IN THE COURT OF APPEALS FOR MUSKINGUM COUNTY, OHIO
FIFTH APPELLATE DISTRICT

STATE OF OHIO,	:	Court of Appeals Case No.: CT2022-0031
	:	
Appellee,	:	On Appeal from
	:	the Court of Common Pleas of
v.	:	Muskingum County, Ohio
	:	Criminal Division
TARA HOLLINGSHEAD	:	
	:	Case No.: CR2021-0494
Appellant.	:	

BRIEF *INSTANTER* OF *AMICI CURIAE* MEDICAL AND PUBLIC HEALTH EXPERTS IN SUPPORT OF APPELLANT

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I. INTERESTS OF *AMICI CURIAE*

Amici curiae (collectively, *Amici*) include eight Ohio and national organizations and 31 individuals with recognized expertise in the areas of maternal, fetal, and neonatal health and in understanding the effects of drug use on pregnant people, pregnancies, and babies. For the convenience of the Court, *Amici*'s statements of interest are set forth in the Appendix hereto. *Amici* respectfully request that this Court reverse the conviction of Appellant Tara Hollingshead and address a question of first impression raised by her criminal conviction in this case. The conviction, without legal basis, expands the scope of the crime of Corrupting Another with Drugs, R.C. 2925.02, to include women in relation to their own pregnancies, and endangers – rather than protects – pregnant women, fetuses, and children.

II. SUMMARY OF CASE

In May 2021, after giving birth to her child, Tara Hollingshead was charged pursuant to R.C. 2925.02(A)(5) with corruption of another with a fentanyl-related compound (in this case, herself). Although she challenged the applicability of this provision in a pretrial motion to dismiss, as well as a Criminal Rule 29 motion, she was found guilty on April 28, 2022 by a jury in Muskingum County Common Pleas Court. The trial took ninety minutes in total, with a little over an hour of deliberation by the jurors. Ms. Hollingshead was sentenced to 8-12 years in prison.

III. SUMMARY OF THE ARGUMENT

This case presents a question of first impression in Ohio and one of monumental importance to the health and well-being of Ohio women and their families. The prosecutor's expansion of the criminal code, the trial court's sanction of that expansion and refusal to entertain the question of what "another" means in the statute, and Ms. Hollingshead's conviction constitute impermissible prosecutorial and judicial expansions of the criminal code. R.C. 2925.02(A)(5) prohibits "furnish[ing] or administer[ing] a controlled substance to a pregnant woman … when the

offender knows that the woman is pregnant." The prosecutor, court, and jury then applied that law to a pregnant woman using drugs *herself*. Appellant's conviction has created new law that reaches well beyond the General Assembly's clear intent, to permit the improper prosecution and punishment of a pregnant woman for furnishing drugs to herself, with profound and detrimental implications for the health and welfare of women, children, and families.

Amici urge this Court to reverse the conviction below and deny the trial court's expansion of this criminal statute. As Appellant demonstrates in her brief, such expansion is contrary to the plain language and legislative history of the statute, as well as the rules of construction this Court might apply to the statute if it deems it ambiguous. Moreover, it is contradicted by scientific research that confirms that illegal drugs cannot be singled out from innumerable other actions, inactions, and exposures that pose potential risks to a fetus or to a child once born; is contrary to the consensus judgment of medical practitioners and their professional organizations; and undermines individual and public health.

Amici are committed to reducing potential drug-related harms at every opportunity. *Amici* do not endorse the nonmedicinal use of drugs—including alcohol, caffeine, or tobacco—during pregnancy. Nor do *Amici* assert that there are no health risks associated with the use of controlled substances during pregnancy. *Amici* recognize a strong societal interest in protecting the health of women, children, and families. In the view of *Amici*, however, such interests are undermined, not advanced, by the judicial expansion of the corrupting-another-with-drugs statute to apply to pregnant women who self-administer drugs. As the Appellant explains in detail in her brief, the General Assembly agrees, because it has consistently declined to enhance criminal punishments for pregnant women—going back to its 1991 decision not to enact S.B. 82, which would have criminalized prenatal maternal drug use.

The consequences of Ms. Hollingshead's conviction for pregnant women and their families are significant and far-reaching. 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.[1]

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 development of the law, this Court should find: (1) that R.C. 2925.02(A)(5) was not intended to apply to pregnant women who furnish drugs to themselves; and (2) that claims concerning substance use and pregnancy must be supported by evidence-based scientific research and public health recommendations.

A. The Conviction Should Be Reversed Because the Prosecutorial and Judicial Expansion of the Corrupting Another with Drugs Statute to Punish Pregnant Women Who Self-Administer Drugs Endangers Maternal, Fetal, and Child Health

As is argued more fully in the Appellant's brief, after reviewing relevant policy concerns and expertise, the General Assembly demonstrated clear intent not to include pregnant women as a category of criminal actors, recognizing that targeting pregnant women for specific criminal charges—that do not apply to any other category of person—harms rather than helps maternal, fetal, and child health.[2]

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[1] McCabe, *Criminalization of Care: Drug Testing Pregnant Patients*, J. Health & Social Behavior (Nov. 18, 2021), 162–76.

[2] *See* Appellant's Brief, Part II.

1. Sanctioning this Prosecutorial Expansion of the Law and Permitting this Conviction to Stand Will Deter Pregnant Women from Seeking Health Care for Themselves or Their Families

Comprehensive, early, and high-quality prenatal care is one of the most effective ways to promote maternal and fetal health, especially for women experiencing a substance use disorder.[3] The best way to manage opioid use disorder is with the assistance of a trusted medical provider who knows what exposures exist.[4] Additionally, the risks of illicit drug use—other substances mixed with the drug, infectious complications, unpredictable doses—can be mitigated through harm reduction strategies, supervised drug use, or medications for opioid use disorder.[5] Prosecuting women for drug use and pregnancy will deter pregnant women from seeking prenatal care,[6] erodes trust in the medical system,[7] and will increase the negative health ramifications of pregnant mothers and their families.

All leading medical and public health organizations in the country, of which many *Amici* are leading members, have concluded that criminal responses to pregnancy and drug use are

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[3] Harm Reduction Coalition and Academy of Perinatal Harm Reduction, *Pregnancy and Substance Use Toolkit* ("Harm Reduction Toolkit"), https://harmreduction.org/wp-content/uploads/2020/10/09.17.20_Pregnancy-and-Substance-Use-2.pdf (accessed July 14, 2022), at 41.

[4] Harm Reduction Toolkit at 41.

[5] *Id.* at 26, 28-29.

[6] Haffajee et al., *Pregnant Women with Substance Use Disorders—The Harm Associated with Punitive Approaches*, 384 N. Engl. J. Med. 2364 (2021); Faherty et al., *Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome*, JAMA Network Open (Nov. 2019); Goodman et al., *It's Time to Support, Rather Than Punish, Pregnant Women With Substance Use Disorder*, JAMA Network Open (2019).

[7] Am. Coll. Of Obstetricians & Gynecologists, *Opposition to Criminalization of Individuals During Pregnancy and Postpartum Period* (2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period (accessed July 14, 2022).

harmful, because such responses undermine maternal, child, and public health. Many of these national medical associations have chapters and members in Ohio and several *Amici* hold leadership positions in these chapters. For example, several of the *Amici* hold leadership positions within the American College of Obstetricians and Gynecologists ("ACOG"), which recognizes:

> [c]onfidentiality and trust are at the core of the patient-practitioner relationship. Policies and practices that criminalize individuals during pregnancy and the postpartum period create fear of punishment that compromises this relationship and prevents many pregnant people from seeking vital health services.[8]

ACOG has further determined that punitive responses pose "serious threats to people's health and the health system itself ... [by] erod[ing] trust in the medical system, making people less likely to seek help when they need it." Further, "[t]he fear of interrogation, arrest, and prosecution while seeking health care services and medical treatment creates a barrier to accessing care. Any statute or legal measure that utilizes the criminal legal system as a way to control or manage behaviors during pregnancy is counterproductive to the overarching goal of improving maternal and neonatal outcomes."[9] For these and other reasons, numerous other leading health organizations, such as the American Psychiatric Association have concluded that "[a] public health response, rather than a punitive legal approach to substance use during pregnancy is critical."[10]

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[8] *Id.*

[9] *Id.*

[10] Am. Psychiatric Assn., Position Statement, *Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders* (2019); *see also* March of Dimes, Fact Sheet, *Policies and Programs to Address Drug-Exposed Newborns* (2014) ("The March of Dimes opposes policies and programs that impose punitive measures on pregnant women who use or abuse drugs... The March of Dimes believes that targeting women who used or abused drugs during pregnancy for criminal prosecution or forced treatment is inappropriate and will drive women away from treatment vital both for them and the child"); Natl. Perinatal Assn., Position Statement, *Perinatal Substance Use* (2017) (Criminalization and incarceration are ineffective and harmful to the health of the pregnant person and their infant.); Am. Soc. of Addiction Medicine, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (2017, archived) ("State and local governments should ... should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care

Further, the American Medical Association has concluded that "[t]ransplacental drug transfer should not be subject to criminal sanctions or civil liability..."[11] Likewise, the American Academy of Pediatrics Committee on Substance Use and Prevention concluded that "[t]he existing literature supports the position that punitive approaches to substance use in pregnancy are ineffective and may have detrimental effects on both maternal and child health."[12]

As the American Psychological Association explains, "punitive approaches result in women being significantly less likely to seek substance use treatment and prenatal care due to fear of prosecution and fear of the removal of children from their custody. This places both the mother and her children at greater risk of harm."[13] Similarly, the American Nurses Association explains,

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services for these women"); Assn. of Women's Health, Obstetric and Neonatal Nurses, *Criminalization of Pregnant Women with Substance Use Disorders* (2015) ("Laws that criminalize drug use during pregnancy have the potential to deter women from seeking prenatal and maternity care that can provide access to appropriate counseling, referral, and monitoring."); Assn. of Women's Health, Obstetric and Neonatal Nurses, Position Statement, *Optimizing Outcomes for Women's Health, Obstetric and Neonatal Nurses* (2019) ("The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) opposes laws and other reporting requirements that result in incarceration or other punitive legal actions against women because of a substance use disorder (SUD) in pregnancy and the postpartum period."); Am. Coll. of Nurse-Midwives, Position Statement, *Substance Use Disorders in Pregnancy* (updated 2018) ("Patients should not be deterred from seeking care during pregnancy due to fear of prosecution.")

[11] Am. Med. Assn., *A Public Health Response to Opioid Use in Pregnancy* (2017); *Legal Interventions During Pregnancy* ("Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.").

[12] Am. Acad. of Pediatrics, Committee on Substance Use and Prevention, Policy Statement, *A Public Health Response to Opioid Use in Pregnancy* (2017).

[13] Am. Psych. Assn., *Pregnant and Postpartum Adolescent Girls and Women with Substance-Related Disorders* (March 2020) https://www.apa.org/pi/women/resources/pregnancy-substance-disorders.pdf (accessed July 14, 2022) (citing Faherty et. al., *Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome*, JAMA Network Open (2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2755304 (accessed July 14, 2022)).

"[c]ontrary to claims that prosecution and incarceration will deter pregnant women from substance use, the greater result is that fear of detection and punishment poses a significant barrier to treatment."[14]

Finally, recent research confirms that criminal legal responses to pregnancy and drug use not only deter pregnant women from seeking medical care,[15] but also that such responses have demonstrable negative impacts on fetal and neonatal health. Tennessee is the only state in the country to date to pass a criminal law specifically targeting pregnant women for actions during their pregnancy. Its "fetal assault" law passed in 2014, but the legislature allowed it to sunset in 2016 after seeing its negative impact.[16] Empirical research found that Tennessee's "fetal assault" law "resulted in twenty fetal deaths and sixty infant deaths" in 2015 alone.[17] Another empirical study found a higher prevalence of neonatal abstinence syndrome in states with punitive policies in effect.[18]

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[14] Am. Nurses Assn., Position Statement, *Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders* (2017).

[15] See Stone, *Pregnant women and substance use: fear, stigma, and barriers to care*, Health Justice (Nov. 12, 2015), https://doi.org/10.1186/s40352-015-0015-5 (accessed July 14, 2022); Bach, *Prosecuting Poverty, Criminalizing Care,* 60 William & Mary L. Rev. 3 (2019); SisterReach et. al., *Tennessee's Fetal Assault Law: Understanding its impact on marginalized women* (Dec. 14, 2020) https://www.sisterreach.org/uploads/1/2/9/0/129019671/abbreviated_report.pdf (accessed July 14, 2022); Roberts et al., *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care,* 15 Maternal Fetal Health J. 33 (2011).

[16] Boone & McMichael, *State-Created Fetal Harm,* 109 Georgetown L. J. 475 (2021) 501, 514; see also Bach, *Prosecuting Poverty, Criminalizing Care*, 60 William & Mary L. Rev. 3 (2019); SisterReach et. al., *Tennessee's Fetal Assault Law: Understanding its impact on marginalized women* (Dec. 14, 2020).

[17] Boone & McMichael, *State-Created Fetal Harm,* 109 Georgetown L. J. 475 (2021), 501, 514.

[18] Faherty et al., *Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome,* JAMA OPEN NETWORK (2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2755304 (accessed July 14, 2022); Haffajee et al., *Pregnant Women with Substance Use Disorders-The Harm Associated with Punitive Approaches,* 384 N. Eng. J. Med. 2364 (2021).

2. Allowing the Expansion of the Ohio Law and Appellant's Conviction to Stand Will Deter Pregnant Women from Sharing Vital Information with Health Care Professionals

In addition to deterring some women from seeking care altogether, the ruling below is also likely to undermine the provider-patient relationship for those women who do seek care. A relationship of trust is critical for effective medical care because the promise of confidentiality encourages patients to disclose sensitive subjects to a physician.[19] Open communication between pregnant women who are dependent on drugs and their health care providers is critical,[20] and courts have long viewed confidentiality as fundamental to this relationship.[21] Allowing the expansion of the law and conviction to stand would therefore place Ohio law directly at odds with the prevailing medical and public health recommendations regarding the treatment of pregnant women with substance use disorders, with potentially serious health consequences.

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[19] Iott et al., *Trust and Privacy: How Patient Trust in Providers is Related to Privacy Behaviors and Attitudes*, AMIA Symposium vol. 2019 (Mar. 4, 2020), 487-493 ("patients with higher trust in provider confidentiality have significantly lower likelihood of reporting having ever withheld important health information.").

[20] See 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), http://ajp.psychiatryonline.org/article.aspx?articleID=1745 91 (accessed July 14, 2022).

[21] 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). The Ohio Supreme Court has similarly recognized that physician-patient privilege is "designed to create an atmosphere of confidentiality, which theoretically will encourage the patient to be completely candid with his or her physician, thus enabling more complete treatment." *Ward v. Summa Health Sys.*, 128 Ohio St.3d 212, 217 (2010).

3. Allowing the Expansion of the Ohio Law and Appellant's Conviction to Stand Will Endanger Maternal and Fetal Health by Incarcerating Pregnant Women

Applying the criminal statute to pregnant women will result, not surprisingly, in the incarceration of more pregnant women.[22] Incarcerating pregnant women creates additional health risks for themselves and their developing pregnancies and is counterproductive to the goals of promoting maternal and fetal health.[23] Incarcerated pregnant women generally receive inadequate prenatal care[24] and are exposed to other health risks such as infectious disease,[25] poor sanitary conditions, poor nutrition,[26] sexual abuse,[27] high stress levels[28] and poor mental health care.[29] Furthermore, incarceration cannot guarantee that pregnant women abstain from the use of

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[22] Muskingum County Prosecutor's Office, *Press Release: Woman found guilty of injecting self with drugs while pregnant* (Apr. 29, 2022).

[23] *See generally* Sufrin, *Jailcare: Finding the Safety Net for Women behind Bars*, 1st Ed. (May 2017), https://www.ucpress.edu/book/9780520288683/jailcare (accessed July 14, 2022), and other related works at https://arrwip.org/publications-press/#journal (accessed July 14, 2022).

[24] Natl. Council on Crimes and Delinquency, *The Spiral of Risk: Health Care Provision To Incarcerated Women* (2006), 14, https://www.evidentchange.org/sites/default/files/publication_pdf/spiral-of-risk.pdf (accessed July 14, 2022).

[25] Am. Med. Assn. Bd. of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2667 (1990).

[26] Natl. Council on Crimes and Delinquency, *The Spiral Risk: Health Care Provision To Incarcerated Women* (2006), 16.

[27] Off. Inspector Gen., U.S. Dept. of Justice, *Deterring Staff Sexual Abuse of Federal Inmates*, (Apr. 2005) (Kathleen Sawyer, a former Bureau of Prisons Director, stated that inmate sexual abuse was the "biggest problem" she faced as Director.), https://oig.justice.gov/sites/default/files/legacy/special/0504/final.pdf (accessed July 14, 2022).

[28] Bastick & Townhead, Quaker United Nations Office, *Women in Prison: A Commentary on the U.N. Standard Minimum Rules for the Treatment of Prisoners* (June 2008), 57 ("The high level of stress that accompanies incarceration itself has the potential to adversely affect pregnancy.").

[29] *See, e.g.*, Crowder, *Settlement Filed in Tutwiler Prison Suit*, Birmingham News (June 29, 2004).

controlled substances,[30] nor that they consistently receive appropriate treatment for substance use disorder in jail.[31]

For instance, in Ohio, inmates who are pregnant and on methadone maintenance therapy are "evaluated on a case-by-case basis … to determine whether to maintain the therapy or to wean the patient during pregnancy," and "[f]ollowing delivery, all methadone maintenance therapy *shall* be discontinued."[32] This is a state-wide policy despite the fact that opioid agonist pharmacotherapy (such as methadone maintenance) "is the recommended therapy and is preferable to medically supervised withdrawal."[33] Furthermore, the rate of premature births in the incarcerated pregnant population in Ohio has been shown to significantly exceed that of the general population's rate.[34]

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[30] *See* Sue, *Getting Wrecked: Women, Incarceration, and the American Opioid Crisis* (Sept. 2019), https://www.ucpress.edu/book/9780520293212/getting-wrecked (accessed July 14, 2022); *Drugs Inside Prison Walls*, Wash. Times (Jan. 27, 2010) ("In many large state prison systems, a mix of inmate ingenuity, complicit visitors and corrupt staff has kept the level of inmate drug abuse constant over the past decade despite concerted efforts to reduce it."), https://www.washingtontimes.com/news/2010/jan/27/drugs-inside-prison-walls/ (accessed July 14, 2022).

[31] Sufrin et al., *Availability of Medications for the Treatment of Opioid Use Disorder Among Pregnant and Postpartum Individuals in US Jails*, JAMA Network Open. (2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788243 (accessed July 14, 2022).

[32] Ohio Dept. of Rehabilitation & Correction, *Women's Health Management* (Jan. 29, 2018), https://www.drc.ohio.gov/Portals/0/Policies/DRC%20Policies/68-MED-23%20(Jan%202018).pdf?ver=2018-01-30-095410-410 (accessed July 14, 2022) (Referencing RC 5101.55, 5101.56; Ohio Adm.Code 5120-9-57) (emphasis added).

[33] American College of Obstetricians and Gynecologists, *Opioid Use and Opioid Use Disorder in Pregnancy. Committee Opinion No. 711*, 130 Obstetrics and Gynecology 2 (2017), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy (accessed July 14, 2022).

[34] Wang, *Unsupportive environments and limited policies: Pregnancy, postpartum, and birth during incarceration*, Prison Policy Initiative (Aug. 19, 2021), https://www.prisonpolicy.org/blog/2021/08/19/pregnancy_studies/ (accessed July 14, 2022) (explaining the published findings of the groundbreaking Pregnancy in Prison Statistics (PIPS) Project and other datasets).

Such policies and conditions are antithetical to the health and well-being of pregnant women and their developing pregnancies.

Enforcing state separation between mother and newborn through incarceration also goes against best practices for treating substance-exposed newborns. The gold standard for treating substance-exposed newborns is by keeping mom and baby together (known as "rooming in"), encouraging breastfeeding, and for healthcare providers to provide trauma-informed care to the mother-infant dyad.[35] Studies prove promoting these practices will improve overall medical outcomes and [bio]psychosocial outcomes.[36] Sanctioning mothers and placing them in jail gravely threatens the lives of both the mother and the newborn; hence, engagement with high-quality, confidential health care divorced from the criminal legal system is the best approach for health outcomes.

B. The Expansion of the Law Makes Ohio an Outlier and Should be Reversed Because the Majority of Sister States Have Refused to Interpret the Criminal Law to Reach Women in Relation to the Fetuses They Carry

The vast majority of state appellate courts to have considered similar issues have refused to expand existing state laws, including drug delivery, child abuse, and homicide laws, to women who become pregnant and continue or attempt to continue to term despite a drug problem. For example, Texas's highest court refused to apply a broad interpretation of a drug delivery statute to pregnant women who use drugs[37] and Florida's highest court reversed the conviction of a woman

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[35] MacMillan et al., *Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome, A Systematic Review and Meta-analysis*, 172 JAMA Pediatr. 345 (2018); Grossman et al., *An Initiative to Improve the Quality of Care of Infants with Neonatal Abstinence Syndrome*, Pediatrics (2017); Abrahams et al., *Rooming-in compared with standard care for newborns of mothers using methadone or heroin*, 53 Can. Fam. Physician 1722 (2007).

[36] *Id.*

[37] *Ex parte Perales*, 215 S.W.3d 418 (Tex.Crim.App.2007).

who used cocaine during pregnancy for "delivering drugs to a minor."[38] A Georgia Court of Appeals held that a statute proscribing distribution of cocaine from one person to another did not apply to a pregnant woman in relation to her fetus; that to interpret the law otherwise would deprive pregnant women of fair notice; and that viewing addiction during pregnancy as a disease and addressing the problem through treatment rather than prosecution was the approach "overwhelmingly in accord with the opinions of local and national medical experts."[39] The Michigan Court of Appeals found that prosecuting a pregnant woman who used cocaine with drug delivery "is so tenuous that we cannot reasonably infer that the Legislature intended this application, absent unmistakable legislative intent."[40]

As another salient example, in 2010, the Supreme Court of Kentucky reversed the opinion of an appellate court and dismissed an indictment charging Ina Cochran for first-degree wanton child endangerment when she gave birth to an infant who tested positive for cocaine.[41] The lower court had judicially expanded the law because it believed the state's feticide law and *Commonwealth v. Morris*, which held that the feticide law supported a homicide charge where a man killed a pregnant woman and her fetus,[42] provided the basis for judicial expansion of the child endangerment law. The Kentucky Supreme Court refused to use these laws—which were intended to reach people who attack pregnant women, not pregnant women themselves—as a basis for rewriting its child endangerment law. The Kentucky Supreme Court concluded, as this Court

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[38] *Johnson v. State*, 602 S.2d 1288, 1296-97 (Fla.1992).

[39] *State v. Luster*, 419 S.E.2d 32, 35 (Ga.Ct.App.1992).

[40] *People v. Hardy*, 469 N.W.2d 50, 53 (Mich.App.1991).

[41] *Cochran v. Commonwealth*, 315 S.W.3d 325 (Ky.2010).

[42] 142 S.W.3d 654 (Ky.2004).

should, that "[i]t is the legislature, not the judiciary, that has the power to designate what a crime is."[43]

Other state courts have also rejected attempts by prosecutors to expand penal statutes in the context of pregnancy.[44]

If this Court allows the expansion of R.C. 2925.02 and Appellant's conviction to stand, it would make Ohio an extreme outlier among its sister states, the vast majority of which have

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[43] *Cochran*, 315 S.W.3d at 330; *see also State v. Geiser*, 763 N.W.2d 469, 471-74 (N.D.2009) (holding that the child endangerment law could not be expanded to punish a pregnant woman who experienced a stillbirth); *State v. Wade*, 232 S.W. 3d 663, 666 (Mo.2007) (despite Missouri's legal authority for protecting the unborn against third parties, legislature did not create penalties for women who experienced poor pregnancy outcomes); *Kilmon v. State*, 905 A.2d 306, 313-14 (Md.2006) (holding reckless endangerment statute not applicable to pregnant drug using women who went to term); *State v. Aiwohi*, 123 P.3d 1210, 1214 (Haw.2005) (holding that the use of the term "person" in the manslaughter statute does not include unborn children); *State v. Gray*, 62 Ohio St.3d 514 (1992) (Ohio Supreme Court holding that the criminal child endangerment statutes did not encompass a pregnant woman who used cocaine).

[44] *See State v. Martinez*, 137 P.3d 1195, 1197 (N.M.Ct.App.2006) ("this court may not expand the meaning of 'human being' to include an unborn viable fetus because the power to define crimes and to establish criminal penalties is exclusively a legislative function"); *State v. Gethers*, 585 So. 2d 1140 (Fla.Dist.Ct.App.4thDist.1991); *Reinesto v. Superior Court*, 894 P.2d 733, 736-37 (Ariz.Ct.App.1995); *State v. Dunn*, 916 P.2d 952, 955-56 (Wash.App.1996); *Reyes v. Superior Court*, 141 Cal. Rptr. 912 (Cal.Ct.App.1997) (all following rules of statutory construction and lenity and refusing to rewrite state child abuse laws to permit punishment of pregnant drug using women who went to term); *State v. Deborah J.Z.*, 596 N.W. 2d 490 (Wis.Ct.App.1999) (granting motion to dismiss first degree homicide and reckless conduct charges brought against a woman who used alcohol during pregnancy). Despite the state's effort to distinguish sister state cases, the core holding in all is the same: plain meaning and clear legislative intent of the states' laws, like Ohio's, did not support the interpretation urged by prosecutors. *See, e.g., Herron v. State*, 729 N.E.2d 1008, 1011 (Ind.App.2000) ("We cannot expand the General Assembly's definition of a dependent and, consequently, the intended application of the neglect of a dependent statute, beyond the fair meaning of the words used. [The statutes] do not criminalize conduct that occurs prior to a child's birth.").

refused to judicially expand the scope of existing criminal statutes to reach the context of pregnancy and birth.[45]

C. The Expansion of the Law is Not Supported or Justified by Scientific Research

Implicit in Appellant's prosecution and conviction is the assumption that harm from prenatal exposure to controlled substances—including illegal drugs—is so great that prosecuting attorneys and trial courts should create new criminal penalties where the General Assembly has not. Evidence-based research, however, does not support the popular, but medically unsubstantiated, assumption that any amount of prenatal exposure to an illegal drug causes unique, severe, or certain harm.[46] Rather, there is no conclusive evidence that exposure to illegal drugs causes harms greater than or different from harm resulting from exposure to legal drugs and

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[45] Even though in several of these states, as in Ohio, civil wrongful-death laws have been expanded to permit recovery for viable fetuses, and in some states, non-viable fetuses, these courts have refused to expand criminal statutes similarly.

[46] Reddy et al., *Opioid Use in Pregnancy, Neonatal Abstinence Syndrome, and Childhood Outcomes: Executive Summary of a Joint Workshop by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Maternal-Fetal Medicine, Centers for Disease Control and Prevention, and the March of Dimes Foundation*, 130 Obstetrics and Gynecology 10 (2017), 10-28 ("The long-term outcome of children with neonatal abstinence syndrome is virtually unknown"); Schempf & Strobino, *Illicit Drug Use and Adverse Birth Outcomes: Is It Drugs or Context?*, 85 J. Urban Health 858 (2008), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2587644/pdf/115 24_2008_Article_9315.pdf (accessed July 14, 2022); Bandstra et al., *Prenatal Drug Exposure: Infant and Toddler Outcomes*, 29 J. Addictive Diseases 245 (2010); Schempf, *Illicit Drug Use and Neonatal Outcomes: A Critical Review*, 62 Obstetric and Gynecological Survey (2007), 749-750 ("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."); Thompson et al., *Prenatal Exposure to Drugs: Effects on Brain Development and Implications for Policy and Education*, 10 Nature Revs. Neuroscience 303 (2009), 303 ("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.").

innumerable actions, conditions, and circumstances common to pregnant women, like poverty.[47] Without evidence of harm, with strong public health evidence to the contrary, and out of respect for the proper role of the legislature versus the courts, this Court should reject the prosecutor and lower court's expansion of R.C. 2925.02 and reverse Ms. Hollingshead's conviction.

1. Popular Concern about Children's Outcomes after Drug Exposure During Pregnancy Is Misguided and Unsupported by the Scientific Literature, Dating Back to the "Crack Baby" Myth That Has Long Been Discredited

Drug exposure is often first discovered in a hospital setting via clinical drug testing. The establishment of testing and reporting practices originates from the "War on Drugs" and the perpetuation of racist and scientifically-unsupported myths regarding "crack babies" in the 1980s and 1990s by popular media.[48] The "crack baby" myth can be traced back to 1985 when the New England Journal of Medicine published an article authored by Dr. Ira Chasnoff, suggesting long-term linkages of causal harm by a mother who used crack during her pregnancy onto her newborn, including her baby remaining smaller, sicker, and less social than other infants.[49] While the study was based on a mere 23 subjects and had grave limitations (including a lack of proper scientific

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[47] More than half of all Ohioans who give birth per year are on Medicaid. Ohio Department of Medicaid, *Report on Pregnant Women, Infants, and Children – SFY 2020* (July 19, 2021), 4, https://medicaid.ohio.gov/static/Stakeholders%2C+Partners/ReportsandResearch/Ohio+Medicaid+2020+Pregnant+Women+Infants+and+Children+Report.pdf (accessed August 17, 2022).

[48] Natl. Institute on Drug Abuse, *Research Report, Cocaine: Abuse and Addiction* (May 2009), 6, http://www.drugabuse.gov/PDF/RRCocaine.pdf (accessed July 17, 2022) ("Many recall that 'crack babies,' or babies born to mothers who used crack cocaine while pregnant, were at one time written off by many as a lost generation. . . . It was later found that this was a gross exaggeration."); U.S. Sentencing Commission, *Report to Congress: Cocaine and Federal Sentencing Policy* (May 2007), 68, 70, https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/drug-topics/200705_RtC_Cocaine_Sentencing_Policy.pdf (accessed July 14, 2022) ("research indicates that the negative effects from prenatal exposure to cocaine, in fact, are significantly less severe than previously believed[.]").

[49] Chasnoff et al., *Cocaine Use in Pregnancy*, 333 N. Eng. J. Med. 666 (1985).

rigor required for a conclusive statement), this single study was wrongly relied upon to establish drug use during pregnancy as necessarily harmful, long-lasting, and detrimental to a fertilized egg, embryo, fetus, or newborn. However, since the mid-to-late 1990s, medical experts and researchers alike have compellingly refuted beliefs that such substances cause fetal harm or pregnancy loss, and asserted that scientific evidence establishes that associated risks are no greater or less than those for other non-scheduled substances.[50] This includes Dr. Ira Chasnoff himself who—five years after his initial study—recanted his preliminary assumptions.[51, 52]

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[50] See Terplan et al., *The Effects of Cocaine and Amphetamine Use During Pregnancy on the Newborn: Myth versus Reality*, 30 J. Add. Dis. 1 (2011); Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613 (2001), 1621.

[51] *Revisiting the Crack Baby Myth that Wasn't*, New York Times (May 20, 2013) 8:09-9:10, https://www.nytimes.com/2013/05/20/booming/revisiting-the-crack-babies-epidemic-that-was-not.html (accessed July 12, 2022).

[52] Indeed, the most careful and comprehensive study to consider the medical evidence concluded: "[T]here is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity difference in severity, scope, or kind from the sequelae of many other risk factors." Without knowing that cocaine was used by their mothers, clinicians could not distinguish so-called "crack-addicted babies" from babies born to comparable mothers who had never used cocaine. *See* Lewis *et al.*, *Physicians, Scientists to Media: Stop Using the Term "Crack Baby"* (2004) (thirty leading doctors and researchers' open letter explaining "Throughout almost 20 years of research, none of us has identified a recognizable condition, syndrome or disorder that should be termed 'crack baby.'").

Numerous major news outlets have since recognized that these sensationalized reports were based on "equal parts bad science and racist stereotypes"[53] and issued apologies.[54] Yet the moral panic has led to the creation of draconian social welfare policies, hospital practices, and criminal system applications—like this one—that continue to divest pregnant women of basic rights and harm children and families.

Today, the so-called War on Drugs and its inflated claims about the effects of drug use on a developing pregnancy have expanded to include opioids, methamphetamine, cannabis, and other prescription drugs. Most particularly with the increase of opioid use, use disorder, and Neonatal Opioid Withdrawal Syndrome (NOWS) and the approximate one-third of insured women of reproductive age filling an opioid prescription annually, this last decade has seen heightened public and public health attention on pregnant women who use opioids while pregnant.[55] Concern about opioid use disorder generally has led to a repeat of the "crack baby myth" but for opioids, now

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[53] New York Times Editorial Board, *Slandering the Unborn: How Bad Science and a Moral Panic, Fueled in Part by the News Media, Demonized Mothers and Defamed a Generation*, New York Times (Dec. 28, 2018), https://www.nytimes.com/interactive/2018/12/28/opinion/crack-babies-racism.html (accessed July 14, 2022) (An apology from the New York Times explaining "how bad science and a moral panic [about pregnant women and crack], fueled in part by the news media, demonized mothers and defamed a generation"). *See also* Lewis et al., *Physicians, Scientists to Media: Stop Using the Term "Crack Baby"* (2004) (thirty leading doctors and researchers' open letter explaining "Throughout almost 20 years of research, none of us has identified a recognizable condition, syndrome or disorder that should be termed 'crack baby.'").

[54] *Crack Babies: Twenty Years Later*, Tell Me More, National Public Radio (May 3, 2010), https://www.npr.org/templates/story/story.php?storyId=126478643 (accessed July 12, 2022); Vargas, *Once Written off, 'Crack Babies' Have Grown into Success Stories*, The Washington Post (Apr. 18, 2010), https://www.washingtonpost.com/wp-dyn/content/article/2010/04/15/AR2010041502434.html (accessed July 14, 2022).

[55] Terplan & Minkoff, *Neonatal Abstinence Syndrome and Ethical Approaches to the Identification of Pregnant Women Who Use Drugs*, 129 Obstetrics and Gynecology 1 (2017), 164-167; Ailes et al., *Opioid prescription claims among women of reproductive age—United States, 2008–2012*, MMWR Morb Mortal Wkly Rep (2015), 64:37–41.

targeting predominantly poor rural white women.[56] The myth of "oxytots," a slanderous label to refer to newborns exposed to opioids in-utero, evocative of the "crack baby" label, has repeatedly been debunked as there is "a lack of evidence on the long-term effects of prenatal opioid exposure."[57]

Drug testing—with consent, without consent, and or at random—is not recommended by the American College of Obstetricians and Gynecologists ("ACOG"), at any point in pregnancy, delivery, or for the newborn.[58] A positive drug test only reveals if there is a chemical compound present in the bodily fluid collection,[59] and it cannot determine whether a person: occasionally uses a drug; has a substance use disorder; suffers any physical or emotional disability from that substance use disorder; or is more or less likely, if they are parents, to abuse or neglect their children.[60]

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[56] Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy*, 133 Harvard L. Rev. 3 (Jan. 10, 2020).

[57] Reddy et al., *Opioid Use in Pregnancy, Neonatal Abstinence Syndrome, and Childhood Outcomes: Executive Summary of a Joint Workshop by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Maternal-Fetal Medicine, Centers for Disease Control and Prevention, and the March of Dimes Foundation*, 130 Obstetrics and Gynecology 1 (2017), 10-28.

[58] American College of Obstetricians and Gynecologists, *Policy Priorities, Substance Use Disorder in Pregnancy* (2022), https://www.acog.org/advocacy/policy-priorities/substance-use-disorder-in-pregnancy#:~:text=ACOG%20joins%20every%20leading%20medical,reporting%20laws%20or%20criminal%20prosecution (accessed July 14, 2022).

[59] Substance Abuse & Mental Health Servs. Admin., *Clinical Drug Testing in Primary Care* (2012), 9, https:// store.samhsa.gov/system/files/sma12-4668.pdf (accessed July 14, 2022).

[60] U.S. Dep't of Justice, *Drugs, Crime, and the Justice System: A National Report from the Bureau of Justice Statistics* (1992), 119; see also Boyd, *Gendered drug policy: Motherisk and the regulation of mothering in Canada*, 68 Intl. J. Drug Policy 109 (2019) ("Drug use in and of itself does not equal risk, nor is it the only factor that shapes family life — neoliberal social and economic policies also reproduce social inequality and other social ills (like drug laws,

2. There Is No Conclusive Evidence That Exposure to Illegal Drugs Causes Harms Greater Than or Different from Harms Resulting from Legal Drugs and Innumerable Actions, Conditions, and Circumstances Common to Pregnant Women

The prosecution's expanded interpretation of Ohio's "corrupting another with drugs" statute is based on the scientifically and medically unsupported assumption that a pregnant woman's own use of an illegal drug causes unique and certain harm to her fetus. These assumptions are often unjustified, based on presumption and prejudice, and medical misinformation, rather than scientific fact.[61] Further, no law enforcement official, forensic pathologist, or even average medical doctor—including a pediatrician—is qualified to say a certain drug causes a certain outcome;[62] this is because, in the context of an adverse pregnancy outcome, the mere presence of drug metabolites does not explain the event, just as the absence of a substance does not prevent it.[63]

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homelessness and inadequate wages and social benefits) that make parenting difficult for families.").

[61] Singer et al., *Fifty Years of Research on Prenatal Substances: Lessons Learned for the Opioid Epidemic*, 1 Adversity and resilience science 4 (2020), 223-234; Ctr. 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. *See also* Nossiter, *In Alabama, A Crackdown on Pregnant Drug Users*, New York Times (Mar. 15, 2008), at A10, http://www.nytimes.com/2008/03/15/us/15mothers.html (accessed July 14, 2022) (describing Alabama Prosecutor Greg Gambril's arrests of at least eight women who were pregnant and sought to continue to term in spite of their drug use problems).

[62] National Advocates for Pregnant Women, *Confronting Pregnancy Criminalization: A Practical Guide for Healthcare Providers, Lawyers, Medical Examiners, Child Welfare Workers, and Policymakers*, (June 2022), https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2022/06/1.Confronting-Pregnancy-Criminalization_6.22.23-1.pdf (accessed July 14, 2022); Boone & McMichael, *State-Created Fetal Harm,* 109 Georgetown L. J. 475 (2021), 475, 501, 514; *see also In re Unborn Child of Starks*, 18 P.3d 342 (Okla. 2001).

[63] Smid & Terplan, *What Obstetrician-Gynecologists Should Know About Substance Use Disorders in the Perinatal Period*, J. Obstetrics & Gynecology (Feb. 1, 2022), 317-37.

With respect to opioids, at issue here, there is no scientific evidence that prenatal exposure is associated with birth defects or other long-term adverse health outcomes for the child.[64] Of note, in assessing these outcomes, it is particularly difficult for physicians and researchers to isolate the effects of opioids from other confounding factors, such as use of other substances (tobacco, alcohol, nonmedical drugs) and exposure to environmental and other medical risk factors (*e.g.*, low socioeconomic status or poor prenatal care).[65]

Some newborns exposed prenatally to opioids experience an abstinence (withdrawal) syndrome at birth. Indeed, as Appellant explains in her brief, providers admitted baby K.H. to a special nursery where she received appropriate care for this diagnosis . Withdrawal symptoms may also occur when adults with opioid dependence abstain from opiate use, as well as with exposure to certain uncontrolled substances commonly prescribed in pregnancy.[66] In pregnant women, withdrawal symptoms are known to cause uterine contractions, miscarriage or early labor, but these symptoms can be prevented through medication for opioid use disorder, such as

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[64] Smith & Lipari, *Women of Childbearing Age and Opioids*, The CBHSQ Report, (2017), https://www.samhsa.gov/data/report/women-childbearing-age-and-opioids (accessed July 14, 2022); American College of Obstetricians and Gynecologists, *Opioid Use and Opioid Use Disorder in Pregnancy, Committee Opinion No. 711*, Obstetrics and Gynecology, vol. 130, no. 2, (2017), e81-e94, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy; Nanji & Carvalho, *Pain Management During Labour and Vaginal Birth, Best Practice & Research Clinical Obstetrics & Gynaecology* (common opioids used in global obstetric practice include meperidine (pethidine), morphine, diamorphine, fentanyl, and remifentanil); Anderson, *A review of systemic opioids commonly used for labor pain relief*, 56 J. Midwifery & Women's Health 3 (2011), 222-39.

[65] American College of Obstetricians and Gynecologists, *Opioid Use and Opioid Use Disorder in Pregnancy. Committee Opinion No. 711*, 130 Obstetrics and Gynecology 2 (2017) e81-e94, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy (accessed July 14, 2022).

[66] Kocherlakota, *Neonatal Abstinence Syndrome*, 134 Pediatrics 2 (2014), e547-e561.

buprenorphine or methadone, that is specifically recommended during pregnancy. The U.S. Department of Health and Human Services advises:

> Women who are pregnant or breastfeeding can safely take methadone. Comprehensive methadone maintenance treatment should include prenatal care to reduce the risks of complications during pregnancy and at birth. Undergoing methadone maintenance treatment while pregnant does not cause birth defects.[67]

For those newborns who do experience withdrawal, identification of such infants by trained caregivers is not difficult, and safe and effective treatment can be instituted.[68] Withdrawal symptoms are transitory, treatable and, according to the limited high-quality data available, do not have documented, long-term effects.[69]

The idea that children who were prenatally exposed to drugs will be forever harmed is inaccurate and harmful to those children, who face unnecessary stigma.[70] Intrauterine exposure to tobacco has much clearer and well-documented long term negative effects,[71] including an

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[67] SAMHSA, *Methadone*, U.S. Department of Health and Human Services, https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone (accessed July 14, 2022).

[68] *See generally* Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *Methadone Treatment for Pregnant Women*, Pub. No. SMA 06-4124 (2006); Grossman et al., *A Novel Approach to Assessing Infants With Neonatal Abstinence Syndrome*, 8 Hosp Pediatr. 1 (2018), (promoting Eat Sleep Console treatment rather than morphine or other medication, to decrease length of hospital stay).

[69] *See* Jones, et.al., *Maternal Opioid Treatment: Human Experimental Research (MOTHER) – Approach, Issues, and Lessons Learned*, J. Addiction (Nov. 2012), 28-35, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4497510/ (accessed July 14, 2022); Bach, *Prosecuting Poverty, Criminalizing Care*, 60 Wm. & Mary L. Rev. 809 (2019), 832–33.

[70] *See, e.g.*, Vargas, *Once written off, 'crack babies' have grown into success stories*, Washington Post (April 18, 2010), https://www.washingtonpost.com/wp-dyn/content/article/2010/04/15/AR2010041502434_pf.html (accessed July 14, 2022); Reed & Hoye, *Former crack baby: 'It's another stigma, another box to put me in'*, America Tonight, Al Jazeera (March 10, 2015), http://america.aljazeera.com/watch/shows/america-tonight/articles/2015/3/10/crack-baby-myth.html (accessed July 17, 2022).

[71] Gibson & Porter, *Drinking or Smoking While Breastfeeding and Later Cognition in Children*, 142 Pediatrics 2 (2018).

increased risk of respiratory infections, asthma, infantile colic, bone fractures, and childhood obesity.[72] Yet people who smoke during pregnancy are rarely met with criminal penalties. Instead, we take an appropriate, public-health approach and deal with any concerns as a medical matter between patient and provider.

Poverty, in particular, has a much clearer negative effect on children's long-term health outcomes than any prenatal substance exposure.[73] The state's resources would be better spent relieving the stresses of poverty and providing broad, evidence-based addiction services than criminally prosecuting people like Ms. Hollingshead for a substance use disorder during pregnancy.

Because the prosecution of Ms. Hollingshead is motivated by a fundamental misunderstanding of evidence-based scientific research, this Court should reverse her conviction and refuse to judicially expand R.C. 2925.02.

D. The Expansion of the Law Reflects a Misunderstanding of the Nature of Substance Use Disorder

Medical groups have long recognized that substance use disorder is not a failure of individual willpower. The American Society of Addiction Medicine defines addiction as "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics,

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[72] American College of Obstetrics & Gynecologists, *Tobacco and Nicotine Cessation During Pregnancy, Committee Opinion No. 807* (May 2020),

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/05/tobacco-and-nicotine-cessation-during-pregnancy (accessed July 14, 2022).

[73] Francis et al., *Child Poverty, Toxic Stress, and Social Determinants of Health: Screening and Care Coordination*, 23 Online Journal of Issues in Nursing 2 (2018); Hurt et al., *Children with and without gestational cocaine exposure: a neurocognitive systems analysis*, 31 Neurotoxicology and teratology 6 (2009), 334-41 ("None of the analyses showed an effect of gestational cocaine exposure on neurocognitive function. In contrast, child characteristics, including age at testing and childhood environment, were associated with neurocognitive function.").

the environment, and an individual's life experiences."[74] Addiction has pronounced physiological factors that heavily influence the user's behavior and affect his or her ability to cease use or seek treatment.[75]

1. Substance Use Disorder Is Not a Voluntary Act That Is Cured by Threats

The medical profession has long acknowledged that substance use disorder has biological and genetic dimensions and cannot be overcome without treatment.[76] Substance use disorder is marked by "compulsions not capable of management without outside help."[77] This is why the vast majority of people with substance use disorder cannot simply "decide" to refrain from drug use or achieve long-term abstinence without appropriate treatment and support. Because of the compulsive nature of addiction, warnings or threats (even threats of criminal punishment) are unlikely to deter drug use among pregnant women.

2. Substance Use Disorder Is a Medical Condition That Is Difficult to Overcome

In Ohio, hundreds of thousands of adults with substance use disorders do not receive the treatment they need. An estimated 484,000 adults need, but have not received, treatment at a

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[74] Amer. Soc. Addiction Med., *Definition of Addiction* (2022), https://www.asam.org/quality-care/definition-of-addiction (accessed July 14, 2022).

[75] *Id.*; Bhuvaneswar et al., *Cocaine and Opioid Use During Pregnancy: Prevalence and Management*, 10 Primary Care Companion J. Clinical Psychiatry 59 (2008), 61, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2249829/pdf/i1523-5998-10-1-59.pdf (accessed July 14, 2022).

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

[77] *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 who is in a state of psychic or physical dependence, or both.").

special facility for illicit drug use.[78] Another 946,000 adults need, but have not received, treatment for an identified alcohol use disorder.[79]

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies only eight treatment facilities in the entire state that list themselves as serving pregnant women.[80] Such programs, however, are often not actually accessible because of transportation barriers, cost, waiting lists, and lack of childcare and mental health services, which impede access to successful treatment, particularly in the short time frame of pregnancy.[81]

Many pregnant women do not have access to health care, quality housing, and safe environments, which might assist in managing behavioral health problems such as a substance use disorder.[82] Extending Ohio's "corrupting another with drugs" statute to those who are unable to overcome their drug problem in the short term of pregnancy misunderstands substance use disorder and the nature of effective treatment.

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[78] Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *2019-2020 National Survey on Drug Use & Health State-Specific Tables* (2021), https://www.samhsa.gov/data/report/2019-2020-nsduh-state-specific-tables (accessed July 14, 2022) (Table 81B. Past Year Substance Use Disorder and Treatment: Among People Aged 12 or Older in *Ohio*; by Age Group, Estimated Numbers (in Thousands), 2020.).

[79] *Id.*

[80] Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *Substance Abuse Treatment Facility Locator*, https://findtreatment.gov/ (accessed July 14, 2022).

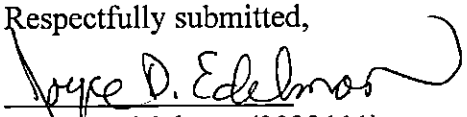
[81] *See* Brady & Ashley, *Women in Substance Abuse Treatment: Results from the Alcohol and Drug Services Study (ADSS)* (Sept. 2005); see also Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. Drug Issues 285 (2003), https://doi.org/10.1177/002204260303300202; Roberts et al., *Dismantling the legacy of failed policy approaches to pregnant people's use of alcohol and drugs*, 33 Intl. Rev. of Psychiatry 6 (2021), 502-513 (accessed July 14, 2022).

[82] Smid & Terplan, *What Obstetrician-Gynecologists Should Know About Substance Use Disorders in the Perinatal Period*, J. Obstetrics & Gynecology (Feb. 1, 2022), 317-37.

IV. CONCLUSION

Because the expansion of the law and Appellant's conviction below are inconsistent with the General Assembly's intent, unsupported as a matter of science, misguided as a matter of public health, and without authority under the law, *Amici* respectfully ask this Honorable Court to reverse her conviction.

Respectfully submitted,



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APPENDIX: STATEMENTS OF INTEREST OF AMICI CURIAE

ORGANIZATIONAL AMICI

The **American Medical Association** (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, virtually all physicians, residents, and medical students in the United States are represented in the AMA's policymaking process. AMA members practice in every state, including Ohio, and in every medical specialty. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes.

The **Ohio Association for the Treatment of Opioid Dependence** ("OATOD") represents the federally certified and state licensed opioid treatment programs throughout Ohio and is the Ohio affiliate of the American Association for the Treatment of Opioid Dependence. OATOD has an active interest in this litigation because its membership is engaged in policy advocacy and education about the use of MAT as an evidenced-based best practice.

The **Ohio Council of Behavioral Health and Family Services Providers** ("The Ohio Council") is a statewide trade and advocacy organization representing 160 community-based organizations that deliver prevention, addiction treatment, mental health, and family services throughout Ohio. Its mission is to strengthen Ohio's families and communities by helping members be providers and advocates for high quality and efficient behavioral health and family services. The Ohio Council has a strong interest in this litigation because of its policy advocacy and education to support greater access to addiction services, address stigma, and support a comprehensive continuum of care for Ohioans in need of evidence-based services.

Ohio Society of Addiction Medicine (OHSAM) is a group of addiction specialists and other providers focused on caring for patients with substance use disorder. OHSAM is a chapter of ASAM, founded in 1954, which is a professional society representing over 4,300 physicians, clinicians and associated professionals in the field of addiction medicine. OHSAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

Academy of Perinatal Harm Reduction is a source for evidence-based, stigma-free education and support. Our mission is to improve the lives of pregnant and parenting people who use substances. Our collaborative approach provides a fresh framework for multi-disciplinary, critical analysis of the most current research.

The **American Association for the Treatment of Opioid Dependence** (AATOD) was founded in 1984 to enhance the quality of patient care in treatment programs by promoting the growth and development of comprehensive opioid treatment services throughout the United States.

American Society of Addiction Medicine (ASAM) represents more than 7,000 physicians, clinicians, and associated professionals who prevent, treat, and promote remission and recovery from the disease of addiction. ASAM members are dedicated to increasing access and improving

the quality of addiction treatment, educating physicians and the public, and supporting research and prevention of addiction. ASAM is deeply committed to reducing potential drug-related harms at every reasonable opportunity and to the health and well-being of children and pregnant and parenting people.

The **Association for Multidisciplinary Education and Research in Substance use and Addiction** (AMERSA) is a non-profit professional organization whose mission is to improve health and well-being through interdisciplinary leadership and advocacy in substance use education, research, clinical care and policy. Our members include academic addiction professionals from a multitude of disciplines, including physicians, nurses, physician assistants, pharmacists, social workers, psychologists, dentists, and public health experts. AMERSA is particularly concerned about the exponential harm caused by criminal justice actions pursued against persons who use drugs during pregnancy and is committed to supporting and advocating for the rights and protections of pregnant persons and their families.

INDIVIDUAL AMICI*

**Individuals have joined as* amici curiae *in their personal capacities; institutional affiliations are noted for identification purposes only.*

Danielle Bessett, PhD, is a Professor of Sociology at the University of Cincinnati who studies sociology of reproduction and co-leads the Ohio Policy Evaluation Network (OPEN), which promotes rigorous, interdisciplinary research to assess Ohioans' reproductive health and well-being. Dr. Bessett has published many peer reviewed papers on disparities in access to prenatal and abortion care and the experiences of those seeking and receiving reproductive health care.

Jennifer M. Baker, MD, is the Medical Director of a local addiction services clinic that includes a comprehensive Maternal Addiction program. Dr. Baker supports policies that increase access to treatment and decrease stigma for patients with addiction.

Thomas Baker, MD, is an Emergency Medicine physician at an area hospital who heads an effort to increase access to addiction treatment in the Emergency Department. He is opposed to criminalizing and stigmatizing those suffering from addiction and believes such policies are counterproductive.

Nia Bhadra-Heintz, MD, MS, is a trained Addiction Medicine and Obstetrics and Gynecology physician with a background in cross-cultural psychology. She completed medical school at the Boston University School of Medicine, OB/GYN residency at the University of Pennsylvania, and an addiction medicine fellowship at the Ohio State University. She currently practices at the University of Pennsylvania as an academic OB/GYN generalist with a specialization in peripartum addiction medicine. Her research interests include treatment of substance use disorders in peripartum women, stigma related to addiction medicine treatment, intimate partner violence, and disparities within women's health.

Danielle Czarnecki, PhD, is a medical sociologist and postdoctoral fellow at the Ohio Policy Evaluation Network, where she researches how state policies impact patients and providers in reproductive healthcare settings.

Krisanna Deppen, MD, is a board-certified Family Medicine and Addiction Medicine physician practicing at OhioHealth-Grant Medical Center as the program director of their Addiction Medicine Fellowship. After graduating from Northeast Ohio Medical University, She completed her Family Medicine Residency at Grant Medical Center in Columbus followed by an Addiction Medicine Fellowship at Swedish Medical Center in Seattle, Washington. During her fellowship she developed a passion to provide care for pregnant women with substance use disorders and has continued to engage in local and national conversations regarding best practices. Dr. Deppen supports increasing access to trauma-informed, evidence-based care for pregnant women with substance use disorders. Dr. Deppen has also worked with the Supreme Court of Ohio Judicial College to provide education to Ohio judges related to substance use disorders and evidence-based treatment.

Marjorie Greenfield, MD, FACOG, is a board-certified obstetrician-gynecologist who practiced and taught obstetrics and gynecology for over thirty years. She is currently Vice Chair of Obstetrics and Gynecology and a Distinguished Senior Physician at University Hospitals Cleveland Medical Center and Associate Dean for Student Affairs and Professor at Case Western Reserve University School of Medicine. Dr. Greenfield has written extensively for the public, including authoring Dr. Spock's Pregnancy Guide and The Working Woman's Pregnancy Book.

Kathryn Lancaster, PhD, MPH, is an Associate Professor of Epidemiology in the College of Public Health at The Ohio State University. Dr. Lancaster is an infectious disease and substance use epidemiologist who focuses on reducing global health disparities among populations made vulnerable, particularly those who engage in sex work and people who use drugs. Her research examines and evaluates interventions addressing the interrelationships between gender, substance use (e.g., drugs and alcohol), and blood-borne and sexually-transmitted infections. Dr. Lancaster's work has resulted in over 50 peer-reviewed papers featured in numerous journals, including the Journal of the International AIDS Society, Lancet, International Journal of Drug Policy, PLoS One, and the Journal of Medical Ethics. She has received funding as a Principal Investigator (PI), site PI, co-investigator through National Institute of Drug Abuse (NIDA), National Institute of Allergy and Infectious Diseases (NIAID), and the National Center for Advancing Translational Sciences (NCATS)

Tani Malhotra, MD, FACOG, is a Maternal Fetal Medicine Specialist at University Hospitals and Assistant Professor of Reproductive Biology at Case Western Reserve University with a special focus on substance use disorders in pregnancy. She has presented nationally on the ethics of universal drug screening in pregnancy. Dr. Malhotra works with various national organizations to develop policies that enhance equitable care for pregnant people.

Ryan Marino, MD, is a medical toxicologist, emergency physician, and addiction medicine specialist at University Hospitals Cleveland Medical Center and an assistant professor in the departments of emergency medicine and psychiatry at Case Western Reserve University School of Medicine. He recently started University Hospital's medical toxicology division as well as UH's emergency department addiction services and emergency addiction bridge clinic at Cleveland Medical Center. His research and advocacy work focuses on better understanding and best practice medical management of substance use disorders, reducing barriers for both patients and providers

in treating substance use disorders and combating stigma and misinformation. Outside of addiction work, he is also active in identifying and addressing social determinants of health and advocating for patients who have been traditionally overlooked by the medical establishment.

Michelle L. McGowan, PhD, is a member of the Division of General and Community Pediatrics and the Ethics Center at Cincinnati Children's Hospital, and a Research Professor with the University of Cincinnati Departments of Pediatrics and Department of Women's, Gender, and Sexuality Studies. Her research has been published in respected journals, such as *The New England Journal of Medicine, The Journal of Law, Medicine and Ethics, The American Journal of Human Genetics, Genetics in Medicine* and *The Journal of Clinical Ethics.* She has more than 15 years of experience in the fields of ethics of reproduction and genetic testing, and started working at Cincinnati Children's Hospital Medical Center in 2016. Her research focuses on ethical and social implications of enrolling pregnant people in research. She is a member of Ethics and Law Workgroup of the Healthy Brain and Child Development consortium that is enrolling pregnant people who use a range of substances during pregnancy in a longitudinal study of their child's brain development. She was selected to serve as an ethics consultant for the American College of Obstetricians and Gynecologists in 2016 and continues to serve in this role today.

Marsha Michie, PhD, is a social scientist and bioethicist whose work focuses on the ethics of reproduction, genetics/genomics, and biomedical research. Dr. Michie is a faculty member in the Department of Bioethics at Case Western Reserve University School of Medicine in Cleveland, Ohio, and currently leads two US federally-funded studies focusing on ethical and social implications of genomics during and following pregnancy.

Nichole Nidey, PhD, is an assistant professor of epidemiology at Cincinnati Children's Hospital Medical Center. Her research is focused on improving healthcare outcomes for individuals and families affected by substance use through patient-centered research.

Tamika C. Odum, PhD, is an Associate Professor of Sociology at the University of Cincinnati. Dr. Odum's work explores how communities of color, especially African American women, navigate and understand reproductive health and agency including aspects of contraception use and motherhood across their life course. She is a qualitative researcher specializing in community engaged research and identifies as a public sociologist committed to disseminating knowledge beyond the academy.

Kara Rood, MD, is board certified in both Maternal-Fetal Medicine and in Addiction Medicine and currently practices in Columbus, Ohio. Her career has been dedicated to caring for and advocating for pregnant individuals with substance use disorder with focus on keeping mother and infant dyad together. She is the medical director of the Substance Treatment Education and Prevention Program that has provided high risk obstetrical and addiction care to over 1000 pregnant individuals during pregnancy and for first year postpartum. She has published numerous peer reviewed articles on best practices for management of pregnancies complicated by substance use disorders and importance of harm reduction, medication for opioid use disorder and overdose prevention strategies.

Sarah E Rubin, PhD, is an associate professor and medical anthropologist at the Ohio University Heritage College of Osteopathic Medicine. She studies the effects of structural racism on health

inequities for mothers and infants globally and in Ohio. She teaches and mentors medical students in bioethics, health justice, reproductive health equity, and evidence-based medicine. She opposes any policy or ruling that limits a pregnant person's autonomy over their body or hinders a person's choice concerning their health and that of their children.

Lynn Singer, MA, PhD clinical psychology, MEd, is a developmental psychologist who has conducted research and published extensively on the sequelae of prenatal drug exposures. She is a professor of population & quantitative health sciences, pediatrics, psychiatry and psychology at the School of Medicine at Case Western Reserve University. Dr. Singer has directed a number of large, federally and privately funded research programs. These include a 19-year study of high-risk, preterm infants with lung disease and their families; a longitudinal study of cocaine-exposed infants in Cleveland from birth to 12 years; and a birth cohort study of MDMA exposure in London, England. She also directed the Cleveland site research of a multisite industry study that evaluated the effects of long-chain polyunsaturated acids (LCPUFAS) on infant development that resulted in a patent. She has edited two books, Psychosocial Assessment of Adolescents, and Biobehavioral Assessment of Infants, and authored more than 150 articles in medical and psychological literature. Dr. Singer has participated in numerous NIH, federal review and international review committees and serves on the Governing Council of the Neurobehavioral Teratology Society and Editorial Board of Neurotoxicology and Teratology. She was Chair of the NIH Center for Scientific Review Committee on Child Psychopathology and Developmental Disabilities. Dr. Singer's prior experience included work as a special education teacher for emotionally disturbed children at Bellefaire School, as Department Director of Psychological Services at Health Hill Hospital, and of Pediatric Psychology and the Medical-Behavioral Center at Rainbow Babies and Children's Hospital. At Rainbow and Metro Medical Health Center, she also co-directed the Center for Advancement of Mothers and Children, a clinic for drug-using women and their children.

James Van Hook, MD, is the Rita T. Sheely Chair of the Department of Obstetrics and Gynecology at the University of Toledo College of Medicine and Life Sciences (Toledo, Ohio). He is a practicing Obstetrician Gynecologist board certified and additionally fellowship trained as Maternal Fetal Medicine and Critical Care OBGYN subspecialist caring for pregnant women with medical and fetal illness. He has practiced and worked administratively as a subspeciality board certified Addiction Medicine specialist (20+ years). Clinical research that he has been involved with included the areas of substance use disorder in pregnancy. Consequently, on a daily basis, he directly cares for pregnant women with substance use disorders.

Christine Wilder, MD, MHES, is an Associate Professor and Co-Director, Addiction Sciences Division, Department of Psychiatry and Behavioral Neuroscience, University of Cincinnati College of Medicine. She is board certified in General and Addiction Psychiatry and has been providing substance use disorder treatment for 15 years with a particular focus on the treatment of parent-infant dyads with opioid use disorder. She has over 50 peer-reviewed research publications, including articles on opioid overdose prevention, treatment disparities in pregnant people with substance use disorders, and treatment retention for pregnant and postpartum people with opioid use disorder. She was involved in the development and national implementation of the Opioid Overdose Education and Naloxone Distribution program in the Veterans Health Administration

and is active in the Cincinnati community as a member of the Hamilton County Mental Health and Recovery Services Board.

Mae Winchester, MS, MD, is a board-certified obstetrician-gynecologist specializing in maternal fetal medicine and based in Cleveland, and a fellow with Physicians for Reproductive Health, a national physician-led advocacy organization. She has previously published research on drug use in pregnancy. She opposes policies and procedures that penalize pregnant patients as this decreases patient engagement in prenatal care which only serves to harm the maternal-fetal dyad.

Lulu Zhao, MD, FACOG, FASAM, is a board-certified obstetrician/gynecologist and addiction medicine specialist in Cleveland, OH. She is the director of the RISE-Moms program at University Hospitals Cleveland Medical Center. RISE treats pregnant and postpartum women and their substance exposed children, with over 100 mother-baby dyads treated annually.

Loretta P. Finnegan, M.D., LLD (Hon.), ScD (Hon.) is President of Finnegan Consulting, LLC which addresses education, research, and treatment in issues relating to perinatal addiction. Dr. Finnegan is recognized nationally and internationally as an expert in these fields. She is an advocate for pregnant women with substance use disorder and their babies and is credited with the development of an assessment tool for Neonatal Abstinence Syndrome (NAS) which is used widely in neonatal units in the United States and many other countries. At Thomas Jefferson University in Philadelphia, she was founder and Director of Family Center, a landmark program providing comprehensive, multidisciplinary services for pregnant and parenting women with substance use disorder (SUD) and their children. As Professor of Pediatrics, Psychiatry and Human Behavior, she directed a research program to delineate effects of and management for pregnant women with SUD and their children. For her efforts on behalf of her research and clinical accomplishments, she has received numerous awards most recently The Surgeon General's Medallion presented by the First Lady of the United States, the Secretary of Health and Human Services and the Assistant Secretary of Health for her pioneering leadership and innovative performance both as a clinician and as the Executive Officer of the College on Problems of Drug Dependence and the development of the Finnegan Score, a groundbreaking key assessment tool for babies born with NAS.

Professor Cynthia Daniels is an expert in constitutional law, reproductive politics and privacy rights. She has taught at Harvard University and Rutgers University for thirty years. She is the author of books published by Harvard University Press and Oxford University Press. She is also the Director of the Informed Consent Project at Rutgers which tracks medical misinformation in mandated state "informed consent" materials related to patients' access to reproductive health care.

Elizabeth Mitchell Armstrong, PhD, is a professor of sociology and public affairs at Princeton University. Dr. Armstrong is a medical sociologist who has written widely on reproductive health policy. She is the author or coauthor of articles in Health Affairs, Social Science and Medicine, Journal of Marriage and the Family, International Family Planning Perspectives, and Studies in Family Planning. Her book, Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder, was the first to examine critically claims about alcohol use during pregnancy.

Joelle Puccio, BSN, RN, Director of Education, Academy of Perinatal Harm Reduction, is a registered nurse working in the field of Perinatal and Neonatal Intensive Care since 2004. They worked for 7 years as the Director of Women's Services for the People's Harm Reduction Alliance, a peer run syringe access program in Seattle, WA, and served on the Board of Directors until 2021. They currently serve on the Community Professional Advisory Board of University of Oregon Health & Sciences (OHSU) Prevention Sciences Institute Center on Parenting and Opioids and the Strategic Advisory Body of the Women in Harm Reduction International Network. They are a national expert in the field of perinatal and neonatal intensive care, and have been invited to speak at conferences convened by the Harm Reduction Coalition (HRC), the Drug Policy Alliance (DPA), the Centers for Disease Control and Prevention (CDC), the Office of National Drug Control Policy (ONDCP), the American College of Obstetricians and Gynecologists (ACOG), and more. They became passionate about advocating for people who use drugs after realizing that everything they had been taught about drugs from childhood through nursing school was wrong.

Marcela Smid MD, MA, MS, is a board certified Maternal Fetal Medicine and Addiction Medicine physician at the University of Utah. She has been a member of the Utah Perinatal Mortality Committee since 2016. She is the medical director of the Substance Use & Pregnancy – Recovery, Addiction, Dependence (SUPeRAD) specialty prenatal clinic, a multi-disciplinary clinic for pregnant and postpartum women with substance use disorder. Her research focus is on perinatal addiction, interventions for pregnant and postpartum women with substance use disorders, maternal mortality and maternal mental health.

Rebecca Stone, PhD, MPH, is an Assistant Professor of Sociology and Criminal Justice at Suffolk University in Boston, Massachusetts. Her dissertation research analyzed the experiences of women who used alcohol and other drugs during pregnancy and the harmful effects of stigma and criminalization on their help-seeking experiences. She has written widely on topics concerning women, substance use, victimization, and justice system involvement. Her most recent project concerns the co-occurrence of intimate partner violence and opioid use and the lack of appropriate and accessible support services in rural areas.

Kimberly Sue, MD, PhD, is an Assistant Professor of Medicine with the Program in Addiction Medicine (Division of General Internal Medicine) at Yale University School of Medicine. She is also the Medical Director of the National Harm Reduction Coalition, a nonprofit which strives to improve the health and wellbeing of people who use drugs. Currently, she serves as an Attending Physician at the Central Medical Unit, APT Foundation, which provides primary care to patients receiving methadone and other substance use treatment services and supervises fellows and trainees within the Yale Addiction Medicine Fellowship program. She also is an Attending Physician on the hospital-based Yale Addiction Medicine Consult Service. She also holds board certification in both Internal Medicine and Addiction Medicine. Dr. Sue trained at Harvard's MD-PhD Social Science Program, and has a PhD in sociocultural anthropology. Her book, Getting Wrecked: Women, Incarceration, and the American Opioid Crisis (2019), is based on her research on women with opioid use disorder in Massachusetts prison and jails. Her current research interests include harm reduction, stigma, gender/women and substance use, and overdose response strategies on local, state, and federal levels.

Carolyn Sufrin, MD, PhD, is associate professor at Johns Hopkins School of Medicine, Department of Gynecology and Obstetrics and Johns Hopkins Bloomberg School of Public Health.

She is the director of the research group Advocacy and Research on Reproductive Wellness of Incarcerated People (ARRWIP). She conducts research on reproductive health care for people behind bars, including extensive research on substance use disorder treatment for pregnant people who are incarcerated.

Mishka Terplan, MD, MPH, FACOG, DFASAM, is board certified in both obstetrics and gynecology and in addiction medicine. His primary clinical, research and advocacy interests lie along the intersections of reproductive and behavioral health. He is Medical Director at Friends Research Institute, Deputy Chief Clinical Officer at the Department of Behavioral Health and adjunct faculty at the University of California, San Francisco where he is a Substance Use Warmline clinician for the National Clinician Consultation Center. Dr.Terplan has active grant funding and has published over 140 peer-reviewed articles with emphasis on health disparities, stigma, and access to treatment. He has spoken at local high schools and before the United States Congress and has participated in expert panels at CDC, SAMHSA, ONDCP, OWH, FDA and NIH primarily on issues related to gender and addiction.

Tricia Wright, MD, MS, FACOG, DFASAM, is a board-certified OB/GYN and Addiction Medicine physician who has been caring for pregnant people who use drugs for over 15 years. She has written several papers on the effects of methamphetamines during pregnancy, and has seen first-hand the harmful effects of draconian drug laws, stigma, and discrimination on pregnant people who use drugs. These policies are much more harmful than the drugs themselves. She has lectured extensively on the effects of these policies, and is recognized as a national expert on the care of pregnant people who use drugs.

CERTIFICATE OF SERVICE

I certify that, on August 29, 2022, a copy of this amicus brief *instanter* was served by regular U.S. Mail upon the following counsel of record:

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