IN THE DISTRICT COURT IN AND FOR OKLAHOMA COUNTY

STATE OF OKLAHOMA

STATE OF OKLAHOMA, Plaintiff, and	)	
	)	Case No. CF-2004-4801
THERESA LEE HERNANDEZ, Defendant.	)	

MOTION TO FILE AMICUS BRIEF AND AMICUS BRIEF IN SUPPORT OF THE MOTION TO DISMISS THE INFORMATION IN *STATE V. HERNANDEZ*

COMES NOW Douglas Parr, attorney for the *Amici*, and moves this Honorable Court to accept the Amicus Brief In Support of the Motion to Dismiss the Information in *State v. Hernandez*.

STATEMENT OF INTEREST

Amici include Oklahoma and national physicians, nurses, counselors, social workers, public health practitioners, and their professional associations.[1] These individuals and organizations have recognized expertise and longstanding concern in the areas of maternal and neonatal health, in understanding the effects of drugs and other substances on users, their families and society, and the ways those effects can best be minimized. *Amici* join this brief because the prosecution of Ms. Hernandez cannot be reconciled with evidence-based, peer-reviewed, medical and scientific research.

INTRODUCTION AND SUMMARY OF ARGUMENT

On April 17, 2004, Theresa Hernandez's 32 weeks of pregnancy ended in a stillbirth. Shortly thereafter, the District Attorney charged Ms. Hernandez, a low-income mother of five, with first and alternatively, second degree murder based on the claim that her use of

[1] Descriptions of the *amici* are set forth in Appendix A of this brief; their policy statements are included in Appendix B.

methamphetamine during pregnancy caused the stillbirth. This unprecedented prosecution seeks to make the state's homicide laws applicable to the context of pregnancy loss. Such an interpretation of the state laws shifts pregnancy loss from a medical and public health matter (occasioning treatment and support) to a criminal one, requiring forensic investigation and state sanctioned punishment, which has devastating implications for maternal and fetal health.

While *Amici* would never suggest that ingestion of methamphetamine during pregnancy is in any way benign, it is our obligation to note that, as a matter of medical science, the effects of in utero exposure to methamphetamine are not well-established and as yet no link has been found between exposure to methamphetamine and pregnancy loss. Stillbirth is associated with a vast array of conditions, activities, and inactions during pregnancy, ranging from working in a dangerous environment to carrying a multi-fetal pregnancy to term. Indeed, pregnancy risks inherent in the use of two substances, cigarettes and alcohol, far more commonly used than all illegal drugs combined, have been extensively documented for many years.

There is however, extensive evidence that responding to issues of drug use and pregnancy through threats of arrest and prosecution will undermine the health of women and children. Moreover, medical, scientific and social science research fail to support the numerous assumptions that this prosecution rests on, among these: that addiction is simply a matter of willpower, that pregnant women can guarantee the outcome of their pregnancies, and that the insertion of the criminal justice system into the delivery room will protect children. Accordingly, *amici curiae* respectfully urge this Court to dismiss the homicide charges pending against Ms. Hernandez.

I. Judicially Reinterpreting Homicide Law As Sought by the Prosecution Will Harm the Health and Welfare of Pregnant Women and Children of Oklahoma.

Over the course of nearly two decades, every leading medical organization, governmental body, and nearly every court to consider the question has concluded that responding to issues of drug use and pregnancy through the criminal justice system is likely to produce even worse outcomes for children. Fear of prosecution operates as a deterrent to pursuing drug treatment, prenatal care, and labor and delivery care, and it discourages disclosure of critical medical information to health professionals – all with potentially devastating results. Finally, given the realities of drug addiction, the difficulty of obtaining appropriate treatment, and the nature of recovery, laws that threaten women who seek to carry their pregnancies to term with homicide prosecution in the event a miscarriage or stillbirth occurs place substantial pressure on women to terminate wanted pregnancies.

A. Expansion of the Homicide Law to Women Suffering Stillbirths Will Deter Drug-Dependent Women from Seeking Health Care.

Researchers and courts long ago determined that punishing drug-dependent pregnant women for drug use severely threatens the health of their fetuses because fear of criminal prosecution can trigger a "flight from care." Poland, et al*., Barriers to Receiving Adequate Prenatal Care,* AM. J. OB. & GYN., 297-303 (1987). As the U.S. Supreme Court recently observed, there is "near consensus in the medical community" that addressing problems of drug use and pregnancy through the criminal justice system will "harm, rather than advance the cause of prenatal health." *Ferguson v. City of Charleston*, 532 U.S. 67, 84 n.23 (2001) (noting the *amicus* submissions of numerous public health organizations concluding that searching pregnant women for evidence of drug use and facilitating their arrest will harm prenatal health by discouraging women from seeking prenatal care.) State courts have

similarly adopted the medical professionals' conclusion that criminal penalties for drug use during pregnancy are ineffective public policy and endanger fetal health by discouraging care. *State v. Luster*, 419 S.E.2d 32, 35 (Ga. App. 1992); *State v. Deborah J.Z.*, 596 N.W. 2d, 490, 495 (Wis. App. 1999).

Eminent medical organizations, including the American Medical Association, have uniformly condemned punitive approaches to the problem of drug use during pregnancy. *Legal Intervention During Pregnancy*, 264 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION ("JAMA") 2663, 2670 (1990) ("[c]riminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.") The March of Dimes, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics also condemn this approach as dangerous to both women and children. (*See* March of Dimes, *Statement on Maternal Drug Abuse 1* (1990) ("[making a] pregnant woman criminally liable solely based on the use of drugs during pregnancy, is potentially harmful to the mother and to her unborn child…. Fear of punishment may cause women most in need of prenatal services to avoid health care professionals."); *see also* Appendix B.

Research confirms that threats of punishment undermine rather than advance state interests in encouraging healthy pregnancies and improved birth outcomes. 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." *See* Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, J. DRUG ISSUES (2003); U.S. General Accounting Office, *ADMS Block Grant: Women's Set Aside Does Not Assure Drug Treatment for Pregnant*

Women 5, 20 (1991) (identifying "the threat of prosecution" as a "barrier to treatment for pregnant women.") In fact, the consensus of both criminal justice and medical professionals is that the lack of prenatal care associated with criminal prosecution creates a much graver risk to fetal health than drug use during pregnancy. *See* C.J. Sovinski, *The Criminalization of Maternal Substance Abuse: A Quick Fix to a Complex Problem*, 25 PEPP. L. REV. 107-139 (1997) (concluding that "[p]unitive approaches to the problem of substance abuse during pregnancy threaten the health of women and children and seriously erode women's rights to privacy.")

The State of Oklahoma has implicitly recognized the danger of discouraging drug-dependent women from seeking care. In 2000, House Bill 2487 proposed criminalizing the abuse of alcohol or other drugs by pregnant women. After debate about the bill's unintended consequences, it was rechristened as an authorization for a special task force to study the issue of pregnant women who are addicted to drugs or alcohol. HB 2487 (2000), the "Oklahoma Prenatal Addiction Act," codified as Title 63 Oklahoma Statutes Section 1-546.1. Critics of the original bill pointed out that criminalizing alcohol or drug use would discourage a substantial group of women from seeking any prenatal care in an effort to avoid discovery and prosecution. The legislature's shift from punitive to educational measures underscores its commitment to maternal and fetal health and concedes the potentially devastating effects that criminal punishment can have.

B. Prenatal Care and Drug Treatment are Vital to Maternal and Fetal Health.

Deterring drug-dependent women from seeking prenatal care and drug treatment is especially troubling because both have been associated with improved maternal and fetal health outcomes. Prenatal care is strongly associated with improved outcomes for fetal

development even for women who are not able to overcome their addiction problem before their due dates. For example, pregnant women who use cocaine but who had at least four prenatal care visits significantly reduced their chances of delivering low birth weight babies. 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); *see also*, Funai, et al., *Compliance with Prenatal Care in Substance Abusers*, 14 J. MATERNAL FETAL NEONATAL MED. 329-332 (2003).

Drug-dependent pregnant women who are deterred from receiving prenatal care will lose the opportunity for medical interventions needed to address the many co-occurring risk factors such as poor nutrition, and tobacco and alcohol use that are associated with drug use and are associated with poor fetal development. *See* Tronick & Beeghly, *Prenatal Cocaine Exposure, Child-Development, and the Compromising Effects of Cumulative Risk*, 26 CLIN. PERINATOL. 151-71 (1999) (noting that "[i]nterventions are more likely to succeed if they attempt to reduce the overall burden of risk rather than targeting risks.")

Research also proves that drug treatment, when available and appropriate, can contribute to healthier pregnancies and pregnancy outcomes. *See* Sweeney, et al., *The Effect of Integrating Substance Abuse Treatment With Prenatal Care on Birth Outcomes*, 20 J. PERINATOL. 219-24 (2000) (finding that outcomes are "significantly improved for infants born to substance abusers who receive[d] [drug] treatment concurrent with prenatal care."); Center on Addiction and Substance Abuse (CASA), SUBSTANCE ABUSE & THE AMERICAN WOMAN 82 (1996) ("pregnant women in treatment give birth to larger, higher birth weight infants than women who are not in treatment") (hereafter "CASA REPORT.")

Indeed, the State of Oklahoma officially recognizes the benefits of drug treatment for pregnant women. Office of Child Abuse Prevention, State Interagency Child Abuse Prevention Task Force, *Oklahoma State Plan: For the Prevention of Child Abuse and Neglect*, 99 (2004) (hereafter "*Oklahoma State Plan*"). The Legislature noted that the "most effective means of preventing birth defects and health problems due to substance abuse by pregnant women is for prenatal care and appropriate substance abuse treatment services to be readily available and accessible." (63 Okl. Stat. § 1-546.2.)

C. Those Drug-Dependent Women That Do Seek Treatment Will Be Deterred from Sharing Critical Medical Information with Their Physicians.

The threat of criminal prosecution, particularly for homicide, in the event of a miscarriage or stillbirth will discourage pregnant women from being truthful about drug use, corroding the formation of trust that is fundamental to any doctor-patient relationship. As the U.S. Supreme Court has recognized, a "confidential relationship" is a necessary precondition for "successful [professional] treatment." *Jaffee v. Redmond*, 518 U.S. 1, 12; 116 S.Ct. 1923, 1929; 135 L.Ed. 2d 337 (1997). Medical treatment is greatly enhanced when patients feel comfortable divulging highly personal, stigmatizing, and potentially incriminating information. *Id.* (observing that a "patient must be willing to tell a physician, who is often a total stranger, about such matters as drug usage"); *see also* American College Obstetrics and Gynecology (ACOG) Committee on Ethics, *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice* (Opinion No. 294, 2004) (punitive measures "endanger the relationship of trust between physician and patient . . . [and can] actually increase the risks to the woman and the fetus."))

Open communication between drug-dependent pregnant women and their doctors is especially critical. Drug use is rarely obvious and typically remains undiagnosed unless

disclosed by the patient. *See* Chasnoff, *Drug Use in Pregnancy: Parameters of Risk,* 35 PEDIATRIC CLINICS N. AM. 1403, 1410 (1988); 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). Even absent the threat of criminal prosecution, drug-dependent pregnant women infrequently report drug use to their doctors. Feelings of shame, fear, and low self-esteem are significant barriers to establishing the trust prerequisite to patients' full disclosure of this medically vital information. *See* S. Kandall, SUBSTANCE & SHADOW: WOMEN & ADDICTION IN THE UNITED STATES, 278-79 (1996). Additionally, the exceptionally high rates of depression among drug-dependent women mean that their prospects of successfully completing treatment depend on their forming a strong "therapeutic alliance" with care providers. *See* CASA REPORT at 64; *Social Consequences of Substance Abuse Among Pregnant and Parenting Women,* 20 PEDIATRIC ANNALS, 548-552 (1991). Failure to disclose drug use prior to the end of a pregnancy poses special dangers not present in other medical contexts. *See*, *e.g.*, Campbell, et. al., *Unrecognized "Crack" Cocaine Abuse in Pregnancy*, 77 BRIT. J. ANESTHESIOLOGY 553, 555 (1996).

Because the threat of criminal prosecution discourages drug-dependent pregnant women from open, honest communication with their doctors or from treatment altogether, reinterpreting criminal laws to apply to the context of pregnancy will ironically and tragically contribute to the very adverse pregnancy outcomes that the prosecution in this case claims it seeks to prevent.

D. Prosecuting Women Based on the Outcomes of Their Pregnancies Discourages Women from Carrying Wanted Pregnancies to Term.

A legal regime that threatens prosecution and harsh punishment in the event of an adverse pregnancy outcome creates an extraordinary risk to women who carry their

pregnancies to term. Women, who cannot overcome an addiction on pregnancy's timetable, can eliminate such a risk by deliberately terminating a pregnancy. The risk of criminal prosecution thus may induce drug-using women who become pregnant to avoid any potential criminal prosecution by having an abortion. *Whitner v. South Carolina*, 492 S.E. 2d 777, 787 (S. Car. Sup. Ct. 1997) (*J. Moore dissenting); see also* Heather Sprintz, *The Criminalization of Perinatal Aids Transmission*, 3 HEALTH MATRIX: J. LAW-MED. 495 (1993) (criminal prosecution of prenatal drug use "implicitly advocates for abortion, rather than childbirth, to avoid prosecution.")

Inducing women to terminate otherwise wanted, healthy pregnancies is manifestly inimical to the purposes this prosecution is intended to serve. This prospect is so dreadful that groups as diverse as NARAL: Pro-Choice America and the National Right to Life Committee, which rarely agree on any issue, have united in opposition to policies that are far less punitive to drug using women than Oklahoma's. *See To Stop Abortion by Addict, Her Brother Steps In*, N.Y. TIMES, Feb. 23, 1992, at A16.

E. Expansion of the State's Homicide Laws will Undermine Accepted Standards of Care for Treating Women Who Suffer Stillbirths

Following stillbirth, parents, and particularly mothers, usually experience intense bereavement and grief. *See e.g.,* L. Hammersley & C. Drinkwater, *The Prevention of Psychological Morbidity Following Perinatal Death,* 47 BRIT. J. OF GENERAL PRACTICE 583 (1997). Feelings of depression, guilt, anxiety, isolation, and bitterness are often heightened when fetal loss occurs late in pregnancy. H. Janssen et al., *Controlled Prospective Study on the Mental Health of Women Following Pregnancy Loss*, 153 AM. J. PSYCHIATRY 226 (1996). Grief is exacerbated by the physical and emotional strain stemming from giving birth to a stillborn child. Consequently, parents who suffer fetal loss often grieve with the same

intensity as those who lose a close relative, and need to engage in certain rites and rituals. K. Kobler et al, "*Meaningful Moments: the Use of Ritual in Perinatal and Pediatric Death*," 32 AMER. J. MATERNAL/CHILD NURSING 288, 290-293 (2007).

As with other momentous medical events, physicians and psychologists have developed treatment protocols to address the psychosocial difficulties that accompany stillbirth. Interpreting the homicide laws to apply to stillbirths and allowing this prosecution to go forward will upend all accepted medical standards for the care of women who suffer stillbirths. *See* K. Gold, *Navigating Care After a Baby Dies: a Systematic Review of Parent Experiences with Health Providers,* 27 J. PERINATOL. 234 (2007) ("Any hospital which provides obstetrical or pediatric care should establish training and protocol for fetal and infant death.")

Such an interpretation of the law shifts pregnancy loss from a medical and public health matter (occasioning treatment and support) to a potential criminal act requiring forensic investigation and state sanctioned punishment. As a likely consequence, therapy and support for many women who suffer stillbirths will be compromised and curtailed, if not withdrawn altogether, in the wake of law enforcement needs.

II. Neither Law Nor Medical Science Supports the Application of Oklahoma's Homicide Laws to Women Who Suffer Pregnancy Losses.

A. The Existing Scientific Record Does Not Support the Popular Assumption That Illicit Drugs Such As Methamphetamine Pose Uniquely High or Well-Established Risks of Harm Including Stillbirth.

Criminal proscription of methamphetamine relates to its potential for abuse and its potential to induce dependence, *see* 21 U.S.C. §. 812, not to any proven unique risk to fetuses. A national expert panel recently reviewed published studies concerning the developmental effects of methamphetamine and related drugs, and concluded that "the data

regarding illicit methamphetamine are insufficient to draw conclusions concerning developmental toxicity in humans." Center For The Evaluation Of Risks To Human Reproduction, REPORT OF THE NTP-DERHR EXPERT PANEL ON THE REPRODUCTIVE & DEVELOPMENTAL TOXICITY OF AMPHETAMINE & METHAMPHETAMINE (2005), 163, 174.

In 2006, the American College of Obstetrics and Gynecology ("ACOG") created a special information sheet about methamphetamine use in pregnancy, noting 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." ACOG, *Information about Methamphetamine Use in Pregnancy* (3/03/06) (Appendix B). In 2005, more than 90 leading medical doctors, scientists, psychological researchers, and treatment specialists released an open letter requesting that "policies addressing prenatal exposure to methamphetamines and media coverage of this issue be based on science, not presumption or prejudice" and warning that terms such as "meth babies" lack medical and scientific validity and should not be used. *See* CESAR Weekly Fax from the Center for Substance Abuse Treatment, Vol 14 Issue 33 (Aug 2005).

Most recently, a peer-reviewed research article concerning stillbirths concluded that "despite widespread reports linking methamphetamine use during pregnancy with preterm birth and growth restriction, *evidence confirming its association with an increased risk of stillbirth remains lacking*." Silver, *et al.*, *Workup of Stillbirth: A Review of the Evidence*, 196 AMER. J. OBSTETRICS & GYNECOLOGY, 433-444, 438 (May 2007) (emphasis added) (Appendix B.)

Nearly two decades of experience with misinformation about the effects of *in utero* cocaine exposure counsels that assumptions about illegal drug use must be carefully scrutinized. Previous courts have properly refused to expand the reach of criminal laws to the context of pregnancy based on public fears fueled largely by media accounts and a handful of methodologically flawed research studies suggesting that cocaine use during pregnancy had yielded a "lost generation" of irretrievably damaged "crack babies." L. Gómez, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE 14 (1997).

Although responsible voices struck a cautionary note by emphasizing that findings concerning biological effects were "contradictory" and that evidence of harm remained "slim" and "inconclusive" *See*, *e.g.*, Mayes, et al., *The Problem of Prenatal Cocaine Exposure: A Rush to Judgment*, 267 JAMA 406 (1992), a comprehensive analysis of the adverse developmental effects of cocaine exposure did not appear until 2001. The conclusion of the analysis was that the claimed link between prenatal exposure to cocaine and harm to children was largely unfounded. *See* D. Frank, *et al., Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613 (2001). The Oklahoma Department of Health has also concluded that the alleged physical and mental developmental delays of "crack babies" have not been experienced as expected. (*Oklahoma State Plan*, *supra,* 78.)

The principal import of existing research is not that methamphetamine ingestion during pregnancy is "safe," but rather that no legal basis exists for assuming that the risks presented by this drug are any greater than those associated with many other conditions and activities common in pregnancy.

B. Risks Associated With Drug-Dependency Are Not Different In Kind or Magnitude from Other Pregnancy Risks.

As many as 20-30 percent of all pregnancies end in miscarriage or stillbirth. Approximately 26,000 American women experience stillbirths each year, an estimated 247 of whom are from Oklahoma. *See* MacDorman, Marian, et. al, *Fetal and Perinatal Mortality – United States – 2003*, National Vital Statistics Reports, Center for Disease Prevention and Control, Volume 55, Number 6, page 12. At least ten percent but as many as fifty percent of all stillbirths go entirely unexplained. *See,* WILLIAMS OBSTETRICS 1073 (F.G. Cunningham et al. eds., 21st ed. 2001) at 1075. *See also* M.A. Sims & K.A. Collins, Fetal Death: A 10-Year Retrospective Study, 22 AM. J. FORENSIC MED. & PATH. 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 (Apr. 2001). http://www.nationalshareoffice.com/about_research_sb_research.shtml

While the causes of stillbirth remain relatively unknown, numerous substances, circumstances and behaviors are *associated* with increased risks of harm including stillbirth -- many of the substances are far more well-established and frequently used than all illegal drugs combined and there is far more research supporting an association between those substances and pregnancy outcome. For example, fetal harm and pregnancy loss "resulting" from cigarette smoking are serious and well-established. *See* K. Wisborg, *et al.*, *Exposure to Tobacco Smoke in Utero and the Risk of Stillbirth and Death in the First Year of Life*, 154 AM. J. EPIDEMIOLOGY 322 (2001); *see also* CASA REPORT at 39 (cigarettes are "the single most powerful determinant of poor fetal growth in the developed world.")

Similarly, potential harm from prenatal exposure to alcohol is significantly more well-established than those associated with prenatal exposure to illegal drugs. *See Oklahoma State Plan*, *supra,* 77 ("Alcohol has a greater and longer-lasting developmental effect . . . than that of cocaine or other illicit drugs."); *see also Fetal Alcohol and Drug Effects*, NEUROLOGIST 9(6): 267-279 (2003) (alcohol "is linked to life-long impairments).

There is at least a comparable basis for concern about the potential for serious adverse effects of numerous prescription drugs, including anticonvulsants, mood-stabilizers, benzodiazepines (a class which includes Valium, Librium and Xanax), as well as some antibacterial, anticoagulant, and antihypertensive drugs. *See* K. Jones, SMITH'S RECOGNIZABLE PATTERNS OF HUMAN MALFORMATION. p. 495 (5th ed. 1997); J Berstein, HANDBOOK OF DRUG THERAPY IN PSYCHIATRY, pp. 407-25 (2d ed. 1988); THE MERCK MANUAL OF DIAGNOSIS AND THERAPY, p. 1859 (R. Berkow ed., 16th ed. 1992.) Accutane, a popular skin medication, has been called "the most widely prescribed birth-defect causing medicine in the United States." E. Rafshoon, *What Price Beauty?* BOSTON GLOBE MAGAZINE (April 27, 2003), p. 15 (Describing confirmed reports of 160 drug-affected births.)

Women who take fertility drugs and choose to carry three or more embryos to term often experience pregnancy loss and risk severe, lifelong harm to the children who survive. B. Steinbock, *The McCaughey Septuplets: Medical Miracle or Gambling with Fertility Drugs?,* ETHICAL ISSUES IN MODERN MEDICINE (5th ed.) 375, 376 (1999) ("Even if they are born alive, 'super-twins' (triplets, quadruplets and quintuplets) are 12 times more likely than other babies to die within a year.") Other factors are also highly associated with stillbirth and poor pregnancy outcomes. *See Kentucky v. Welch*, 864 S.W.2d 280, 283 (Ken. Sup. Ct. 1993), *Reinesto v. Superior Court*, 894 P.2d 733 (Ariz. App. Div. 1995) (identifying poor

nutrition, maternal age and genetic make-up as only a few of the many factors that could significantly affect the heath of a fetus.)

"Women ages 35 and older who bear children are at a significantly increased risk of giving birth to low birth weight babies and may have increased risk of stillbirth," even when controlling for diabetes, hypertension, and other complications associated with increased maternal age. *See* Tough, et al., *Delayed Childbearing and Its Impact on Population Rate Changes in Lower Birthweight, Multiple Birth, and Preterm Delivery*, 109 PEDIATRICS 399-403 (March 2002). So do those who suffer from hyperthyroidism and other diseases. *See*, e.g., Atkins, et al., *Drug Therapy for Hyperthyroidism in Pregnancy: Safety Issues for Mother and Fetus,* 23 DRUG SAFETY 229 (2000), and women employed in certain jobs. *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 Johnson Controls*, 886 F.2d 871, 914 & n.7 (7th Cir. 1989) (Easterbrook, J., dissenting) (noting that an estimated 15 to 20 million jobs entail exposure to chemicals that pose fetal risk); Khattak, et al., *Pregnancy Outcome Following Gestational Exposure to Organic Solvents: a Prospective Controlled Study*, 281 JAMA 1106-9 (1999) (finding that pregnant women exposed to organic solvents on the job have a 13-times greater risk of giving birth to babies with major malformations than those not exposed).

Pregnancy outcome is also influenced by actions or inactions women take before ever becoming pregnant. For example, in Oklahoma, 21.5% of women with a recent live birth were not aware of folic acid benefits before they became pregnant, 73.5% did not consume multivitamins at least four times per week during the month before pregnancy, and 84.8% did not receive preconception counseling from a health-care provider. *See* Surveillance of Preconception CDC, MMWR Weekly, *Health Indicators Among Women Delivering Live-*

Born Infants --- Oklahoma, 2000--2003, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5625a3.htm. Finally, pregnancy outcome does not depend on the woman alone. Studies demonstrate that the outcome can also be influenced by male contribution. *See* Daniels, C.R. EXPOSING MEN, THE SCIENCE AND POLITICS OF MALE REPRODUCTION, 124 (2006) (linking pregnancy loss to paternal workplace exposure to ionizing radiation and paternal smoking.)

Because the risks associated with drug-dependency are not fundamentally different from other pregnancy risks, singling out stillbirths that occur to pregnant drug users for homicide prosecutions lacks rational basis and opens the door to unprecedented and counterproductive surveillance and punishment of women who seek to carry their pregnancies to term.

C. Criminally Prosecuting A Drug-Dependent Woman For Drug Use During Pregnancy Misunderstands The Nature of Addiction.

1. The Threat Of Criminal Prosecution Is Not Effective in Addressing Drug Use by Pregnant Women

There is no empirical evidence that criminal prosecution has significantly reduced the rate of drug use in the United States. *See* Jeffrey A. Miron, *The Economics of Drug Prohibition and Drug Legalization*, SOCIAL RESEARCH (2001). For addicts, criminal prosecution has virtually no impact on use. Similarly, risk of prosecution does not dissuade pregnant women from using drugs. *See* Antoinette Clarke, *Fins, Pins, Chips & Chins: A Reasoned Approach to the Problem of Drug Use During Pregnancy*, 29 SETON HALL L. REV. 634, 659 (1994). Applying Oklahoma's homicide statute to women like Ms. Hernandez simply will not work to protect fetal health or deter prenatal drug use. "Enforcement of these laws does not deter addicts from using drugs during pregnancy; it is unrealistic to believe that heavier penalties will make a difference." *Id*.

Comprehensive treatment is a better method for addressing drug dependence than incarceration. Congress has recognized the important benefits of "encouraging all women to abstain from alcohol consumption during pregnancy," but has identified "educational and vocational training, appropriate therapies, counseling, medical and mental health, and other supportive services," as the proper means of pursuing that objective. (42 U.S.C. § 280f.)

2. Addiction Presents Complex Health and Welfare Issues, Not Properly Addressed Through the Expansion of the Criminal Law.

Women, upon becoming pregnant, do not suddenly have greater access to the right kinds of health care, better housing, safer environments, or enhanced capacity to overcome behavioral health problems such as diabetes, obesity, and addiction. While numerous studies indicate that pregnant women are especially motivated to address addiction and change behavior for "the sake of the child," *See e.g.*, Murphy & Rosenbaum, *supra*, 83-99; Susan C. Boyd, MOTHERS AND ILLICIT DRUGS: TRANSCENDING THE MYTHS (1999), pregnancy does not create unique capacity to obtain and maintain recovery on pregnancy's timetable.

Courts and 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." 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); National Academy of Sciences, Institute of Medicine, DISPELLING THE MYTHS ABOUT ADDICTION, Ch. 8.

Although there has been extensive debate within the treatment community regarding whether addiction is a "disease," there is no dispute that addiction has biological and genetic

dimensions. *See Linder v. United States*, 268 U.S. 5, 18; 45 S.Ct. 446, 449; 69 L.Ed. 2d 819 (1925); *Robinson v. California*, 370 U.S. 660, 667; 82 S.Ct. 1417, 1420; 8 L.Ed. 2d 758 (1962); American Psychiatric Ass'n, THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS - 4TH EDITION (2000) ("DSM-IV-TR"), 176-181 (specifying diagnostic criteria for "Substance Dependence"); (*Oklahoma State Plan*, *supra,* 75.) (Oklahoma's Department of Health acknowledging the biological nature of addiction, finding that an individual's genetic predisposition to addiction was "responsible for 60% to 80% of the differences in abuse and dependence.")

As a matter of law and medical science, addiction is marked by "compulsions not capable of management without outside help." *Robinson*, 370 U.S. at 671; 82 S.Ct. at 1422; 8 L.Ed. 2d 758 (Douglas, J., concurring); *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.") As described in the DSM-IV-TR, one of the hallmarks of drug dependency is the inability to reduce or control substance abuse despite adverse consequences. DSM-IV-TR, at 179. *See also National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 676 (1989) ("[A]ddicts may be unable to abstain even for a limited period of time.") This is why the vast majority of drug-dependent people -- whether they are prominent radio talk show hosts, respected physicians in the community, or low-income mothers of five -- cannot simply "decide" to refrain from drug use or achieve long-term abstinence without appropriate treatment.

Criminal punishment is especially inappropriate for drug-dependent women because in many cases women turn to drug use to self-medicate the trauma of prior sexual abuse. A startling series of research findings link a high proportion of substance-abusing women to

early sexual abuse. *See* CASA REPORT, *supra*, at 8; *see also* Hans, *Demographic and Psychosocial Characteristics of Substance-Abusing Pregnant Women*, 26 CLIN. PERINATOL., 55-74 (1999); Martin, *Women in a Prenatal Care/Substance Abuse Treatment Program: Links Between Domestic Violence & Mental Health*, 2 MATERNAL CHILD HEALTH J. 85-94 (1998) (reporting that 42% of substance abusing women had experienced both sexual violence and other forms of physical violence.).

3. Low Income, Vulnerable Pregnant and Parenting Women Face Numerous Obstacles to Accessing Appropriate Drug Treatment and Other Health Care

Federal, State, and Health agencies recognize the effectiveness of drug treatment. *See, e.g.*, U.S. Substance Abuse & Mental Health Service Admin., THE NATIONAL TREATMENT IMPROVEMENT EVALUATION STUDY (1997); National Ass'n of State Alcohol & Drug Abuse Directors, TREATMENT WORKS: A REVIEW OF 15 YEARS OF RESEARCH FINDINGS ON ALCOHOL AND OTHER DRUG ABUSE TREATMENT OUTCOMES (1990); Marwick, *Physician Leadership on National Drug Policy Finds Addiction Treatment Works*, 279 JAMA 1149 (1998); Oklahoma Department of Mental Health and Substance Abuse Services ("ODMHSAS") *The Impact of Treatment on Substance Abuse* Fact Sheet, http://www.odmhsas.org/News%20Stories%20PDF/09-03%20Impact%20of%20Substance%20Abuse%20Treatment %20Fact%20Sheet.pdf). Unfortunately, many people, particularly marginalized populations such as low income women, have difficulty obtaining treatment. As an ODMHSAS Overview notes, "[m]any barriers keep people from the treatment they need." ODMHSAS, *Overview: Access to Recovery From Alcohol and Drug Use Disorders,* ("Overview") http://www.odmhsas.org/New04PDF/08-20-4%20Access%20to%20Recovery%20Facts.pdf. Among these are the "cost of treatment," noting that as " state budgets tighten, the money

available to fund treatment programs is shrinking, making it more difficult for Americans to obtain access to local treatment programs." (*Id*.) For many Oklahomans, including the more than 600,000 who have no health insurance whatsoever, access to medical care of any kind may be beyond their reach. (http://www.captc.org/pubpol/Medicaid/Oklahoma_uninsured.pdf.) Furthermore, many women have significant care responsibilities for children and other family members, often rendering inaccessible the treatment that is available or to which they are referred or even ordered to go. *See* ODMHSAS Overview (specific barriers include "treatment systems that do not have the facilities or staff to accommodate the needs of some individuals" such as those with "childcare issues.") As a study of Oklahoma Incarcerated Women and their Children noted, in many cases the only "treatment" women received were twelve-step programs (AA/NA) or some form of substance abuse education. *See* http://www.okkids.org/documents/Phase2.pdf, at 12-14. The shortage of appropriate drug treatment for pregnant women compounds the difficulty of ending addiction as does a climate of fear engendered by prosecutions for drug use.

Finally, while women can and do take many steps to improve pregnancy outcomes, including obtaining prenatal care and drug treatment, no woman can guarantee that she has a healthy pregnancy. Because addiction, recovery, and pregnancy itself are complex medical and public health issues, not simply matters of willpower, they should not be addressed through the expansion of the state's homicide laws.

CONCLUSION

The Oklahoma County prosecutor's effort to radically reinterpret state homicide laws to apply to the context of pregnancy should be dismissed because it lacks foundation in both

law and medicine and threatens substantial harm to maternal and fetal health throughout the State of Oklahoma.

Respectfully submitted,

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