IN THE COURT OF SPECIAL APPEALS OF MARYLAND

No. 1478
September Term, 2005

KELLY LYNN CRUZ,

Appellant,

v.

STATE OF MARYLAND,

Appellee.

Appeal from the Circuit Court for Talbot County, Maryland
(The Hon. William S. Horne, Presiding)

BRIEF OF *AMICI CURIAE* THE INTERNATIONAL CENTER FOR ADVANCEMENT OF OPIOID DEPENDENCE, NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE (NATIONAL CHAPTER AND MARYLAND CHAPTER), MARYLAND SOCIETY OF ADDICTION MEDICINE, NAADC – THE ASSOCIATON FOR ADDICTION PROFESSIONALS, OBSTETRICAL AND GYNECOLOGIC SOCIETY OF MARYLAND, AND 34 OTHER CONCERNED ORGANIZATIONS AND PROFESSIONALS IN SUPPORT OF APPELLANT

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INTRODUCTION

Amici Curiae submit this Brief to explain how the policy of the Talbot County State's Attorney to criminally prosecute women, who continue pregnancies to term in spite of drug dependency, lacks foundation in law and medical science and to inform this Court of the dangers the trial court's decision portends for pregnant women, their children, treatment professionals, and their patients in general.

Amici urge the Court that this case cannot be resolved in isolation from the public health context in which the case arises: were the Court to affirm the decision below, it would set a precedent that would seriously hamper the very measures – drug treatment and prenatal care – that promote healthy pregnancies and birth outcomes. *Amici* are also concerned that such prosecutions threaten to undermine the long-standing recognition by courts, the General Assembly, and the public health and medical community that, drug addiction is best addressed as a disease that should be treated rather than as a crime that should be addressed through the costly criminal justice system.

Most importantly, *Amici* are concerned that this case be resolved based on an accurate understanding of the medical evidence concerning the effects of *in utero* exposure to cocaine and of the nature of drug addiction. Since the 1990s, state appellate courts have served as the bulwark against prosecutions fueled by widely-held, now largely discredited, assumptions that the adverse effects of cocaine ingestion during pregnancy were different in kind from those associated with other activities and conditions which raise pregnancy risks –and by equally serious misunderstandings about women with drug dependencies.

Amici therefore urge that, in addition to the plain language of the statute, the clear legislative intent, the prohibition on adopting legislative interpretations that lead to absurd results, and the constitutional claims raised by Cruz's counsel, principles of scientific integrity, and the health and well-being of Maryland children and their mothers, require this Court to conclude that the crime of reckless endangerment of another does not apply to the context of pregnancy.

STATEMENT OF INTEREST OF *AMICI CURIAE*

As more fully described in the Appendix, *Amici* consist of Maryland and national health care providers, counselors, bio-ethicists, social workers, social welfare advocates, public health practitioners, and their professional associations. These individuals and organizations have recognized expertise and longstanding interest in the areas of maternal and neonatal health and in the understanding of the effects of drugs and other substances on users, their families and society, and the ways those effects can best be minimized.

While there is great variety among *Amici* as to experience, expertise, and perspective on medical, scientific, and public health issues, *Amici* are united in their condemnation of Talbot County's decision to arrest and criminally prosecute a woman based on pregnancy and a positive drug toxicology, and the trial court's decision upholding this unprecedented and legally unfounded prosecution. *Amici* join together in this Brief to elucidate the medical background which underlies the legal questions that this Court must address.

BRIEF BACKGROUND & SUMMARY OF ARGUMENT

The instant appeal concerns a recent decision from the Circuit Court for Talbot County (Horne, J., presiding) that presents a troubling and unwarranted departure from scientific understanding and established medical practice. Kelly Lynn Cruz, a thirty-year-old woman, was convicted of endangering the welfare of another pursuant to Md. Code Ann. Crim. Law § 3-204 (2005), under the theory that her ingestion of cocaine during pregnancy contributed to the birth of her son with a low birth weight.

Amici oppose the Talbot County State Attorney's wrongful and counterproductive decision to bring *criminal* charges against Ms. Cruz, and the Circuit Court's decision to uphold this unprecedented application of the reckless endangerment law. *Amici* are well aware of the strong societal interest in protecting the interests of children. In the view of *Amici*, however, such protective instincts are undermined, rather than advanced, by holding women criminally liable based on conditions, actions, or inactions they experience during pregnancy and for pregnancy outcomes. Indeed, the policy of seeking criminal arrests and prosecutions of pregnant women who use drugs during pregnancy ("the Talbot policy" or "the policy") is contrary to law, objective scientific research, and to the consensus judgment of American medicine.

First, the Talbot policy reflects a basic misunderstanding of the nature of drug use and dependency. The prosecution of Ms. Cruz for being pregnant and using cocaine vitiates the longstanding recognition by the courts and the medical community that addiction is a disease that requires treatment, not a crime. It cannot be cured merely by an exercise of self-discipline, nor can it be cured by subjecting addicts to criminal

penalties. The core premise of this application of the reckless endangerment of another law is that the patients who seek prenatal care can stop themselves from ingesting drugs simply as a result of being warned of the negative consequences that could befall them (arrest) or their children, is wholly inconsistent with medical knowledge about drug dependency, its causes, and the most promising treatment approaches. Accordingly, criminal prosecutions are not an effective means of addressing the public health disease of pregnant women using drugs and suffering from a drug addiction.

Second, over the course of nearly two decades, every leading medical organization, governmental body, and nearly every court to consider the question has concluded that inserting the criminal law into these situations is likely to produce *worse outcomes* for children birthed by pregnant women. Attaching a threat of arrest and prosecution for drug use by pregnant women operates as a barrier to pursuing drug treatment, prenatal care, and labor and delivery care. Additionally, the threat of arrest and prosecution weakens the physician-patient relationship by discouraging the disclosure of critical medical information to health professionals.

The state of affairs that a punitive regime threatens is especially tragic and intolerable because the evidence also establishes that appropriate medical interventions in these situations can dramatically improve outcomes. Drug treatment can be effective for pregnant women, and the adverse effects associated with drug, alcohol, tobacco use, and other conditions that raise pregnancy risks are substantially mitigated when women receive treatment and regular prenatal care. Unfortunately, in Maryland there are a limited number of treatment facilities that accept pregnant women, and even fewer offer

residential treatment for pregnant women with children. As a result, threats of punishment as an incentive to seek non-existent care cannot work. Moreover, such threats are counterproductive and misleading by falsely suggesting that sufficient and appropriate medical care is available to such women and children when in fact there is not.

Third, criminal prosecutions of pregnant women are also counterproductive because, through arrest, the State removes the mother from the child. Contrary to promoting children's interest, the children are likely to suffer serious psychological harm as a result of the deprivation of the parental bond at a critical point of their lives – just after birth. Empirical evidence suggests that even infants with prenatal exposure to cocaine, as a group, fare better in the care of their mothers than in the care of relatives or foster parents.

Fourth, scientific and medical evidence fails to substantiate the alleged harms that prompted the prosecution of Ms. Cruz. In Talbot County, prosecutions have focused particularly on women who allegedly used cocaine during their pregnancies, reflecting a reliance on exaggerated and inaccurate media reports on the "epidemic" of "crack babies" rather than sound medical findings. Researchers, to the contrary, have concluded that medical evidence from the newborn period fails to demonstrate any clear predictions about the effects of intra-uterine exposure to cocaine on the course and outcome of child growth and development. Thus, scientific and medical studies fail to support the belief underlying Ms. Cruz's prosecution and the prosecutions of others similarly situated.

Finally, the Talbot policy contravenes a key policy that the Maryland General Assembly has adopted to protect children: the provision of drug treatment programs and child protective services in a civil, not criminal, context. Those services include services to preserve families, rather than destroy them. Rather than pursue the aim of child protection, Talbot County unwisely turned to punitive measures that disrupted families. By resorting to the punitive approach of law enforcement intervention, the policy also failed to make use of less disruptive preventive services available through child protective agencies. Accordingly, *Amici Curiae* respectfully urge this Court to reverse the conviction of Ms. Cruz for endangering the welfare of another under Md. Code Ann. Crim. Law § 3-204, and issue a clear statement that this statute cannot be the basis for prosecuting women for becoming pregnant and giving birth while using drugs.

ARGUMENT

V. Imposing Criminal Sanctions on Women who Continue Pregnancies in Spite of Drug Dependency Problems Contradicts Broadly Accepted Principles of Law and Is also Ineffective in Halting Drug Abuse

Following a toxicology report on Ms. Cruz and her newborn child, Deandre Michael Thomas Cross, test results for both Ms. Cruz and Deandre reflected the presence of cocaine metabolites. On the basis of this evidence alone, Ms. Cruz was arrested and prosecuted for, *inter alia*, reckless endangerment of another.[1] *Id*. Implicit in the decision

[1] Ms. Cruz was charged with the following crimes: (1) second degree child abuse, Md. Code Ann. Crim. Law § 3-601(d)(1)(i) (2005) ("A parent or other person who has permanent or temporary care or custody or responsibility for the supervision of a minor may not cause abuse to a minor"); (2) reckless endangerment of another, *id*. § 3-204 (a) (1) (2005) ("A person may not recklessly [] engage in conduct that creates a substantial risk of death or serious physical injury to another"); (3) contributing to delinquency, *id*.

to prosecute Ms. Cruz is the assumption that the threat of criminal prosecution would be sufficient to prevent a woman from abusing drugs. In other words, patients who truly want to avoid prosecution will cease drug use simply through the power of individual will. This assumption is fundamentally flawed, particularly in the context of using threats of prosecution for women who are drug dependent. Although not all women who use alcohol or drugs during pregnancy are addicted, using drugs near delivery may be an indicator of drug dependency or addiction. Gehshan, MPP, *Missed Opportunities for Intervening in the Lives of Pregnant Women Addicted to Alcohol or Other Drugs*, 50 JAMA 160 (Sept/Oct 1995).[2]

As will be explained, an addiction is a disease – not the result of poor judgment – the hallmark of which is an inability to cease drug use despite the possibility of adverse consequences.[3]

Cts. & Jud. Proc. § 3-8A-30 (a) (2005) ("It is unlawful for an adult willfully to contribute to, encourage, cause or tend to cause any act, omission, or condition which results in a violation, renders a child delinquent or in need of supervision); and (4) possessing a controlled dangerous substance, *id*. Crim. Law § 5-601 (a) (1) (2005) ("[A] person may not [] possess or administer to another a controlled dangerous substance, unless obtained directly or by prescription or order from an authorized provider acting in the course of professional practice").

[2] *See also* Gehshan, *A Step Toward Recovery*, at 1 (Southern Reg. Proj. on Infant Mortality 1993) (In the 1990's a regional study concerning access to substance abuse treatment for pregnant and parenting women concluded, "the 'typical' chemically dependent woman" . . ."is most likely white, divorced or never married, age 31, a high school graduate, on public assistance, the mother of two or three children, and addicted to alcohol and one other drug. "); Gehshan, *MPP, Missed Opportunities for Intervening in the Lives of Pregnant Women Addicted to Alcohol or Other Drugs*, 50 JAMA 160 (Sept./Oct. 1995) ("Of course, not all women who use alcohol or drugs during pregnancy are addicted, but using drugs near delivery can indicate a serious problem.").

[3] The decision to begin to use drugs initially reflects either ignorance or poor judgment. But once addicted, a person's drug use is a symptom of his or her disease. *See Nat'l*

Since as early as 1925, the United States Supreme Court observed that drug dependent persons "are diseased and proper subjects for [medical] treatment." *Linder v. United States*, 268 U.S. 5, 18 (1925). The Supreme Court reaffirmed this principle nearly four decades later in *Robinson v. California*, 370 U.S. 660, 667 n.8 (1962), when it found unconstitutional a law making the status of narcotic addiction a criminal offense. The Court stated that "narcotic addiction is an illness . . . which may be contracted innocently or involuntarily." *Id*. In his concurring opinion, Justice Douglas noted that, "the addict is under compulsion not capable of management without help." *Id*. at 671.

The medical profession has long recognized that "addiction is not simply the product of a failure of individual willpower," American Medical Ass'n Board of Trustees, Drug Abuse in the United States: A Policy Report 236, 241 (1988), or a "character defect." National Academy of Sciences, Institute of Medicine, Dispelling The Myths About Addiction, Ch. 8 (1997). The vast majority of drug-dependent women – and drug-dependent men – cannot simply "decide" to refrain from drug use, and in most cases, their dependence cannot be overcome without professional treatment. American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders – 4th Edition* (1994) ("DSM-IV") (specifying diagnostic criteria for "Psychoactive Substance Dependence"); Dispelling The Myths at 37 (summarizing evidence that addiction "causes

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Treasury Employees Union v. Von Raab, 489 U.S. 656 676 (1989) ("[A]ddicts may be unable to abstain even for a limited period of time."); *see also* 21 U.S.C. § 802(1) (2005) ("The term 'addict' means any individual who habitually uses any narcotic drug so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his [or her] addiction.").

long-lived alterations in the biochemical and functional properties of selected groups of neurons in the brain").[4] Indeed, as described in the DSM-IV, one of the hallmarks of drug dependency is the inability to reduce or control substance abuse *despite adverse consequences*.[5] As the Board of Trustees of the American Medical Association ("AMA") points out, punishing people for substance abuse:

> [i]gnores the impaired capacity of substance abusing individuals to make decisions for themselves. In all but a few cases, taking a harmful substance such as cocaine is not meant to harm the fetus but to satisfy an acute psychological and physical need for that particular substance.[6]

The disease is often further complicated for poor, pregnant, and drug-dependent women by depression and low self-esteem, and/or disorders associated with sexual or other physical abuse.[7]

More importantly, because of the compulsive nature of drug dependency, criminal sanctions are unlikely to achieve the goal of deterring drug use among pregnant women, but instead will only act to further demonize them. Physicians are generally impressed with the amount of personal health risk and voluntary self-restraint exhibited by pregnant

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[4] Although there has been long-running debate within the treatment community as to the utility of describing addiction as "a disease," there is no dispute that there are biological and genetic *dimensions*, and many of the intuitive bases for distinguishing drug dependency from other medical conditions do not withstand scrutiny. For example, the etiology of many health problems – including hypertension, heart disease, and diabetes – also have important behavioral dimensions. *See* Physicians Leadership on National Drug Policy, Position Statement (1997) 10-11 (noting that "no person eats fatty foods with the purpose of developing heart disease, . . . just as no drug user begins . . . with the hope of becoming addicted").

[5] DSM-IV, *supra*, at 179 (emphasis added).

[6] AMA, *Legal Intervention During Pregnancy*, 264 Journal of the American Medical Association ("JAMA") 2663 (1990).

[7] *See* Wallen, *A Comparison of Male and Female Clients in Substance Abuse Treatment*, 9 J. Substance Abuse Treatment 243 (1992).

women with drug dependencies for the sake of their fetuses' health, even absent the threat of prosecution.[8]

The United States Supreme Court and the medical community have long held that drug addiction should be treated as an illness. Accordingly, in the context of women who are drug dependent, the threat of arrests for drug use may be particularly ineffective and flout both Supreme Court precedent and a firmly established body of medical knowledge. For the foregoing reasons, this Court should be particularly careful of allowing prosecutors to declare drug use during pregnancy to be a criminal act.

VI. The Overriding Social Interest in Promoting Health and Welfare of Pregnant Women and Children Is Disserved By Judicially Expanding the Reckless Endangerment of Another Law in the Manner Sought By the Prosecution

Medical and public health professionals uniformly object to the prosecution of women for their behavior during pregnancy because such prosecutions have been shown to erode women's willingness to seek health care or to confide in their health care providers if they do seek such care. As a result of these barriers to health care, the health of the woman and the fetus deteriorates. Moreover, the child's physical and psychological health is impaired when mothers avoid drug treatment, prenatal care, and hospital deliveries, or when children are removed from their mothers' custody during the critical post-natal bonding period.

In sum, the purported goal of this prosecution – protecting the health and well-being of pregnant women and their future children – is put at greater, not lesser, risk by

[8] Nelson & Milliken, *Compelled Treatment of Pregnant Women*, 259 JAMA 1060, 1065 (1988).

the State's actions in cases such as this. For these reasons, *Amici* urge the Court to decline to dramatically expand the reckless endangerment statute to cover the facts of this case.

D. Criminal Prosecution Deters Drug-Dependent Women from Obtaining Health Care and Undermines the Quality of Care Such Women Receive when they Seek it

For nearly two decades, courts and researchers have described the central danger inherent in the punitive approach: that fear of criminal prosecutions will trigger a "flight from care," among drug-dependent women. *See* Poland, *et al*., *Barriers to Receiving Adequate Prenatal Care*, AM. J. OB. & GYN., 157(2): 297-303 (1987). Thus, in a 1990 policy statement, the American Medical Association highlighted the danger that criminal penalties would "exacerbate the harm done to fetal health by deterring pregnant substance abusers from help or care from . . . the very people who are best able to prevent future abuse."[9]

Indeed, numerous other expert bodies and authoritative commissions have found that the intrusion of the criminal justice system on health care practices increases the already strong reluctance of pregnant substance abusers to seek medical attention and treatment. After a comprehensive three-year study of prenatal substance abuse in southern states, the Southern Regional Project on Infant Mortality, an initiative of the Southern Governors Association and the Southern Legislative Conference, concluded:

[9] AMA, supra n. 5 at 2667; *see also id*. at 2670 (reporting AMA resolution that "[c]riminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate").

> If pregnant women . . . feel that they will be 'turned in' by health care providers or substance abuse treatment centers, they will avoid getting care. If women are able to discuss their addiction with providers without fear of retribution . . . they are more likely to enter treatment.[10]

The American Society of Addiction Medicine, comprised of the leading specialists in the field of substance abuse treatment and prevention, declared that "criminal prosecution of chemically dependent women will have the overall result . . . of increasing, rather than preventing, harm to children and to society as a whole."[11] Even a study by the United States General Accounting Office concluded that "the threat of prosecution poses . . . [a] barrier to treatment for pregnant women."[12]

Amici and every other prominent public health and medical organization to have given the subject serious consideration agree that a punitive approach to drug use during pregnancy will worsen rather than resolve the problem. These organizations include, *inter alia*, the American College of Obstetricians and Gynecologists,[13] the American Academy of Pediatrics,[14] the March of Dimes,[15] the National Association of Public Child

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[10] Southern Regional Project on Infant Mortality, *A Step Toward Recovery*: *Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women* 21 (1993).
[11] American Soc'y of Addiction Med., Bd. of Directors, *Public Policy Statement on Chemically Dependent Women and Pregnancy* (Sept. 25, 1989).
[12] United States General Accounting Office, *ADMS Block Grant*: *Women's Set Aside Does Not Assure Drug Treatment for Pregnant Women* 5, 20 (1991).
[13] American College of Obstetricians and Gynecologists ("ACOG"), *Substance Abuse in Pregnancy* 195 ACOG Technical Bulletin 1 (1994) ("In some states, the legal requirement regarding reporting substance abuse threaten[s] to interfere with patient confidentiality and the entire physician-patient relationship.").
[14] American Academy of Pediatrics, Comm. on Substance Abuse, *Drug-Exposed Infants*, 86 Pediatrics 639, 642 (1990) ("The public must be assured of nonpunitive access to comprehensive care which will meet the needs of the substance-abusing pregnant woman and her infant.").
[15] March of Dimes, *Statement on Maternal Drug Abuse*, 1 (Dec. 1990).

Welfare Administrators,[16] the National Council on Alcoholism and Drug Dependence,[17] the American Nurses Association,[18] and the Center for the Future of Children.[19] *See also State v. Luster*, 419 S.E. 2d 32, 35 n.2 (Ga. 1992) (listing medical and public health organizations opposing the prosecution of women for cocaine use during pregnancy); *Ferguson v. City of Charleston*, 532 U.S. 67, 84 n.23 (2001) (in the course of rejecting Fourth Amendment exception for prosecutorial drug-testing of pregnant women, noting *amicus* submissions "claiming a near consensus in the medical community that programs of the sort at issue, by discouraging women who use drugs from seeking prenatal care, harm, rather than advance, the cause of prenatal health");[20] U.S. G.A.O., ADMS Block

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[16] National Ass'n of Public Child Welfare Administrators, *Guiding Principles for Working with Substance-Abusing Families and Drug-Exposed Children*: *The Child Welfare Response* (Jan. 1991) ("Laws, regulations, or policies that respond to addiction in a primarily punitive nature, requiring human service workers and physicians to function as law enforcement agents, are inappropriate.").

[17] Nat'l Council on Alcoholism and Drug Dependence, *Women, Alcohol, Other Drugs and Pregnancy* (1990) (A "punitive approach is fundamentally unfair to women suffering from addictive diseases and serves to drive them away from seeking both prenatal care and treatment for their alcoholism and other drug addictions. It thus works against the interest of infants and children . . .").

[18] American Nurses Ass'n, *Position Statement* (Apr. 5, 1992) ("ANA . . . opposes any legislation that focuses on the criminal punishment of the mothers of drug-exposed infants . . . The threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment for their alcohol and other drug problems.").

[19] Center for the Future of Children, *Recommendations*, 1 The Future of Children 8 (1991) ("A woman who uses illegal drugs during pregnancy should not be subject to special criminal prosecutions on the basis of allegations that her illegal drug use harms the fetus. Nor should states adopt special civil commitment provisions for pregnant women who use drugs.").

[20] Furthermore, "[w]hile dozens of medical, public health, and civil rights groups filed or joined briefs in support of the women's appeal [in *Ferguson*], not one-friend-of-the-court-brief was filed on the city's side." Greenhouse, *Justices Consider Limits of the Legal Response to Risky Behavior by Pregnant Women*, New York Times, Oct. 5, 2000.

Grant: Women's Set Aside Does Not Assure Drug Treatment For Pregnant Women 20 (1991) (identifying "the threat of prosecution" as a "barrier to treatment for pregnant women").

Recent research reinforces these expert judgments. Those who work closely with and study drug-dependent women have reported that "fear and worry about loss of infant custody, arrest, prosecution, and incarceration for use of drugs during pregnancy" is "the[ir] primary emotional state." Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, J. Drug Issues (Spring 2003); *see also* Murphy & Rosenbaum, Pregnant Women on Drugs: Combating Stereotypes and Stigma (1999); *accord* Whiteford & Vitucci, *Pregnancy and Addiction*: *Translating Research and Practice*, Social Science & Med., 44(9): 1371-1380 (1997); Gazmarian, *et al*., *Barriers to Prenatal Care Among Medicaid Managed Care Enrollees*: *Patient and Provider Perceptions*, HMO Practitioner 11(1) (1997).

The threat of criminal punishment also corrodes the formation of trust that is fundamental to any caregiver-patient relationship. Medical and public health professionals and the courts have long recognized that the obligation of confidentiality is not solely a matter of principle: it is a necessary precondition of every relationship between a patient and a physician, nurse, or substance abuse counselor. As the Supreme Court recognized in *Jaffe v. Redmond*, 518 U.S. 1 (1997), "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment." *Id*. at 10. Thus, not only does "[v]iolation of confidentiality . . .

show [] disrespect to the patient as a human being," Arnold, *et al*., *Medical Ethics and Doctor/Patient Communication, in The Medical Interview*: *Clinical Care,* Education and Research 345, 365 (Lipkin, Jr. *et al*., eds., 1995); it substantially impairs the ability of medical providers to do their jobs:

> To make diagnoses and treat patients effectively, the physician must obtain sensitive information about a patient. A patient must be willing to tell a physician, who is often a total stranger, about such matters as drug usage . . . and to allow the physician to examine intimate parts of his or her anatomy. The promise of confidentiality encourages patients to disclose sensitive subjects to a physician without fear that an embarrassing condition will be revealed to unauthorized people.[21]

Unsurprisingly, an environment of open communication and trust is even more paramount when the substance dependent patient is pregnant. First, the fear of criminal prosecutions is likely to chill her willingness to speak openly and make her particularly reticent to give accurate information concerning the nature and extent of her drug use.[22]

Second, drug use is one of the most commonly missed diagnoses in obstetric and pediatric medicine; in most cases, a patient's drug use is not readily apparent if the patient does not voluntarily disclose it.[23] Additionally, health care workers must be able

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[21] *Id*.; *see also* Lazare, *Shame, Humiliation, and Stigma*, in The Medical Interview: Clinical Care, Education and Research 333 (M. Lipkin, *et al*., eds., 1995); Miller & Thalen, *Knowledge & Belief About Confidentiality in Psychotherapy*, 17 Prof. Psychol. Res. & Prac. 15, 18 (1986) ("[P]atients view confidentiality as an all-encompassing, super ordinate mandate for the profession of psychology.").

[22] *See* Southern Regional Project on Infant Mortality, A Step Toward Recovery: Improving Access to Substance Abuse Treatment For Pregnant and Parenting Women, 21 (1993); *see also* United States General Accounting Office, Report to the Chairman, Senate Comm. on Finance, HRD-90-138, at 9-10 (1990) ([S]ome drug-using women are now delivering their infants at home in order to prevent being reported to . . . authorities).

[23] Chasnoff, *Drug Use in Pregnancy*: *Parameters of Risk*, 35 Pediatric Clinics N. Am. 1403, 1410 (1988); Kelly, *et al*., *The Detection & Treatment of Psychiatric Disorders*

to discuss fully with pregnant women many sensitive matters to protect both maternal and fetal health. Among these are whether the mother and fetus are at risk of HIV, Hepatitis C, or herpes infection due to unprotected sex or intravenous drug use.[24]

Similar considerations figure significantly in the provision of drug treatment. For over three decades, researchers have emphasized that pregnant drug-dependent women suffer from depression at high rates.[25] In all cases, their decision to seek medical care at any stage of pregnancy is itself a highly positive step. Because depressed patients often lack the self-esteem that is necessary for completing treatment, it is particularly critical that they form a strong "therapeutic alliance" with their care providers.[26]

Also, women with substance abuse problems often require specially tailored treatment programs. For example, large numbers of drug-dependent women have been victims of sexual or other physical abuse, *see* Whallen, *supra* n.6, and women with substance abuse problems are far more likely than their male counterparts to have child care responsibilities. For women with children, studies have shown that substance abuse treatment outcomes improve substantially when treatment programs take into account

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and Substance Use Among Women Cared For in Obstetrics, AM. J. Psych 158(2): 213-19 (Feb. 2001).

[24] *See, e.g.*, Campbell, *et al.*, *Unrecognized "Crack" Cocaine Abuse in Pregnancy*, 77 Brit. J. Anaesthesiology 553, 555 (1996).

[25] Murphy and Rosenbaum, *Pregnant Women on Drugs*: *Combating Stereotypes and Stigma* (1999).

[26] *See* Center on Addiction and Substance Abuse, Substance Abuse and The American Woman, 64 (1996) ("CASA Report") (noting that "[c]onfrontational therapy programs, which aim to push addicts to shed their denial and assume responsibility for their behavior, may backfire on women by reinforcing feelings of shame, low self-esteem, and depression"); O'Connor, *et al.*, *Shame, Guilt, and Depression in Men and Women in Recovery from Addiction*, J. Substance Abuse Treatment 11(6): 03-510 (1994).

patients' needs for transportation to appointments, job training, primary medical care, education, child care, and medical care for infants and children. Goldberg, *Substance-abusing Women: False Stereotypes and Real Needs*, 40 Social Work 789 (1995). A health care provider cannot assist in appropriate placement into treatment if the avenues of communication are blocked by fear of criminal sanctions.

Accordingly, protecting a climate of confidentiality is essential if patients are to disclose drug use and/or seek continued care and counseling from health professionals in order to reduce the potential harms caused by substance abuse during and after pregnancy. Moreover, as explained more fully below, without such confidentiality, pregnant women who use drugs will often avoid interfacing with health authorities and suffer the additional harms caused by lack of adequate prenatal care.

E. A Criminally Punitive Regime Threatens to Impair Medical Interventions Which Are Effective and Important in Substantially Mitigating Pregnancy Risks

The danger of deterrence is important, because the evidence also shows that there are large potential benefits to the medical interventions that pregnant, drug-dependent women would avoid. Researchers have determined that prenatal care is itself strongly associated with improved outcomes for children exposed to drugs *in utero*. For example, pregnant women who use cocaine but who had at least four prenatal care visits were found to reduce significantly their chances of delivering low birth weight babies.[27] In

[27] Racine *et al*., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 JAMA 1581, 1585-86 (1993); Chazotte, *et al*., *Cocaine Use During Pregnancy and Low Birth Weight*: *The Impact of Prenatal Care and Drug Treatment*, Seminars in Perinatol, 19: 293-300 (1995); Funai, *et al*.,

addition, early, high-quality, comprehensive prenatal care is one of the most effective weapons against infant mortality.[28]

These findings reflect two sides of a reality which recent research has brought into increasingly sharp focus: on the one hand, *in utero* exposure to illegal drugs *does not* itself pose a uniquely severe or insurmountable danger of fetal or developmental harm; but at the same time, many children of drug-dependent women are subject to *other* risk factors, including poverty, poor nutrition, domestic violence, higher incidences of medical conditions such as maternal high blood pressure and thyroid disease, and tobacco and alcohol use, the effects of which could also be addressed through prenatal care. Accordingly, the definitive analysis of the developmental effects of prenatal cocaine use found "no convincing evidence" that intra-urine exposure "is associated with any developmental toxicity different in severity, scope, or kind from the sequelae of many other risk factors." Frank, *et al*., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure*: *A Systemic Review* (*"A Systemic Review"*) 285 JAMA 1613, 1622 (2001). Indeed, adverse outcomes "once thought to be [the] specific [result] of in utero cocaine exposure" were, in fact, driven by "other factors, including prenatal exposure to tobacco, marijuana, or alcohol and the quality of the child's environment," for which earlier researchers had failed to account. *Id*.; *see also* Tronick & Beeghly, *Prenatal Cocaine Exposure, Child-Development, and the Compromising Effect of Cumulative Risk*, Clin. Perinatol. 26(1): 151-71 (1999) (noting

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Compliance with Prenatal Care in Substance Abusers, J. Maternal Fetal Neonatal Med. 14(5); 329-32 (2003).

[28] Southern Regional Project on Infant Mortality, *supra*, at 6.

that "[i]nterventions are more likely to succeed if they attempt to reduce the overall burden of risk rather than targeting risks.").

Research also shows that drug treatment can be effective for pregnant women and can itself beneficially affect pregnancy outcomes. *See* Sweeney, *et al*., *The Effect of Integrating Substance Abuse Treatment With Prenatal Care on Birth Outcomes*, J. Perinatol., 20(4): 219-24 (June 2000) (finding that neonatal outcome "is significantly improved for infants born to substance abusers who receive[d] [drug] treatment concurrent with prenatal care compared with those who received [prenatal care during pregnancy but drug] . . . treatment [only] postpartum"); Kaltenbach & Finnegan, *Prevention & Treatment Issues for Pregnant Drug-Abusing Women and Their Children*, Ann. N.Y. Acad. Sci. 329-34 (June 21, 1998); CASA Report at 82 (1996) (citing studies finding "that pregnant women in [drug] treatment give birth to larger, high[er] birth weight infants than those women who are not in treatment"); *see also* Egelko, *et al*., *Treatment of Perinatal Cocaine Addiction*: *Use of a Modified Therapeutic Community*, Am. J. Drug & Alcohol Abuse, 22(2): 185-202 (1996) (describing effects of one drug treatment program).[29]

F. Empirical Evidence Shows that, when Women are Arrested for Using Drugs while Pregnant, Newborn Children Suffer Serious Psychological Harm As a Result of the Deprivation of the Chance to Bond with their Mothers just after Birth

[29] *Accord* Armstrong, *et al*., *Early Start*: *Obstetric Clinic-Based Prenatal Substance Abuse Intervention Program*, J. Pernatol. 23(1): 3-9 (2003); Jones, *et al*., *Patient Compliance and Maternal/Infant Outcomes in Pregnant, Drug-Using Women*, Substance Use & Misuse 37(11): 1411-22 (2002); Jansson, *et al*., *Pregnancy & Addiction*: *A Comprehensive Care Model*, J. Subst. Abuse Treatment 13(4): 321-29 (July 1996).

Ms. Cruz was arrested following a positive toxicology examination finding traces of cocaine in her blood system. As a result of Ms. Cruz's arrest and prosecution, her newborn child was separated from his mother at the beginning of his life.

As the courts have realized, "society's interest in the protection of children is, indeed, multifaceted, composed not only with concerns about the safety and welfare of children from the community's viewpoint, but also with the child's psychological well-being, autonomy, and relationship to family." *Tenenbaum v. Williams*, 193 F.3d 581, 595 (2d Cir. 1999), *cert. den.*, 120 S. Ct. 1832 (2000) (*quoting*, *Franz v. Lytle*, 997 F.2d 784, 792-93 (10th Cir. 1993)). Indeed, courts have emphasized that "governmental failure to abide by constitutional constraints may have deleterious long-term consequences for the child. . . ." *Wallis v. Spencer*, 202 F.3d 1126, 1130 (9th Cir. 2000).

In addition to the courts, researchers have emphasized the critical timing of the neo-natal period – as a time when parents and child have the best chance to form the emotional bonds that should last a lifetime.[30] Because the human infant is wholly dependent upon his mother or caretaker for all his physical and emotional needs, "the strength of these attachment ties may well determine whether he will survive and develop

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[30] Helfer, *The Prenatal Period*: *A Window of Opportunity for Enhancing Parent-Infant Communication*: *An Approach to Prevention*, 11 Child Abuse and Neglect: The Int'l J. 566 (1987) ("When this sensitive period goes well, the relationship between new parents and their newly-born infant has the potential of progressing far beyond . . . expectations . . . [W]hen this interaction goes poorly, a vicious cycle can develop when the infant and the new parent[s] do not engage . . . which can lead to a breakdown in the interactions between [parent and newborn]."); *see also* Goldstein, Freud & Solnit, *Before the Best Interests of the Child* (1979) ("The younger the child, the greater is his [or her] need for [parents]. When family integrity is broken or weakened by state intrusion, his [or her] needs are thwarted . . . the effect on child development progress is invariably detrimental."). *Id*. at 9.

optimally." Klaus & Kennell, *Mothers Separated From Their Newborn Infants*, 17 Pediatric Clinics of North America 1015 (1970).[31] Moreover, early separation of a newborn from the mother "may be a significant factor" causing child abuse. *Id*. Thus, by separating newborns from their mothers, the arrest and prosecution of pregnant mothers may, ironically, promote the very harm to children it allegedly intends to prevent.[32]

In particular, the separation of newborns from mothers who used drugs during their pregnancy has a deleterious effect upon the newborn's ability to access treatment. A panel of experts convened by the United States Department of Health and Human Services has concluded that the best way to help the drug-exposed child is to help the mother recover from addiction,[33] and the panel also stressed that treatment should be non-threatening, non-stigmatizing and supportive,[34] exactly the opposite of the Talbot policy. *Amici* therefore condemn the practice of law enforcement officials, in carrying out the Talbot policy, separating a child from the parent, by placing the parent in jail, based solely upon the results of a toxicology examination.

VII. Medical Science has Failed to Substantiate the Alleged Harms that Prompted the Prosecution of Ms. Cruz

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[31] *See also* Wald, *State Intervention on Behalf of 'Neglected' Children*: *A Search for Realistic Standards* 27 Stan. L. Rev. 985, 994 (1975) (concluding that the removal of children from their families "may cause serious psychological damage – damage more serious than the harm intervention is supposed to prevent").

[32] This is not to suggest that pregnant women who use drugs do not need any preventive services. However, seeking the arrest of pregnant women who use drugs portends greater harm to these newborn and vulnerable children than the harm of leaving them with their mothers, particularly since numerous studies have found that women who use illicit drugs can be adequate parents. *See* Boyd, Mothers and Illicit Drugs: Transcending the Myths, 14-16 (1999) (listing at least twelve studies which reach that conclusion).

[33] *Id*.

[34] *Id*.

C. Risks Associated with Drug-Dependency Are Not Different in Kind or Magnitude From Other Pregnancy Risks

The medical literature is replete with evidence that myriad lawful activities during pregnancy can result in negative outcomes to the fetus and later to the child. There is at least comparable evidence of the potential for serious adverse effects of numerous prescription drugs, such as anticonvulsants,[35] lithium, and other mood-stabilizers,[36] antipsychotics, and benzodiazepines (the class of medications which include Valium,

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[35] A leading scientific text notes that the teratogenic affects – meaning the development of abnormal cell masses during fetal growth that cause physical defects in the fetus – of anticonvulsants were identified in the 1960's, especially those caused by the drug Dilantin, commonly prescribed for epileptics and that "[n]o dose response curve has been demonstrated, nor has a 'safe' dose been found below which there is no increased teratogenic risk." Jones, *Smith's Recognizable Patterns of Human Malformation* 495 (5th ed. 1997). Other anticonvulsants associated with facial malformations, mental deficiencies, speech disorders, and cardiovascular defects include trimethadione, paramethadione, valproic acid, and warfarin. *Id*. at 495-505. With respect to trimethadione in particular, it warns that "frequency and severity of defects associated with maternal use of these drugs during pregnancy are high enough to warrant consideration of early elective termination of pregnancy." *Id*. at 500 (citing G.L. Feldman, *et al*., *The Fetal Trimethadione Syndrome*, 131 Am. J. Dis. Child 1389 (1977)). Another standard medical text notes: "An association of fetal abnormalities with anticonvulsants is strengthened by increasing reports of cleft palate, cardiac abnormalities, craniofacial anomalies, nail and digit hypoplasia, visceral defects, and mental subnormality in children of epileptic mothers taking anticonvulsant drugs." *The Merck Manual of Diagnosis and Therapy* 1859 (R. Berkow ed., 16th ed 1992) ("Merck Manual").

[36] "Among psychotropic drugs, lithium has been more strongly associated with congenital anomalies than have other agents . . . [N]umerous publications indicate an increased evidence of cardiovascular abnormalities, particularly an increase in Ebstein's anomaly in infants born of lithium-treated mothers." Bernstein, *Handbook of Drug Therapy in Psychiatry* 415 (2d ed. 1988) (citing Robinson *et al*., *The Rationale Use of Psychotropic Drugs in Pregnancy and Postpartum* 31 Can. J. Psychiatry 183 (1986)).

Librium, and Xanax),[37] some antibacterials (especially Tetracyclines),[38] anticoagulants,[39] thyroid medications,[40] and antihypertensive drugs[41] that may adversely affect pregnancy outcomes. *See* Jones, Smith's Recognizable Patterns of Human Malformation 495 (5th ed. 1997); Bernstein, Handbook of Drug Therapy In Psychiatry 407-25 (2d ed. 1988); Whittle & Hanretty, *Prescribing in Pregnancy*: *Identifying Abnormalities*, 293 Br. Med. J. 1485 (1986). Accutane, a popular anti-acne medication, has been called "the most widely prescribed birth-defect causing medicine in the United States."[42] Even "[l]arge doses of *aspirin* may result in delayed onset of labor, premature closure of the fetal ductus arteriosus . . . or neonatal bleeding"[43] (emphasis added).

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[37] Bernstein, *infra*, at 407-21 (citing Berry & St. Clair, *Exposure to Benzodiazepines in Utero* 1 Lancet 1436 (1987)); Whittle & Hanretty, *Prescribing in Pregnancy*: *Identifying Abnormalities*, 293 Br. Med. J. 1485 (1986).

[38] Tetracycline has been associated with permanent discoloration of the teeth, enamel hypoplasia, and a lowered resistance to tooth decay, as well as retarded bone growth, especially when taken during the latter part of the pregnancy. *Merck Manual* at 41.

[39] Certain anticoagulants can cause nasal abnormalities, bone stipling, bilateral optic atrophy, varying degrees of mental retardation, microcephaly, and occasionally fetal and maternal hemorrhage. *Smith's Recognizable Patterns of Human Malformation* at 504.

[40] Some thyroid medications taken during pregnancy can cause severe hypothyroidism, fetal goiter, or scalp defects. *Merck Manual* at 1859.

[41] Antihypertensive drugs may cause fetal respiratory depression, hypotension, paralytic ileus, bradycardia, hypoglycemia, and varying degrees of intrauterine growth retardation. *Id*. at 1861.

[42] Rafshoon, *What Price Beauty?*, *Boston Globe Magazine* (April 27, 2003), p. 15. Describing confirmed reports of 160 drug-affected births, the article explains that "[s]ome of these children died before they reached their first birthdays because of some major organ systems failures. The most seriously affected babies have been institutionalized. The rest live with a variety of severe defects, ranging from heart and central nervous system abnormalities to missing or malformed ears, asymmetrical facial features, and mental retardation. *Id.*

[43] *Id*. at 1859; *see also* Van Marter *et al*., *Persistent Pulmonary Hypertension of the Newborn and Smoking and Aspirin and Nonsteroidal Antiinflammatory Drug Consumption During Pregnancy* 97 Pediatrics 658 (1996) (maternal consumption of

Furthermore, there is a long-standing scientific consensus that prenatal exposure to adverse environmental factors such as poor nutrition, substandard housing, and a lack of social supports and services (all of which are associated with poverty) can also profoundly affect infant heath,[44] as can a childhood spent in the care of adults who suffer from depression or other serious mental illness.[45]

Additionally, women who take fertility drugs and choose to carry three or more embryos to term often experience pregnancy loss and risk severe, lifelong harm to the children who survive.[46] "Women ages 35 and older who bear children are at a significantly increased risk of giving birth to low birth weight babies . . . and may have increased risk of stillbirth," even when controlling for diabetes, hypertension, and other complications associated with increased maternal age. *See* Tough, *et al*., *Delayed Childbearing and Its Impact on Population Rate Changes in Lower Birthweight, Multiple Birth, and Preterm Delivery*, 109 Pediatrics 399-403 (March 2002). So do those who suffer from hyperthyroidism and other diseases, *see, e.g.*, Atkins, *et al*., *Drug Therapy for Hyperthyroidism in Pregnancy*: *Safety Issues for Mother and Fetus*, 23 Drug Safety 229

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aspirin during pregnancy found to be consistently associated with pulmonary hypertension of the newborn, an important cause of respiratory failure in neonates).

[44] Gustavsson & MacEachron, *Criminalizing Women's Behavior*, 27 J. of Drug Issues 673, 675-76 (1997).

[45] *See, e.g.*, Doane, *Family Interaction and Communication Deviance in Disturbed and Normal Families*: *A Review of Research, in Advances in Family Psychiatry* – Vol. II 113 (Howells, ed., 1980).

[46] Steinbock, *The McCaughey Septuplets*: *Medical Miracle or Gambling with Fertility Drugs?*, Ethical Issues in Modern Medicine 375, 376 (5th ed., Arras & Steinbock, eds. 1999) ("Even if they are born alive, 'super-twins' (triplets, quadruplets, and quintuplets) are 123 times more likely than other babies to die within a year . . . . Many will suffer from respiratory and digestive problems. They are also prone to a range of neurological disorders, including blindness, cerebral palsy and mental retardation").

(2000), and women who work with chemicals or solvents, *see Automobile Workers v. Johnson Controls*, 499 U.S. 187, 205 (1991) (noting that "[e]mployment late in pregnancy often imposes risks on the unborn child"); *see also Automobile Workers v. Johnson Controls*, 886 F.2d 877 (7th Cir. 1989) (Easterbrook, J., dissenting) (noting that an estimated 15 to 20 million jobs entail exposure to chemicals that pose fetal risk); *CERHR – The First Five Years*, Birth Defects Res. B, 74: 1, 4 (2005) (summarizing research establishing adverse effects from exposure to 1-bromopropane, methanol, diethylhelxphthalate, and other widely-used industrial chemicals); Khattak, *et al*., *Pregnancy Outcome Following Gestational Exposure to Organic Solvents*: *A Prospective Controlled Study*, 281 JAMA 1106-09 (1999) (finding that pregnant women exposed to organic solvents on the job have a 13-times greater risk of giving birth to babies with major malformations than those not exposed).

To take an especially important example, it is doubtful that there is any medical basis on which the reckless endangerment law, if it covered this case, could exclude low birth weight newborns or infant deaths "resulting" from cigarette smoking – whose prenatal dangers are serious, unusually well-established, and widely known. *See* 15 U.S.C. § 1333(a)(1); Wisborg, *et al*., *Exposure to Tobacco Smoke in Utero and the Risk of Stillbirth and Death in the First Year of Life*, 154 Am. J. Epidemiology 322 (2001). Experts regularly recognize tobacco as "the single most powerful determinant of poor fetal growth in the developed world":

> Each year, smoking during pregnancy causes up to 141,000 miscarriages, 61,000 low birth weight babies, 4,800 prenatal deaths (including stillborn infants and infants who die shortly after birth) and 2,200 infant deaths from Sudden Infant

> Death Syndrome ("SIDS"), and may cause respiratory illness and delay a child's cognitive development. . . . While the infant mortality rate among women who do not smoke during pregnancy is 8.0 per 1,000, it jumps to 12.2 per 1,000 among those who smoke. The risk of infant death is almost as high among lighter smokers (less than a pack a day) as among heavier smokers. . . . Smoking during pregnancy doubles the likelihood that a baby will be born underweight, after controlling for maternal alcohol and drug use, education and employment, and prenatal care. Even passive exposure of pregnant women to cigarette smoke can double the risk. . . . The risk of SIDS is up to five times greater for infants born to women who smoke during the second trimester of pregnancy compared to those who don't smoke at all. . . .Children prenatally exposed to half a pack or more of cigarettes per day have been found to have intelligence scores significantly lower at ages three and four than those with nonsmoking mothers, even after adjusting for the mothers' education level.

CASA Report at 39 (footnotes and citations omitted).

Equally serious are dangers from alcohol. *See* Chiriboga, *Fetal Alcohol and Drug Effects*, Neurologist 9(6): 267-97 (2003) ("Most adverse effects of prenatal drug exposure are self-limited, with catch-up growth and resolution of withdrawal and of prior neurobehavioral abnormalities noted over time. The exception is alcohol, which is linked to life-long impairments (*i.e.*, mental retardation and microcephaly) and possibly cigarette-related behavioral effects."). Congress has expressly found that "children of women who use alcohol while pregnant have a significantly higher infant mortality rate (13.3 per 1,000) than children of those women who do not use alcohol (8.6 per, 1,000)"; that "up to 12,000 infants are born in the United States with Fetal Alcohol Syndrome, suffering irreversible physical and mental damage. . . and thousands more infants are born each year with . . . Alcohol Related Neurobehavioral Disorder ("ARND"), a related and equally tragic syndrome," 42 U.S.C. § 280f; and that "though approximately 1 out of every 5 pregnant women drink alcohol during their pregnancy, we know of no safe dose

of alcohol during pregnancy, or of any safe time to drink during pregnancy." *Id*.; *see also* CASA Report at 40 ("While the infant mortality rate among women who don't drink during pregnancy is 8.6 per 1,000, 'it'. . . . is much higher – 23.5 per 1,000 – among pregnant women who drink an average of 2 or more per day.").

D. Medical Misinformation and Media Hype, Particularly Around Cocaine, Have Been Used to Support Prosecutions Like the Instant One

Nearly two decades' experience with claims about the effects of *in utero* cocaine exposure counsels that assumptions about the consequences of illegal drug use must be subject to staunchly skeptical scrutiny. The 1980s and 1990s were a time of intense public agitation and concern, fueled by media accounts (and a handful of initial studies that had appeared in the medical literature), suggesting that cocaine use during pregnancy had yielded a "lost generation" of severely, irretrievably damaged "crack babies."[47]

Although, responsible voices sought to strike the appropriately cautionary note, emphasizing that findings concerning biological effects were "contradictory," and that evidence of harm remained "slim," and "inconclusive," *see, e.g.*, Mayes, *et al*., *The Problem of Prenatal Cocaine Exposure*: *A Rush to Judgment*, 267 JAMA 406 (1992), it

[47] A review of reporting in 1986, when crack cocaine began to attract substantial media attention, revealed that "six of the nation's largest and most prestigious news magazines and newspapers had run more than one thousand stories about crack cocaine. *Time* and *Newsweek* each ran five 'crack crisis' *cover* stories. . .[T]hree major network television stations ran 74 stories about crack cocaine in six months. . . . Fifteen million Americans watched CBS' prime-time documentary '48 Hours on Crack Street.'" Gomez, Misconceiving Mothers: Legislators, Prosecutors, and the Politics of Prenatal Drug Exposure 14 (1997); Reinarman & Levine, *The Crack Attack*: *Politics and Media in America's Latest Drug Scare*, in Crack in America: Demon Drugs and Social Justice 18, 20-24 (Reinarman & Levine, eds. 1997); *see also* Humphries, Crack Mothers: Pregnancy, Drugs and the Media 19-36 (1999).

was not until 2001 that a comprehensive and systematic analysis, peer-reviewed and published in the JAMA, established the full extent to which claims and "findings" about adverse developmental effects of cocaine exposure were untenable. *See* Frank, *et al.*, *supra* 285 JAMA 1613 (2001).

After performing a rigorous review of 75 different English-language studies addressing the effects of *in utero* cocaine exposure in existence in 2001, Dr. Frank and colleagues determined that there is "no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity differen[ce] in severity, scope, or kind from the sequelae of many other risk factors."[48] Indeed, children born to women with drug problems face a different threat of harm: stigma based on myths perpetuated by media coverage. *Id*. at 1621 (condemning policies that "demonize" pregnant cocaine users). *See* Arendt, *et al*., "Open Letter to the Media," Feb. 25, 2004, (letter signed by leading experts, explaining that the term 'crack baby' – and similarly stigmatizing terms, such as 'meth-babies' and 'ice babies'" – are "scientifically inaccurate" and "dangerous"), *available at http://www.jointogether.org/sa/files/pdf/sciencenotstigma.pdf.*

[48] Once other factors omitted from earlier research studies were taken into consideration, they found cocaine exposure is *not* associated with physical growth retardation, *id*. at 1613; it has little or no impact on children's scores on assessments of cognitive development – in fact, the oldest group of children studied to date registered *no* effect from *in utero* cocaine exposure on any IQ scales or on academic achievement, *id*. at 1616. Upon their exhaustive review of the research, the only adverse effect found attributable to prenatal cocaine exposure was the potential for decreased emotional expressiveness, *id*., at 1620, and even that finding was offset by findings that "[f]ull-term cocaine – exposed infants show [] *better* arousal modulation than their unexposed counterparts." *Id*. at 1617 (emphasis added).

The principal import of this research is not that cocaine ingestion during pregnancy is "safe," but rather that the risks presented by illegal drugs should not be assumed to be – and are likely not – different in kind or gravity from those associated with many other conditions and activities common in pregnancy. Yet the Court can safely assume that activity *more* strongly associated with poor pregnancy outcomes than cocaine ingestion will *not* be prosecuted as reckless endangerment. On that assumption, the trial court's construction of the statute at issue in this case must not stand. Such a regime is an affront to core constitutional principles: "the law [may not] lay[] an unequal hand on those who have committed intrinsically the same quality of offense," *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942), and statutes must not permit "policemen, prosecutors, and juries to pursue their personal predilections." *Smith v. Goguen*, 415 U.S. 566, 575 (1974).

VIII. Criminal Prosecution of Pregnant Women For Acts During Pregnancy Contravenes the Intent of the Maryland General Assembly

The Maryland General Assembly recognizes the important role that medical professionals play in assisting their pregnant patients' access to prenatal care, and has clearly supported the need to treat, rather than punish, women who use drugs while they are pregnant. Rather than creating criminal penalties for women who are pregnant and use drugs, the Maryland General Assembly has instead chosen civil court mechanisms. A woman who uses drugs while pregnant may face the termination of her parental rights under Maryland's civil statutes. Importantly, however, even these penalties are subject to further findings that drug treatment was offered and available to the woman, *and* that she

failed to participate or fulfill sufficient treatment. *See* Md. Code Ann. Fam. Law § 5-710(b);[49] *id*. § 5-313;[50] *id*. Cts. & Jud. Proc. § 3-818.[51] More importantly, however, the focus of these statutes is on the parent's ability to give the proper care and attention that the child needs, rather than on whether the prenatal drug use caused harm or a risk of harm. Although there are significant federal and state constitutional issues even with these civil statutes, they reflect the Maryland General Assembly's explicit decision to address pregnant women who use drugs – through the civil rather than criminal justice system, and that the State should provide such women with a meaningful opportunity to obtain drug treatment.

Additionally, the State has mandated that publicly funded (either partially or in whole) substance abuse treatment programs are required to accept pregnant and postpartum women for treatment on a *priority* basis. Md. Code Ann., Health-Gen. § 8-

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[49] Md. Code Ann. Family Law § 5-710 ("Actions by local department and State's Attorney's office") provides that the department of child services may initiate proceedings to terminate a woman's parental rights to a subsequently born child, *if*: (1) either she or the newborn child tested positively for cocaine at childbirth; (2) the department of child services offers drug treatment to the woman; and (3) she fails to accept the treatment up to the recommended level within 45 days, or fails to fully participate in the program. *Id*.

[50] Md. Code Ann. Family Law § 5-313(d)(1)(iv) ("[When parental consent not required] – Guardianship; adoption in general") provides that a court, in determining whether to terminate parental rights, must consider whether: (1) the child was born exposed to cocaine or the mother tested positive for cocaine upon childbirth, *and* (2) the mother refuses the recommended level of drug treatment. *Id*.

[51] Md. Code Ann. Cts & Jud. Proc. § 3-818 ("Presumption that child is not receiving proper care and attention") provides that within 1 year after a child's birth, there is a presumption that the child is not receiving proper care and attention from the mother for purposes of the civil child delinquency statute if the child is born exposed to cocaine or the mother tested positive for cocaine upon childbirth, *and* "[d]rug treatment is made available to the mother and the mother refuses the recommended level of drug treatment, or does not successfully complete the recommended level of drug treatment." *Id*.

403.1 (2005). The General Assembly mandates that such programs must also have in place a referral system to medical services and are to be linked by referral agreements with local departments of health and social services. *Id*. Again, this evidences the Maryland General Assembly's intent to provide, through civil laws, drug treatment access for pregnant women who are drug users, as opposed to criminal punishment.

In practice, however, pregnant and parenting women seeking access to drug treatment services continue to face few options in Maryland. There is a shortfall of drug treatment statewide, but the shortage is particularly acute for pregnant and parenting women. The City of Baltimore, for example, estimates that of its approximately 75 publicly funded treatment programs that treat 20,000 people per year, many have "months-long waiting lists."[52] Indeed, researchers have found that waiting lists to enter drug treatment programs are often so long that women become discouraged and stop trying.[53] Moreover, there is a shortage of qualified addiction counselors statewide, resulting in vacancies at treatment programs critical to serving the needs of parenting and pregnant women.[54] Most importantly, according to the Maryland Alcohol and Drug Abuse Administration, there are only ten drug treatment service providers in the entire state that accept pregnant women. *See* Maryland Alcohol and Drug Abuse Adm., Resource Directory Search, *available at http://maryland-adaa.org/resource/index.cfm?*

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[52] *See* MacGillis, The Association of Baltimore Area Grantmakers, *Local Philanthropy Headlines*: *Helping Those on the Threshold*, *available at http://www.abagmd.org/info-url2446/info-url_show.htm?doc_id=307836* (Oct. 12, 2005).
[53] *See* Communities Against Rape & Abuse, *Birth Control is Liberation for Women*, *available at http://www.cara-seattle.org/crack_bc.html*.
[54] *Interim Report*, *supra*.

CFID=64464&CFTOKEN=41284788. Such small numbers contradict one of the thirteen factors that the public health community has identified as crucial to successful treatment outcomes – that "[drug] treatment needs to be readily available."[55]

In 1988, the General Assembly created a Task Force to Study Increasing the Availability of Substance Abuse Programs in Maryland ("Substance Abuse Task Force" or "Task Force") Md. Ann. Code, art. 41, § 18-316(a) & (d) (6) (2005), confirming that the unavailability of drug treatment is a serious problem in Maryland. The Substance Abuse Task Force was charged with developing a comprehensive strategy to fund substance abuse programs, and examining the availability of substance abuse programs designed for women, and women with children. *Id*. In December 1999, the Substance Abuse Task Force issued an interim report, which found that "[in the State of Maryland] there is presently insufficient capacity to meet the need of those who both need and are amenable to receiving treatment."[56] The Task Force also found that insufficient treatment capacity throughout Maryland was primarily due to "insufficient funding for treatment by the State."[57] In seeking to correct the unavailability of drug treatment services for parenting and pregnant women, the Task Force recommended providing

[55] National Institute on Drug Abuse ("NIDA"), *Principles of Drug Addiction Treatment*: *A Research-Based Guide*, (October 1999).
[56] Maryland Task Force to Study Increasing the Availability of Substance Abuse Programs, *Interim Report by the Committee on Availability and the Committee on Effectiveness*, (December 1999) ("Interim Report").
[57] *Id*.

treatment on request for Maryland's uninsured and underinsured, 24 hours a day, seven days a week.[58]

The scarcity of drug treatment services for pregnant and parenting women in the State, thwarts the General Assembly's preference for treatment for parenting and pregnant women because drug treatment programs that are designed for men are inadequate for women. Male model programs do not offer the child care, child services, family planning, physical and mental health care, parenting, and family-building skills that women need.[59] In fact, most American drug treatment providers do not "offer care to pregnant women facing addictions."[60] As in Maryland, with the exception of the ten drug treatment programs accepting pregnant women, "some drug and alcohol treatment facilities [actually] exclude pregnant women."[61] Assuming pregnant and parenting women can find the appropriate drug treatment they so desperately need, such women face additional obstacles. According to the Maryland Alcohol and Drug Abuse Administration, of the ten drug treatment providers accepting pregnant women, only three have long-term residential prenatal care available to women. *See* Maryland Alcohol and Drug Abuse Adm., Resource Directory Search, *available at http://maryland-adaa.org/resource/index.cfm? CFID=64464&CFTOKEN=41284788*. Because there are

[58] *Id*.
[59] NAADAC, The Association for Addiction Professionals, *Issue Brief*: *Addiction Treatment for Women ("Addiction Treatment for Women").*
[60] *Id*.
[61] *Id*.

very few long-term treatment centers that offer prenatal care for pregnant drug-users the cards stacked against these women grow even higher.[62]

As a result, it is understandable that members of the public health community have concluded that nationwide "women are second-class citizens when it comes to treatment for drug addiction []."[63]

CONCLUSION

For the foregoing reasons, *Amici Curiae* respectfully request that the Court rule that this statute cannot be the basis for prosecuting women for carrying pregnancies to term while using drugs.

Respectfully submitted,

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[62] *Id.*
[63] *Addiction Treatment for Women, supra*.
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RULE 8-112 (c) STATEMENT

This Brief was prepared using 13 point Times New Roman with double spacing in the text and one line spacing in footnotes. Md. Rules 8-112(c) and 8-504(a)(8).

APPENDIX

DESCRIPTIONS OF *AMICI*

I. *Amici* Organizations

The **American Association for the Treatment of Opioid Dependence ("AATOD")** was founded in 1984 as the Northeast Regional Methadone Treatment Coalition, Inc. AATOD treatment providers joined together to support the legitimacy of methadone maintenance treatment for opioid dependence and to increase the availability of comprehensive treatment services to people in need of care.

The **Black Women's Health Imperative ("BWHI")**, the new name of the National Black Women's Health Project, is a leading African-American health education, research, advocacy, and leadership development institution. Founded in 1983 by health activist Byllye Y. Avery, BWHI has been a pioneer in promoting the empowerment of African-American women as educated health care consumers and a strong voice for the improved health status of African-American women. BWHI is gaining the well-earned reputation as the leading force for health for African-American women. BWHI possesses national stature as the only national organization devoted solely to the health of the nation's 19 million Black women and girls.

The **Center for Gender and Justice ("CGJ")** seeks to develop gender responsive policies and practices for women and girls who are under criminal justice supervision. CGJ is committed to research and to the implementation of policies and programs that will encourage positive outcomes for this underserved population.

Citizens for Midwifery ("CIM") is a national, non-profit, and consumer-based group that promotes maternal and child health through advocating the Midwives Model of Care, and seeks to have these practices recognized as an accepted standard of care for childbearing mothers. In focusing on the normalcy of child birth and the uniqueness of any childbearing woman and family, this model includes monitoring the physical, psychological, and social well-being of childbearing mothers, providing pregnant women with individualized prenatal care, and hands-on assistance during interventions, and identifying women who require obstetrical assistance. As an organization, CFM also provides information on midwifery and childbirth issues, encourages, and provides guidance for midwifery and child abuse issues, and represents consumer interests regarding mid-wifery and maternity care.

Doctors of the World – USA was founded in 1990 by a group of volunteer physicians and is an international health and human rights organization working where health is diminished or endangered by violations of human rights and civil liberties. Reaching out to the most vulnerable and marginalized populations, in concert with local partners around the globe, Doctors of the World – USA's projects build long-term solutions addressing urgent health issues, with particular focus on women's health and vulnerable children.

The **Family Defense Clinic** at New York University School of Law is committed to advancing a sensible policy in child welfare that protects children's safety and devotes appropriate resources to vulnerable families so that children can be raised in their families of origin to the greatest extent feasible.

Finding Common Ground ("FCG") is a collaborative effort between researchers at Columbia University's Mailman School of Public Health and Boston Medical Center. The project is dedicated to developing a public health agenda that integrates the health care needs and rights of women and children, and to reframing public discourse so that advocacy for one is seen to benefit both. FCG research focuses on poverty, domestic violence, the impact of welfare reform on reproductive health, and race and ethnicity in regard to the health of women and children.

The **Global Lawyers and Physicians ("GLP")** is a non-governmental organization that was formed in 1996 to reinvigorate the collaboration of the legal and medical/public health professions to protect the human rights and dignity of all persons. With lawyer and physician members, GLP collaborates and partners at the local, national, and international levels with individuals, non-governmental organizations, international government organizations, and governments on issues that address health and human rights. GLP also provides support and assistance in developing, implementing, and advocating public policies and legal remedies which protect and enhance human rights and health.

The **Harm Reduction Coalition ("HRC")** is committed to reducing drug-related harm among individuals and communities by initiating and promoting local, regional, and national harm reduction education, interventions, and community organizing. HRC fosters alternative models to conventional health and human services and drug treatment; challenges traditional client/provider relationships; and provides resources and educational materials. HRC also supports health professionals and drug users in their

communities to address drug-related harm. HRC believes in every individual's right to health and well-being as well as in their competency to protect and help themselves, their loved ones, and their communities.

The **Hygeia Foundation, Inc. ("the Foundation")** is concerned with Pregnancy Loss (miscarriage, stillbirth, neonatal death), Maternal and Child Health, and narrowing disparities in access to Information Technologies and Women's Health Services. The Foundation is committed to improving universal access to healthcare services and healthcare information with respect, dignity, and advocacy. The Foundation also provides solace and bereavement for parents whose children have died before and after birth. The Foundation commits its resources and mission to underserved, vulnerable, and disadvantaged women, children, and families and seeks philanthropic donations to: develop and implement its unique programs, fund in-kind programs in patient care and basic science research related to Perinatal Health and Loss, and support public health initiatives to reduce perinatal and neonatal morbidity and mortality so as to improve the health of medically and economically disadvantaged families.

The **International Center for Advancement of Addiction Treatment ("ICAAT")** is a non-profit organization based in New York City. ICAAT's mission is to promote among medical professionals the humane treatment of people who are living with opioid addiction by making available to health care providers relevant medical, legal, and policy information and by advocating for change in attitudes that constrain optimal treatment delivery. ICAAT is generously supported by The Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center, which shares

the ICAAT's commitment to advance the quality of care for people living with opioid addiction.

The **Maryland Society of Addiction Medicine ("MSAM")** is the Maryland Chapter of the American Society of Addiction Medicine. As a professional society, consisting entirely of physician members, who specialize in the diagnosis and treatment of addictive disorders, MSAM conducts educational activities, promulgates knowledge, and provides direct care in the area of addiction medicine. MSAM supports efforts to adequately provide and fund treatment for those suffering from addictive disorders. MSAM also maintains an interactive liaison with other providers of addiction medicine in various disciplines.

NAADAC – The Association for Addiction Professionals is the nation's largest organization of alcohol and drug counselors with over 14,000 members. NAADAC's members have special expertise in the substance abuse treatment needs of pregnant women. NAADAC joins this Brief because it is deeply concerned that a wrong decision will undermine the quality of care that substance abuse professionals can provide patients, and will deter these women from seeking these essential services.

The **National Advocates for Pregnant Women ("NAPW")** is a non-profit organization dedicated to securing the human and civil rights, health and welfare of pregnant and parenting women, and furthering the interests of their family. NAPW seeks to ensure that women do not lose their constitutional and human rights as a result of pregnancy, that addiction and other health and welfare problems they face during pregnancy are addressed as health issues, not as crimes; that families are not needlessly

separated, based on medical misinformation; and that pregnant and parenting women have access to a full range of reproductive health services, as well as non-punitive drug treatment services.

The **National Association of Nurse Practitioners in Women's Health ("NPWH")** is a national membership organization for nurse practitioners who provide care to women. Members of the NPWH practice in a variety of settings including private practice, managed care, hospital, and public facilities. NPWH promotes evidenced based practice and clinical decision-making.

The **National Council on Alcoholism and Drug Dependence, Inc. ("NCADD")** fights the stigma and the disease of alcoholism and other drug additions. Founded in 1944 by Marty Mann, the first women to find long-term sobriety in Alcoholics Anonymous, NCADD provides education, information, help, and hope to the public. NCADD advocates prevention, intervention, and treatment through offices in New York and Washington, and a nationwide network of Affiliates.

The **National Council on Alcoholism and Drug Dependence, Inc., Maryland Chapter ("NCADD-Maryland")**, formed in 1988, is a statewide organization that provides education, information, help, and hope in the fight against the chronic, often fatal diseases of alcoholism and other drug addictions. NCADD-Maryland advocates for prevention, intervention, research, and treatment and is dedicated to ridding these diseases of their stigma and their sufferers from their denial and shame. Since 1992, NCADD-Maryland has initiated its Access to Treatment program to assist individuals in finding treatment.

The **National Perinatal Association ("NPA")** promotes the health and well-being of mothers and infants enriching families, communities, and our world. NPA seeks to increase access to comprehensive health-care as this has an immeasurable impact on birth outcomes. NPA opposes all policies which endanger the well-being of infants or their mothers.

The **Obstetrical and Gynecologic Society of Maryland ("Society")** is a Section of District IV of the American College of Obstetricians and Gynecologists that represents Maryland physicians who serve the obstetrical and gynecological needs of Maryland women and their families. The Society works primarily in four areas: the Society (1) serves as a strong advocate for quality health care for women; (2) maintains the highest standards of clinical practice and continuing education for its members; (3) promotes patient education and stimulates patient understanding of and involvement in medical care; and (4) increases awareness among its members and the public of the changing issues facing women's health care.

Our Bodies Ourselves ("OBOS") provides clear, truthful information about health, sexuality, and reproduction from a feminist and consumer perspective. OBOS vigorously advocates for women's health by challenging the institutions and systems that block women from full control over our bodies and devalue our lives. OBOS is noted for its long-standing commitment to serve only in the public interest and its bridge-building capacity. OBOS is dedicated to the autonomy and well-being of all women.

Physicians for Reproductive Choice and Health ("PRCH") seek to enable concerned physicians to take a more active and visible role in support of universal

reproductive health. PRCH is dedicated to ensuring that all people have the knowledge, equal access to quality services, and freedom of choice to make their own reproductive health decisions.

The **Power Inside**, a program of Fusion Partnerships, Inc., is a non-profit program for women impacted by incarceration, street life, and abuse. The Power Inside's services help women build self-sufficiency, heal from violence, and avoid future criminal justice contact. The Power Inside serves 300 women annually many of whom struggle with drug addiction.

II. *Amici* Individuals

Elizabeth M. Armstrong, Ph.D., and M.P.A., holds a joint appointment in the Department of Sociology and the Woodrow Wilson School at Princeton University and is a faculty associate at both the Office of Population Research and the Center for Health and Wellbeing. Dr. Armstrong has published articles in the scholarly literature on substance use during pregnancy, family planning, adolescent motherhood, and the sociology of pregnancy and birth. Dr. Armstrong is the author of *Conceived Risk, Bearing Responsibility*: *Fetal Alcohol Syndrome and the Diagnosis of Mortal Disorder* (Johns Hopkins University Press, 2003), the first book to challenge the conventional wisdom about drinking during pregnancy. Dr. Armstrong's current research includes a longitudinal study of agenda setting around disease in the U.S. and a study of fetal personhood and obstetrical ethics. Dr. Armstrong has an M.P.A. from Princeton University and a Ph.D. from the University of Pennsylvania.

Nancy D. Campbell, Ph.D., is the author of *Using Women*: *Gender, Drug Policy, and Social Justice* (Routledge 2000), a history of how pregnant women are used to call for drug policies that are unjustifiably harsh and ill considered in terms of their social consequences.

Stephanie Covington, M.D., has more than twenty-five years of experience in the design, development, and implementation of treatment services for women. Dr. Covington is recognized for her work on gender-responsive services in both the public and private sectors. Her fifteen years of experience in the criminal justice system include training, speaking, and writing, as well as consulting with varied national, state, and local correction agencies in the United States and Canada. Dr. Covington has published extensively including co-authoring the multi-year National Institute of Corrections project report "Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders."

Nancy Day, M.P.H., Ph.D., is Professor of Psychiatry and Epidemiology at the University of Pittsburgh, School of Medicine. She has studied the effects of prenatal exposures to alcohol, marijuana, cocaine, and tobacco for over 20 years. She has multiple publications and has received grants from NIH in support of this work. Dr. Day is currently the Director of the Maternal Health Practices and Child Development Project, a consortium of projects centered on the identification of the long-term effects of prenatal substance abuse.

Fonda Davis Eyler, Ph.D., is a Professor in the Department of Pediatrics of the University of Florida College of Medicine and is also a licensed Developmental

Psychologist. Dr. Eyler is Developmental Director of Early Steps, an early intervention program for children from birth to three years of age, who live in the surrounding sixteen counties and have developmental delays and disabilities. She is a Principle Investigator on a prospective, longitudinal research study that has been following a cohort of the children born to women who used cocaine during their pregnancy and a matched comparison group of pregnant women who were not addicted to cocaine and their children. Dr. Eyler brings a wealth of knowledge concerning the impact on children of drug abuse during pregnancy.

Judith M. Garner, Ph.D., is a member of numerous professional societies including the Society for Research in Child Development and the International Society for the Study of Behavioral Development. While a post-doctoral Fellow at the Einstein College of Medicine, Dr. Garner received the Rosenbaum Award for Excellence in Research. Dr. Garner's research, continually funded since 1986 by the National Institutes of Health, studies brain-behavior relations over early development, specifically how early arousal and attention in high-risk neonates affects subsequent autoregulation and cognitive and motor development. Dr. Garner is the Newsletter Editor for International Society for Infant Studies (since 1990) and held the same post (from 1999 to 2003) for Division 7, American Psychological Association. Dr. Garner was elected a Fellow at the American Psychological Association in 1998. Since 1988, Dr. Garner has been a Senior Research Scientist and founding member of the Department of Infant Development at the New York State Institute for Basic Research, Staten Island, N.Y., heads the Infant Neurobehavioral Laboratory and currently is the Acting Chair. Dr. Garner also holds an

appointment in the Department of Pediatrics, Division of Neonatology, at the St. Vincent's Catholic Medical Center, St. Vincent's Hospital, Staten Island, N.Y.

Michael A. Grodin, M.D., F.A.A.P., is Director of the Bioethics and Human Rights Program and Professor of Health Law, Bioethics, Human Rights, Socio-Medical Sciences, and Community Medicine and Psychiatry at the Boston University Schools of Public Health and Medicine, where he is the recipient of the Norman A. Scotch Award for Excellence in Teaching. In addition, Dr. Grodin is a Professor of Philosophy in the College of Arts and Sciences. Dr. Grodin has been on the faculty of Boston University for the past 26 years. Dr. Grodin is the Medical Ethicist at Boston Medical Center and for thirteen years served as the Human Studies Chairman for the Department of Health and Hospitals of the City of Boston. Professor Grodin serves on the Ethics Committee of the Massachusetts Center for Organ Transplantation, is a consultant to the National Human Subjects Protection Review Panel of the National Institutes of Health AIDS Program Advisory Committee, and is a consultant on Ethics and Research with Human Subjects for the International Organizations of Medical Sciences and the World Health Organization. Dr. Grodin is the Co-Founder of Global Lawyers and Physicians.

Stephen R. Kandall, M.D., is a pediatrician who has cared for over a thousand babies exposed to drugs. Dr. Kandall is also Chief of Neonatology at Beth Israel Medical Center in New York and has written a book (*Substance and Shadow*: *Women and Addiction in the United States*, Cambridge: Harvard University Press, 1996) outlining the horrors of prosecuting women who need drug treatment.

Bernard Z. Karmel, Ph.D., is head of the Neurophysiological Development Laboratory in the Infant Development Department of the New York State Institute for Basic Research in Developmental Disabilities, Staten Island, NY. Dr. Karmel is an adjunct Professor in the Developmental Neuroscience Program of the Biology Department of the City University of New York. Dr. Karmel is internationally known for his research on early infant attention and brain-behavior relationships. Dr. Karmel's most recent research has concentrated on early infant neurobehavioral and neurophysiological development in infants assigned to the Neonatal Intensive Care Unit at birth or who were exposed to drugs of abuse *in utero* such as cocaine.

Donald J. Kurth, M.D., FASAM, is an Associate Professor and Chief of Addiction Medicine in the Chemical Dependency Unit of Loma Linda University Behavioral Medicine Center ("BMC") in Southern California. He is Medical Director of the Chemical Dependency Unit at the BMC, an 18-bed inpatient detoxification and rehabilitation unit with a large outpatient rehabilitation unit. The Chemical Dependency Unit at the BMC is known throughout the world for its expertise in the treatment of chemically dependent patients suffering from chronic pain syndrome. Dr. Kurth also serves on the Editorial Board of the *Journal of Addictive Diseases* and has recently written the therapeutic communities chapter for April 2002 edition of the book, *Principles of Addiction Medicine*, published by the American Society of Addiction Medicine and he serves as Treasurer of the American Society of Addiction Medicine. Dr. Donald Kurth has been involved in the addiction treatment and addiction treatment policy

for over thirty years, serving on the Board of Governors of Daytop Village drug rehabilitation center in New York City since 1975.

Katherine A. McQueen, M.D., is an Assistant Professor in the Menninger Department of Psychiatry, Internal Medicine, at the Baylor College of Medicine, UTHSC-Houston in Houston, Texas.

Prasanna Nair, M.D., M.P.H., is a Professor of Pediatrics at the University of Maryland Medical Center. Dr. Nair received her M.D. from Lady Harding Medical College, University of Delhi, India. Dr. Nair finished her residency at the University of Maryland Medical Center, and she received a Fellowship in General Pediatrics from the University of Maryland Medical Center. Dr. Nair is certified in pediatrics and her research interests include early inoculation, high-risk infants, maternal drug abuse, child abuse and neglect, and infants at risk for HIV-infection. Since 1990, Dr. Nair has been involved in an ongoing longitudinal NIDA funded study of the effects of fetal exposure to heroin and/or cocaine on child outcome. Dr. Nair also directs a clinic at University Hospital, called the SPICE clinic, that provides primary care to infants born to HIV positive women.

Judy Norsigian, is the Executive Director and co-founder of the Boston Women's Health Book Collective, and a co-author of *Our Bodies, Ourselves* (BT Bound, 1974, 25th Anniversary Edition 1999) and *Our Bodies, Ourselves for the New Century* (Touchstone Books: Carmichael, CA 1998). She served on the board of the National Women's Health Network for over 14 years and is now a member of the board of Public Responsibility in Medicine and Research ("PRIM&R"). She has served on several

Institute of Medicine committees related to contraceptive research, planning committees for the Office of Research on Women's Health at NIH, and the advisory board of the Council for Responsible Genetics. Her primary interests include reproductive health, tobacco and women, genetics, and midwifery advocacy. She has appeared on numerous national television and radio programs, including Oprah, Donahue, the Today Show, Good Morning America, and NBC Nightly News with Tom Brokaw. In 2002, she was the recipient of the Massachusetts Health Council annual award.

Diana Romero, Ph.D., is Project Director for the Finding Common Ground project and Assistant Professor at the Heilbrunn Department of Population and Family Health. In her role with Finding Common Ground, Dr. Romero has helped to design and implement research aimed at investigating the potential impact of welfare reform policies on the health of poor women and children. These activities have involved quantitative and qualitative research methods at the national, state, community, and clinical levels. In addition, she has been working on a related project specifically focusing on the impact of these policies on native and immigrant Hispanic women.

Ruth Rose-Jacobs, Sc.D., is Professor of Pediatrics and a Research Scientist at the Boston University School of Medicine. Her major research interests include the development of typical and high-risk infant/children and their families – due to biological and social factors including substance abuse, violence, maternal depression, prematurity, and food insufficiency. In 2002, she received a certificate of appreciation in recognition of outstanding work with children and families from the Casey Family Programs and Center for Substance Abuse Prevention. She has also served as Co-investigator on

numerous studies regarding the effects of cocaine exposure in fetuses and has traced these individuals for years after birth.

Carol Sakala, Ph.D., M.S.P.H., has been involved with maternity issues as an educator, researcher, author, and policy analyst for over two decades, with a continuous focus on meeting the needs of childbearing families. For the past six years, she has served as director of programs for the nation's oldest national organization advocating on behalf of mothers and babies, where she directs a long-term national program to promote evidence-based maternity care.

F. David Schneider, M.D., M.S.P.H., is a family physician and an Associate Professor of Family and Community Medicine at the University of Texas Health Science Center and is a recognized expert on issues of health care and domestic violence. Dr. Schneider is the president of the newly established Academy on Violence and Abuse, a member of the AMA Advisory Council on Violence and Abuse, and the Chair of the American Academy of Family Physicians Commission on Public Health.

Keerthy Sunder, M.D., M.S., is an obstetrician and gynecologist with an interest in addiction psychiatry. Dr. Sunder is a member of the faculty at the University of Pittsburgh. Dr. Sunder believes that the treatment of addictions in pregnancy requires a multidisciplinary approach. Dr. Sunder also finds that criminal prosecution endangers both the mother and the fetus.

Linda L.M. Worley, M.D., is an Associate Professor in the College of Medicine at the University of Arkansas for Medical Sciences ("UAMS") and directs the campus wide Student Mental Health Service. Dr. Worley is a board certified Psychiatrist with

sub-specialization in Addiction Psychiatry. Dr. Worley was recruited to join the UAMS, Department of Psychiatry Faculty in 1992 and was promoted with tenure in 1998 in the clinician educator track. Dr. Worley has strong interests in psychosomatic medicine and in the well-being of health care providers.

CERTIFICATE OF SERVICE

I hereby certify that on this 29th day of November, 2005, I mailed first class, postage prepaid, two copies of the foregoing Brief of Amici Curiae to the following:

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