlled substance is administering it to "another," for whom the drug was not prescribed.

Many types of controlled substances enumerated in O.R.C. § 3719.41 are medications, including painkillers, anti-seizure drugs, and stimulants that are routinely, appropriately prescribed for patients—including pregnant women.[21] A recent survey of obstetricians and gynecologists found "that approximately a third of their pregnant patients took at least one prescription medication other than prenatal vitamins during pregnancy prior to labor."[22] The

[21] *See* Maria A. Morgan et al., *Management of Prescription and Nonprescription Drug Use During Pregnancy*, 23 J. Maternal-Fetal & Neonatal Med, 813 (2010) (noting, "Many preexisting chronic conditions require continued drug management during pregnancy, and pregnant women may develop diseases or pregnancy-related disorders that require treatment during pregnancy. Further, given that about half of pregnancies in the United States are unplanned, women may inadvertently be exposed to medications during pregnancy.").

[22] *Id.* at 815-817 (OB-Gyns reported prescribing medications to both pregnant and non-pregnant patients for the following conditions: Chlamydia, urinary tract infection, depressed mood, generalized anxiety disorder, chronic insomnia, asthma, major depressive disorder, hypertension, frequent/severe headaches, flu, and diabetes.).

survey found that overall, "OB-Gyns were more likely to recommend prescription medications for a greater number of conditions in pregnant than nonpregnant patients."[23] A survey of pregnant women showed that over half (56%) were prescribed at least one drug during pregnancy, many of which were controlled substances under both federal and state laws.[24] A study analyzing data from two national surveys that tracked all doctor visits made by pregnant women in 1999 and 2000 found that about half of all pregnant women visiting had one or more medications, including several controlled substances such as: the benzodiazepines alprazolam, triazolam, midazolam, lorazepam to treat anxiety; anti-epileptic drugs like pentobarbital and Phenobarbital; and codeine and other analgesics to treat pain.[25] Narcotic analgesics are also standard second-line treatments for pregnant women suffering severe migraine and tension headaches,[26] conditions that affect up to 18% of pregnant women.[27] In fact, hydromorphone, an opioid analgesic classified under Ohio law as a schedule II substance, O.R.C. § 3719.41

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[23] *Id*. at 817.

[24] Erika Hyde Riley, et al. *Correlates of Prescription Drug Use During Pregnancy*, 14 J. Women's Health 401, 401 (2005) (finding that 18% of pregnant women surveyed were prescribed analgesic medications, many of which are listed in schedules II-V). *See also*, Euni Lee et al., *National Patterns of Medication Use During Pregnancy*, 15 Pharmacoepidemiology & Drug Safety 537 (2006) (finding that among the medications most commonly prescribed to pregnant women were analgesic drugs); Brian J. Cleary et al., *Medication Use in Early Pregnancy: Prevalence and Determinants of Use in a Prospective Cohort of Women*, 19 Pharmacoepidemiology & Drug Safety 408, 410-411 (2010) (finding that analgesics were among the most commonly reported medications in a sample of 23,989 pregnant women, each of whom reported taking at least one medicine during their pregnancy, including other controlled substances like benzodiazepines).

[25] Lee et al., *supra* note 24, at 541.

[26] *See e.g.*, Tiffany Von Wald & Anne D. Walling, *Headache During Pregnancy: CME Review Article*, 57 Obstetrical & Gynecological Survey 179, 181 (2002); Rukmini Menon & Cheryl D. Bushnell, *Headache and Pregnancy*, 14 The Neurologist 108, 115 (2008), *available at* http://www.neurologia.org.mx/portalweb/documentos/reunion_anual/2.pdf; Stephen A. Contag et al., *Migraine During Pregnancy: Is it More Than a Headache?*, 5 Nature Revs.: Neurology 449 (2009), *available at* http://www.nature.com/nrneurol/journal/v5/n8/pdf/nrneurol.2009.100.pdf.

[27] Contag et al., *supra* note 26, at 454.

Schedule II (A)(1)(k), is "considered relatively safe in pregnancy" by neurologists to treat migraine symptoms.[28] Central nervous system depressants, such as alprazolam (Xanax©), diazepam (Valium©) and lorazepam (Ativan©), are schedule IV substances, *see* O.R.C. § 3719.41 Schedule IV (B), and are sometimes prescribed to women suffering from anxiety or depression during pregnancy.[29]

The American College of Obstetricians and Gynecologists Committee on Obstetrics Practice, in a joint statement with the American Society of Anesthesiologists on the management of pain during labor, has recognized that labor may cause "severe pain for many women," and that "there is no other circumstance where it is considered acceptable for an individual to experience untreated severe pain, amenable to safe intervention, while under a physicians care."[30] According to one seminal medical text, "this statement implies that all women should have access to effective pain relief during labor."[31] However, many of the commonly used opiate drugs—such as fentanyl, which is administered both intravenously[32] and as part of epidural analgesia,[33] appear on the schedule of controlled substances. O.R.C. § 3719.41 Schedule II (B)(9). As a result of the trial court's decision, use of any of these medications, even under a doctor's orders, transforms the pregnant woman into a criminal.

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[28] Menon & Bushnell, *supra* note 26 at 113 (stating that the federal Food and Drug Administration gives hydromorphone a "B" rating, indicating its relative safety in pregnancy for acute migraine treatment).
[29] Riley, *supra* note 24, at 404, 407.
[30] Am. Coll. of Obstetricians & Gynecologists, Comm. On Obstetric Practice, *Committee Opinion 295: Pain Relief During Labor,* July 2004, *reaff'd* 2008. *available at* http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Pain_Relief_During_Labor.aspx.
[31] F. Gary Cunningham et al., *Williams Obstetrics* 486 (22d ed. 2005).
[32] *Id.* at 476.
[33] *Id.* at 487.

Methadone is also a schedule II controlled substance under Ohio law. O.R.C. § 3719.41 Schedule II (B)(15). This means that if the lower court's opinion is upheld, it will be a crime for pregnant women to receive the methadone treatment that is recommended by the U.S. government for pregnant women with opioid addictions.[34]

The lower court's expansion of the Corrupting Another with Drugs usurped the legislative function and created a "foolish" law that fails to address the medically appropriate use of prescription drugs. If the trial court's opinion is not overturned, this judicially rewritten law will create great uncertainty among health care providers as to whether the treatment they prescribe will subject their patients to criminal liability, chilling their ability to practice according to their medical judgment and the applicable standard of care.

The adverse consequences of applying the statute to the context of pregnancy are severe. The decision below sends a perilous message to pregnant women who have used controlled substances: not to seek prenatal care or drug treatment, not to confide their drug-use or addiction to health care professionals, not to continue vital medical treatments, or not to continue their pregnancies and bring forth life. As a result, the statute as re-written by the court below is an affront to the intent of the Ohio Legislature, failing to further any recognized state interest.

II. The Decision Below Is Not Supported or Justified by Scientific Research.

Implicit in trial court's ruling on the motion to dismiss below is the assumption that harm from prenatal exposure to controlled substances—including illegal drugs—is so great that district attorneys and courts should create new criminal penalties where the Legislature has not. Amici

[34] Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *Methadone Treatment for Pregnant Women,* Pub. No. SMA 06-4124 (2006)[hereinafter *SAMHSA Methadone Pamphlet*] ("If you're pregnant and using drugs such as heroin or abusing opioid prescription pain killers, it's important that you get help for yourself and your unborn baby. Methadone maintenance treatment can help you stop using those drugs. It is safe for the baby, keeps you free of withdrawal, and gives you a chance to take care of yourself.").

begin by noting that a positive test result for an illegal drug is not evidence of any physical harm. *Cf. N.J. Div. of Youth & Family Servs. v. A.L.*, 59 A.3d 576, 592 (N.J. 2013) ("[A]mici contend that there is broad consensus within the scientific community that prenatal drug exposure, on its own, does not establish harm or a substantial risk of harm after birth."). Moreover, evidence-based research does not support the popular, but medically unsubstantiated, assumption that any amount of prenatal exposure to an illegal drug causes unique, severe, or even inevitable harm.[35]

The assumption that exposure to illegal drugs is necessarily harmful has been rejected by courts that have evaluated the scientific research. For example, the Supreme Court of South Carolina unanimously overturned the conviction of a woman who suffered a stillbirth that allegedly was caused by the use of cocaine, noting specifically that the research the prosecutor relied on was "outdated" and that trial counsel failed to call experts who would have testified about "recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor." *McKnight v. State*, 661 S.E.2d 354, 358 n.2 (S.C. 2008).

A. There is No Conclusive Evidence that Exposure to Illegal Drugs Causes Harms That are Greater Than or Different From Harms Resulting From Legal Drugs and Innumerable Actions, Conditions, and Circumstances Common to Pregnant Women.

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[35] Ashley H. Schempf & Donna M. Strobino, *Illicit Drug Use and Adverse Birth Outcomes: Is It Drugs or Context?*, 85 J. Urban Health 858 (2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2587644/pdf/11524_2008_Article_9315.pdf; Emmalee S. Bandstra et al., *Prenatal Drug Exposure: Infant and Toddler Outcomes*, 29 J. Addictive Diseases 245 (2010); Ashley H. Schempf, *Illicit Drug Use and Neonatal Outcomes: A Critical Review*, 62 Obstetric & Gynecological Survey 749, 750 (2007) ("Although the neonatal consequences of tobacco and alcohol exposure are well established, the evidence related to prenatal illicit drug use is less consistent despite prevalent views to the contrary."); Barbara L. Thompson et al., *Prenatal Exposure to Drugs: Effects on Brain Development and Implications for Policy and Education*, 10 Nature Revs. Neuroscience 303, 303 (2009) ("Many legal drugs, such as nicotine and alcohol, can produce more severe deficiencies in brain development than some illicit drugs, such as cocaine. However, erroneous and biased interpretations of the scientific literature often affect educational programs and even legal proceedings.").

The prosecution of Ms. Clemons for Corrupting Another with Drugs is based on the scientifically and medically unsupported assumption that a pregnant woman's use of an illegal drug causes unique and certain harm her fetus. The drugs identified in this case were THC (marijuana), and two forms of opiate-based painkillers, morphine and oxycodone (Appellant's Br. 1). Amici bring the existing scientific research to the Court's attention because this research contradicts many popular myths about the use of controlled substances—including marijuana and opiates—during pregnancy and does not support the expansion of the charge of Corrupting Another with Drugs to permit the prosecution of women who continue their pregnancies and use a controlled substance.

Research makes clear that prenatal exposure to opiates, most commonly heroin and oxycodone, is not associated with birth defects.[36] While some newborns exposed prenatally to opiates experience an abstinence syndrome at birth, here, the record does not suggest that Ms. Clemons' baby experienced any such symptoms. For those babies who do experience neonatal abstinence syndrome, safe and effective treatment can be instituted in the nursery setting.[37] Likewise, for pregnant women, withdrawal symptoms are known to cause uterine contractions, miscarriage, or early labor, but these symptoms can be prevented through methadone maintenance treatment, the medically approved treatment for opiate addiction that is particularly recommended during pregnancy.[38]

In recent years, the popular press has been suffused with highly prejudicial, inaccurate and exaggerated information about the effect of *in utero* exposure to opiates, reminiscent of the now-debunked alarmist misinformation perpetuated about cocaine exposure in the 1980s and

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[36] Gary D. Helmbrecht & Siva Thiagarajah, *Management of Addiction Disorders in Pregnancy*, 2 J. Addiction Med. 1, 9 (2008).
[37] *SAMHSA Methadone Pamphlet*, *supra* note 34.
[38] *Id.*

'90s.[39] Recognizing the stigmatizing effect that public dissemination of such misinformation may have on pregnant women and their babies, a group of experts including nationally and internationally renowned doctors and researchers recently published an open letter denouncing the myths about the known and treatable effects of opiate exposure during pregnancy.[40] These physicians and researchers have called on the press to refrain from using medically misleading and erroneous terms such as "addict" to describe babies born with *in utero* opiate exposure and urged that policies addressing prenatal exposure to opiates, and media coverage of this issue, be evidence-based rather than perpetuate and generate misinformation and prejudice. [41]

So too, in spite of numerous myths and misconceptions, science has failed to establish that in utero exposure to other illegal drugs, including marijuana, causes certain, unique harms distinguishable from those caused by other uncontrollable factors.[42]

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[39] *See* Susan Okie, *The Epidemic that Wasn't*, N.Y. Times, Jan. 26, 2009, *available at* http://www.nytimes.com/2009/01/27/health/27coca.html (describing the media misinformation prevalent in the late 1980s and '90s, and citing scientific research indicating that long-term effects of cocaine exposure on children's brain development and behavior appears relatively small.); Deborah A. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure*, 285 J. Am. Med. Ass'n 1613 (2001) (Analyzing the consequences of prenatal exposure to cocaine and concluding that "many findings once thought to be specific effects of *in utero* cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana, or alcohol, and the quality of the child's environment.").

[40] Robert G. Newman et al., *Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women* (March 11, 2013), *available at* http://idhdp.com/media/32950/rnewmanopenexpertletter_-_3.11.13.pdf.

[41] *Id*. at 2.

[42] For evidence-based information about the effects of prenatal exposure to marijuana, s*ee e.g.,* Schempf, *Illicit Drug Use and Neonatal Outcomes*, *supra* note 35 at 750 (finding "[s]tudies that have examined the impact of prenatal marijuana use on birth outcomes have generally reported small and inconsistent effects… In addition to null or negative effects, several studies have reported unexpected, positive effects of marijuana on gestational age-adjusted birth weight."); Peter Fried & Andra M. Smith, *A Literature Review of the Consequences of Prenatal Marihuana Exposure: An Emerging Theme of a Deficiency in Aspects of Executive Function*, 23 Neurotoxicology & Teratology 1, 8 (2001) (In a 2001 review of the scientific literature about the

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 Ohio's interest in reducing drug-related harm. It is irrational, however, to rewrite the law to address the issue when science has yet to support the need for such a law and when the harms to maternal and fetal health that result from such prosecutions are clear.

III. The Decision of the Court Below Reflects a Misunderstanding of the Nature of Pregnancy, Drug Use, and Addiction.

The assertion that pregnant women who use a controlled substance are creating harm akin to a person who administers a drug to another person "[b]y force, threat, or deception," O.R.C. § 2925.02(A)(1), is dangerously misinformed and flies in the face of every understanding of pregnancy, use of controlled substances, and addiction.

A. The Relationship Between a Pregnant Woman and the Fetus She Carries and Sustains is Not an Act of Force, Threat, Deception, or Corruption.

The understanding of pregnancy, and the relationship between a woman and her child *in utero* underlying the prosecution of Ms. Clemons is contrary to any modern understanding of pregnancy. The trial court's opinion treats the movement of ingested substances through the placental barrier and the umbilical cord as a form of "force, threat, or deception" by which Ms. Clemons "administered" controlled substances to her daughter prior to delivery, thus "corrupting" her. O.R.C. § 2925.02(A)(1).

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effect of prenatal exposure to marijuana, the authors concluded that, to the extent some studies have found effects,"[t]he consequences of prenatal exposure to marihuana are subtle."); David M. Fergusson et al., *Maternal Use of Cannabis and Pregnancy Outcome*, 109 BJOG: Int'l J. Obstetrics & Gynecology 21, 21-22 (2002) *available at* http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2002.01020.x/pdf; Anja Huizink & Eduard Mulder, *Maternal Smoking, Drinking or Cannabis Use During Pregnancy and Neurobehavioral and Cognitive Functioning in Human Offspring*, 30 Neuroscience & Biobehavioral Revs. 1, 35-36 (2005).

The processes and mechanisms by which a pregnant woman, at risk to her own life and health,[43] nurtures and sustains a fetus through its growth and development from conception until birth are complex. The pregnant woman provides oxygen and nutrients from her own circulatory system by way of the placenta, and the fetus transfers carbon dioxide and other metabolic wastes to her via the placenta so that they may be processed by her circulatory system.[44] The maternal and fetal circulatory systems work together in an intricate give-and-take, but there is generally no intermingling of maternal and fetal blood.[45] They are independent but cooperative systems, with transfer through the placenta occurring through diffusion and other molecular mechanisms.[46] Nothing in the involuntary, symbiotic biological and biochemical processes by which the pregnant woman nourishes and sustains her fetus is properly characterized as force, coercion, deception, or corruption pursuant to the criminal law.

Ohio prosecutors have, in the past, attempted to argue that the "transfer of blood in which [a controlled substance was] present, through the umbilical cord, between mother and child" was a form of child endangerment. *State v. Gray*, 1990 Ohio App. LEXIS 3782 at *3 (Ohio Ct. App., Lucas County Aug. 31, 1990), *aff'd State v. Gray,* 62 Ohio St.3d 514. This argument, however, is so fundamentally different from either a medical or commonsense understanding of pregnancy that the Court of Appeals for the Sixth Appellate District held that it violated legislative intent, *id.* at *3, and that to endorse this understanding would violate the court's duty to construe the statute as to avoid unreasonable consequences, *id.* at *3-4.

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[43] *See, e.g.,* Amnesty International, *Deadly Delivery: The Maternal Health Crisis in the United States* (2010), *available at* http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf.
[44] Cunningham et al., *supra* note 31, at 97.
[45] *Id.*
[46] *See, id.* at 98-100.

Similarly, when prosecutors in sister states have attempted to define the movement of controlled substances across the placental barrier as a form of drug "delivery," courts have consistently refused to uphold such a reinterpretation of the nature of pregnancy. *See Johnson v. State*, 602 So. 2d at 1292 (reversing the conviction of a woman who gave birth to a substance-exposed newborn under a drug delivery statute, noting that the court could find "no case where 'delivery' of a drug was based on an involuntary act such as diffusion and blood flow"); *State v. Armstard*, 991 So. 2d 116, 122 (La. 2008) ("Our review of the Louisiana jurisprudence involving the charge of cruelty to a juvenile has revealed no cases where the mistreatment or neglect was based on an *involuntary* act such as the pumping of blood through the umbilical cord during the birthing process after having earlier ingested drugs or alcohol.") (emphasis in original); *People v. Hardy*, 469 N.W.2d 50, 55 (Mich. Ct. App. 1991) (holding that application of the state's drug delivery statute to a pregnant woman who allegedly "delivered" cocaine to her child through the umbilical cord violated legislative intent and due process notice); *State v. Luster*, 419 S.E.2d 32, 35 (Ga. Ct. App. 1992) (holding that a statute proscribing distribution of cocaine from one person to another did not apply to pregnant women in relation to their fetuses, that to interpret the law otherwise would deprive pregnant women of fair notice, and noting that viewing addiction during pregnancy as a disease and addressing the problem through treatment rather than prosecution was the approach "overwhelming in accord with the opinions of local and national medical experts").

Amici urge this court to overturn the ruling of the trial court, following the wisdom of Ohio and sister state courts in rejecting a radical reinterpretation of pregnancy and the maternal-fetal relationship as a form of administration by force or threat, and an act of corruption.

B. Addiction is Not a Voluntary Act Cured by Threats.

For those women whose drug use has become dependency or addiction, medical groups recognize that addiction is not simply the product of a failure of individual willpower. In August 2011, the American Society of Addiction Medicine announced a definition of addiction based on a four year process with more than 80 experts actively working on it, including top addiction authorities, addiction medicine clinicians and leading neuroscience researchers from around the country.[47] Accordingly, this new definition is that addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry.[48] It must be treated like diabetes or cardiovascular disease and is not the manifestation of an individual's poor choices.[49] Dependency has been described as the product of complex hereditary and environmental factors.[50] Addiction has pronounced physiological factors that heavily influence the user's behavior and affect his or her ability to cease use and seek treatment.[51]

The medical profession has long acknowledged that drug dependence cannot often be overcome without treatment.[52] Addiction is marked by "compulsions not capable of management without outside help."[53] This is why the vast majority of drug-dependent people cannot simply

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[47] Press Release, Am. Soc'y of Addiction Med., *New Definition of Addiction* (August 15, 2011), *available at* http://www.asam.org/docs/pressreleases/asam-definition-of-addiction-2011-08-15.pdf.

[48] Am. Soc'y of Addiction Med., *Definition of Addiction* (April 19, 2011), *available at* http://www.asam.org/research-treatment/definition-of-addiction.

[49] Am. Soc'y of Addiction Med., Press Release, *supra* note 47, at 2.

[50] Am. Med. Ass'n Bd. of Trustees, *Legal Interventions During Pregnancy,* 264 J. Am. Med. Ass'n 2663, 2669 (1990).

[51] Chaya G. Bhuvaneswar et al., *Cocaine and Opioid Use During Pregnancy: Prevalence and Management*, 10(1) Primary Care Companion J. Clinical Psychiatry 59, 61 (2008), *available at* www.psychiatrist.com/pcc/pccpdf/v10n01/v10n0110.pdf.

[52] *See e.g.*, "Psychoactive Substance Dependence" is listed as a mental illness with specific diagnostic criteria in the Am. Psychiatric Ass'n., *The Diagnostic and Statistical Manual of Mental Disorders*, 176 (4th ed. 1994). *See Linder v. United States*, 268 U.S. 5, 18 (1925); *Robinson v. California*, 370 U.S. 660 (1962).

[53] *Robinson v. California*, 370 U.S. at 671 (*Douglas, J., concurring*); *see also* 42 U.S.C. § 201(q) (1970) ("'drug dependent person' means a person who is using a controlled substance . . . and

"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.

C. Addiction is a Medical Condition that is Difficult to Overcome.

In Ohio, tens of thousands of substance-abusing adults do not receive the treatment they need. An estimated 199,000 Ohio adults need, but have not received, treatment for a drug abuse problem.[54] Another 616,000 Ohio adults need, but have not received, treatment for alcohol problems.[55]

Of the 290 treatment facilities throughout Ohio, only 36 in the entire state list themselves as serving pregnant women.[56] Such programs, however, are often not actually accessible because of transportation barriers, cost, waiting lists, and lack of childcare and mental health service, which impede access to successful treatment, particularly in the short time frame of pregnancy.[57]

Many pregnant women do not have access to health care, quality housing, safe environments, nor does pregnancy give women an enhanced capacity to overcome behavioral

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who is in a state of psychic or physical dependence, or both.").

[54] Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *2009-2010 NSDUH State Estimates of Substance Use and Mental Disorders, available at* http://www.samhsa.gov/data/NSDUH/2k10State/NSDUHsae2010/NSDUHsaeCountTabs2010.htm (Table 21. – Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year, by Age Group and State: Estimated Numbers (in Thousands)).

[55] *Id.* (Table 22. – Needing But Not Receiving Treatment for Alcohol Use in the Past Year, by Age Group and State: Estimated Numbers (in Thousands)).

[56] Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *Substance Abuse Treatment Facility Locator*, *available at* http://findtreatment.samhsa.gov/facilitylocatordoc.htm.

[57] *See* Thomas M. Brady & Olivia S. Ashley, *Women in Substance Abuse Treatment: Results from the Alcohol and Drug Services Study (ADSS)*, Sept. 2005, *available at* http://oas.samhsa.gov/WomenTX/WomenTX.htm; *see also* Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. Drug Issues 285 (2003), *available at* http://www.nnvawi.org/pdfs/alo/Humphreys_barriers_substance_treatment.pdf.

health problems such as addiction.[58] Extending the Corrupting Another with Drugs statute to women who are unable to overcome their drug problem in the short term of pregnancy misunderstands addiction and the nature of effective treatment.

[58] Bhuvaneswar et al., *supra* note 51, at 64 (2008) ("Even for motivated women, obtaining treatment is not always straightforward. The scarcity of specialized treatment centers has already been noted."), *available at* www.psychiatrist.com/pcc/pccpdf/v10n01/v10n0110.pdf.

CONCLUSION

Because the prosecution of Astasia Clemons for Corrupting Another with Drugs is unsupported as a matter of science, is misguided as a matter of public health, and is without authority under the law, amici curiae respectfully request that this Honorable Court grant relief to Ms. Clemons and overturn the ruling of the trial court.

/s/ Elizabeth Cooke

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I hereby certify that I have served a copy of the Brief of Amicus Curiae on the following by placing a copy of same in U.S. Mail, postage prepaid and properly addressed on this, the 3rd day of May, 2013:

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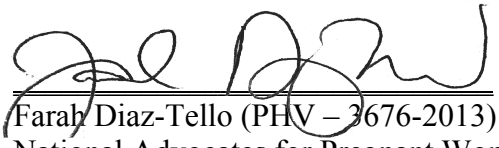

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APPENDIX A: LIST OF AMICI

Amicus Curiae **American Academy of Addiction Psychiatry (AAAP)** is an international professional membership organization made up of practicing psychiatrists, university faculty, medical students and other related professionals. Founded in 1985, it currently represents approximately 1,000 members in the United States and around the world. AAAP is devoted to promoting access to continuing education for addiction professionals, disseminating new information in the field of addiction psychiatry, and encouraging research on the etiology, prevention, identification, and treatment of addictions. AAAP opposes the prosecution of pregnant women based on the belief that the disclosure of personal drug use to law enforcement for use in criminal prosecutions will undermine prenatal care, discourage many women from seeking substance abuse treatment, and damage the medical provider-patient relationship that is founded on principles of confidentiality.

Amicus curiae **American Society of Addiction Medicine (ASAM)** is a nationwide organization of more than 3000 of the nation's foremost physicians specializing in addiction medicine. We believe that the proper, most effective solution to the problem of substance abuse during pregnancy lies in medical prevention, i.e. education, early intervention, treatment, and research on chemically-dependent pregnant women. We further believe that state and local governments should avoid any measures defining alcohol or other drug use during pregnancy as a crime and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health services.

Amicus curiae **Child Welfare Organizing Project (CWOP)** was established in 1994 as an organization of parents and professionals seeking reform of child welfare practices through increased, meaningful parent/client involvement in child welfare decision-making at all levels, from case planning to policy, budgets, and legislation. CWOP has approximately 1,500 parent members. Most of CWOP's staff, and about half of CWOP's Board of Directors, are parents who have had direct personal involvement with child welfare systems. A significant percentage of CWOP members are mothers in recovery. A large part of CWOP's work involves debunking prevailing stereotypes about child welfare-involved parents and families, putting a human face on parents who are often unfairly and inaccurately demonized, and bringing CWOP's unique insights into policy discussions. CWOP hopes this will result in more enlightened public policy that effectively identifies and addresses real problems and challenges to successful family life, ultimately protecting children by helping and strengthening their families and communities.

Amicus curiae **Harm Reduction Coalition (HRC)** is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use. HRC was founded in 1993 and incorporated in 1994 by a working group consisting of syringe exchange providers, advocates, and drug users. Today, HRC is a diverse network of community-based organizations, service providers, researchers, policy-makers, academics, and activists challenging the persistent stigma placed on people who use drugs, and advocating for sensible policy reform. HRC advances policies and programs that help people address the adverse effects of the “War on Drugs” and drug use including overdose, HIV, Hepatitis C, addiction, and incarceration. We recognize that the structures of social inequality impact the lives and options of affected communities. Since its inception in 1994, HRC advances harm

reduction philosophy, practice, and public policy by prioritizing areas where structural inequalities and social injustice magnify drug related harm.

Amicus curiae **Institute for Health and Recovery (IHR)** is a statewide service, research, policy, and program development agency. IHR's mission is to develop a comprehensive continuum of care for individuals, youth, and families affected by alcohol, tobacco, and other drug use, mental health problems, and violence/trauma. IHR's work is based on principles of establishing collaborative models of service delivery, integrating gender-specific, trauma-informed and relational/cultural models of prevention, intervention, and treatment; fostering family-centered, strength-based approaches; and advancing multicultural competency within the service delivery system.

Amicus curiae **International Centre for Science in Drug Policy** is an organization dedicated to improving community health and safety by conducting research and public education on best practices in drug policy while working collaboratively with communities, policy makers, law enforcement, and other stakeholders to help guide effective and evidence-based policy responses to the many problems posted by illicit drugs.

Amicus curiae **International Doctors for Healthy Drug Policies (IDHP)** is an organization of medical doctors from 49 countries devoted to increasing the participation of medical doctors in drug policy reform. Drug policies effect the health of us all, but especially people who use drugs and those who are living with HIV and chronic pain. There is a gap between evidence based practice and drug policy in many countries and IDHP aims to influence changes in drug policies and practices to promote harm reduction and create healthy drug policies internationally.

Amicus curiae **International Mental Disability Law Reform Project** is a human rights advocacy organization that is housed within the Justice Action Center at New York Law School. It is involved in legislative reform, lawyer and law student training, pro bono legal assistance, and the full range of law reform projects that relate to the practice of mental disability law. This project is closely related to the online, distance learning Mental Disability Law program that now offers thirteen separate courses in all aspects of mental disability law

Amicus curiae **National Advocates for Pregnant Women (NAPW)** is a non-profit organization dedicated to ensuring the human and civil rights, health, and dignity of pregnant and parenting women. NAPW advocates for reproductive and family justice, including the right to carry a pregnancy to term, access to culturally appropriate and evidence based medical care, and the rights of parents and children to family integrity undisrupted by inappropriate state action.

Amicus curiae **National Association of Social Workers (NASW)** and **National Association of Social Workers Ohio Chapter** is the world's largest association of professional social workers with 150,000 members in fifty-six chapters throughout the United States and abroad. Founded in 1955 from a merger of seven predecessor social work organizations, NASW is devoted is devoted to promoting the quality and effectiveness of social work practice, advancing the knowledge base of the social work profession, and improving the quality of life through utilization of social work knowledge and skills. NASW believes that criminal prosecution of women who use drugs during their pregnancy is inimical to family stability and counter to the

best interests of the child. The needs of society are better served by treatment of addiction, not punishment of the addict. NASW's policy statement, *Alcohol, Tobacco, and Other Drugs* supports "an approach to ATOD [alcohol, tobacco, and other drugs] problems that emphasize prevention and treatment" and efforts to "eliminate health disparities that accrue from ATOD problems and discriminatory practices from the criminal justice system. " (NASW, Social Work Speaks, 8th ed., 2009).

Amicus curiae the **National Institute for Reproductive Health** works to help women in communities across the country gain access to the full range of quality reproductive health care options, the freedom to exercise their reproductive rights, and the opportunity to have healthy pregnancies. The National Institute promotes reproductive rights and health through bold advocacy, creative education campaigns, and high-impact local partnerships across the country.

Amicus curiae **National Latina Institute for Reproductive Health** works to ensure the fundamental human right to reproductive health and justice for Latinas, their families and their communities through public education, community mobilization, and policy advocacy. Latinas face a unique and complex array of reproductive health and rights issues that are exacerbated by poverty, gender, racial and ethnic discrimination, and xenophobia. These circumstances make it especially difficult for Latinas to access reproductive health care services.

Amicus curiae **National Perinatal Association (NPA)** promotes the health and well being of mothers and infants enriching families, communities and our world. NPA is a multi-disciplinary organization comprised of doctors, nurses, midwives, social workers, administrators, parents, and those interested in collaborating to improve perinatal health.

Amicus curiae **Susan Boyd, PhD,** is Professor in Studies in Policy, University of Victoria. She is a drug policy researcher and author of numerous journal articles and books, including: *Hooked: Drug War Films from Britain, Canada, and the U.S.*; *From Witches to Crack Moms: Women, Drug Law, and Policy*; *Mothers and Illicit Drugs*; and co- editor of *With Child: Substance Abuse During Pregnancy: A Woman-Centered Approach*.

Amicus curiae **Wendy Chavkin, MPH, MD,** is a Professor of Clinical Public Health and Obstetrics and Gynecology at the Mailman School of Public Health and the College of Physicians and Surgeons at Columbia University. She has written extensively about women's reproductive health issues and done extensive research related to pregnant women, punishment and barriers to care for over two decades.

Amicus curiae **Loretta Finnegan, MD,** is the president of Finnegan Consulting, which addresses education, research and treatment issues regarding women's health and perinatal addiction. For sixteen years she was with the National Institutes of Health in several capacities: Senior Advisor on Women's Issues, National Institute on Drug Abuse; Director, Women's Health Initiative, Office of the Director; and Medical Advisor to the Director, Office of Research on Women's Health, Office of the Director. Dr. Finnegan was a Professor of Pediatrics in the Psychiatry and Human Behavior Department at Jefferson Medical College of Thomas Jefferson University for fourteen years. She was founder and Director of a groundbreaking program called "Family Center," a comprehensive multidisciplinary program for addicted pregnant women and their

children at Jefferson Medical College and Hospital in Philadelphia. As a recognized nationally and internationally expert in the field, she has published widely and has given nearly 1,000 presentations throughout the world on clinical research and knowledge of women's health and perinatal addiction.

Amicus curiae **Deborah A. Frank, MD,** is a Professor of Pediatrics at Boston University School of Medicine. Dr. Frank is also an Assistant Professor of Social and Behavioral Sciences at the Boston University School of Public Health. Since 1981, she has been the Director of the Failure to Thrive Program at the Boston Medical Center where she is also a staff physician in the Child Development Unit. In 1993, she was named a Fellow of the Society for Pediatric Research. Dr. Frank is a recognized expert on the effect of maternal substance abuse on fetal development and newborn behavior. She has published widely on these topics, including numerous articles concerning prenatal cocaine and methamphetamine exposure. In 2002, Dr. Frank testified before the United States Sentencing Commission concerning the effects of prenatal cocaine exposure. Dr. Frank comes to this Court in her capacity as amicus curiae in order to ensure that prevalent stigma and stereotypes about the nature of women who use drugs during pregnancy do not prevent the Court from understanding the medical issues in this case.

Amicus curiae **Steven Kandall, MD,** served as Chief of Neonatology at Beth Israel Medical Center from 1976 to 1998 and retired in 1998 as Professor of Pediatrics at the Albert Einstein College of Medicine. Most of Dr. Kandall's 90 contributions to the medical literature deal with perinatal drug use, and he has contributed chapters to many standard textbooks, including *Substance Abuse: A Comprehensive Textbook* and *Principles of Addiction Medicine*, as well as his own definitive book on the history of women and addiction in the United States, *Substance and Shadow*. Dr. Kandall has lectured throughout the United States, as well as Belgium, Italy, Austria and Australia. He has served as president of his local medical societies, as an advisor to many commissions and panels on drug abuse (including the March of Dimes, Narcotic and Drug Research, Inc., and the Scott Newman Foundation in Los Angeles), and currently advises legislative subcommittees on perinatal health in North Carolina.

Amicus curiae **John McCarthy, MD,** is the Executive/Medical Director of the Bi-Valley Medical Clinic, an outpatient addiction treatment program that specializes in the medical treatment of addiction to opiates, based in Sacramento, California. Dr. McCarthy also serves as an Assistant Professor of Psychiatry at the University of California, Davis. He has been published numerous times on the issues of opiate use impacts on maternal and perinatal health and appropriate treatment.

Amicus curiae **Robert Newman, MD, MPH,** was until January 2001, President and CEO of Continuum Health Partners, Inc., a $2.2 billion hospital network in New York City. Prior to the creation of Continuum in 1997 he was CEO of the Beth Israel Health Care System for 20 years. He is now President Emeritus of Continuum and Director of The Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center. For over 40 years Dr. Newman has played a major role in planning and directing some of the largest addiction treatment programs in the world - including the New York City Methadone Maintenance and Ambulatory Detoxification Programs, which in the mid- 33,000 patients annually. He has also been a strong addiction treatment advocate in Europe, Australia and Asia. Throughout his career he has

championed the right of drug-dependent persons to treatment access and choice of provider, and the right to be cared for under the same conditions as apply to the management of all other chronic medical conditions.

Amicus curiae **Michael Perlin, JD**, is the Director of the International Mental Disability Law Reform Project and the Online Mental Disability Law Program of the New York Law School. He is an internationally-recognized expert on mental disability law, and has authored 23 books and nearly 250 scholarly articles on the subject. He has spoken and taught around the world on issues related to the human rights of people with mental disabilities. Under the aegis of Mental Disability Rights International (MDRI), a Washington, DC-based human rights advocacy NGO, Professor Perlin has done site visits and conducted mental disability law training workshops in Hungary, Estonia, Latvia, Uruguay, and Bulgaria.

Amicus curiae **Linda Worley, MD,** is a Professor of Psychiatry with a secondary appointment in Obstetrics and Gynecology in the College of Medicine at the University of Arkansas for Medical Sciences (UAMS). She directs the campus side Student Mental Health Program, the College of Medicine Faculty Wellness Program, and is the consulting psychiatrist to the ANGELS program in the department of Obstetrics and Gynecology. Dr. Worley is a board certified Psychiatrist with sub-specialization in Psychosomatic Medicine. Dr. Worley was recruited to join the UAMS, Department of Psychiatry Faculty in 1992. She received the American Psychiatric Association Gold Award for directing a model program for the nation for addiction treatment for women with their children.

Amicus curiae **Trecia Wouldes, PhD,** is a developmental psychologist and Senior Lecturer in the Department of Psychological Medicine in the Faculty of Medical and Health Sciences at the University of Auckland. She is also a member of the Executive Board of the Werry Centre for Child and Adolescent Mental Health. The focus of her teaching and research is the health, mental health, and development of children exposed to biological and/or psychological insults that occur prenatally or during early childhood. She is currently the Director of the Auckland, New Zealand site of the 5-site Infant Development Environment And Lifestyle (IDEAL) study investigating the developmental outcomes of children born to mothers who use methamphetamine during their pregnancy. Through her research, Dr. Wouldes has developed a special interest in the provision of early, evidence-based interventions for infants, toddlers and pre-school children.

Amicus curiae **Tricia E. Wright, MD, MS,** is an assistant professor of Obstetrics, Gynecology at the University of Hawaii John A. Burns School of Medicine and the founder, former medical director, and now Women's Health Liaison of the PATH Clinic, an outreach clinic of Waikiki Health Center, which provides prenatal, postpartum and family planning to women with a history of substance use disorders. She is board certified in both OB/Gyn and Addiction Medicine and a Fellow of the American College of Obstetricians and Gynecologists. She specializes in taking care of pregnant women with substance use disorders and psychiatric illness. She won funding approval in 2006 from the Hawaii legislature to start the first perinatal clinic for women with substance use issues in the state. Her research interests include substance use disorders among pregnant women, including barriers to family planning, best practices for treatment, and the effects of methamphetamine and tobacco on the placenta.