UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

TAMARA LOERTSCHER,
Plaintiff-Appellee,

-v.-

ELOISE ANDERSON AND BRAD SCHIMEL,
Defendants-Appellants.

On Appeal From The United States District Court
For The Western District of Wisconsin, Case No. 14-cv-870
The Honorable James D. Peterson, Judge

BRIEF OF WISCONSIN MEDICAL SOCIETY (SOCIETY), AMERICAN MEDICAL ASSOCIATION (AMA), AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG), AMERICAN ACADEMY OF ADDICTION PSYCHIATRY (AAAP), AMERICAN ACADEMY OF PEDIATRICS (AAP), AMERICAN MEDICAL WOMEN'S ASSOCIATION (AMWA), AMERICAN NURSES ASSOCIATION (ANA), AMERICAN PUBLIC HEALTH ASSOCIATION (APHA), AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM), AND WISCONSIN SOCIETY OF ADDICTION MEDICINE (WISAM) IN SUPPORT OF PLAINTIFF-APPELLEE AND AFFIRMANCE

CORPORATE DISCLOSURE STATEMENT

In accordance with Fed. R. App. P. 26.1, the Drug Policy Alliance, undersigned counsel for *amici curiae* Wisconsin Medical Society (Society), American Medical Association (AMA), American College of Obstetricians and Gynecologists (ACOG), American Academy of Addiction Psychiatry (AAAP), American Academy of Pediatrics (AAP), American Medical Women's Association (AMWA), American Nurses Association (ANA), American Public Health Association (APHA), American Society of Addiction Medicine (ASAM), and Wisconsin Society of Addiction Medicine (WISAM), hereby certifies that:

1. None of the *amici* is a subsidiary or affiliate of a publicly owned corporation; and

2. None of the *amici* is a publicly held corporation and none has a financial interest in this case.

DATED: July 27, 2017

Respectfully submitted,

/s/ Joy F. Haviland

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INTERESTS OF *AMICI CURIAE*[2]

Amici are ten national and state medical and public health organizations. These *amici* have recognized and longstanding expertise in the areas of maternal, fetal, and neonatal health, and in the effects of alcohol and controlled substances on families and society. Together, *amici* represent tens of thousands of healthcare providers in Wisconsin and hundreds of thousands across the country. Each of the *amici curiae* is committed to reducing potential drug-related harms at every reasonable opportunity and does not endorse the non-medical use of drugs – including alcohol or tobacco – during pregnancy. It is entirely consistent with *amici*'s public health and ethical mandates to bring to this Court's attention that the government interventions permitted under Act 292 are harmful to maternal and fetal health. The intervention at issue cannot be reconciled with evidence-based and peer-reviewed medical and scientific research.

***Amicus curiae* the Wisconsin Medical Society (the Society)** is a non-profit association established in 1841 to promote the science and art of medicine to improve public health. Today, the Society is the largest physician advocacy association in Wisconsin, representing over 12,500 physicians, residents, and medical students. The Society's mission is to improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-

[2] No counsel for a party authored this brief in whole or in part, and no counsel for a party (nor a party itself) made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici* or their counsel made a monetary contribution to its preparation or submission.

quality patient care in a changing environment. The Society is a trusted health policy leader and is routinely granted leave to appear in state and federal courts on matters with the potential to impact Wisconsin physicians and their patients.

***Amicus curiae* 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 Wisconsin, 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.

***Amicus curiae* American College of Obstetricians and Gynecologists (ACOG)** is a non-profit educational and professional organization founded in 1951 that represents more than 58,000 members. ACOG's objectives are to foster improvements in all aspects of women's health care, to establish and maintain the highest possible standards for education, to publish evidence-based practice guidelines, to promote high ethical standards, and to encourage contributions to medical and scientific literature.

***Amicus curiae* American Academy of Addiction Psychiatry (AAAP)** is an international professional membership organization made up of practicing psychiatrists, university faculty, medical students, and other related professionals.

It currently represents approximately 1,000 members in the United States and around the world. AAAP is devoted to promoting access to continuing education for addiction professionals, disseminating new information in the field of addiction psychiatry, and encouraging research on the etiology, prevention, identification, and treatment of addictions.

***Amicus curiae* American Academy of Pediatrics (AAP)** is a national not-for-profit professional organization of over 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. Since its founding in 1930, the AAP has become a powerful voice for children's health through education, research, advocacy, and expert advice and has demonstrated a continuing commitment to protecting the well-being of America's children.

***Amicus curiae* American Medical Women's Association (AMWA)** is an organization of women physicians, medical students, and others dedicated to serving as the unique voice for women's health and the advancement of women in medicine. AMWA does this by providing and developing leadership, advocacy, education, expertise, and mentoring.

***Amicus curiae* American Nurses Association (ANA)** is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses. In addition to its own membership of over 170,000 registered nurses, ANA's 25 organizational affiliates represent over 300,000 RNs.

***Amicus curiae* the American Public Health Association (APHA)** champions the health of all people and all communities and strengthens the profession of public health, shares the latest research and information, promotes best practices, and advocates for public health issues and policies grounded in research.

***Amicus curiae* American Society of Addiction Medicine (ASAM)** is a national medical specialty society representing more than 4,300 physicians and allied health professionals who specialize in the treatment of addiction. ASAM's mission is to increase access to and improve the quality of addiction treatment, to educate physicians, other health care providers, and the public, to support research and prevention, and to promote the appropriate role of the physician in the care of patients with addiction.

***Amicus curiae* Wisconsin Society of Addiction Medicine (WISAM)** is a Wisconsin Chapter of the American Society of Addiction Medicine.

SUMMARY OF ARGUMENT

1997 Wisconsin Act 292 permits state and local authorities to treat a fetus of any gestational age as a child in need of protective services and to initiate legal proceedings against pregnant women alleged to "habitually lack self-control" in the use of controlled substances or alcohol. Wis. Stat. § 48.01 *et seq*. (West 1998). Under Act 292, the State may detain pregnant women and control their private medical decisions. *Id*. *Amici curiae* agree with Plaintiff-Appellee that the district court ruled correctly that Act 292 relies on assumptions that are not supported by medical or scientific evidence and provides no meaningful standards for enforcement.

Amici recognize a strong societal interest in protecting the health of women, children, and families. However, such interests are undermined, not advanced, by Act 292, which authorizes state control over pregnant women who seek to continue their pregnancies to term and who have used or continue to use controlled substances or alcohol. This control is contrary to the consensus judgment of medical practitioners, public health experts, and their professional organizations. Act 292 treats use of controlled substances during pregnancy as a maternal-fetal conflict and places the pregnant woman at odds with her fetus, fundamentally misunderstanding the relationship between fetal and maternal health. This law elevates the fetus to a status that threatens the health and pregnancy of the woman carrying the fetus. The fundamental approach of Act 292 thus fails to advance the State of Wisconsin's asserted interest in protecting the health of the fetus, may in fact cause harm to the very interests it seeks to protect, and cannot be reconciled with medical or legal standards.

The medical and public health communities have long recognized that even when drug use becomes problematic and constitutes a disorder, it is nevertheless a medical condition best addressed through non-punitive, non-coercive medical and public health approaches that protect and respect patient privacy and decision making.

On appeal, the State relies on two medically and scientifically unsupported assumptions that *amici* seek to correct. First, the State relies on the popular, but scientifically disproven, perception regarding the relative harms of in utero exposure to controlled substances. As the district court correctly noted after considering expert testimony presented by both the State and Ms. Loertscher, "no one knows what level of drug or alcohol use poses a risk to the child." *Loertscher v. Anderson*, No. 14-CV-870-JDP, 2017 WL 1613654, at *14 (W.D. Wis. Apr. 28, 2017).

Second, the State falsely assumes that subjecting pregnant women to state intervention and control ensures healthier birth outcomes. In fact, as *amici* will demonstrate, laws and policies like Act 292 present a grave risk to both maternal and fetal health. The State's approach contradicts the extraordinary consensus among medical practitioners and public health organizations that subjecting pregnant women to state control damages trust between patient and provider and undermines maternal and fetal health by discouraging women from seeking treatment and prenatal care.

ARGUMENT

I. MEDICAL AND PUBLIC HEALTH EXPERTS ARE UNEQUIVOCAL IN THEIR OPPOSITION TO SUBJECTING PREGNANT WOMEN WHO USE ALCOHOL OR CONTROLLED SUBSTANCES TO STATE INTERVENTION AND CONTROL.

Every major medical and public health organization in this country to weigh in on the issue, including all of the organizations listed as *amici* – Wisconsin Medical Society (Society),[3] American Medical Association (AMA),[4] American College of Obstetricians and Gynecologists (ACOG),[5] American Academy of Addiction Psychiatry (AAAP),[6] American Academy of Pediatrics (AAP),[7] American Medical

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[3] Wis. Med. Soc., Policy, *MCH-026: Alcohol, Tobacco, Drug Abuse and Pregnancy* (2017) ("The Society . . . oppose[s] legislation that criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement. . ."); Wis. Med. Soc., Policy, *ALC-004: Mandatory Reporting of Unborn Child Abuse* (2017) ("The Wisconsin Medical Society does not support extending the jurisdiction of the juvenile court to unborn fetuses and their expectant mothers, when substance abuse is suspected to such a severe degree that abuse poses a substantial current health risk to the fetus, because it would interfere with the physician-patient relationship and erect a barrier that would keep pregnant women from seeking prenatal care."); Wis. Med. Soc., Policy, *ALC-014: Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services* (2017) ("Exempting health care professionals from 1997 Wisconsin Act 292, restoring the legal requirement for confidentiality between pregnant women and their health care professional.").

[4] Am. Med. Ass'n, Policy, *H-420.969: Legal Interventions During Pregnancy* (1990) (reaffirmed 2016) ("Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.").

[5] Am. Coll. Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *Committee Opinion 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist,* 117 OBSTET. GYNECOL. 200 (2011) (reaffirmed 2014) ("Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties. . .").

[6] Am. Acad. of Addiction Psychiatry, Policy, *Use of Illegal and Harmful Substances by Pregnant Women* (Nov. 2001) (reaffirmed May 2015) ("AAAP is opposed to punitive actions against pregnant women who use substances . . .").

[7] Am. Acad. of Pediatrics, Comm. on Substance Abuse, *A Public Health Response to Opioid Use in Pregnancy*, 139 PEDIATRICS e20164070 (2017) ("A public health response, rather than a punitive approach to the opioid epidemic and substance use during pregnancy, is critical . . .").

Women's Association (AMWA), American Nurses Association (ANA),[8] American Public Health Association (APHA),[9] American Society of Addiction Medicine (ASAM),[10] and Wisconsin Society of Addiction Medicine (WISAM)[11] – and many other organizations, such as March of Dimes,[12] the American Psychiatric Association (APA),[13] and the National Perinatal Association (NPA),[14] have criticized government interventions like 1997 Wisconsin Act 292 that subject pregnant women who use controlled substances to state control and civil or criminal punishment.

The renowned health experts represented by the above list strongly suggest that

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[8] Am. Nurses Ass'n, Position Statement, *Non-Punitive Treatment for Pregnant and Breast-Feeding Women with Substance Use Disorders* (Mar. 15, 2017) ("ANA opposes laws that may result in punitive legal actions and result in incarceration of pregnant women because of substance use disorder.").

[9] Am. Pub. Health Ass'n, Policy, *No. 9020: Illicit Drug Use by Pregnant Women* (Jan. 1, 1990) ("Reaffirms the Association's view of use of illicit drugs by pregnant women as a public health problem, and recommends that no punitive measures be taken against pregnant women who are users of illicit drugs . . .").

[10] Am. Soc'y of Addiction Med., Policy, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (Jan. 18, 2017) ("State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as 'child abuse or maltreatment,' and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care services for these women.").

[11] As a chapter of ASAM, WISAM adopts the same policies on use of alcohol and controlled substances during pregnancy as its national parent organization. *See* Am. Soc'y of Addiction Med, *supra* note 10.

[12] March of Dimes, Policy, *Policies and to Address Drug-Exposed Newborns* (Dec. 2014) ("The March of Dimes opposes policies and programs that impose punitive measures on pregnant women who use or abuse drugs.").

[13] Am. Psychiatric Ass'n, Position Statement, *Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders* (Dec. 2016) ("The use of the legal system to address perinatal alcohol, tobacco, and other substance use disorders is inappropriate.").

[14] Nat'l Perinatal Ass'n, Position Paper, *Substance Abuse among Pregnant Women* (Jun. 2012) ("NPA opposes punitive measures that deter women from seeking appropriate care during the course of their pregnancies.").

such approaches are inappropriate and harm fetal health by detaining pregnant women, removing them from their homes, incarcerating them, denying them prenatal and medical care and access to appropriate, evidence-based treatment, and eroding the doctor-patient relationship. In fact, the ACOG Committee on Health Care for Underserved Women has called upon doctors to actively fight state laws and policies that lead to punitive interventions based on their understanding that "use of the legal system to address perinatal alcohol and substance abuse is inappropriate."[15] The ANA has also called upon registered nurses who work with pregnant women who use controlled substances to seek out providers that offer clinically "appropriate rehabilitative therapy, rather than law enforcement or the judicial system."[16]

The medical and public health communities have long recognized that even when use of alcohol and controlled substances becomes problematic and constitutes a disorder, it is nevertheless a medical condition best addressed through non-punitive, non-coercive medical and public health approaches that protect and respect patient privacy and decision making.[17] Indeed, the consensus view among health care organizations is to treat drug use during pregnancy as a medical and public health issue and to provide non-punitive and family-centered treatment. This response includes ensuring access to quality prenatal and primary medical care,

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[15] Am. Coll. Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *supra* note 5, at 2.

[16] Am. Nurses Ass'n, *supra* note 8, at 1.

[17] *See e.g.,* Am. Soc'y of Addiction Med, *supra* note 10, at 3 ("Punishing pregnant women impedes proper medical care and the promotion of public health.").

evidence-based education on drug use during pregnancy, comprehensive drug treatment programs that keep mothers and children together, and social service programs such as life skills training, mental health services, relapse strategies, and stress management.[18]

Addiction, or substance use disorder (SUD), is a primary, chronic illness of brain reward, motivation, and memory that is the product of complex hereditary and environmental factors.[19] As a chronic disease, SUD should be managed as a medical condition and not treated as a failure of willpower or a manifestation of poor choices.[20] Yet the vague and unconstitutional standard set forth in Act 292 that is directed to a pregnant woman's "habitual lack of self-control" continues to track these outdated tropes and runs contrary to widespread consensus that use of controlled substances during pregnancy should be treated as a medical and public health issue.

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[18] *Id.* at 3-6.

[19] Am. Soc'y of Addiction Med., *Definition of Addiction* (Apr. 19, 2011); U.S. Dep't of Health & Human Servs., Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (2016).

[20] *Id.*

II. THERE IS NO MEDICAL OR SCIENTIFIC BASIS FOR SUBJECTING PREGNANT WOMEN WHO USE ALCOHOL OR CONTROLLED SUBSTANCES TO STATE CONTROL.

A. Medical and scientific evidence does not support the State's assumption that exposure to controlled substances during pregnancy causes harms different from those resulting from the myriad factors affecting pregnancy.

The State argues that the "consequences of exposure to illicit drugs and alcohol in utero can be severe" and that prenatal substance exposure has presently "reached an 'epidemic crisis' in Wisconsin." Appellant Br. at 4. This same justification – a "crisis of prenatal substance abuse" – motivated the Wisconsin Legislature to adopt Act 292 in 1997. *Id.* at 3. Despite the almost 20 years this law has been in effect, the State has not produced a single study or any form of research to substantiate its claim that Act 292 has actually changed, much less improved, perinatal and neonatal health outcomes.[21]

The reason for this is simple: the underlying theory of Act 292 – that fetal harm from prenatal exposure to controlled substances is so great that it justifies subjecting women who use controlled substances during pregnancy to state intervention and control, forced treatment, and detention – is unsupported by medical and scientific research. In fact, the research does not support the popular assumption by the State that any amount of prenatal exposure to controlled

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[21] The U.S. response to crack cocaine should serve as a cautionary tale: for over two decades, the popular press was suffused with highly prejudicial, inaccurate, and exaggerated information about the effects of in utero cocaine exposure. Contemporary research, however, has debunked the "crack baby" myth that mere exposure to cocaine is causally linked to identifiable fetal harms. *See*, *e.g.,* D.A. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure*, 285 J. AM. MED. ASS'N 1613 (2001).

substances causes unique, severe, or even inevitable harm.[22] And an argument premised on an unsubstantiated assumption should not provide a basis for upholding a vague, unconstitutional law.

After weighing the testimony of experts presented by both Ms. Loertscher and the State, the district court rightly concluded that "no one knows at what level drug or alcohol use will pose a risk to the unborn child" and that therefore "an expectant mother…simply cannot know when she would be subject to the Act." *Loertscher*, 2017 WL 1613654, at *14. Scientific studies have failed to prove that in utero exposure to controlled substances – such as cocaine,[23] methamphetamine,[24] heroin,[25]

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[22] *See, e.g.*, *id*; G.D. Helmbrecht & S. Thiagarajah, *Management of Addiction Disorders in Pregnancy*, 2 J. ADDICTION MED. 1 (2008); A.H. Schempf, *Illicit Drug Use and Neonatal Outcomes: A Critical Review*, 62 OBSTET. GYNECOL. SURV. 749 (2007).

[23] One comprehensive study concluded that "there 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." D.A. Frank et al., *supra* note 21. Subsequent studies confirmed these findings. *See, e.g.*, H.S. Bada et al., *Impact of Prenatal Cocaine Exposure on Child Behavior Problems Through School Age*, 119 PEDIATRICS e328 (2007); D.S. Messinger et al., *The Maternal Lifestyle Study: Cognitive, Motor, and Behavioral Outcomes of Cocaine-Exposed and Opiate-Exposed Infants Through Three Years of Age*, 113 PEDIATRICS 1677 (2004) (confirming that "infant prenatal exposure to cocaine and to opiates was not associated with mental, motor, or behavioral deficits").

[24] A national expert panel that concluded that "the data regarding illicit methamphetamine are insufficient to draw conclusions concerning developmental toxicity in humans." Ctr. for the Evaluation of Risks to Human Reproduction, *Report of the NTP-DERHR Expert Panel on the Reproductive & Developmental Toxicity of Amphetamine and Methamphetamine*, 74 BIRTH DEFECTS RES. B. DEV. REPROD. TOXICOL. 471 (2005). *See also* Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 479: Methamphetamine Abuse in Women of Reproductive Age*, 117 OBSTET. GYNECOL. 751 (2011).

[25] Decades of research makes clear that exposure to opioids is not associated with birth defects. G.D. Helmbrecht & S. Thiagarajah, *supra* note 22. Some newborns who are exposed opioids in utero experience a transitory and treatable set of symptoms at birth known as neonatal abstinence syndrome (NAS) that can be safely and effectively treated in the nursery setting. Substance Abuse & Mental Health Servs. Admin., *Methadone Treatment for Pregnant Woman*, Pub. No. SMA 06-4124 (2006); Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 524: Opioid Abuse, Dependence, and Addiction in Pregnancy*, 119

or marijuana[26] – causes unique or certain harms to the fetus.[27] Moreover, they have failed to prove that these substances cause harm distinguishable from other behaviors, exposures, conditions, or life circumstances that pose potential risks to a fetus or a child. Use of controlled substances by pregnant women may be indistinguishable from other factors – social determinants and environmental factors such as poverty, lack of access to medical care, malnutrition, or chronic stress – that may cause fetal and maternal harm.[28] In fact, it is increasingly recognized that social determinants of health beyond any individual woman's control have the greatest impact on pregnancy outcomes.[29]

Like the district court, other courts that have evaluated this scientific research have also rejected the assumption that prenatal exposure to controlled substances necessarily causes specific harms to the fetus. For example, the

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OBSTET. GYNECOL. 1070 (2012) (finding that opioid use during pregnancy is mitigated by opioid-assisted therapy offered in collaboration with pediatric care).

[26] Marijuana use by pregnant women has not been shown to cause specific harm to the fetus or child. Science has failed to establish that in utero exposure to marijuana causes unique harms distinguishable from those caused by other uncontrollable factors. *See*, *e.g.*, A.H. Schempf, *supra* note 22. *See also* Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 637: Marijuana Use During Pregnancy and Lactation*, 126 OBSTET. GYNECOL. 234 (2015).

[27] While heavy alcohol use does pose a substantial risk to fetal health, there are no clear guidelines as to when drinking should be considered heavy. *See e.g.*, Am. Med. Ass'n, Policy, *H-420.991: Fetal Effects of Maternal Alcohol Use* (2013).

[28] *See e.g.*, Am. Pub. Health Ass'n, *Transforming Public Health Works: Targeting Causes of Health Disparties*, 46 THE NATION'S HEALTH 1 (2016) ("at least 50% of health outcomes are due to the social determinants . . ."); M.M. van Gelder et al., *Characteristics of Pregnant Illicit Drug Users And Associations Between Cannabis Use and Perinatal Outcome in A Population-Based Study, National Birth Defects Prevention Study*, 109 DRUG ALCOHOL DEPEND. 243 (2010).

[29] *Id*.

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

This is not to say that prenatal exposure to controlled substances is benign. While current studies are unable to causally link to specific harms caused by exposure to controlled substances during pregnancy, neither do they conclude that such exposure is completely harmless.[30] *Amici* agree that more research is warranted. Existing research on use of controlled substances during pregnancy, however, both as a matter of science and law, does not support the State's intervention into Ms. Loertscher's life or other women in a similar situation. In Ms. Loertscher's case, the most pressing medical need for both her and her fetus's health was treatment of her thyroid issue. Appellee Br. at 15. Instead of addressing this need, the State incarcerated her for a perceived drug problem and withheld medical care. *Id.* at 20. As with other medical conditions – such as diabetes or

[30] The largest (and only longitudinal) research study of women who used methamphetamine while pregnant and their infants reported "only subtle neurobehavioral findings in exposed newborns." L.M. Smith et al., *Prenatal Methamphetamine Use and Neonatal Neurobehavioral Outcome*, 30 NEUROTOXICOL. TERATOL. 20 (2008). *See also* L.H. Lu, *Effects of Prenatal Methamphetamine Exposure on Verbal Memory Revealed with fMRI*, 30 J. DEV. BEHAV. PEDIATR.185 (2009); C. Derauf et al., *Neuroimaging of Children Following Prenatal Drug Exposure*, 20 SEMIN. CELL DEV. BIOL. 441 (2009).

asthma – that require management of a pregnant woman's use of prescribed medications for underlying medical conditions, the potential for fetal harm is actually greater when a pregnant woman's use of alcohol or controlled substances is not treated by her health care provider in conjunction with prenatal care.

Furthermore, a drug test alone cannot distinguish between drug use – including the use of drugs during or prior to pregnancy – and diagnosed drug dependency nor establish that a particular drug caused a particular harm. Toxicology tests may provide evidence of controlled substance use at one point in time, but they do not enable medical providers to determine the frequency or degree of use.[31] Although the State took a different position below, on appeal, the State claims that Act 292 only targets pregnant women who are "very addicted substance abusers" (Appellant Br. at 21) and that Act 292 serves the "State's legitimate goals of separating sporadic users from those who are severely addicted." *Id.* at 35. In this case, though, the State intervened in Ms. Loertscher's life because she tested positive for trace amounts of methamphetamine and tetrahydrocannabinol, the active ingredient in marijuana. Positive drug tests, at best, only demonstrate that a pregnant woman took or was exposed to a drug within a certain period of time and cannot be the basis for determining who is "severely addicted," "very addicted," or a "habitual user" as the State suggests.[32] The State's reliance on drug tests as a basis

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[31] Am. Acad. of Pediatrics, Comm. on Substance Abuse, *supra* note 7.

[32] The State's terminology does not comport with any medical diagnoses and may in fact elicit and perpetuate stigmatizing attitudes about individuals who use drugs. J.F. Kelly, *Does It Matter How We Refer to Individuals with Substance-Related Conditions? A Randomized Study of Two Commonly Used Terms*, 21 INT. J. DRUG POLICY 202 (2010).

for control of pregnant women and determination of risk is therefore medically and scientifically unsupported.[33]

B. Medical and scientific evidence does not support the State's assumption that subjecting pregnant women to state intervention and control ensures healthy birth outcomes.

1. Treating pregnancy as a maternal-fetal conflict leads women to forego treatment and prenatal care and undermines maternal and fetal health.

Act 292 mandates that the best interests of the "unborn child *shall always be of paramount consideration*" when the State assumes jurisdiction over a pregnant woman and her "unborn child." Wis. Stat. § 48.01(1) (emphasis added). However, the State's tendency to see the pregnant woman and her fetus at odds, their interests individual rather than mutual, is medically unsupported. Medical and public health experts agree that fetal health cannot be separated from maternal health.[34]

Laws and policies that subordinate the interests of pregnant women in the name of the fetus, such as Act 292, fundamentally misunderstand the relationship between fetal and maternal health. The maternal–fetal relationship is unique in medicine because of the physiologic dependence of the fetus on the pregnant woman. Therapeutic access to the fetus occurs through the body of the pregnant woman, and any intervention by the State to ostensibly protect the fetus – including

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[33] *See, e.g.,* Am. Med. Ass'n, Policy, *H-95.985: Drug Testing* (2016) ("Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use, nor does it provide valid or reliable information about harm or potential risk of harm to children . . .")

[34] *See, e.g.*, Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 664: Refusal of Medically Recommended Treatment During Pregnancy*, 127 OBSTET. GYNECOL. e175 (2016); Am. Pub. Health Ass'n, *supra* note 9.

incarceration, civil commitment, coerced treatment, suspension or loss of parental rights, and control over private medical decisions – has consequences for the pregnant woman's health, autonomy, and privacy, which in turn impact the health of the fetus.[35] *Amicus* ACOG articulated this position in a committee opinion last year:

> Intervention on behalf of the fetus must be undertaken through the pregnant woman's body. Thus, questions of how to care for the fetus cannot be viewed as a simple ratio of maternal and fetal risks but should account for the need to respect fundamental values, such as the pregnant woman's autonomy and control over her body.[36]

The threat of incarceration and forced treatment is ineffective[37] and compromises maternal and fetal health by dissuading women from seeking out drug treatment and prenatal care during their pregnancies. Indeed, empirical research demonstrates that pregnant women who are threatened with criminal sanctions or mandated treatment are likely to be deterred from seeking care that is critical to the health of both the woman and the fetus.[38] Studies have found that pregnant women who use controlled substances "fear and worry about loss of infant custody, arrest . . . and incarceration for use of drugs."[39] Even a small number of stories of pregnant

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[35] *Id.* at e177 (citing H. Minkoff & M. F. Marshal, *Fetal Risks, Relative Risks, and Relatives' Risks*, 16 AM. J. BIOETH. 3 (2016)).

[36] *Id.*

[37] *See* H. Pollack et al., *If Drug Treatment Works So Well, Why Are So Many Drug Users Incarcerated?, in* CONTROLLING CRIME: STRATEGIES AND TRADE-OFFS (Phil Cook et al. eds., 2011).

[38] *See* Southern Reg'l Project on Infant Mortality, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING WOMEN 6 (1993) . *See also* S. C. Roberts & A. Nuru-Jeter, *Women's Perspectives on Screening for Alcohol and Drug Use in Prenatal Care*, 20 WOMENS HEALTH ISSUES 193 (2010).

[39] M.A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug*

women being placed under state control, such as Ms. Loertscher's, may have a chilling effect on drug-using women's likelihood of seeking out medical treatment while pregnant.[40] Studies have repeatedly shown that the "fear of being reported to the police or child welfare authorities [is] related strongly to a lack of prenatal care."[41]

For those women who are not completely deterred from seeking care, fear of detention, coerced treatment, or incarceration is likely to discourage them from being truthful about controlled substance use, thereby limiting their ability to access beneficial treatment. Although open communication between pregnant women who use controlled substances and their doctors is critical,[42] fear of state involvement negatively impacts this relationship. *Amicus* ACOG has stated that pregnant women's fear of prosecution discourages honest communication with their health care providers and prevents them from obtaining appropriate care.[43] In one study, women who used controlled substances during their pregnancy avoided or delayed

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Dependent Women, 33 J. DRUG ISSUES 285 (2003). *See also* A.H. Schempf & D.M. Strobino, *Drug Use and Limited Prenatal Care: An Examination of Responsible Barriers*, 200 AM. J. OBSTET. GYNECOL. 412.e1 (2009); M.L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 DRUG ALCOHOL DEPEND. 199 (1993); W. Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 AM. J. PUBLIC HEALTH 483 (1990).

[40] *See* K. Burgess, *Comment: Protective Custody: Will It Eradicate Fetal Abuse and Lead to the Perfect Womb?*, 35 HOUS. L. REV. 227, 265–66 (1998).

[41] A.H. Schempf & D.M. Strobino, *supra* note 39. *See also* R. Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUSTICE 1, 3 (2015) ("[F]ear of detection and punishment presents a significant barrier to care for mothers and pregnant women.")

[42] *See* R.H. Kelly et al., *The Detection & Treatment of Psychiatric Disorders and Substance Use Among Pregnant Women Cared for in Obstetrics*, 158 AM. J. PSYCH. 213 (2001).

[43] Am. Coll. Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *supra* note 5.

prenatal care because they did not trust their health care providers to protect them from the social and legal consequences of identification as drug users.[44]

In addition, Act 292's portrayal of drug users' "habitual lack of self-control" perpetuates stigma that prevents pregnant women who use controlled substances from being truthful with their health care providers. Even absent the threat of punishment, drug-using pregnant women's feelings of shame, fear, and low self-esteem are significant barriers to establishing the trust requisite to patients' full disclosure of this medically vital information.[45] Additionally, the exceptionally high rate of depression among drug-dependent women means that their prospects of successfully completing treatment depend upon their forming a strong "therapeutic alliance" with care providers – the very alliance that is undermined by the reporting requirement in Act 292.[46]

While laws such as Act 292 are promoted and adopted with the stated goal of advancing the health and well-being of the developing fetus, they have been developed in the absence of evidence-based medical and scientific opinion. Act 292 fails to appreciate the negative health implications of subjecting pregnant women to state control. Comprehensive, early, and high-quality prenatal care is one of the

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[44] S.C. Roberts & A. Nuru-Jeter, *supra* note 38. *See also* A. El-Mohandes et al., *Prenatal Care Reduces the Impact of Illicit Drug Use on Perinatal Outcomes*, 23 J. PERINATOL 354 (2003).

[45] *See* S. Kandall, SUBSTANCE & SHADOW: WOMEN & ADDICTION IN THE UNITED STATES 278-79 (1996).

[46] *See* Ctr. on Addiction & Substance Abuse, SUBSTANCE ABUSE & THE AMERICAN WOMAN 64 (1996); C.E. Tracy, *Social Consequences of Substance Abuse Among Pregnant and Parenting Women*, 20 PEDIATR. ANN. 548 (1991).

most effective tools for reducing infant mortality, even for women experiencing drug dependency.[47] The mortality rate for infants with mothers who begin prenatal care after the first trimester, or not at all, is forty-five percent higher than the rate for infants with mothers who begin receiving care during the first trimester.[48] Additional studies indicate that prenatal care greatly reduces the negative effects of drug dependency during pregnancy, including decreased risks of low birth weight and prematurity.[49] Furthermore, research suggests that women who obtain prenatal care – whether or not they have also obtained treatment for their drug use – reduce their use of controlled substances.[50] By deterring pregnant women who use controlled substances from seeking out this vital care and from honestly communicating with their physicians, Act 292 undermines the very interests that it

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[47] *See, e.g.*, Southern Reg'l Project on Infant Mortality, *supra* note 38, at 6; P. Moran et al., *Substance Misuse During Pregnancy: Its Effects and Treatment*, 20 FETAL MATERN. MED. REV. 1 (2009); A. Racine et al., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York* City, 270 J. AM. MED. ASS'N 1581, 1585-86 (1993) (finding that pregnant women who use cocaine but who have at least four prenatal care visits significantly reduce their chances of delivering low birth weight babies).

[48] *See* T.J. Matthews & M.F. MacDorman, *Infant Mortality Statistics from the 2013 Period Linked Birth/Infant Death Data Set*, 64 NATL. VITAL STAT. REP. 1, 2 (2015); T.J. Matthews & M.F. MacDorman, *Infant Mortality Statistics from the 2003 Period Linked Birth/Infant Death Data Set*, 62 NATL. VITAL STAT. REP. 1, 6 (2006) (infant mortality rates based on access to prenatal care were not reported in 2013; however, the report noted that pregnant women with other risk factors, e.g., low income, were less likely to receive prenatal care).

[49] A. El-Mohandes et al., *supra* note 44.

[50] *See* Substance Abuse & Mental Health Servs. Admin., *Curriculum for Addiction Professionals (CAP): Level 1*, *available at* http://www.fasdcenter.samhsa.gov/educationTraining/courses/CapCurriculum/ glossary.cfm ("Prenatal care is necessary for healthy pregnancies, particularly for women with alcohol or drug issues."); N.C. Goler et al., *Substance Abuse Treatment Linked with Prenatal Visits Improves Perinatal Outcomes: A New Standard*, 28 J. PERINATOL. 597, 602 (2008) ("Women who admit to use might be more motivated to stay clean in pregnancy. However, they will only get better if they receive appropriate support that they can access without . . . stigmatization or fears of criminal investigation.").

seeks to protect, erroneously prioritizes fetal health above maternal health and, in doing so, permits significant state intervention into the lives of pregnant women that is damaging to their health and ultimately to fetal and child health.

2. The lack of evidence-based standards in Act 292 leads to erratic enforcement and undermines maternal and fetal health.

In further repudiation of medical and scientific consensus, Act 292 fails to promote fetal health because it does not provide government officials with evidence-based standards for determining what actions they should take when drug exposure is identified. In addition, nothing in Act 292 requires that mandated treatment be clinically appropriate or medically necessary. In the absence of such guidelines, state officials may take measures that run directly counter to scientific evidence and that pose an imminent danger to the health and safety of the fetus.

Despite its lengthy description of the written processes for the implementation of Act 292 (Appellant Br. at 9-14), the State fails to clarify any of the fundamental ambiguities in Act 292. Although Act 292 directs state officials to "offer to provide appropriate services" to pregnant women who fall under its jurisdiction, nowhere in the statute is there a requirement that these "appropriate services" conform to evidence-based standards. Wis. Stat. § 48.981(3)(c)(1)(a). Act 292 also allows for temporary custody of a pregnant woman in situations in which there is a "substantial risk [to] the physical health of the unborn child," despite the fact that no scientific or medical consensus identifies when this "substantial risk" exists. Wis. Stat. § 48.981(3)(b)(2m). As noted by the district court, "the expert evidence here makes one thing abundantly clear: current medical science cannot tell

us what level of drug or alcohol use will pose a substantial risk of serious damage to an unborn child." *Loertscher*, 2017 WL 1613654, at *14. Once a pregnant woman is taken into state custody, the State may move to hold her in contempt of court if she does not comply with state-mandated treatment, without regard for the consequences of such an order to maternal or fetal health. Without clear standards, "[e]rratic enforcement, driven by the stigma attached to drug and alcohol use by expectant mothers, is all but ensured." *Id*. at 15.

In Ms. Loertscher's case, the county supported having her held in contempt of court, a holding which would – and did – result in Ms. Loertscher incarceration in jail. Appellee Br. at 19-20. Several studies have demonstrated that incarceration itself can lead pregnant women to experience psychological distress, multiple complications, and poor birth outcomes.[51] Additionally, nothing in Act 292 required the State to determine what, if any, health care would be provided to Ms. Loertscher during her incarceration and, in fact, while in jail, Ms. Loertscher's thyroid medications were withheld for a period of time, she was denied transfer to two previously scheduled prenatal appointments, and she was not provided with any drug treatment or education. *Id.*

Such misuse of authority without regard for medical opinion is not limited to Ms. Loertscher's case. In July 2013, Alicia Beltran, a 28-year-old Wisconsin woman, informed her provider that she had previously been addicted to prescription pain

[51] *See e.g.,* B.J. Shelton et al., *Childbearing While Incarcerated*. 8 MCN AM. J. MATERN. CHILD NURS. 23 (1983); B.J. Shelton & D.G. Gill, *Childbearing in Prison: A Behavioral Analysis*, 18 . J. OBSTET. GYNECOL. NEONATAL NURS. 301 (1989).

killers. Petition for Writ of Habeas Corpus at 8, *Beltran v. Loenish*, No. 2:13-cv-01101-CNC (E.D. Wis. Sept. 30, 2013). She had used Suboxone – a medication designed to relieve withdrawal, reduce craving, and block the effects of opioids – to successfully wean herself offf of pain killers without a prescription.[52] Despite this, the provider recommended that Ms. Beltran submit to a prescribed regimen of Suboxone, and, when she refused, reported her past drug use to the authorities. *Id.* at 9. She was then arrested, required to submit to a doctor's evaluation, and, despite the doctor's finding that both she and her fetus were healthy, the district attorney of Washington filed action against her pursuant to Act 292. *Id*. Following the hearing, Ms. Beltran was transported in handcuffs and shackles to a treatment center that provided only drug treatment through counseling rather than the indicated medication-assisted treatment. *Id*. at 10. At the treatment center, Ms. Beltran was subjected to a urinalysis test, which was negative for the presence of all controlled substances, including Suboxone. *Id*. Ms. Beltran was nevertheless held at the treatment center pursuant to court order for over two months until she filed a habeas petition and the State dismissed the Act 292 case. *Id*.; Supplemental Memorandum Regarding Status of State Court Proceedings at 1, *Beltran v. Loenish*, No. 2:13-cv-01101-CNC (E.D. Wis. Sept. 30, 2013).

Similarly, according to news reports, in 2005, Rachel Lowe, voluntarily sought help at Waukesha Memorial Hospital for opioid dependency and was

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[52] E. Eckholm, *Case Explores Rights of Fetus Versus Mother*, N.Y. TIMES, Oct. 23, 2013, at A1.

reported to state officials who petitioned for her detention pursuant to Act 292. She was taken into custody and ordered into a psychiatric ward at an area hospital against her will, where she received no prenatal care, was put on more medications than she had been taking when she originally, and was denied access to counsel for 12 days.[53] When admitted to the psychiatric unit, Ms. Lowe was placed on many more medications than she had originally been taken, some of which carried greater risk to fetal health than just the opioids.[54] At the first hearing, the State was unable to offer any information regarding the fetus's wellbeing, and, in a subsequent hearing, an attending physician testified that Ms. Lowe had not placed her fetus at any significant risk.[55] The court ordered Ms. Lowe's release, but the State delayed her release for several days and maintained State supervision for the remaining term of her pregnancy, in violation of both the court's order and expert medical opinion.[56]

It is clear from the facts of these cases that the lack of evidence-based guidelines in Act 292 protects neither the pregnant woman nor the fetus. Access to prenatal care dramatically benefits maternal and fetal health and the State's actions ensured that Ms. Loertscher would not have access to this critical care.

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[53] D. Steinkraus, *Pregnant, Addicted Woman Asks for Help, Gets Locked Up*, J. TIMES (Racine, Wis.) (May 11, 2005); D. Steinkraus, *Pregnant and Addicted – Hooked on OxyContin, Woman Remains Confined as She Seeks Help for Herself, Her Unborn Baby*, J. TIMES (Racine, Wis.) (May 12, 2005); D. Steinkraus, *Judge Frees Addict Mom,* J. TIMES (Racine, Wis.) (May 24, 2005).

[54] *Id.*

[55] *Id.*

[56] *Id.*

CONCLUSION

For the foregoing reasons, *amici curiae* respectfully request this Court to deny the appeal, affirm the district court's ruling that Act 292 is void for vagueness, and affirm the permanent injunction of its enforcement.

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Respectfully submitted,

/s/ Joy F. Haviland

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief conforms to the rules set forth in Fed. R. App. P. 32 and Circuit Rule 29:

1. This brief complies with the type-volume limitation set forth in Circuit Rule 29 because it contains 6985 words, based on the "Word Count" feature of Microsoft Word 2016.

2. This brief complies with the typeface and type style requirements set forth in Circuit Rule 32 because this brief has been prepared in a proportionally-spaced typeface using Microsoft Office Word in 12-point Century Schoolbook font.

DATED: July 27, 2017

/s/ Joy F. Haviland

CERTIFICATE OF SERVICE

I hereby certify that on July 27, 2017, I electronically filed the foregoing with the Clerk of Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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