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IN THE MISSISSIPPI SUPREME COURT

NO. 2010-M-819

RENNIE T. GIBBS,

PETITIONER,

VS.

STATE OF MISSISSIPPI,

RESPONDENT.

FILED
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SUPREME COURT
COURT OF APPEALS

ON PETITION FOR PERMISSION TO FILE AN INTERLOCUTORY APPEAL FROM THE CIRCUIT COURT OF LOWNDES COUNTY, MISSISSIPPI

BRIEF OF *AMICUS CURIAE* OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, THE NATIONAL ASSOCIATION OF SOCIAL WORKERS—MISSISSIPPI CHAPTER, THE MISSISSIPPI YOUTH JUSTICE PROJECT, THE MISSISSIPPI HUMAN SERVICES AGENDA, THE AMERICAN CIVIL LIBERTIES UNION OF MISSISSIPPI, THE MISSISSIPPI NATIONAL ORGANIZATION FOR WOMEN, THE AMERICAN ACADEMY OF ADDICTION PSYCHIATRY, THE ASSOCIATION FOR MEDICAL EDUCATION AND RESEARCH IN SUBSTANCE ABUSE, THE NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC., ET AL, IN SUPPORT OF PETITIONER RENNIE T. GIBBS

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INTERESTS OF AMICI

Amici include Mississippi and national physicians, nurses, counselors, social workers, drug treatment specialists, public health practitioners, advocates for women and children's health and their professional associations.[1] These individuals and organizations have recognized expertise in the areas of maternal and neonatal health, and in understanding the effects of drugs and other substances on users, their families and society.

At the outset, it must be noted that each *amicus curiae* is committed to reducing potential drug-related harms at every opportunity. Thus, *amici* do not endorse the non-medicinal use of drugs—including alcohol or tobacco—during pregnancy, by either parent. Nor do *amici* contend that there are no health risks associated with cocaine use during pregnancy. Nonetheless, it is entirely consistent with *amici*'s public health and ethical mandates to bring to this Court's attention the relevant medical and scientific information—none of which supports the prosecution of Ms. Gibbs for murder.

Amici join this brief because Ms. Gibbs' prosecution cannot be reconciled with evidence-based, peer-reviewed, medical and scientific research, or with the clear and explicit language of Mississippi law. *Amici* urge this court to grant Ms. Gibbs' Petition for Interlocutory Review and resolve this issue expeditiously so that pregnant women in Mississippi can immediately seek prenatal care and substance abuse treatment without fear of prosecution.

SUMMARY OF ARGUMENT

The prosecution of Rennie Gibbs lacks any legal, medical or scientific foundation. Ms. Gibbs was only fifteen years old when she became pregnant. She turned sixteen while pregnant, and then, in approximately her 36th week of pregnancy experienced a stillbirth. Ms. Gibbs also had a drug problem. The decision to prosecute her as an adult for homicide because she

[1] A full description of each *amicus curiae* is included in the Motion for Leave to File Brief of *Amicus Curiae*

attempted to continue her pregnancy to term is unsupported by law or public policy. The prosecution in this case is contrary to the plain language and meaning of the State's depraved heart murder statute, undermines legislative intent, usurps the legislative function, and requires the court to radically rewrite and expand the State's homicide law.

Amici believe there is a strong societal interest in protecting the health of children. In the view of *amici*, however, such protective instincts are *undermined*, not advanced, by prosecuting pregnant women and girls who experience pregnancy losses that may have been caused by a vast range of conditions, circumstances and actions they may experience during pregnancy. Indeed, the policy of prosecuting pregnant women and girls with drug dependency or other health problems is contrary to law, scientific research, and the consensus judgment of medical practitioners and their professional organizations. Furthermore, given the paucity of treatment available in Mississippi, low income women and children would be particularly vulnerable to punishment if unable to access drug treatment or prenatal care due to barriers of poverty. This prosecution jeopardizes the well-being of women and their children.

This amicus brief underscores the fact that the prosecution of Ms. Gibbs' lacks any legal, medical or scientific foundation. Interpreting Mississippi's depraved heart murder statute to apply to the context of pregnancy will lead to absurd and dangerous public health consequences. Such prosecutions deter pregnant women from seeking prenatal care and drug and alcohol treatment. And they create a disincentive for pregnant women who do seek medical care from disclosing important information about drug use to health care providers out of fear that the disclosure will lead to possible criminal sanctions.

Prosecuting women and girls for continuing to term despite a drug addiction encourages them to terminate wanted pregnancies to avoid criminal penalties. The State could not have intended this result when it adopted the homicide statute.

Finally, this prosecution reflects a basic misunderstanding of the nature of drug dependency. The medical community has long recognized that addiction is not a crime but a medical condition that can respond successfully to treatment.

On April 23, 2010, the Circuit Court of Lowndes County denied Ms. Gibbs' Motion to Dismiss, recognizing that this is a case of first impression under Mississippi law and granting Ms. Gibbs leave to file an interlocutory appeal. This Court should grant Ms. Gibbs' Petition for Interlocutory Review. To do otherwise would prolong the considerable fear and confusion among health professionals and their pregnant patients in Mississippi that has resulted from the prosecution of Ms. Gibbs. The Supreme Court should seek to clarify the scope of this statute as quickly as possible.

ARGUMENT

I. This Prosecution Is Not Substantiated By Science

The causes of stillbirth are often entirely unknown. Stillbirths affect tens of thousands of women in the United States each year.[2] In Mississippi in 2008, there were as many as 470 reported cases of stillbirths, 89 of which were to girls under the age of 19.[3] A wide range of medical conditions and environmental factors are believed to contribute to fetal death. Nevertheless, a small but significant number of pregnancies result in unexplained pregnancy loss. These inexplicable outcomes account for approximately ten to even fifty percent of all stillbirths.[4]

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[2] R.L. Goldenberg et al., *Stillbirth: A Review*, 16 Journal of Maternal-Fetal & Neonatal Medicine 79 (2004) ("stillbirth is one of the most common adverse outcomes of pregnancy . . . in the year 2000, there were nearly 27,000 of these events.").

[3] Mississippi State Board of Health Handbook on Registration and Reporting of Vital Events: Live Births, Deaths, Spontaneous Fetal Deaths, Induced Terminations of Pregnancy, 19-20 (2009) *available at* http://www.msdh.state.ms.us/phs/Handbook_Reg_Reporting_Vital_Events.pdf.

[4] F. Gary Cunningham et al., *Williams Obstetrics*, 21st ed. 1073, 1075 (2001). *See also* M.A. Sims & K.A. Collins, *Fetal Death: A 10-Year Retrospective Study*, 22 Am. J. Forensic Med. & Pathology 261 (2001) ("Despite efforts to identify the etiologic factors contributing to fetal death, a substantial portion of fetal deaths are still classified as unexplained intrauterine fetal demise.").

Indeed, many people wrongly believe that women have a high degree of control over their pregnancy outcomes.[5] The longstanding and constant medical reality, however, is that as many as 20-30 percent of all pregnancies will end in miscarriage or stillbirth.[6] In fact, stillbirth is one of the most common adverse outcomes of pregnancy,[7] and it occurs despite the best intentions and precautions taken by women and their doctors.

The medical community agrees that the causes of stillbirth are not fully understood.[8] As a recent article states: "In many cases it is difficult to be certain of the etiology of stillbirth. First, many cases are unexplained, despite intensive investigation of potential causes. Second, more than one condition may contribute to stillbirth in an individual case."[9] Moreover, "it may not be possible to precisely determine which disorder was directly responsible for the loss. Indeed, it is likely that some cases of stillbirth are due to complications from multiple factors. Finally, conditions may be *associated* with stillbirth without directly *causing* them."[10]

Experts at a March 26, 2001 National Institute of Health Workshop discussed the possibility that the cause of death for up to 50 percent of stillbirths is undetermined. *See* SHARE Pregnancy & Infant Loss Support, Inc., *Report on Stillbirth Workshop at the National Institute of Health* (Apr. 2001), *available at* http://www.nationalshareoffice.com/about_research_sb_research.shtml.

[5] *See e.g.*, A. Eisenberg et. al., *What to Expect When You're Expecting*, 54-57 (2d ed. 1996) (popular pregnancy advice book warning women to avoid contact with anyone who is smoking, to avoid changing a cat litter box, consuming unpasteurized cheese or undercooked meat, gardening without gloves, inhaling when handling household cleaning products, and ingesting caffeine).

[6] C. Malacrida, *Complicating Mourning: The Social Economy of Perinatal Death*, 9(4) Qualitative Health Research 504, 505 (July 1999) .

[7] R.L. Goldenberg et al., *Stillbirth: A Review*, 16 Journal of Maternal-Fetal & Neonatal Medicine 79 (2004).

[8] Laurie Barclay, MD, *ACOG Issues Guidelines for Stillbirth Management*, 113 Obstetrics & Gynecology 748-761 (2009),, quoting Ruth C. Fretts, MD, from Harvard Vanguard Medical Associates and Harvard Medical School in Boston, Massachusetts, who assisted in the development of ACOG's new practice bulletin, "... we have a long way to go before we have a clearer understanding of the causes of stillbirth."

[9] R.M. Silver et al., *Work-up of Stillbirth: A Review of the Evidence*, 196(5) Am. J. of Obstetrics & Gynecology, 433-44 (2007).

[10] *Id.* (emphasis added). *See also* Cunningham, *supra* note 3 at 1073-75 (2001) (noting substantial percentage of perinatal deaths are unexplained.).

Accordingly, experts warn that "the associations between exposures and stillbirth should be viewed with caution."[11] There are many alternative explanations for stillbirth, which include age, race and socioeconomic factors,[12] hypertension, diabetes, thrombophilia, infections, maternal smoking,[13] paternal smoking, paternal workplace exposure to ionizing radiation, exposure to pain medications, and poverty.[14]

Ms. Gibbs' is being prosecuted for *homicide* for an act that the State can not prove caused the stillbirth. Science has yet to provide the tools to determine the cause of many stillbirths, and, in any event those causes are likely beyond any woman's control, and should not be the basis for criminal prosecution.

A. Cocaine Has Not Been Found to Cause Stillbirths

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[11] C. Stanton et al., *Stillbirth Rates: Delivering Estimates in 190 Countries*, 367 Lancet 1487-94 (2006) ("Data for the causes of stillbirth, especially largely preventable causes such as syphilis, are needed to prioritize action and reduce stillbirths. However, even in settings with the possibility of extensive investigation, the cause of death might not be established in a third of stillbirths.").

[12] Laurie Barclay, MD, *ACOG Issues Guidelines for Stillbirth Management*, 113 Obstetrics & Gynecology 748-761 (2009),. "Risk factors for stillbirth include non-Hispanic black race, with a stillbirth rate of 11.25 per 1000 births in this group, vs less than 6 per 1000 in Hispanic, Asian, American Indian, and white women. Greater prevalence of diabetes, hypertension, placental abruption, and premature rupture of membranes in black women may help explain this disparity.... Non-Hispanic black race, nulliparity, advanced maternal age, and obesity are the risk factors most often associated with stillbirth."

[13] Even among activities that are much more definitively linked to adverse pregnancy outcomes than cocaine/illegal drug use, such as cigarette smoking, the connection to stillbirths are complex and modest. *See* Center on Addiction and Substance Abuse (CASA), Substance Abuse and the American Woman 50 (1996) (smoking during pregnancy increases infant mortality from 8.0 per 1,000 to 12.2 per 1,000)). *See also* Helene M. Cole, *Legal Interventions during Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2666 (1990). "Cigarette smoking may cause "spontaneous abortion, premature birth, increased infant perinatal mortality, low birth weight, and negative effects on later growth and development in infants."

[14] *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); *see also* P. Atkins et al., *Drug Therapy for Hyperthyroidism in Pregnancy*: *Safety Issues for Mother and Fetus*, 23 Drug Safety 229 (2000); Sohail Khattak et al., *Pregnancy Outcome Following Gestational Exposure to Organic Solvents*: *A Prospective Controlled Study*, 281 JAMA 1106-09 (1999); C. Stanton et al., *Stillbirth Rates: Delivering Estimates in 190 Countries*, 367 Lancet 1487-94 (2006); R.M. Silver, et al., *Work-up of Stillbirth: A Review of the Evidence*, 196(5) Am. J. of Obstetrics & Gynecology, 433-44 (2007); Cynthia Daniels, *Exposing Men, the Science and Politics of Male Reproduction*, 124 (Oxford, 2006).

A positive toxicology for cocaine does not establish causation for a stillbirth. Two well-constructed, independent studies to determine if cocaine could be linked to an increased risk of stillbirths concluded that the *cause and effect relation of cocaine and fetal demise is not clear and requires additional research*. The first study, a ten-year retrospective of pediatric toxicological deaths, found not a single neonatal or fetal death attributed to cocaine use, even where cocaine metabolites were present.[15] The second study focused on the 42 fetal deaths referred for autopsy between 1990 and 1999.[16] In 29 percent the cause of death was undetermined.[17] All of the cocaine associated deaths were designated as "natural" or "undetermined." In short, in a large number of fetal deaths, forensic pathologists were unable to establish causation, and even where cocaine was present, it was not listed as a primary cause of death. Against this backdrop, the State's assertion that cocaine caused Ms. Gibbs' stillbirth derives not from medicine or science, but from prosecutorial overreaching.

In 2001, The Journal of the American Medical Association ("JAMA") published a comprehensive analysis of developmental consequences for the fetus or child based on maternal cocaine use during pregnancy.[18] The report exposes as erroneous the belief that prenatal cocaine exposure is associated with developmental toxicity and condemns as "irrational[]" policies that selectively "demonize" *in utero* cocaine exposure and that target pregnant cocaine users for special criminal sanction.[19]

There are many widely held, deeply rooted misconceptions about cocaine. For over two decades, the popular press has been suffused with highly prejudicial and inaccurate information

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[15] T.A. Campbell & K.A. Collins, *Pediatric Toxicologic Deaths: A 10 Year Retrospective Study*, 22 Am. J. Forensic Med. & Pathology 184 (2001).
[16] Sims, *supra* note 3.
[17] *Id.* at 263.
[18] D. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613 (2001).
[19] *Id.* at 1621. *See also* A. Addis et al., *Fetal Effects of Cocaine: an Updated Meta Analysis*, 15 Reproductive Toxicology 341-369 (2001).

about the effects of *in utero* cocaine exposure. However, contemporary research on the developmental impact of cocaine use during pregnancy has debunked the myth that mere exposure to cocaine causes certain fetal harms.[20] It is scientifically inappropriate to declare fetal cocaine exposure to be the sole or even primary cause of fetal death.[21] In 2004, doctors and researchers signed an open letter denouncing the "crack baby" myth and called on the press to refrain from using the medically misleading and erroneous terms "crack baby."[22]

This is not to say that prenatal cocaine exposure is benign. While current studies are unable to link cocaine use to adverse fetal developments, neither do they exclude cocaine as a potential fetotoxin. More research is needed. But, it is irrational and unjust to charge Ms. Gibbs with murder when science has yet to speak with causal assurance.

B. The Pathologist's Conclusions Are Not Supported by Science

As explained above, the claim that cocaine causes stillbirth is not supported by existing scientific research. Nonetheless, the State is seeking to use the depraved heart statute in an entirely unprecedented manner based on an examination conducted by the State's witness, Dr. Steven T. Hayne. Amici caution against relying on Dr. Hayne's medical opinion as the basis for radically expanding state law.

A review of published articles and funded research indicates that Dr. Hayne himself has conducted no independent research on the effects of prenatal exposure to cocaine. In addition, he has been removed from the State's designated list of pathologists.[23] In reaching its decision regarding the purely legal question of whether Mississippi's depraved heart murder statute was

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[20] Campbell, *supra* note 14.
[21] *Id.* at 264.
[22] Open Letter from thirty American and Canadian researchers and scientist explaining that such terms as "crack baby" and "crack addicted baby" lack any basis in science, *available at* http://www.jointogether.org/sa/files/pdf/sciencenotstigma.pdf. *Meth Science Not Stigma: Open Letter to the Media*, July 25, 2005, *available at* http://www.jointogether.org/news/yourturn/commentary/2005/meth-science-not-stigma-open.html.
[23] *See* WTOK.com, Newscenter 11, *Mississippi Officials Cut Ties with Pathologist*, Aug. 5, 2008, *available at* http://www.wtok.com/home/headlines/26283229.html.

intended to punish pregnant woman and girls who suffer stillbirths, this Court must consider that such an interpretation would be based on claims that lack scientific or medical validity made by a pathologist whose findings and conclusions in other cases have been called into question.[24]

II. The Prosecution of Ms. Gibbs Under the State's Depraved Heart Murder Statute Will Harm the Health of Mothers and Children

The prosecution of those who suffer stillbirths and especially the prosecution of those who use drugs and experience coincidental stillbirths will undermine the quality and accessibility of health care for many pregnant women and girls.

Every leading medical organization and governmental body to consider this issue has concluded that responding to drug use during pregnancy through criminal sanction is likely to undermine the health of pregnant women and children.[25] This is true even if the unsupported claim of harm from exposure to drugs is true, because fear of prosecution operates as a deterrent to pursuing drug treatment, prenatal care, and labor and delivery care, and discourages disclosure of critical medical information to health professionals.

A. This Prosecution Will Deter Drug-Dependent Pregnant Women and Girls from Seeking Health Care

Pregnant women and girls who face criminal sanctions will be deterred from seeking care that is critical to both their own health and the health of the fetus.[26] This prosecution could serve

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[24] *See e.g.*, *Edmonds v. State*, 955 So.2d 787 at 802-803 (Justice Diaz concurring)(detailing other incidents where Dr. Hayne's qualifications and findings have been questioned).

[25] *See e.g.* Am. Med. Ass'n, *Legal Intervention During Pregnancy*, 264 JAMA 2663, 2670 (1990) (reporting AMA resolution that "[c]riminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate."); Am. Psychiatric Ass'n, *Care of Pregnant and Newly Delivered Women Addicts: Position Statement*, APA Document Reference No. 200101 (2001) (policies of prosecuting pregnant "are likely to deter pregnant addicts from seeking either prenatal care or addiction treatment, because of fear of prosecution and/or civil commitment.").

[26] *See, e.g.*, The Southern Legislative Conference, *Southern Reg'l Project on Infant Mortality, A Step Toward Recovery: Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women*

to deter some women from seeking prenatal care and drug and alcohol treatment altogether, by discouraging pregnant women and girls who do seek medical treatment from disclosing critical information about their drug use to their health care providers, and by creating an incentive for women and girls who cannot overcome their addictions in the short term of pregnancy to have abortions rather than face criminal charges upon the birth of a child.

State and national medical and public health organizations and experts unanimously condemn punitive state interventions during pregnancy because, as one public health expert observed two decades ago in the New England Journal of Medicine:

> [M]arriage of the state and medicine is likely to harm more fetuses than it helps, since many women will quite reasonably avoid physicians altogether during pregnancy if failure to follow medical advice can result in . . . involuntary confinement, or criminal charges. By protecting . . . the integrity of a voluntary doctor-patient relationship, we not only promote autonomy; we also promote the well-being of the vast majority of fetuses.[27]

State law should not deter women from seeking care, whether it is prenatal care,[28] drug treatment,[29] or other general health care, all of which can help improve (but not guarantee) pregnancy outcomes.

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6 (1993). *See also* A. Srinivasan & G. Blomquist, *Infant Mortality and Neonatal rates: The Importance of Demographic Factors in Economic Analysis* (2002), *available at* http://gatton.uky.edu/GradStudents/srinivasan/InfantHealth.pdf (examining infant mortality in Kentucky); A. 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) (finding that pregnant women who use cocaine but who have at least four prenatal care visits significantly reduce their chances of delivering low birth weight babies).

[27] G. Annas, *Protecting the Liberty of Pregnant Patients*, 316 New Eng. J. Med. 1213, 1214 (1987).

[28] Prenatal care has been found to be strongly associated with improved outcomes for children exposed to drugs in utero. Racine et al., *supra* note 26; Edward F. Funai et al., *Compliance with Prenatal Care in Substance Abusers*, 14(5) J. Maternal Fetal Neonatal Med. 329, 329 (2003); Cynthia Chazotte et al., *Cocaine Use During Pregnancy and Low Birth Weight: The Impact of Prenatal Care and Drug Treatment*, 19(4) Seminars in Perinatology 293, 293 (1995).
Conversely, lack of prenatal care is associated with poor health outcomes for mothers and newborns. *See* Anthony M. Vintzileos et al., *The Impact of Prenatal Care on Neonatal Deaths in the Presence and Absence of Antenatal High-Risk Conditions*, 186(5) Am. J. of Obstetrics and Gynecology 1011, 1013

As the American Medical Association has stated, "Pregnant women will be likely to avoid seeking prenatal or open medical care for fear that their physician's knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment."[30] The even graver threat that a stillbirth could result in a homicide conviction greatly exacerbates such fears and will hinder access to vital medical care and substance abuse services for women and girls in Mississippi.[31]

B. This Prosecution Will Deter Pregnant Women and Girls from Sharing Vital Information with their Doctors

If this Court allows the prosecution of Ms. Gibbs, any pregnant Mississippian who confides in her health care provider that she has used drugs risks being charged with homicide if she suffers a stillbirth. Even for those women and girls who are not deterred from seeking care, fear of prosecution is likely to discourage them from being truthful about drug use, corroding the formation of trust that is fundamental to any health care provider-patient relationship.

(2002); Vivian B. Faden et al., *The Relationship of Drinking and Birth Outcome in a U.S. National Sample of Expectant Mothers*, 11 Pediatric & Perinatal Epidemiology 167, 171 (1997) (finding "increased risk of adverse outcomes among mothers who had no prenatal care").

[29] The research also shows that drug treatment can be effective for pregnant women and can itself produce beneficial pregnancy outcomes. *See* Patrick J. Sweeney et al., *The Effect of Integrating Substance Abuse Treatment with Prenatal Care on Birth Outcomes*, 20(4) J. Perinatology 219, 219 (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 but] . . . treatment postpartum").

[30] Report of American Medical Association Board of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2667 (1990). *See also* American Medical Association, *Treatment Versus Criminalization: Physician Role in Drug Addiction During Pregnancy*, Resolution 131 (1990) (resolving "that the AMA oppose[s] legislation which criminalizes maternal drug addiction").

[31] Studies of drug-dependent pregnant women have found that "fear and worry about loss of infant custody, arrest, prosecution, and incarceration for use of drugs during pregnancy" is "the[ir] primary emotional state." *See* Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. Drug Issues 285 (2003); M.L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 Drug Alcohol Dependence 199 (1993).

A relationship of trust is critical for women and girls, because "[t]he promise of confidentiality encourages patients to disclose sensitive subjects to a physician."[32] Open communication between drug-dependent pregnant women and girls and their doctors is especially critical.[33] The exceptionally high rates of depression among drug-dependent women mean that their prospects of successfully completing treatment depend on forming a strong "therapeutic alliance" with care providers.[34]

Courts have long viewed confidentiality as fundamental to the patient-care provider relationship. As the U.S. Supreme Court recognized, a "confidential relationship" is a necessary precondition for "successful [professional] treatment," and "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."[35] Allowing the prosecution of Ms. Gibbs to move forward will erode this relationship, undermining maternal, fetal, and child health.

C. Prosecuting Drug-Dependant Women and Girls For Suffering A Stillbirth Discourages Women and Girls from Carrying Pregnancies to Term

Prosecuting drug-addicted pregnant women and girls will not only deter them from seeking treatment and confiding in their doctors, but it incentivizes abortion. The Mississippi legislature surely did not intend the depraved heart murder statute to have this consequence.

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[32] R. Arnold et al., *Medical Ethics and Doctor/Patient Communication, in The Medical Interview: Clinical Care, Education and Research* 365 (M. Lipkin, Jr. et al. eds., 1995) (citing W. Winslade, *Confidentiality, in Encyclopedia of Bioethics* (W. T. Reich ed.)). *See also*, S.H. Ebrahim & J. Gfroerer, *Pregnancy-Related Substances Use in the United States During 1996-1998*, 101(2) Obstetrics and Gynecology 374 (February 2003) ("Pregnancy-or childbirth-related contact of women with the health care system gives health care providers a unique opportunity to access women who use substances and possibly their partners to facilitate substance abuse treatment, the benefits of which extend to their infants and future pregnancies.").

[33] *See* Rosemary H. Kelly et al., *The Detection & Treatment of Psychiatric Disorders and Substance Use Among Pregnant Women Cared For in Obstetrics*, 158 Am. J. Psych. 213-19 (2001).

[34] *See* Center on Addiction and Substance Abuse (CASA), Substance Abuse and the American Woman 64 (1996); C.E. Tracy & H.C. Williams, *Social Consequences of Substance Abuse Among Pregnant and Parenting Women*, 20 Pediatric Annals 548 (1991).

[35] *Jaffee v. Redmond*, 518 U.S. 1 at 10, 12 (1997).

Courts have recognized that this type of prosecution "may also unwittingly increase the incidence of abortion."[36] Although it is difficult to know how frequently abortions result from fear of prosecution, one study reported that "two-thirds of the women [surveyed] who reported using Cocaine during their pregnancies ... considered having an abortion."[37]

The adverse consequences stemming from the prosecution's interpretation of the law are severe; the criminal investigation and possible prosecution of girls like Ms. Gibbs sends a perilous message to pregnant addicts *not* to seek prenatal care or drug treatment, *not* to confide their addiction to health care professionals, and *not* to give birth with medical care—or not to carry the fetus to term. Accordingly, such prosecutions fail to serve any legitimate purpose, and undermine maternal and fetal health.

III. This Prosecution Reflects a Misunderstanding of the Nature of Addiction

The assertion that Ms. Gibbs' addiction is an act evincing a depraved heart is dangerously misinformed. Medical groups have long recognized "that addiction is not simply the product of a failure of individual willpower. Instead, dependency is the product of complex hereditary and environmental factors."[38] Addiction has pronounced physiological factors that heavily influence the user's behavior and affect his or her ability to cease use and seek treatment.[39]

A. Addiction Is Not Simply A Voluntary Act that Is Cured by Threats

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[36] *See e.g., Johnson v. State*, 602 So. 2d 1288 at 1296 (Fla. 1992): "Prosecution of pregnant women for engaging in activities harmful to their fetuses or newborns may also unwittingly increase the incidence of abortion."

[37] *See* Jeanne Flavin, *Our Bodies, Our Crimes: The Policing of Women's Reproduction in America* 112 (New York University Press, 2009),.

[38] American Medical Association, *Proceedings of the House of Delegates: 137th Annual Meeting, Board of Trustees Report NNN* 236, 241, 247 (June 26-30, 1988). *See also* R. K. Portenoy & R. Payne, *Acute and Chronic Pain,* in *Substance Abuse, A Comprehensive Textbook* 563, 582-84 (J.H. Lowinson et al. eds., 1997) (*citing* AMA task force); National Academy of Sciences, Institute of Medicine, *Dispelling The Myths About Addiction*, Ch. 8 (1997). *See also* CME publication *Cocaine Abuse and Dependence* (2008), citing M.A. Schuckit, *The Treatment of Stimulant Dependence*, 89 Addiction 1559, 1563 (1994). "The etiology of dependence in any one person is multifactorial, representing the convergence of a multitude of biological, psychological, social and interpersonal factors."

[39] Chaya G. Bhuvaneswar, MD, et al., *Cocaine and Opioid Use During Pregnancy: Prevalence and Management*, 10(1) Primary Care Companion Journal of Clinical Psychiatry 59–65 (2008).

The medical profession has long recognized that drug dependence has biological and genetic dimensions and cannot often be overcome without treatment.[40]

As a matter of law and medical science, addiction is marked by "compulsions not capable of management without outside help."[41] This is why the vast majority of drug-dependent people cannot simply "decide" to refrain from drug use or achieve long-term abstinence without appropriate treatment and support. Because of the compulsive nature of drug dependency, warnings or threats are unlikely to deter drug use among pregnant women and girls; rather, such sanctions are likely to drive addicted women and girls away from critical health care opportunities.

B. Addiction Is A Difficult Medical Condition for Children to Overcome

Ms. Gibbs was only fifteen years old when she became pregnant and allegedly ingested cocaine. Given the paucity of treatment options available to her, it is not surprising that she continued her pregnancy to term without obtaining help.

According to the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), there is not a single treatment facility within 100 miles of Lowndes County that provides substance-abuse treatment services of any kind (whether publicly or privately funded, inpatient or outpatient) to pregnant, adolescent girls.[42]

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[40] *See, e.g.,* "Psychoactive Substance Dependence" is listed as a mental illness with specific diagnostic criteria in the Am. Psychiatric Ass'n., The Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994), used by mental health professionals to diagnose mental illness. *See Linder v. United States*, 268 U.S. 5, 18; 45 S.Ct. 446, 449; 69 L.Ed. 2d 819 (1925); *Robinson v. California*, 370 U.S. 660, 667; 82 S.Ct. 1417, 1420; 8 L.Ed. 2d 758 (1962); American Psychiatric Ass'n, *The Diagnostic and Statistical Manual of Mental Disorders - 4th Edition* 176-181 ("DSM-IV-TR") (2000) (specifying diagnostic criteria for "Substance Dependence").

[41] *Robinson*, 370 U.S. at 671; 82 S.Ct. at 1422; 8 L.Ed. 2d 758 (*Douglas, J., concurring*); *see also* 42 U.S.C. § 201(q) ("'drug dependent person' means a person who is using a controlled substance . . . and who is in a state of psychic or physical dependence, or both.").

[42] United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Substance Abuse Treatment Facility Locator, *available at* http://findtreatment.samhsa.gov/facilitylocatordoc.htm.

In Mississippi, an estimated 10,000 children between the ages of 12 and 17 need, but have not received, treatment for an illicit drug abuse problem. Another 10,000 children in that age group need, but have not received, treatment for alcohol problems.[43] In 2008, only 5.2% of all substance abuse treatment admissions in the state of Mississippi were of minors under the age of 18 (or roughly 217 patients).[44]

Girls, upon becoming pregnant, do not suddenly have greater access to health care, better housing, safer environments, or enhanced capacity to overcome behavioral health problems such as addiction.[45] In addition to the lack of appropriate programs there are other barriers such as cost, stigma, and long waiting-lists, which impede access to successful treatment.

Mississippi law protects children in almost every legal sphere.[46] Neither common sense nor science justifies abandoning such protections when a child becomes both pregnant and addicted. To the contrary, given the psychological burdens of teen pregnancy, the burdens of teen motherhood, and the severe consequences of criminal proceedings, the law must protect children from the harsh, punitive nature of the criminal justice system.

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[43] United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *2007 State Estimates of Substance Use & Mental Health--Mississippi*, "Table 49. Selected Drug Use, Perceptions of Great Risk, Average Annual Marijuana Initiates, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, Serious Psychological Distress, and Having at Least One Major Depressive Episode in Mississippi, by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2006-2007 NSDUHs." (2008), *available at* http://oas.samhsa.gov/2k7State/Mississippi.htm.

[44] United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Treatment Episode Data Set (TEDS), "Mississippi State Profile: Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity" (2008), *available at* http://wwwdasis.samhsa.gov/webt/quicklink/MS08.htm.

[45] Chaya G. Bhuvaneswar, MD, et al., *Cocaine and Opioid Use During Pregnancy: Prevalence and Management*, 10(1) Primary Care Companion Journal of Clinical Psychiatry 59, 65 (2008). "Even for motivated women, obtaining treatment is not always straightforward. The scarcity of specialized treatment centers has already been noted."

[46] For example, in addressing the rights of minors and the need to afford them extra protection, the judiciary and legislature enacted the Youth Court Act and child support provisions and laws regarding statutory rape. *See Edmonds v. State*, 2004-KA-02081-COA (Miss. 2006) (Lee, J., concurring).

Moreover, Ms. Gibbs (at fifteen years old) should not be solely responsible for obtaining proper treatment for a medical condition, especially when no treatment in her county existed. For the State to then subject a teenage girl to the full weight of the criminal justice system by charging her with homicide under a radically new and expanded version of the state's homicide statute violates fundamental tenets of common sense and public policy.

CONCLUSION

Because the prosecution of Rennie Gibbs for homicide by depraved heart is unsupported as a matter of science, is inappropriate as a matter of public health, and is unfounded as a matter of law, *amici curiae* respectfully request this Honorable Court to grant Ms. Gibbs' Petition for Interlocutory Review and to dismiss the charges against her.

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Respectfully submitted,

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