UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

TAMARA M. LOERTSCHER,

Plaintiff,

v.

J.B. VAN HOLLEN, in his official capacity as ATTORNEY GENERAL OF THE STATE OF WISCONSIN, and

ELOISE ANDERSON, in her official capacity as SECRETARY OF THE DEPARTMENT OF CHILDREN AND FAMILIES,

Defendants.

CIVIL ACTION

Case No. 14-cv-870

PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Plaintiff Tamara M. Loertscher hereby respectfully moves this Court to issue a preliminary injunction that (1) declares that 1997 Wisconsin Act 292, amending multiple section of, *inter alia*, Chapter 48, Wis. Stat. § 48.01 *et seq.*, ("the Act") is unconstitutional on its face; (2) enjoins enforcement of the Act throughout the State of Wisconsin until this Court issues its final judgment regarding Plaintiff's request that the Act be permanently enjoined; and (3) orders Defendants to release Ms. Loertscher immediately from state supervision and control.

As set forth in Plaintiff's Brief in Support of Motion for Preliminary Injunction, filed herewith, there is an urgent need for preliminary injunctive relief in this case. Without such relief, Ms. Loertscher, a 30-year-old pregnant woman, will be prevented from making her own medical decisions, forced to submit to regular drug testing, and subjected to continued supervision by local officials—all in violation of the United States Constitution. Because her

child is due near the end of this month—on January 29, 2015—she faces the prospect, absent preliminary injunctive relief, of giving birth under the supervision of state actors authorized to enforce the Act against her, including a guardian ad litem who is empowered by the Act to override her medical decisions based on his subjective judgment as to what decisions are in the best interests of Ms. Loertscher's fetus.

Accordingly, for the reasons set forth in the accompanying brief, Ms. Loertscher respectfully requests that the Court adopt Plaintiff's Proposed Findings of Fact and issue a preliminary injunction declaring that the Act is unconstitutional on its face; enjoining enforcement of the Act; and ordering Defendants to release Ms. Loertscher immediately from state supervision and control.

Dated this 7th day of January, 2015.

Respectfully submitted,

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PLAINTIFF'S BRIEF IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

In Wisconsin, an adult woman alleged to have consumed alcohol or drugs during pregnancy may be forced, without the benefit of counsel, into secret juvenile court proceedings originally designed to protect abused children, in which she faces severe penalties. As detailed below, under 1997 Wisconsin Act 292 ("the Act"), judicial officers, state and local officials, hospital staff, social workers, or law enforcement personnel can initiate legal proceedings against a pregnant woman alleged to "habitually lack self-control" in the use of alcohol or controlled substances. Once such allegations have been made, a juvenile court may order the woman into custody and then keep her detained if that court is "satisfied" that the woman may pose "substantial risk" to the fertilized egg, embryo, or fetus inside of her. The juvenile court then holds a series of confidential proceedings to determine whether the woman should be maintained in custody, ordered into a mandatory treatment facility, placed under the control of a friend or relative, or have other restrictions placed upon her freedom of movement or activity. At each of these hearings, the fertilized egg, embryo or fetus must be represented by a guardian ad litem, but in the critical early hearings, the pregnant woman herself is not provided counsel.

The legal standards employed in these proceedings are vague and undefined, but the consequences for the woman subjected to them are concrete, severe and long-lasting. She may be detained, forced to undergo medically unnecessary and/or inappropriate drug and alcohol treatment, denied appropriate prenatal and other medical care, and subjected to findings of fact and legal orders that may impact her employment or result in termination of parental rights. Because the juvenile court system, to which these unusual proceedings are assigned, was designed to protect the privacy of potentially abused children, all of this occurs in secret, through confidential proceedings that preclude public scrutiny.

Plaintiff Tamara Loertscher is a 30-year-old pregnant woman currently subjected to state control under this Act in clear violation of her constitutional rights. Last August, when she realized she might be pregnant, Ms. Loertscher voluntarily sought medical assistance from a hospital in Taylor County. In the course of providing information to further that treatment, she confided that she had used controlled substances and a small amount of alcohol prior to learning she was pregnant. Under authority granted by the Act, state actors then used Ms. Loertscher's private medical information for law enforcement purposes without her consent, appointed a guardian ad litem to represent her then 14-week fetus, and initiated proceedings under the Act.

A juvenile court held adversarial proceedings against Ms. Loertscher, who was without counsel, and as a result, Ms. Loertscher was ordered detained, coerced into unwanted medical treatment, arrested, and ultimately jailed. While she was incarcerated, state actors deprived her of necessary medical and prenatal care and subjected her to harassment and abuse, jeopardizing her health and the health of her future child. Ms. Loertscher was released only after she agreed to a consent decree authorizing continued state control over her private medical decisions. A guardian ad litem remains appointed to represent Ms. Loertscher's fetus for the duration of her pregnancy, and Ms. Loertscher must comply with the terms of the consent decree upon pain of renewed incarceration and possible suspension or loss of parental rights with regard to her child when born. Ms. Loertscher therefore brings this facial constitutional challenge under 42 U.S.C. § 1983 and seeks an immediate statewide injunction against enforcement of the Act.

On its face, the Act is plainly unconstitutional. It violates some of the most basic fundamental Constitutional rights recognized by the Supreme Court, including the right to be free from bodily restraint, the right to freedom from coerced medical treatment, the right to procreate, and the right to control and custody of one's children. None of these intrusions are

narrowly tailored to serve a compelling state interest, the level of scrutiny demanded by the fundamental nature of the rights at stake. By its terms, the Act applies to women from the moment they are carrying a fertilized egg, and it imposes draconian punishments and Kafkaesque legal proceedings on adult women without any regard for their actual impact on maternal and fetal health. In fact, many of the proceedings and their consequences reduce the likelihood that a pregnant woman will receive appropriate prenatal care, undermining, rather than promoting, the objective the Act purports to address.

In addition, the Act violates several other constitutional protections. The Act imposes an undue burden on a woman's right to choose to terminate her pregnancy because it subjects her to detention and forced medical treatment without any provision for her exercise of her right to choose to have an abortion. Moreover, nothing in the Act prohibits the guardian ad litem tasked with representing the interests of the fertilized egg, embryo, or fetus, from challenging a woman's right to exercise her right to terminate a pregnancy. The Act is also void for vagueness on due process grounds because it fails to provide adequate notice of prohibited conduct and encourages arbitrary and discriminatory enforcement. The Act violates the Equal Protection Clause by infringing fundamental rights, imposing substantial burdens on women alone, and by subjecting pregnant women to byzantine proceedings with due process protections far below those available to people facing involuntary civil commitment proceedings for mental health reasons, none in the service of a state interest that justifies the intrusion.

Ms. Loertscher is likely to prevail on the merits of each of these constitutional claims. Furthermore, she has suffered irreparable harm through the deprivation of her constitutional rights and has no adequate remedy at law. Without preliminary injunctive relief from this Court, those constitutional violations will continue, preventing her from making her own medical

decisions, forcing her to submit to regular drug testing, and subjecting her to continued supervision by local officials. Because Ms. Loertscher's child is due on January 29, 2015, she also faces the prospect of giving birth under the supervision of state actors authorized to enforce the Act against her. These include the guardian ad litem, who is empowered to override her medical decisions, including potentially how she gives birth, if he unilaterally decides that his decisions are in the best interests of her fetus. Ms. Loertscher therefore requests that this Court declare the Act unconstitutional, enjoin further enforcement of the Act throughout the State of Wisconsin, and order Defendants to release her immediately from state supervision and control.

SUMMARY OF THE CHALLENGED ACT

Originally passed as 1997 Wisconsin Act 292, and codified at *inter alia,* Wis. Stat. § 48.01 *et seq.*, the Act explicitly gives juvenile courts exclusive original jurisdiction over fertilized eggs, embryos, and fetuses—from the moment of fertilization—under the State's child abuse and neglect code, whenever lack of "self-control" regarding drug or alcohol use is alleged against a pregnant woman. *See* Wis. Stat. § 48.133 (providing for juvenile court jurisdiction over "adult expectant mother" of an "unborn child"); Wis. Stat. § 48.02(19) ("'Unborn child' means a human being from the time of fertilization to the time of birth.").[1]

The Act was passed in direct response to the Wisconsin Supreme Court's decision in *State ex rel. Angela M.W. v. Kruzicki*, 561 N.W.2d 729 (Wis. 1997), which held that the

[1] Plaintiff uses the phrase "fertilized egg, embryo, or fetus" to accurately describe the reach of this Act, rather than the medically inappropriate term "unborn child." (*See* PFOF 176). In reality, pregnancy does not occur when an ovum is fertilized, but rather at the point when a fertilized egg (a blastocyst, or pre-embryo) successfully implants in a woman's uterus; once a woman is actually pregnant, the developing zygote begins to go through a procession of stages with enormous biological differences. (PFOF 177-179). The Act's use of the term "unborn child" to describe this process reflects the attempt of proponents of the Act to define human life and personhood as existing from the moment of fertilization. Such an endeavor is contrary to the express directive of *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."). Moreover, it pits the interest of the pregnant woman against that of the fertilized egg, embryo, or fetus she carries, despite the biological fact that these interests are intimately intertwined, no matter one's beliefs concerning the beginning of human life. (*See* PFOF 191).

Wisconsin children's code did not authorize a juvenile court to exercise jurisdiction over an adult pregnant woman in connection with a proceeding regarding a "child alleged to be in need of protection or services," also known as a "CHIPS" proceeding. *See* Kenneth A. De Ville & Loretta M. Kopelman, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy*, 27 J.L. Med. & Ethics 332, 332 (1999) (Appendix 3, attached). The Legislature then passed the Act to authorize the very jurisdiction the state supreme court had rejected, granting juvenile courts jurisdiction over "an unborn child" and the "adult expectant mother" when that expectant mother

> habitually lacks self-control in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, to the extent that there is a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered unless the expectant mother receives prompt and adequate treatment for that habitual lack of self-control.

Wis. Stat. § 48.133.

When a court takes jurisdiction over a pregnant woman pursuant to Section 48.133, the court must appoint a guardian ad litem ("GAL") to represent the interests of the fertilized egg, embryo, or fetus. Wis. Stat. §§ 48.235(1)(f) & 48.02(19). The Act does not require the GAL or any other state actor to act on behalf of or in the interests of the pregnant woman. In fact, the GAL for the fertilized egg, embryo, or fetus may file a petition against the pregnant woman alleging abuse and neglect of the fertilized egg, embryo, or fetus she is carrying. Wis. Stat. § 48.25(1). A district attorney, corporation counsel for a county or state department of human services, or any other "appropriate" government official representing the "interests of the public" may also file such a petition as specified under Section 48.09. Wis. Stat. § 48.25(1).

Any juvenile court that has exercised this jurisdiction over a pregnant woman and her fertilized egg, embryo, or fetus under Section 48.133 may also issue a warrant to take that

pregnant woman into custody based upon a "showing satisfactory" to the judge that the woman meets the criteria granting the court jurisdiction under Section 48.133. Wis. Stat. § 48.193(1)(a)-(c). In addition, law enforcement personnel may themselves take a pregnant woman into custody if, in their independent judgment, "reasonable grounds" exist to believe that the conditions for jurisdiction under § 48.133 are satisfied. Wis. Stat. § 48.193(1)(d)(2). The Act even grants human services intake workers "the power of police officers or deputy sheriffs" to take a pregnant woman into custody if they believe the conditions for jurisdiction under Section 48.133 have been satisfied. Wis. Stat. § 48.08(3). After a pregnant woman is taken into custody, an intake worker with the state or county department of human services may unilaterally decide to "release the adult expectant mother to an adult relative or friend of the adult expectant mother," or may decide to keep the pregnant woman detained. Wis. Stat § 48.203(1)&(2).

If a pregnant woman is detained under Section 48.203, a court must hold a hearing within 48 hours to determine if probable cause exists for her continued detention as set out in Section 48.205(1m). Wis. Stat. § 48.213(1)(a). Pregnant women are not entitled to appointment of counsel for this hearing. Wis. Stat. § 48.213(2)(e). A juvenile court judge presiding over a probable cause hearing may order a pregnant woman into an inpatient facility as described in Section 48.207(1m). Wis. Stat. § 48.213(3)(b). The court may also order the pregnant woman to be placed outside her home at the home of a friend or relative selected by the court. Wis. Stat. § 48.213(3)(b); Wis. Stat. § 48.207(1m)(a). Alternatively, the court may opt to release the pregnant woman but impose unspecified restrictions on her "travel, association with other persons or places of abode." Wis. Stat. § 48.213(3)(a). It may also require her to return to custody, subject her to the supervision of a state agency, and place other unspecified restrictions on her "conduct." *Id*.

Within 30 days of the filing of a CHIPS petition under the Act, a court must hold a hearing for a pregnant woman to enter a plea responding to the petition alleging child abuse or neglect regarding her fertilized egg, embryo, or fetus. Wis. Stat. § 48.30(1). At the plea hearing, the pregnant woman must be advised of the rights afforded her under 48.243, which includes the right to court-appointed counsel in certain circumstances. *See* Wis. Stat. § 48.23(2m). However, the pregnant woman is not entitled to representation by court-appointed counsel at the plea hearing, even if she qualifies for the appointment in connection with a subsequent fact-finding hearing. *See* Wis. Stat. §§ 48.23(2m)(b) & (4). At the plea hearing, she must decide how to plead in response to the allegations against her, whether to invoke or waive her right to a jury trial, and whether to request substitution of the judge. Wis. Stat. § 48.30(2).

Finally, the court must hold a fact-finding hearing to determine if the allegations in the CHIPS petition under the Act have been established by "clear and convincing" evidence. Wis. Stat. § 48.31(1). If a woman is threatened with placement outside her home under the Act, then she is entitled to court-appointed counsel for the first time in the course of the proceedings against her, provided she meets the statutory criteria for indigency. *See* Wis. Stat. §§ 48.23(2m)(b) &(4). If she is threatened with state supervision or involuntary court-ordered counseling or medical treatment, *see* Wis. Stat. §§ 48.347(1), (2), (4) & (5), then she is not entitled to court-appointed counsel. If the pregnant woman invoked her right to a jury trial during the prior plea hearing, then a jury is tasked with fact-finding concerning the allegations in the petition, although the ultimate decision regarding whether the fertilized egg, embryo, or fetus, is in need of protection or services is reserved for the juvenile court. Wis. Stat. § 48.31(2) & (4).

Ultimately, over a pregnant woman's objection and regardless of any denial of the allegations against her set out in the petition, and without any requirement that it consider

scientifically reliable evidence, the juvenile court may order a pregnant woman to undergo counseling, supervision, or drug and alcohol treatment— including involuntarily at an inpatient facility—for the duration of the woman's pregnancy. *See* Wis. Stat. § 48.347. Further, Section 48.347(7) authorizes a court, during a woman's pregnancy, to order services or treatment for the child when born including removal from the home and substitution of legal custody. *See* Wis. Stat. § 48.345. Moreover, the Act provides for permanent involuntary termination of parental rights based solely on the fact that the mother was previously placed outside her home during her pregnancy. Wis. Stat. § 48.415(2)(a). At any time, a GAL appointed to represent a fertilized egg, embryo, or fetus, may, among other actions, petition for revision or extension of a dispositional order, and may also petition for termination of parental rights of a pregnant woman over her child once born. Wis. Stat. § 48.235(4m)(a). A woman subject to the Act may also be subject to a determination, separate and apart from a CHIPS proceeding, that she has abused her unborn child. *See* Wis. Stat. §§ 48.981(3)(c)(1)(a) & (5m).

Wisconsin courts are empowered to order remedial and punitive sanctions for contempt of court in cases where a pregnant woman is deemed to have intentionally disobeyed any order issued by the court under the jurisdiction conferred by Section 48.133. *See* Wis. Stat. §§ 785.01 & 785.02. Penalties for contempt include up to 1 year of jail time. *See* Wis. Stat. § 785.04.

STATEMENT OF FACTS

A. Background

Tamara Loertscher is a 30 year-old pregnant resident of Taylor County, Wisconsin (PFOF 1). She is currently pregnant with her first child, which is due January 29, 2015. (PFOF 7).

Due to radiation treatment Ms. Loertscher had as a teenager, she is without a functioning

thyroid. (PFOF 8). As a result, Ms. Loertscher suffers from severe hypothyroidism, and cannot produce vital thyroid hormones without medication. (PFOF 9). She also understood that hypothyroidism would make it difficult or impossible for her to become pregnant. (PFOF 10). (Indeed, it is well established that hypothyroidism can disrupt ovulation, leading to irregular periods; it is also a cause of infertility. (PFOF 11)). Without her thyroid medication, Ms. Loertscher experiences severe symptoms of depression and fatigue. (PFOF 13 & 14). Ms. Loertscher also has a history of clinically diagnosed depression, a condition that is compounded by the symptoms of untreated hypothyroidism (PFOF 12-14).

Ms. Loertscher has been unemployed since February 2014. (PFOF 15). Previously, she worked as a certified nurse's aide. (PFOF 16). When Ms. Loertscher became unemployed, she was no longer able to pay for her thyroid medication and related blood testing. (PFOF 17). She attempted to apply for BadgerCare, Wisconsin's version of Medicaid, but was told by officials that there was a waiting list of more than a year to process any new applications (PFOF 18). Accordingly, she was without any medical treatment for her hypothyroidism beginning in February 2014. (PFOF 19).

Without treatment for her thyroid condition, Ms. Loertscher sank into a deep depression. (PFOF 19). She also began to experience severe fatigue, as well as head and neck pain. (PFOF 20). During this time period, Ms. Loertscher began to use methamphetamine about two or three times per week to help her get out of bed in the morning. (PFOF 21). Ms. Loertscher had no history of drug dependency or addiction, and had never even used methamphetamine or any other illegal drug —except marijuana very occasionally—in her life before February 2014. (PFOF 22). Ms. Loertscher used marijuana during this time period as well, but very intermittently—fewer than 10 times in the year preceding the end of July 2014. (PFOF 23 & 24).

Ms. Loertscher did not, however, feel much like drinking alcohol during this time period. In fact, she only had a beer on occasion in early 2014, then stopped drinking alcohol at all, except for one half of one glass of wine she had at a birthday celebration at the end of July 2014.

In the beginning of July 2014, Ms. Loertscher began to wonder if she might be pregnant, and took a home pregnancy test which appeared to return a positive result. (PFOF 27). However, she assumed she was not actually pregnant because of her understanding of the effect of hypothyroidism on fertility, as well as the fact that the absence of thyroid medication affects her menstrual cycle and she was experiencing what appeared to be a spotty, light period at that time. (PFOF 28).

Ms. Loertscher used methamphetamine again approximately two or three times after taking the pregnancy test in early July. (PFOF 29). On approximately July 30, 2014, Ms. Loertscher took another pregnancy test, just in case she might be pregnant. (PFOF 30). When that test was also positive, she believed for the first time that she might actually be pregnant. (PFOF 31). Ms. Loertscher has not used methamphetamine, marijuana, or any other illegal drug, nor consumed any alcohol, since the day she took the second pregnancy test on July 30, 2014. (PFOF 32).

B. Ms. Loertscher Seeks Medical And Prenatal Care

Two days later, on August 1, 2014, Ms. Loertscher went to the Taylor County Department of Human Services ("TCDHS") for help. (PFOF 33). She was concerned that she might actually be pregnant, wanted confirmation of that pregnancy, and wanted appropriate treatment for her depression, as well as fatigue and other serious symptoms of her untreated thyroid condition. (PFOF 34). TCDHS personnel advised Ms. Loertscher to present herself to the Eau Claire Mayo Clinic Hospital ("Mayo Clinic") emergency room that day, and she did so.

(PFOF 35).

At the emergency room, Ms. Loertscher explained to medical personnel that she needed medical and psychiatric care. (PFOF 36). She told also told them that she believed she was pregnant but wanted confirmation; she also wanted to make sure, if she was in fact pregnant, that the pregnancy was healthy. (PFOF 36). At the request of Mayo Clinic personnel, Ms. Loertscher provided a urine sample that day. (PFOF 37). No one at the hospital informed Ms. Loertscher that her urine would be tested for drugs. (PFOF 38). Because Ms. Loertscher had stopped using drugs and had no intention of using them any longer, she was not seeking addiction treatment when she presented at Mayo Clinic for care. (PFOF 39) Ms. Loertscher has had serious medical problems in her life, but has never struggled with drug addiction. (PFOF 40).

Mayo Clinic personnel used Ms. Loertscher's urine sample to perform a drug screen. The results returned "unconfirmed positive" for methamphetamine, amphetamine, and tetrahydrocannabinol (THC), the active ingredient in marijuana. The test results did not quantify concentrations, and the results were labeled, "FOR MEDICAL USE ONLY, ALL RESULTS UNCONFIRMED." The results further stated "NOTIFY LAB IF FURTHER CONFIRMATION IS NECESSARY." (PFOF 41).

A doctor informed Ms. Loertscher that the pregnancy test was positive, and that "trace amounts" of methamphetamine and marijuana had been found in her urine; the doctor advised Ms. Loertscher that drug use is very bad for a baby, but that if she stopped now everything should be okay. (PFOF 42 & 43). Ms. Loertscher responded that she wanted more than anything for her baby to be okay. (PFOF 44). Although Ms. Loertscher had not intended to become pregnant, and didn't believe that it was possible, once she learned she was pregnant she wanted to have the baby, and wanted to take care of herself and her pregnancy as best as she could.

(PFOF 45).

Later that evening, Ms. Loertscher was admitted to the Mayo Clinic Behavioral Health Unit. (PFOF 46). The next morning, she was given levothyroxine to treat her hypothyroidism. (PFOF 47). A psychiatrist then visited her, and informed her that her TSH (thyroid stimulating hormone) levels were very high and that healthy thyroid functioning is very important to a healthy pregnancy. (PFOF 48). Indeed, maternal hypothyroidism has been associated with a wide range of adverse outcomes including miscarriage, stillbirth, and impaired cognitive function in newborns. (PFOF 51). Ms. Loertscher's hypothyroidism upon admission to the Mayo Clinic was exceptionally severe; in fact, Ms. Loertscher's TSH levels were so extraordinarily high they were literally out of range of the assay as it was higher than the cut point for the test. (PFOF 49 & 50).

The psychiatrist also asked Ms. Loertscher about her past drug use. (PFOF 52). Ms. Loertscher candidly explained that she had been self-medicating her depression and extreme lethargy with occasional marijuana but mainly with methamphetamine. (PFOF 53). She emphasized that she had only done this before she became convinced she might actually be pregnant. (PFOF 54). Ms. Loertscher was very worried about her pregnancy because she did not know what affect her hypothyroidism and depression might have on her pregnancy. (PFOF 56). She was also worried about her past drug use and its impact on the baby (PFOF 57). Accordingly, she was very honest with the psychiatrist about her past drug use because she believed that if she was truthful and told the doctor everything, then the doctors could help her ensure a healthy pregnancy. (PFOF 55).

Later that evening, Ms. Loertscher met with an obstetrician, who showed Ms. Loertscher the ultrasound images of her fetus and told her the baby looked fine; Ms. Loertscher was so relieved she started to cry. (PFOF 58 & 59). Then the doctor asked Ms. Loertscher about her

alcohol use. (PFOF 60). Ms. Loertscher explained that during the time she was pregnant, but did not know it yet, she drank one half of a glass of wine. (PFOF 60).

C. Legal Proceedings Begin Against Ms. Loertscher Under the Act

While Ms. Loertscher was in the hospital, personnel from the Mayo Clinic, without Ms. Loertscher's knowledge or consent, shared her confidential medical information with agents of TCDHS, which operates in conjunction with law enforcement under the direction and oversight of the Wisconsin Department of Children and Families. (PFOF 61). Sometime thereafter, a Taylor County commissioner appointed a GAL on behalf of Ms. Loertscher's fetus. (PFOF 62).

On approximately the third or fourth day of Ms. Loertscher's stay at the Mayo Clinic, she met with a hospital social worker. (PFOF 63). Ms. Loertscher felt the social worker was asking her questions that were inappropriately focused on her past drug use, rather than her health. (PFOF 64). She advised hospital staff that she did not wish to speak to the social worker again, because the social worker had been judgmental and unhelpful. (PFOF 65). Around this time, Ms. Loertscher began to feel that she was not receiving the care she needed for her health concerns because the hospital staff were focused on her past drug use, and that the hospital staff did not really care about her baby's health at all. (PFOF 66). On approximately the fourth day of her hospital stay she informed hospital staff that she wished to leave. (PFOF 67). The nursing manager then told her that there was a "hold" on her, and threatened to call security if she did not get away from the door to the Behavioral Health Unit. (PFOF 68).

On August 5, 2014, the social worker led Ms. Loertscher into a conference room within the Mayo Clinic, and told her that there was a judge on the phone for her. (PFOF 70). Ms. Loertscher realized from what she heard over the telephone that some kind of formal proceeding was taking place, but she had no idea what was actually going on. (PFOF 43). The social worker

also placed some kind of legal papers on the table in front of Ms. Loertscher, but Ms. Loertscher did not understand what they were. (PFOF 72). Ms. Loertscher stated that she did not wish to speak without legal representation, and did not want to take part in any proceeding until she had a lawyer. (PFOF 73). She then returned to her hospital room. (PFOF 74). The social worker followed Ms. Loertscher to her hospital room, and tried to continue the telephone call with the judge from there. (PFOF 75). Ms. Loertscher laid down on the bed facing away from the social worker and pleaded "just please leave, just leave me alone." (PFOF 76).

In fact, the legal documents placed in front of Ms. Loertscher in the conference room of the Mayo Clinic Behavioral Health Unit were a Temporary Physical Custody Request and an as-yet-unfiled "Petition for Protection or Care of an Unborn Child" ("the Petition") against Ms. Loertscher. (PFOF 69 & 77). The Temporary Physical Custody Request stated that Ms. Loertscher had been taken into custody at the hospital on the basis of a serious health risk to [an] unborn child. (PFOF 78). The Petition alleged that if Ms. Loertscher were no ordered held in custody by the juvenile court, "there is a substantial risk that the physical health of the unborn child, and the child when born, will be seriously affected or endangered by Tamara M. Loertscher's habitual lack of self-control in the use of alcohol beverages, controlled substances, or controlled substance analogs." (PFOF 79).

The telephone call on August 5, 2014, was deemed by the juvenile court to be a hearing on the as-yet-unfiled Petition against Ms. Loertscher. (PFOF 80). On the other end of the phone were the Taylor County Court Commissioner, TCDHS Corporation Counsel, the court-appointed GAL on behalf of Ms. Loertscher's fetus, and three TCDHS personnel. (PFOF 81).

After Ms. Loertscher stated that she would not participate without counsel and returned to her hospital room, the court found that Ms. Loertscher had waived her appearance at the hearing

and that the hearing would continue in her absence. (PFOF 82). The court then heard testimony from a Mayo Clinic obstetrician, responding to questions from counsel for TCDHS concerning Ms. Loertscher's personal medical information and health history. (PFOF 83). The doctor stated that she did not have Ms. Loertscher's authorization to discuss her personal medical information, but, once Taylor County counsel said that Ms. Loertscher's authorization was not needed, the doctor responded to questions concerning drug use and pregnancy, and further testified that her greatest concern for Ms. Loertscher's pregnancy related to her hypothyroidism and her ability to get appropriate prenatal care. (PFOF 84-86). Although no one at the Mayo Clinic had evaluated Ms. Loertscher for a substance use disorder (*see* PFOF 88), the obstetrician testified that she recommended inpatient drug treatment for Ms. Loertscher. (PFOF 87). At the close of the August 5, 2014, hearing, the juvenile court entered an order of "Temporary Physical Custody" against Ms. Loertscher. (PFOF 90). The Order required Ms. Loertscher to remain at the Mayo Clinic until she was "cleared," at which time the court ordered that she be transferred to an inpatient drug treatment facility during the remaining term of her pregnancy. (PFOF 91).

On August 6, 2014, a Mayo Clinic social worker informed Ms. Loertscher that a judge had ordered her to stay in the hospital, and then to go directly to the Fahrman Center, a residential addiction treatment facility in Eau Claire, Wisconsin. (PFOF 92); *see* http://www.lsswis.org/LSS/Services/Addiction/Inpatient-Treatment1.htm). The next day, Mayo Clinic personnel informed Ms. Loertscher that she would need to submit to a blood test for tuberculosis before she could be admitted to that facility. (PFOF 93). Ms. Loertscher offered to take a skin test for tuberculosis, but refused to consent to a blood draw because she no longer trusted these health care workers. (PFOF 94). She also informed hospital personnel that she wanted to stay on her thyroid medication, start prenatal vitamins, choose her own health care

providers, and leave the hospital immediately. (PFOF 95). Ms. Loertscher was given a prescription for levothyroxine and iron, and was released from the hospital that day. (PFOF 96). No one advised her that by leaving the hospital she would be doing anything wrong, or that she could be subjected to arrest for doing so. (PFOF 97). At that time, she believed the whole episode was over. (PFOF 97).

D. Further Legal Proceedings Against Ms. Loertscher Under The Act

On August 11, 2014, the GAL appointed on behalf of Ms. Loertscher's fetus filed a Notice of Motion and Motion for Remedial Contempt against Ms. Loertscher in Taylor County Circuit Court. (PFOF 98). The GAL requested that if Ms. Loertscher did not comply with the terms of the Temporary Physical Custody Order she should be subject to remedial sanctions under Wisconsin Statute Section 785.04, which could include a jail term of up to 6 months. (PFOF 99). Attached to the Notice was an affidavit from a TCDHS social worker alleging that Ms. Loertscher was in contempt of the juvenile court's August 5, 2014, Temporary Physical Custody Order because she had refused a TB test and otherwise failed to comply with TCDHS directives. (PFOF 100). The Notice set a hearing date on the contempt motion of August 25, 2014. (PFOF 101).

On August 13, 2014, Taylor County Corporation Counsel filed a "Motion to Take Expectant Mother into Immediate Custody" on behalf of TCDHS. (PFOF 102). The Motion stated as grounds that Ms. Loertscher had not been in contact with TCDHS and had otherwise failed to comply with the earlier Order for her placement at the Fahrman Center. (PFOF 103). The same day, the court granted the TCDHS Motion and entered an Order to Take Expectant Mother into Immediate Custody. (PFOF 104). The Order stated that it was "contrary to the unborn child's best interests for the expectant mother to have been released from custody and

returned home due to the expectant mother's habitual use of controlled substances and her violation of the TPC [Temporary Physical Custody] Order." (PFOF 105).

When she received the Notice of Motion and Motion for Remedial Contempt, Ms. Loertscher saw that the documents had an August 25, 2014, court date on them. (PFOF 106 & 107). But she did not understand the documents and therefore wanted to hire a lawyer to get advice; she met in person with a lawyer in Wausau, but was unable to hire him because she could not afford the retainer fee. (PFOF 108).

The afternoon after she received the Notice, a police officer came to Ms. Loertscher's grandparents' house, where she had been staying. (PFOF 109). Ms. Loertscher was upstairs at the time, and did not come down. (PFOF 109). The police officer returned three times, and told Ms. Loertscher's family that he had come to arrest her pending a court date, scheduled for a week later. (PFOF 110). Ms. Loertscher's grandfather assured the police officer that Ms. Loertscher would appear at the scheduled hearing, and the officer left without arresting her. (PFOF 111). Ms. Loertscher was horrified and humiliated; she did not understand what was happening, and felt extremely frightened and distressed. (PFOF 112).

On August 25, 2014, Ms. Loertscher appeared in Taylor County Circuit Court for the hearing. (PFOF 113). Present were the GAL on behalf of Ms. Loertscher's fetus, Corporation Counsel for TCDHS, and two TCDHS social workers. (PFOF 114). Ms. Loertscher was not represented by counsel, and did not understand what was happening during the hearing. (PFOF 115 & 116). Ms. Loertscher requested that a different judge hear the case, and the hearing was then cut short. (PFOF 117). The court rescheduled the hearing for September 4, 2014, before a different judge. (PFOF 118).

During the evening of August 25, 2014, another police officer came to Ms. Loertscher's

grandparents' home, stating he had a warrant for her arrest. (PFOF 119). Ms. Loertscher and her family explained that she had been in court that day and had an upcoming hearing. (PFOF 120). The officer said "I don't know anything, I just know that there's a warrant." (PFOF 121). Ms. Loertscher's family explained that she was pregnant and stressed and did not need to be in jail. (PFOF 122). Ultimately, the police officer agreed to leave without arresting Ms. Loertscher. (PFOF 122).

On September 4, 2014, Ms. Loertscher appeared, without counsel, in Taylor County Circuit Court for the hearing on the contempt motion. (PFOF 123). Present were the GAL, TCDHS Corporation Counsel, as well as Ms. Loertscher's boyfriend, her mother, and her mother's boyfriend. (PFOF 124). The court asked the GAL what his plea was "on behalf of the child." (PFOF 125). The GAL admitted all the allegations against Ms. Loertscher on behalf of her fetus. (PFOF 125). The court then heard testimony from a TCDHS social worker, who testified that Ms. Loertscher had not complied with the August 5, 2014, Order because she did not take a TB test, did not go to inpatient treatment at the Fahrman Center, and otherwise failed to comply with TCDHS directives. (PFOF 126). Without the benefit of counsel, Ms. Loertscher then tried to counter the contempt charge against her, as well as the underlying proceedings alleging abuse and neglect of her fetus. (PFOF 127).

Ms. Loertscher had very little understanding of what was happening at the hearing, but tried to answer the claim that she needed drug treatment. (PFOF 128 & 129). She testified: "I don't feel like I need treatment. Like I feel like I went to the hospital and sought treatment and then they violated my rights and all these people got this information that I feel they shouldn't have gotten. And I feel my whole stay there was made worse[.]" (PFOF 130). At the end of the hearing, the court found Ms. Loertscher in contempt and ordered her to either cooperate with

TCDHS and go to the Fahrman Center, or to serve 30 days in jail.[2] (PFOF 131).

Immediately following the September 4, 2014 hearing, Ms. Loertscher was led to a conference room in the courthouse where she met with TCDHS social workers. (PFOF 133). Ms. Loertscher asked them what they wanted from her; one of them responded, "we just want a healthy baby." (PFOF 133). Ms. Loertscher said that this is what she wanted, too. (PFOF 133). Ms. Loertscher then asked if "this would all go away if I had an abortion?" The social workers responded, "Yes, it would." (PFOF 134).

E. Ms. Loertscher's Incarceration Under the Act

On the evening of September 4, 2014, Ms. Loertscher surrendered herself to the Taylor County Jail, (PFOF 135 & 136), where she was held for a total of 19 days, (*see* PFOF 137). During her stay in jail, Ms. Loertscher received no prenatal care. (PFOF 138). She was denied her thyroid medication on two occasions: during the first day of her incarceration, the Taylor County Jail failed to provide it to her and wouldn't allow her family to bring it to her (PFOF 139); later, after Ms. Loertscher had been forced to wait for the prescription to be refilled, jail staff refused to give her the medication when it arrived. (PFOF 140). They told her it was okay for her to miss a dose and that this would keep the medication on schedule. (PFOF 141). Ms. Loertscher has always been advised by her doctors that she should take the medication as soon as possible after a missed dose. (PFOF 141). Ms. Loertscher was also forced to miss two previously scheduled prenatal care appointments while she was in jail; she asked jail staff to take her to these appointments, but they refused, and told her that missing them was her own fault because she was in jail. (PFOF 142 & 143).

[2] The GAL appointed to represent the interests of the fetus made no objection to sending the fetus and the woman carrying it to jail for 30 days, (PFOF 132), where, as will be explained below, Ms. Loertscher was denied access to prenatal care.

Ms. Loertscher began to experience a lot of pain and cramping while she was in jail. (PFOF 144). It became especially severe toward the end of the first week of her incarceration, and she became frightened that she might have a miscarriage. (PFOF 145). She asked repeatedly to see an obstetrician, and finally was told that she could see the jail doctor, who was not an obstetrician. (PFOF 146). The jail doctor did not examine her, other than to feel her stomach, and then stated "if you're going to miscarry while you're here, there's nothing that I can do about it." (PFOF 147). This response made Ms. Loertscher extremely upset and frightened for her pregnancy. (PFOF 148).

This same doctor then demanded that Ms. Loertscher take a pregnancy test. Believing this absurd, Ms. Loertscher refused. (PFOF 149). After this refusal, a guard threatened to tase Ms. Loertscher and that guard and other jail personnel put her in solitary confinement. (PFOF 150). She was kept in solitary confinement for more than 24 hours in a filthy room with nothing but a toilet and a metal bed frame (and, briefly, a thin blanket and mattress pad), and released when the same doctor told jail staff that Ms. Loertscher had the right to refuse to take the pregnancy test. (PFOF 151 & 152).

While she was in jail, Ms. Loertscher found a list by the phone of all the public defenders in Taylor County. (PFOF 153). She called the telephone number on the list, and explained to an intake worker that she was in jail and needed representation. (PFOF 153). A public defender was then appointed to represent her in the contempt proceeding. (PFOF 154).

F. The Consent Decree And Continuing State Enforcement Of The Act

Upon the advice of her newly appointed attorney, Ms. Loertscher signed a consent decree so that she could be released from jail. (PFOF 155). The Consent Decree permitted Ms. Loertscher to go home so long as she agreed to complete an Alcohol and Other Drug Abuse

(AODA) Assessment; comply with any recommended treatment resulting from that assessment; submit to drug testing on at least a weekly basis at her own expense; sign any and all releases necessary for transfer of drug test results to TCDHS; and sign any other releases as requested by TCDHS. (PFOF 156). The Consent Decree also provides that the GAL will remain appointed for Ms. Loertscher's fetus for the duration of her pregnancy, and that any violation of its terms is contempt of court. (PFOF 157). Ms. Loertscher agreed to these terms because she wanted to leave jail and she was not using drugs or alcohol and did not have a problem with drug use. (PFOF 158).

At a hearing on September 22, 2014, the juvenile court adopted the Consent Decree and made compliance with its terms sufficient to purge the earlier finding of contempt. (PFOF 159). Ms. Loertscher was released from the Taylor County Jail that day. (PFOF 137). Ms. Loertscher has complied with, and is continuing to comply with, all the terms of the Consent Decree. She has taken numerous drug tests, which have all returned negative results, and has completed the required AODA assessment. (PFOF 160 & 161).

By notice dated September 29, 2014, Ms. Loertscher was informed that TCDHS issued an administrative determination that she had committed "child maltreatment." (PFOF 162). Wisconsin Statute Section 48.133 was quoted in its entirety as the "basis" for the determination. (PFOF 163). The notice stated that the finding was appealable within 30 days, and Ms. Loertscher appealed it. (PFOF 164). By letter dated November 10, 2014, Ms. Loertscher received notice that the TCDHS Agency Director had conducted a "desk review" of her appeal and affirmed the finding that Ms. Loertscher had committed child maltreatment of her fetus, stating that the "preponderance of the evidence" drawn from Ms. Loertscher's medical records "indicates that prior to conception illicit drug use and alcohol were misused habitually." (PFOF

165 & 166). It further states that "the notation in the record that there was a time where you as the mother 'feels guilty for taking illicit drugs during pregnancy,' is a clear indication of a lack of self-control." (PFOF 167).

In fact, the records from Ms. Loertscher's stay at the Mayo Clinic do not indicate that she has a substance use disorder (PFOF 168). Whatever the terms of the Act may mean (they are undefined in the statute), substance use is not medically the same thing as a substance use disorder (also called addiction) (PFOF 169). Prior use of drugs does not, alone, provide the necessary information to make a medical diagnosis of substance use disorder. (PFOF 170). Nor does a urine toxicology test. (PFOF 170). Further, nothing in Ms. Loertscher's medical records from her stay in the Mayo Clinic indicates that she was screened for, or received, a diagnosis of substance use disorder; nor is there anything to indicate that she received treatment for such a diagnosis while she was in the hospital. (PFOF 171). Inpatient drug treatment is a medically unnecessary and inappropriate treatment recommendation for a patient like Ms. Loertscher with no medical diagnosis of a substance use disorder. (PFOF 172).

Ms. Loertscher remains subject to the Act and the Consent Decree's terms, including drug testing, restrictions on her freedom of movement, continued state supervision, and potential intervention by the GAL (*see* PFOF 156). Ms. Loertscher is due to give birth on January 29, 2015. (PFOF 7). She faces the prospect of state officials overriding her medical decisions during that birth and imposing restrictions on her relationship with her newborn child, including potential loss of that child.

ARGUMENT

Ms. Loertscher is entitled to a declaration that the Act is facially unconstitutional and to a statewide preliminary injunction against any further enforcement of the Act. A facial

constitutional challenge to a statute is appropriate when there are "no set of circumstances [] under which the Act would be valid," *United States v. Salerno*, 481 U.S. 739, 745 (1987), and the law is "unconstitutional in all of its applications." *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008). As the Seventh Circuit has explained, in the context of a facial challenge, "the claimed constitutional violation inheres in the terms of the statute, not its application." *Ezell v. Chicago*, 651 F.3d 684, 698 (7th Cir. 2011). Thus "[f]acial challenges are to constitutional law what res ipsa loquitur is to facts—in a facial challenge, *lex ipsa loquitur*: the law speaks for itself." *Id*. at 697 (emphasis in original). Accordingly, a court adjudicating a facial challenge need "have only the [statute] itself," and the "statement of basis and purpose that accompanied its promulgation." *Reno v. Flores*, 507 US. 292, 300-01 (1993). Further, the remedy for the constitutional violation "is necessarily directed at the statute itself and *must* be injunctive and declaratory; a successful facial attack means the statute is wholly invalid and cannot be applied *to anyone*." *Ezell*, 651 F.3d. at 698 (emphasis in original).

In this case, the plain text of the statute leaves no question that the Act is unconstitutional on its face. The Act expressly authorizes multiple infringements of fundamental substantive due process rights, including the right to liberty and to be free from bodily restraint, the right to bodily integrity and to refuse unwanted medical treatment, the right to procreate, the right to family unity, and the right to decide whether to carry a pregnancy to term. Thus the Act is subject to strict scrutiny, a standard of constitutional adjudication it cannot survive because it neither serves a compelling state interest nor is it narrowly tailored to serve the interests it purports to advance. Further, the plain text of the statute demonstrates that it is void for vagueness under the Due Process clause because it does not provide constitutionally adequate notice to citizens of what conduct it prohibits, and because it authorizes arbitrary and

discriminatory enforcement.

Finally, the statute on its face violates the Equal Protection Clause: first, because the law infringes pregnant women's fundamental rights, and cannot survive strict scrutiny; second, because the law discriminates on the basis of gender, and cannot survive intermediate scrutiny; and third, because its denial to pregnant women of the procedural protections afforded others facing involuntary civil commitment is not rationally related to any legitimate governmental interest, and thus the Act also cannot withstand even rational basis review.

The Seventh Circuit has explained that in the context of a facial challenge, "[o]nce standing is established, the plaintiff's personal situation becomes irrelevant." *Ezell*, 651 F.3d at 697. Nonetheless, the facts in Ms. Loertscher's case support the facial challenge here. The Seventh Circuit has cautioned that, in connection with adjudicating a facial challenge, a court "must be careful not to go beyond the statute's facial requirements and speculate about 'hypothetical' or 'imaginary' cases." *Center for Individual Freedom v. Madigan*, 697 F.3d 464, 476 (7th Cir. 2012) (citing *Washington State Grange*, 552 U.S. at 450). Ms. Loertscher's case demonstrates that the constitutional violations expressly authorized by the plain terms of the Act are neither hypothetical nor imaginary, but in fact have been, and are currently being, inflicted on a Wisconsin citizen under the terms of the Act.

Accordingly, this Court should enjoin enforcement of the Act because, as set forth below, Ms. Loertscher can demonstrate that she is likely to succeed on the merits of her constitutional claims, has no adequate remedy at law, and will suffer irreparable harm in the absence of immediate injunctive relief. *See*, *e.g.*, *ACLU v. Alvarez*, 679 F.3d 583, 589-90 (7th Cir. 2012).

I. PLAINTIFF IS LIKELY TO SUCCEED ON THE MERITS OF HER CLAIM THAT THE ACT VIOLATES FUNDAMENTAL SUBSTANTIVE DUE PROCESS RIGHTS

The Due Process Clause of the Constitution, applied to the states through the Fourteenth Amendment, protects certain rights and liberties that [are] "deeply rooted in this Nation's history and tradition." *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977). These rights are "so rooted in the traditions and conscience of our people as to be ranked as fundamental," *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934), and so "implicit in the concept of ordered liberty," that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-326 (1937). Among these fundamental rights are the right to freedom from bodily restraint, *Foucha v. Louisiana*, 504 U.S. 71 (1992); the right to bodily integrity, *Rochin v. California*, 342 U.S. 165 (1952), and freedom from coerced medical treatment, *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990); the right to procreate, *Skinner v. Oklahoma*, 316 U.S. 535 (1942); the right to control and custody of one's children, *Meyer v. Nebraska*, 262 U.S. 390 (1923), and the right to continue a pregnancy to term and the right to have an abortion, *Planned Parenthood of SE Pa. v. Casey*, 505 U.S. 833 (1992).

Consistent with the recognition that "the right to be let alone" is perhaps "the right most valued by civilized [society]," *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), "the Fourteenth Amendment forbids the government to infringe fundamental liberty interests *at all*, no matter what process is provided, unless the interest is narrowly tailored to serve a compelling state interest." *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997) (citation omitted). (emphasis in original). The Act infringes numerous fundamental rights. Because it is not narrowly tailored to serve a compelling interest, it cannot withstand strict scrutiny review.

A. The Act Infringes Numerous Fundamental Substantive Due Process Rights

As the Supreme Court recognized more than a century ago, "[n]o right is held more sacred, or is more carefully guarded… than the right of every individual to the possession and control of his own person, free from all restraint or interference of others[.]" *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891). Thus the Supreme Court has repeatedly placed the right to be free from bodily restraint among the most central fundamental substantive due process rights. *See, e.g., Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (*"*Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action.") (internal citations omitted); *Youngsberg v. Romeo*, 457 U.S. 307, 316 (1982) ("[L]iberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental intervention.") (citation omitted). The constitutional protections afforded by this right apply regardless of whether the government seeks detention for criminal or civil purposes. *See Foucha*, 504 U.S. at 80*; Jones v. United States*, 463 U.S. 354, 361 (1983) ("commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection"); *accord Addington v. Texas*, 441 U.S. 418, 425 (1979). Even in the civil setting, the Court has recognized "the individual's strong interest in liberty," and cautioned that courts must "not minimize the importance and fundamental nature of this right." *United States v. Salerno*, 481 U.S. 739, 750 (1987).

The plain text of the Act demonstrates that it impinges upon the fundamental right to freedom from bodily restraint. It authorizes multiple enforcers to take a pregnant woman into physical custody. *See* Wis. Stat. § 48.193(1)(a)-(c) (juvenile court may issue warrant based on "satisfactory showing" that woman meets statutory criteria of § 48.133); Wis. Stat. § 48.193(1)(d)(2) (law enforcement may take pregnant woman into custody if they believe

"reasonable grounds" exist to believe § 48.133 criteria are satisfied); Wis. Stat. § 48.08(3) (granting human services personnel "the power of police officers and deputy sheriffs" to take pregnant woman into custody if they believe § 48.133 criteria are satisfied). Strikingly, the Act authorizes the placement of pregnant women in physical custody, either in an inpatient drug treatment facility or in the home of a friend or relative. *See* Wis. Stat. § 48.203 (1) & (2) (intake worker may unilaterally "release adult expectant mother to an adult relative or friend of the adult expectant mother" or may decide to keep the pregnant woman detained); Wis. Stat. § 48.207(1m) (listing places where adult expectant mother may be held in custody); Wis. Stat. § 48.347(3) (authorizing ultimate out-of-home "placement" of adult expectant mother). It also explicitly authorizes the juvenile court to impose restrictions on a pregnant woman's right to travel and associate with other persons. *See* Wis. Stat. § 48.213(3)(a) (court may impose restrictions on pregnant woman's "travel, association with other persons or places of abode," require a return to custody, or place other unspecified restrictions on a pregnant woman's "conduct"). A pregnant woman deemed to have intentionally violated any order issued by the juvenile court is subject to remedial and punitive sanctions for contempt, which may include incarceration for up to one year. *See* Wis. Stat. §§ 785.01-785.05.

What happened to Ms. Loertscher in this case demonstrates the magnitude of the restraint on liberty authorized by the Act's plain terms: the juvenile court ordered that she be detained at the Eau Claire Mayo Clinic (where she had voluntarily sought medical treatment), from which she was to be transported to an inpatient facility against her will (PFOF 91) and, when she declined to accept the unwanted confinement in an inpatient drug treatment facility, she was found in contempt of court and ordered to jail. (PFOF 131).

But the Act authorizes more than detention; it also requires pregnant women to submit to

medical treatment, in direct contravention of the right to refuse unwanted medical treatment. *See Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."); *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) ("We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment."). Accordingly, the Court has held that a prisoner "possesses a significant liberty interest in avoiding the unwanted administration of anti-psychotic drugs," *Washington v. Harper*, 494 U.S. 210, 221 (1990), and has recognized a fundamental substantive due process right to bodily integrity among criminal suspects, *Rochin v. California*, 342 U.S. 165, 209-210. Moreover, in *Parham v. J.R.*, 442 U.S. 584, 600 (1979), the Court held that both children and adults have "a substantial liberty interest in not being confined unnecessarily for medical treatment." The Court has also specifically recognized that "mandatory behavior modification as a treatment for mental illness" is a deprivation of liberty. *Vitek v. Jones*, 445 U.S. 489, 494 (1980). Consistent with this Supreme Court precedent, the Seventh Circuit has held that "any medical procedure implicates an individual's liberty interests in personal privacy and bodily integrity" because "there is a general liberty interest in refusing medical treatment." *United States v. Husband*, 226 F.3d 626, 632 (7th Cir. 2000) (citing *Cruzan*, 497 U.S. at 278).

Infringement of this liberty interest is the core function of the Act. The Act expressly strips a pregnant woman of her right to medical decision-making, forcing her to submit to medical testing and treatment against her will. *See* Wis. Stat. § 48.205(1m) (permitting an intake worker to take a pregnant woman into custody if "there is probable cause to believe that" the "adult expectant mother is refusing or has refused to accept any alcohol or other drug abuse

services offered to her . . ."); Wis. Stat. § 48.203(3) (authorizing the intake worker or "other appropriate person" to deliver the expectant mother to a hospital or physician's office for diagnosis and treatment); Wis. Stat. § 48.347 (authorizing "placement" of adult expectant mother outside her home if "she is refusing or has refused to accept any alcohol or drug abuse services offered to her," and permitting court to mandate counseling, supervision, "special treatment or care," alcohol or drug treatment education, and inpatient drug or alcohol treatment).

Moreover, once a guardian ad litem (GAL) is appointed to advocate for the fertilized egg, embryo, or fetus, that GAL may challenge any medical decisions by the pregnant woman. *See* Wis. Stat. §§ 48.235(3)(b)(2) (directing GAL to make "clear and specific recommendations" to the court concerning "best interest of the …unborn child at every stage of the proceeding"); 48.235(4m)(4) & (5) (authorizing GAL to petition court for revision or extension of dispositional orders, which may include forced medical treatment); 48.235 (4m)(8) (authorizing GAL to "[p]erform any other duties consistent with this chapter."). The GAL is required by statute to consider *only* the best interests of the fertilized egg, embryo, or fetus. *See* Wis. Stat. § 48.01(1) ("the best interests of the… unborn child shall always be of paramount consideration"); Wis. Stat. § 48.235(3)(a) (GAL shall be an advocate for "best interests of …unborn child for whom the appointment is made"). Nowhere does the Act require the GAL or other state actors to consider the interests of the pregnant woman. The consequences of appointing a GAL to override a pregnant woman's medical decision-making can be deadly, as demonstrated by the use of a similar mechanism in the District of Columbia. In *In re A.C.*, 533 A.2d 611 (D.C. 1987), *vacated*, 573 A.2d 1235 (1990), GAL appointed for a fetus successfully argued for forced cesarean surgery, contributing to the death of both the pregnant woman and the fetus.

Here, as expressly authorized by the Act, the GAL appointed to represent Ms.

Loertscher's fetus actively, and successfully, sought to substitute his decisions concerning Ms. Loertscher's medical treatment for her own. Ms. Loertscher, ill and in the hospital while the Temporary Physical Custody hearing was held at the Taylor County Circuit Court, was not represented by counsel when the juvenile court ordered her involuntary placement in an in-patient drug-treatment facility. The state-appointed GAL appeared at the hearing on behalf of her fetus only, completely separate from and adverse to Ms. Loertscher. Shortly thereafter, the GAL initiated the contempt proceedings against Ms. Loertscher, resulting in her incarceration in Taylor County Jail without access to prenatal care or to the prescribed thyroid medication so essential to her health and to her pregnancy. As authorized under the Act, the GAL currently remains empowered to override Ms. Loertscher's medical decision-making throughout the remainder of her pregnancy and during childbirth, (*see* PFOF 156 (GAL remains appointed under the Consent Decree)), which is why urgent preliminary injunctive relief is needed in this case. (*See* Section IV, *infra*).

An inevitable consequence that flows from the Act's infringement of the right to freedom from bodily restraint and to refuse unwanted medical treatment is an additional burden on the fundamental due process liberty interest in procreation. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (holding that procreation is "one of the basic civil rights of man"). The Act authorizes state actors to take a woman into custody and order coerced medical treatment upon finding (based on unconstitutionally vague criteria (*see* Section II, *infra*)) that she is pregnant and that her past or present use of controlled substances or alcohol rises to a level permitting governmental action. Women subject to the Act who choose to continue their pregnancies are exposed to arrest and detention, *see, e.g.,* Wis. Stat. §§ 48.193(1)(a)-(c), 48.193(1)(d)(2), 48.08(3), 48.203(2); the indignity of an abuse or neglect determination, *see* Wis. Stat.

48.981(3)(a) & (3)(c)(5m); imposition of involuntary medical treatments, *see, e.g.*, Wis. Stat. § 48.347; possible loss of custody during pregnancy, *see* Wis. Stat. §§ 48.347(7) & 48.345; and permanent involuntary termination of parental rights after the child is born, *see* Wis. Stat. § 48.415(2)(a). *See* Dorothy E. Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy," 104 *Harv. L. Rev*. 1419, 1445 (1991) ("It is the *choice of carrying a pregnancy to term* that is being penalized") (emphasis in original).

As the Supreme Court has recognized, penalizing a woman for the decision to remain pregnant and give birth infringes the right to procreate. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 859 (1992) (noting "[*Roe v. Wade*, 410 U.S. 113 (1973)] has been sensibly relied upon to counter…suggestions [that] the State might as readily restrict a woman's right to choose to carry a pregnancy to term as to terminate it."); *Cleveland Bd. of Educ. v. LaFleur,* 414 U.S. 632, 639 (1974) (holding of an employment policy, "[b]y acting to penalize the pregnant teacher for deciding to bear a child, overly restrictive maternity leave regulations can constitute a heavy burden on the exercise of [] protected freedoms."). Yet a pregnant woman subject to the Act faces a stark choice: subject herself to arrest, civil detention, and imposition of involuntary medical treatment under threat of contempt proceedings and incarceration, or terminate a wanted pregnancy. Because both outcomes burden fundamental rights, the ultimatum is unconstitutional. *See New York v. United States*, 505 U.S. 144, 176 (1992) (noting that "[a] choice between two unconstitutional[] [alternatives] is no choice at all.").

Similarly, the Supreme Court has also made clear that a state may not coerce a woman to terminate her pregnancy. *See Casey*, 505 U.S. at 859 (citing with approval circuit court decisions finding state-compelled abortion unconstitutional under *Roe v. Wade*, 410 U.S. 113 (1973)); *Carey*, 431 U.S. at 687-90; *Roe*, 410 U.S. at 153 (holding right of privacy "broad enough to

encompass a woman's decision whether *or not* to terminate her pregnancy.") (emphasis added); *see also Arnold v. Bd. of Educ. of Escambia Cnty. Ala.*, 880 F.2d 305, 311 (11th Cir. 1989) (permitting lawsuit against public school officials accused of coercing a young woman into having an abortion and holding that, "[t]here simply can be no question that the individual must be free to decide to carry a child to term."). In fact, the definition of refugee in the United States Immigration and Nationality Act explicitly defines "a person who has been forced to abort a pregnancy" as someone "persecuted on account of political opinion." 8 U.S.C. § 1101(a)(42)(B); *see also Zhang v. Gonzales*, 434 F.3d 993, 1002 (7th Cir. 2006) ("Again, the pain, psychological trauma, and shame are combined with the irremediable and ongoing suffering of being permanently denied the existence of a son or daughter. Thus, forced abortions, without more, also likely will result in statutory entitlement to asylum eligibility and withholding of removal." (quoting *Qu v. Gonzales*, 399 F.3d 1195, 1202 n.8 (9th Cir. 2005)).

Here, the Act pressures women to abort wanted pregnancies in order to escape the Act's invasion of fundamental personal freedoms. Ms. Loertscher's case demonstrates that this pressure is not merely speculative: Ms. Loertscher asked state social workers after her contempt hearing, just before she was incarcerated, whether "this would all go away if I had an abortion"? The answer from county social workers was "Yes." (PFOF 134).

Finally, the Act's infringement of substantive due process rights extends far beyond a woman's pregnancy to burden the fundamental right to familial relations, including later relations with her child after birth. As the Seventh Circuit has made clear, "[t]he fundamental right to familial relations is an aspect of substantive due process." *Hernandez v. Foster*, 657 F.3d 463, 478 (7th Cir. 2011). Thus it has held that "the most essential and basic aspect of familial privacy" is "the right of the family to remain together without the coercive interference of the

awesome power of the state." *Doe v. Heck*, 327 F.3d 492, 524 (7th Cir. 2003). The Supreme Court, too, has repeatedly recognized the fundamental right to familial relations. Accordingly, the Court deemed the right to bring up one's children "essential," *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923), and described the right to custody of one's children as "far more precious… than property rights," *May v. Anderson*, 345 U.S. 528, 533 (1953). *See also Troxel v. Granville*, 530 U.S. 57, 57 (2000) (recognizing "parents' fundamental right to make decisions concerning the care, custody, and control of their children"); *Santosky v. Kramer*, 455 U.S. 745, 753 (1982) (recognizing the "fundamental liberty interest of natural parents in the care, custody and management of their child"); *accord Moore v. East Cleveland*, 431 U.S. 494, 503-504 (U.S. 1977) ("Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition.").

The Act undermines the sanctity of the family unit by attacking parental fitness during pregnancy and exposing a woman to separation from her newborn or even a loss of custody *during pregnancy*. A pregnant woman deemed to "habitually" lack "self-control" in the use of drugs or alcohol "to a severe degree" and in a manner that creates a "substantial risk that the physical health of the unborn child and of the child when born, will be seriously affected or endangered," *see, e.g.,* Wis. Stat. § 48.133, may lose custody of her future child *while she is still pregnant, see* Wis. Stat. §§ 48. 347(7) & 48.345, and a woman placed outside her home under the Act during her pregnancy is exposed to permanent involuntary termination of her parental rights after her child is born based solely on the fact of that placement, *see* Wis. Stat. 48.415(2)(a). Moreover, the GAL appointed under the Act is independently authorized to petition for termination of a woman's parental rights once the child is born. *See* Wis. Stat. §§ 48.235(4m)(3). As discussed in Section II, *infra*, the Act's vague terms authorize these severe

consequences on the basis of highly questionable "findings" with multiple opportunities for arbitrary and discriminatory enforcement. Such "findings" under the Act may also form the basis for a determination that a woman has committed child maltreatment, a determination that will follow her indefinitely. *See* Wis. Stat. § 48.981(3)(a) & (3)(c)(5m).

The effects of these proceedings linger long after a woman's pregnancy is over and can permanently burden a woman's fundamental right to custody of, and to care for, her children. Indeed, Ms. Loertscher has already been subject to an initial determination by TCDHS that she has committed "child maltreatment" based upon her preconception conduct and her conduct before she knew she was pregnant. (*See* PFOF 166 & 167). If this determination is allowed to stand, Ms. Loertscher will be prohibited from seeking certain types of employment, including working in her previous profession as a nurse's aide. *See* Wis. Stat. § 50.065(4m)(b)(4) (entity that provides care for individuals cannot employ caregiver who has been found to have committed child abuse). And under the Consent Decree, the GAL remains appointed in this case, and thus remains empowered under the Act to seek termination of Ms. Loertscher's parental rights as soon as her child is born. Wis. Stat. §§ 48.235(4m)(3); (*see* PFOF 156).

B. The Act's Infringement Of Fundamental Substantive Due Process Rights Cannot Survive Strict Scrutiny

As the Seventh Circuit has recognized, the due process clause "forbids the government to infringe fundamental liberty interests, *at all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." *Russ v. Watts*, 414 F.3d 783, 789 (7th Cir. 2005) (citing *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997)) (emphasis in original); *see also Collins v. Harker Heights*, 503 U.S. 115, 125 (1992) (observing that "the substantive component of the [Due Process] Clause [] protects individual liberty against certain government actions regardless of the fairness of the procedures used to implement them")

(citations omitted). Because the Act does not further a compelling governmental interest, nor is it narrowly tailored to achieve even the interests it claims to advance, the Act is unconstitutional and its enforcement should be enjoined by this Court.

The Act was purportedly passed out of concern for the health and development of fertilized eggs, embryos, fetuses, and the eventual health of a child when born. *See, e.g.,* Wis. Stat. §§ 48.01(1)(a) ("the paramount goal of this chapter is to protect…unborn children"); 48.01(am)(Act's purpose is "to recognize that unborn children have certain basis needs which must be provided for, including the need to develop physically to their potential and the need to be free from physical harm…"); 48.01(bm) (Act's purpose is "[t]o ensure that unborn children are protected against the harmful effects resulting from the habitual lack of self-control of their expectant mothers…"). The Act's Statement of Legislative Purpose does not express a concern for maternal health. But as the Supreme Court made explicit in *Casey*, even in the limited context of abortion, where courts have recognized that states have an interest in potential life after viability that provides them with the option of restricting one procedure (abortion), any such restrictions must remain subordinate to the woman's own right to life and health. 505 U.S. at 870-71. *See also Gonzales v. Carhart*, 550 U.S. 124, 161 (2007) (recognizing that a prohibition on certain abortion procedures would be unconstitutional "if it subjected women to significant health risks"). No Supreme Court decision recognizes a state interest in fetal life that justifies depriving women of their fundamental civil rights at any stage of their pregnancies (and even in the context of abortion post-viability, no state interest justifies depriving a pregnant woman of her right to have an abortion necessary to protect health or life.

Here, the Act not only deprives pregnant women of their civil rights throughout pregnancy, it subjects a woman to its strictures from the moment of fertilization—which means

that all Wisconsin women capable of becoming pregnant are subject to the Act before they are even pregnant. (*See* PFOF 177 & 178 (fertilization precedes pregnancy, which only occurs if the fertilized egg successfully implants in the uterus)). The state simply has no recognized compelling interest that justifies the Act's sweeping deprivations of fundamental constitutional rights of women both before and during pregnancy. [3]

Moreover, even if the Act did serve a compelling governmental interest (which it does not), it is not narrowly tailored to serve even its articulated interest in fetal health and thus cannot withstand strict scrutiny review for that independent reason. *See Entm't Software Ass'n v. Blagojevich*, 469 F.3d 641, 646 (7th Cir. 2006) ("To survive strict scrutiny review, [a statute] must be narrowly tailored to promote a compelling Government interest."). The Act's claimed interest in fetal health, separated from maternal health, is medically unsupportable; to effectuate any interest in fetal health, prenatal care for the pregnant woman is essential. (*See* PFOF 190 & 191). Yet the Act subjects women who become pregnant and use some (undefined) amount of controlled substances or alcohol to state custody and involuntary medical treatment, in direct contradiction of the medical and public health consensus regarding appropriate prenatal care.

Authorizing health care providers to report pregnant patients to child welfare authorities, who collaborate with law enforcement, as the Act specifically provides, *see* Wis. Stat. § 48.981(2)(d), is antithetical to the physician/patient trust relationship. As the Supreme Court recognized in *Jaffe v. Redmond*, 518 U.S. 1, 10 (1997), "the mere possibility of disclosure [of

[3] Wisconsin legislative counsel partially recognized this problem, warning the Legislature that the Act had a "reasonable probability" of being found unconstitutional "as applied to previable unborn children." Gordon Malaise, Senior Legislative Attorney, Drafter's Note from the Legislative Reference Bureau, November 12, 1997 (Appendix 1); (PFOF 174). But this analysis was only partially correct, because it misinterpreted the state's interest in fetal life in the abortion context to mean that there is a stage of pregnancy during which a state can strip women of virtually all of their constitutional rights. Abortion jurisprudence merely provides that a state may prohibit abortion of a viable fetus when a woman's life or health is not at stake; it is a gross misreading of the decisions to suggest that the state has *carte blanche*, upon the point of fetal viability, to subject a pregnant woman to multiple violations of established constitutional liberties in the name of "fetal health."

patients' confidences] may impede development of the relationship necessary for successful treatment." Indeed, there is an overwhelming consensus among medical and public health organizations that threats of arrest, detention, and loss of parental rights *undermine* maternal, fetal, and child health by deterring women from seeking prenatal care or from speaking honestly with health care providers.[4] Among the organizations and individuals in this consensus are leaders in the care and treatment of pregnant women, including the American Congress of Obstetricians and Gynecologists.[5] Thus the Act actually undermines its alleged purpose, which necessarily means that it fails the narrow tailoring requirement of strict scrutiny review.

Not only does it undermine maternal, fetal and child health, the Act cannot survive strict scrutiny review for the additional reason that it mistakenly focuses on factors not scientifically proven to have a significant or unique impact on fetal health. The Act's Statement of Legislative Purpose says that it was enacted "[T]o ensure that unborn children are protected against the harmful effects resulting from the habitual lack of self-control of their expectant mothers in the

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[4] *See, e.g., Ferguson v. City of Charleston*, 532 U.S. 67, 85 n.23 (2001) (noting the "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"); National Perinatal Association, Position Statement, *Substance Abuse Among Pregnant Women* (December 2013); American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion 321, Maternal Decision Making, Ethics, and the Law* (Nov. 2005); National Organization on Fetal Alcohol Syndrome, Policy Statement, *Pregnant Women Who Drink Alcohol Need Treatment, Not Prison* (March 23, 2004); American Psychiatric Association, Position Statement, *Care of Pregnant and Newly Delivered Women Addicts*, APA Document Reference No. 200101 (March 2001); American Nurses Association, *Position Statement on Opposition to Criminal Prosecution of Women for Use of Drugs While Pregnant and Support for Treatment Services for Alcohol and Drug Dependent Women of Childbearing Age* (Apr. 5, 1991); U.S. Gen. Accounting Office, GAO/HRD-90-138, Report to the Chairman, Comm. on Finance, U.S. Senate, *Drug-Exposed Infants: A Generation at Risk* 9 (1990); Report of American Medical Association Board of Trustees*, Legal Interventions During Pregnancy*, 264 JAMA 2663, 267 (1990); American Medical Association, *Treatment Versus Criminalization: Physician Role in Drug Addiction During Pregnancy*, Resolution 131 (1990); American Academy of Pediatrics, *Committee on Substance Abuse, Drug Exposed Infants*, 86 Pediatrics 639, 641 (1990); American Public Health Association, Policy Statement No. 9020, *Illicit Drug Use by Pregnant Women*, 8 Am. J. Pub. Health 240 (1990); March of Dimes, *Statement on Maternal Drug Abuse* (1990); National Association for Perinatal Addiction Research and Education, *Criminalization of Prenatal Drug Use: Punitive Measures Will Be Counterproductive* (1990); (Appendix 8, Medical Groups Position Statements).

[5] Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, Committee Opinion 473, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, 117 Obst. & Gyn. 200 (2011) ("Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing.") (Appendix 6).

use of alcohol beverages, controlled substances or controlled substance analogs exhibited to a severe degree." Wis. Stat. § 48.01(bm). However, the popular conception that drug use and any amount of alcohol ingestion during pregnancy automatically lead to "harmful effects" is not supported by reputable scientific analysis and evidence-based research. In fact, a quantifiable, definitive connection between ingestion of illegal drugs during pregnancy and particular negative pregnancy outcomes is not supported as a matter of science.

While a newborn exposed in utero to *opiates* – a controlled substance that may either be prescribed to the pregnant woman or used illegally – may experience neonatal abstinence syndrome, that condition is diagnosable and treatable and is not associated with long-term ill health effects. Robert Newman, et al., *Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women*, (March 11, 2013) (Appendix 7) ("[W]hen controlling for factors such as economic status, access to healthcare, and concomitant medical problems, including use of nicotine products and alcohol, decades of studies reported in the professional literature have failed to demonstrate *any* long-term adverse sequelae associated with prenatal exposure to opiates, legal or illegal.") (emphasis in original). No such symptoms have been found to occur following prenatal cocaine or methamphetamine exposure. David C. Lewis, et al., *Open Letter to the Media*, (Feb. 25, 2004) (Appendix 4) & *Open Letter from Doctors Scientists, & Specialists Urging Major Media Outlets Not to Create "Meth Baby" Myth*, (July 27, 2005) (Appendix 5).

Even at the time the Act was passed, researchers had long been calling for caution and pointing to a lack of scientific basis for the disproportionate public concern about the effects of drug use, particularly cocaine, by pregnant women. *See*, *e.g.,* Deborah A. Frank & Barry S. Zuckerman, *Children Exposed to Cocaine Prenatally: Pieces of the Puzzle*, 15 Neurotoxicology

and Teratology 298-300 (1993) (concluding that a rush to judgment based on insufficient evidence "ultimately discredits our scientific endeavor and may inflict immeasurable and unjustifiable social damage"); Linda C. Mayes et al., *The Problem of Prenatal Cocaine Exposure: A Rush to Judgment*, 267 JAMA 406 *passim* (1992) (recommending "suspension of judgment about the developmental outcome of cocaine-exposed babies until solid scientific data are available"). In the decades since, this solid data has yet to materialize. Robert Newman, et al., *Open Letter*, *supra*. (Appendix 7).

Similar assumptions about other drugs, while widely held, have not been supported by medical research. *See* David C. Lewis, et al., *Open Letter re "Meth Baby" Myth*, *supra*. (Appendix 5). While no one recommends use of a wide variety of legal or illegal controlled substances during pregnancy, researchers have simply not found that exposure to any of the criminalized drugs—including methamphetamine and marijuana—pose risks of harm greater than or substantially different from exposure to cigarettes (nicotine). Indeed, risks of harm from cigarettes have been shown to be more significant and are far better established. (PFOF 182 & 188).

Although one study has suggested that low birth weight may be an effect of prenatal methamphetamine exposure, it cannot account for the caregiving environment and the role it plays in child development, nor could it disaggregate the effects of cigarette and alcohol use, which were higher in the methamphetamine group than the control group. (PFOF 181, 183 & 184). This study considered only women and their babies where one or the other or both had tested positive for drugs at birth. (PFOF 184). Thus, the study results cannot be extrapolated to exposure that occurs only early in pregnancy. (PFOF 184). As for marijuana, prenatal exposure is not linked to birth defects. (PFOF 185). Although some studies suggest that marijuana use

during pregnancy may lead to lower birth weight, other studies counter that conclusion. (PFOF 186). There is no conclusive evidence that marijuana use is likely to harm a developing fetus. (PFOF 187).

While fetal alcohol syndrome is a documented consequence of prenatal exposure to large quantities of alcoholic beverages, whether moderate or limited alcohol consumption during pregnancy causes any harm to a developing fetus is not well established. (PFOF 189).[6] Tobacco use, on the other hand, which is not covered by the Act, is demonstrably associated with stillbirth, low birth weight, and other negative pregnancy outcomes. (PFOF 182 & 188).

In short, the overwhelming consensus among medical experts and social scientists is that punitive laws like the Act are detrimental to fetal health because they discourage women from seeking prenatal care, and research indicates that risks associated with the use of controlled substances and alcohol during pregnancy are not unique, quantifiable, necessarily substantial, or certain. A statute seeking to address some kind of problem is only "narrowly tailored," for the purposes of strict scrutiny review, "if it targets and eliminates no more than the exact source of the evil it seeks to remedy." *Entm't Softward Ass'n*, 469 F.3d 641. Because the Act does not advance the interests of maternal, fetal, or child health, but in fact penalizes women like Ms. Loertscher who seek prenatal care, all in the name of addressing a problem—the harms wrought by drug and alcohol use by pregnant women—that has been disproportionately overstated, the Act is not narrowly tailored to serve any state interest.

The Act's infringement of a woman's fundamental liberty interests is extreme: state custody, incarceration, state control of medical decision making, coercion to terminate a pregnancy, and potential loss of a child, all burden "those fundamental rights and liberties which

[6] In Ms. Loertscher's case her untreated hypothyroidism posed a far greater risk to her pregnancy than did her drug and alcohol use. (PFOF 173).

are, objectively, deeply rooted in this Nation's history and tradition," *Glucksberg*, 521 U.S. at 720-21, and significantly encroach on "the respect the Constitution demands for the autonomy of the person." *Lawrence v. Texas*, 539 U.S. 558, 574 (2003). Any state law that so heavily burdens "the exercise of a fundamental liberty interest requires a commensurably substantial justification in order to place the legislation within the realm of the reasonable." *Glucksberg*, 521 U.S. at 767 n.8 (Souter, J. concurring). Because no such justification exists for the heavy burden the Act places on fundamental liberties, the Act is unconstitutional on its face.

C. The Act Places An Undue Burden On A Woman's Substantive Due Process Right To Decide to Terminate A Pregnancy

Yet another inevitable consequence flowing from the terms of the Act is an undue burden on a woman's right to choose to terminate a pregnancy. In *Planned Parenthood v. Casey*, the Supreme Court held that "where state regulation imposes an undue burden on a woman's ability to [obtain an abortion,] the power of the State reach[es] into the heart of the liberty protected by the Due Process Clause." 505 U.S. at 874. A restriction amounts to an "undue burden" if its "purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Id*. at 878. The substantial obstacle must be present within "a large fraction of the cases in which [it] is relevant." *Id*. at 895.

On its face, the Act places just such a substantial obstacle in the path of women seeking to end a pregnancy. The Act authorizes detention of pregnant women throughout pregnancy, without any guidance as to whether and how an abortion may be obtained, *see, e.g,* Wis. Stat. §§ 48.193(1)(d)(2), 48.207(1m), 48.347(3); it authorizes appointment of GALs to act in the supposed best interests of fertilized eggs, embryos and fetuses, and thus presumably would oppose efforts to end a pregnancy, *see* Wis. Stat. § 48.235(1)(f); Wis. Stat. § 48.235(3)(b)(2) (GAL must make "clear and specific recommendations" to the court concerning "best interests of

the …unborn child at every stage of the proceeding"); and it makes access to abortion subject to state approval and modification of a court order if a pregnant woman has been ordered to inpatient drug treatment, *see* Wis. Stat. § 48.357(1) & (2m) (juvenile court must approve change in placement of adult expectant mother).

Selecting the most troubling provisions of this Act's violations of pregnant women's constitutional rights is a challenge, but one of the more disturbing terms of the Act empowers courts to impose "rules for the adult expectant mother's conduct, designed for the physical well-being of the unborn child" whenever a pregnant woman is placed under the "supervision" of a state agency or "an adult relative or friend of the adult expectant mother." *See* Wis. Stat. § 48.347(2). As the Supreme Court held in *Casey*, a State cannot give even the presumed father (a husband) "the kind of dominion over his wife that parents have over their children." *Casey*, 505 U.S. at 898 (striking down Pennsylvania's husband-notification abortion requirement). State authorization of others to control her "conduct" *vis a vis* her pregnancy impermissibly burdens a woman's due process right to terminate a pregnancy and thus the Act should be enjoined. *See Planned Parenthood of Wisconsin v. J.B. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013) (affirming preliminary injunction against enforcement of state law requiring that doctors performing abortions have admitting privileges at hospital within 30 miles from clinic in which abortion is performed because requirement was likely an undue burden on right to abortion); *McCormack v. Hiedeman*, 694 F.3d 1004, 1014-15 (9th Cir. 2012) (holding that imposing criminal penalties on pregnant women for self-inducing an abortion creates an undue burden); *Jackson Women's Health Org. v. Currier*, 2013 WL 1624365, at *5 (S.D. Miss. Apr. 15, 2013) (granting preliminary injunction against regulation of abortion providers which created an undue burden by forcing all women to leave the state to obtain abortion services); *accord Monmouth*

Cnty. Corr. Institutional Inmates v. Lanzaro, 834 F.2d 326 (3d Cir. 1987), *cert. denied*, 486 U.S. 1006 (1988) (finding deliberate indifference to serious medical need in violation of the Eighth Amendment in a prison's policy of providing abortion only after court-ordered release).

II. PLAINTIFF IS LIKELY TO SUCCEED ON THE MERITS OF HER CLAIM THAT THE ACT IS VOID FOR VAGUENESS UNDER THE DUE PROCESS CLAUSE

The Act is void for vagueness on due process grounds because, on its face, it "fail[s] to provide the kind of notice that will enable ordinary people to understand what conduct it prohibits," and because it "authorize[s] and even encourage[s] arbitrary and discriminatory enforcement." *See City of Chicago v. Morales*, 527 U.S. 41, 56 (1999). Because, as discussed in Section I.A, above, the Act threatens the exercise of constitutionally protected rights, the Due Process Clause demands stringent review for vagueness. *See Vill. of Hoffman Estates*, 455 U.S. 489, 499 (1982) ("[P]erhaps the most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of constitutionally protected rights"); *Record Head Corp. v. Sachen*, 682 F.2d 672, 674 (7th Cir. 1982) ("[V]agueness is tested by more exacting standards when constitutionally protected rights are threatened[.]").

First, the Act is void for vagueness because it fails to provide Wisconsin women capable of becoming pregnant with constitutionally adequate notice of what conduct might subject them to its enforcement. [7] Yet "[d]ue process requires that all be informed as to what the State commands or forbids." *Smith v. Goguen*, 415 U.S. 566, 574 (1974). "The dividing line between what is lawful and unlawful cannot be left to conjecture," and a citizen cannot be deprived of her liberty based upon "statutes whose mandates are so uncertain that they will reasonably admit of

[7] The Act by its terms applies from the instant of fertilization and thus renders a woman subject to its enforcement before she could possibly know she is pregnant. *See* Wis. Stat. §§ 48.01(1); 48.02(19) (PFOF 178). Indeed, the proceedings against Ms. Loertscher all flowed from conduct occurring before she knew she was pregnant and in fact believed she was not likely to become pregnant.

different constructions." *Connally v. General Const. Co.*, 269 U.S. 385, 393 (1926); *see also Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972) ("It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined.").

The Act authorizes courts and other state actors to forcibly take pregnant women into state custody and subject them to involuntary medical treatment and state supervision on the basis of five highly-subjective, standard-less, terms: that a woman (1) "*habitually* lacks (2) *self-control*" (3) "to a *severe* degree" in a manner creating (4) "a *substantial* risk" that the pregnancy will be (5) "*seriously* affected or endangered." Wis. Stat. § 48.133. (emphasis added). None of these terms is defined in the Act, and these terms are not consistent with the medical definition of substance use disorders or the current scientific consensus regarding the documented impacts of the use of various substances during pregnancy. *See* Section I.B, *supra*; *accord* Linda Hisgen, Director, Bureau of Programs and Policies, State of Wis. Dep't of Health and Fam. Serv's, *1997 Wisconsin Act 292*, at 1-2 (Memorandum, July 23, 1998) (Appendix 2) (noting that determining under the statute whether the woman's drug use poses serious physical harm, "would have to be done on speculation, since fetal impact research is not conclusive").

Notably, the Act does not use the medically recognized terms "drug-dependent," "alcoholic," and "alcoholism," which *are* significant diagnoses with established criteria defined in Wisconsin's Mental Health Act, which governs civil commitment. *See* Wis. Stat. §§ 51.01(1), (1m) & (8); *c.f.* Wis. Stat. §§ 48.135(1), 48.203(4) (using the terms "drug dependent" and "alcoholism" in provisions of the Act addressing when application of Wisconsin's civil commitment statute, Wis. Stat. § 51, is appropriate). And the Act applies to the use of "controlled substances," a term that includes numerous medications that may be prescribed or obtained over-

the-counter without a prescription. *See* Wis. Stat. § 961.04(4).[8] It also applies to the use of "alcohol beverages." *See* Wis. Stat. § 48.133. Thus merely obeying Wisconsin's criminal prohibition against illegal possession of controlled substances[9] will not ensure that a Wisconsin woman capable of becoming pregnant will not be subject to the Act. Indeed, one of the stated grounds for subjecting Ms. Loertscher to the Act in this case was her alleged misuse of alcohol during pregnancy—her consumption of one half of one glass of wine after she became pregnant but before she knew she was pregnant. (PFOF 26).

Further, the absence of a definition for the term "habitually" stands in stark contrast to all other Wisconsin statutes using that term, which make clear the term applies when an individual has acted in a particular manner which can, and has been, documented a specific number of

[8] Wisconsin's Uniform Controlled Substances Act ("UCSA") defines a "controlled substance" as any substance included in one of the five schedules provided under Chapter 961. Wis. Stat. § 961.01(4). Modeled on the federal Controlled Substances Act, 21 U.S.C. § 801 *et seq*., the UCSA organizes substances into particular schedules based on the perceived risk of abuse associated with a given drug, classifying the most dangerous substances in Schedule I and the least dangerous substances in Schedule V. Specifically, the UCSA defines Schedule I substances as substances with a high potential for abuse, not currently accepted for medical use in treatment in the United States, and lacking acceptable safety for use in treatment under medical supervision. Wis. Stat. § 961.13. Examples include heroin, lysergic acid diethylamide (commonly known as LSD), and tetrahydrocannabinols (commonly known as THC) in any form, including tetrahydrocannabinols contained in marijuana. Wis. Stat. §§ 961.14(3)(k), (4)(j), (t). Similarly, Schedule II substances are defined as substances with a high potential for abuse that can lead to severe dependence; however, unlike Schedule I substances, Schedule II substances have a currently accepted medical use in treatment in the United States. Wis. Stat. § 961.15. Schedule II drugs include morphine, oxycodone, amphetamine ("Adderall"), methamphetamine, ("Desoxyn"), and methylphenidate ("Ritalin"). *Id.* §§ 961.16(2)(a)(10)-(11), (5)(a)-(b), (d); *see also* Controlled Substance Schedules, U.S. Dep't of Jus., Office of Diversion Control, http://www.deadiversion.usdoj.gov/schedules/. Schedule III substances include products containing less than 90 milligrams of codeine per dosage unit, such as Tylenol with codeine. Wis. Stat. §§ 961.18(5)(a)-(b); *see also* Controlled Substance Schedules, U.S. Dep't of Jus., Office of Diversion Control, http://www.deadiversion.usdoj.gov/schedules. Schedule IV drugs include common prescription medications, such as alprazolam ("Xanax"), which is used to treat anxiety, and zolpidem ("Ambien"), which is used to treat insomnia. Wis. Stat. §§ 961.20(2)(a), (p); *see also* Controlled Substances Schedule, U.S. Dep't Jus., Office of Diversion Control, http://www.deadiversion.usdoj.gov/schedules/; Medication Guide: Ambien, FDA, http://www.fda.gov/downloads/Drugs/DrugSafety/ucm085906.pdf. Schedule V drugs include certain cough medicines containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams, such as "Robitussin AC," and pseudoephedrine ("Sudafed"), a decongestant used to treat the common cold. §§ 961.22(2)(a), (2m); *see also* Controlled Substances Schedule, U.S. Dep't Jus., Office of Diversion Control, http://www.deadiversion.usdoj.gov/schedules/.

[9] Wis. Stat. § 961.41(1) criminalizes illegal "manufacture, distribution, or delivery" of controlled substances. Wis. Stat. § 961(1m) criminalized illegal "possession with intention to manufacture, distribute or deliver" controlled substances. Nowhere does Wisconsin's UCSA penalize mere use of any controlled substance.

times. *See e.g.* Wis. Stat. § 125.04 & *State ex rel. Smith v. City of Oak Creek*, 139 Wis. 2d 788, 798-99 (1987) (person has "habitually been a law offender," for purposes of liquor licensing statute, when that individual has been documented to have previously violated the law); Wis. Stat. § 118.16 (a "habitual truant" is "a pupil who is absent from school… for part or all of 5 or more days…"); Wis. Stat. § 351.02 (a "habitual traffic offender" is an individual who has accumulated a certain number of specified violations within a five-year period). By contrast, nowhere does the Act provide guidance as to when an individual may be found to "habitually lack self-control." Thus there is no way for a Wisconsin woman to know the number of times or degree of alcohol or controlled substance use during her lifetime (including the use of drugs prescribed to her by her physician) that could render her subject to the Act in the event she ever becomes pregnant. Ms. Loertscher's case demonstrates that this risk is real: the "desk review" of the TCDHS "child maltreatment" determination cited Ms. Loertscher's use of alcohol "prior to conception" as one of the bases for the Department's determination, pursuant to Section 48.133, that she had maltreated her fetus due to her "habitual" misuse. (PFOF 166).

Not only does the Act fail to provide constitutionally adequate notice to those who may be swept within its ambit, it is void for vagueness for the independent reason that by "fail[ing] to provide a definite standard of conduct," it gives its multiple statutorily-authorized enforcers "unfettered freedom to act on nothing but their own preferences and beliefs." *Karlin v. Foust*, 188 F.3d 446, 465 (7th Cir. 1999) (citations omitted). Drug and alcohol use generally is a highly charged, politicized issue about which people often hold strong opinions that do not rely on scientific research or medical criteria. Indeed, many people are dramatically misinformed about the effects of in-utero drug and alcohol exposure, and moral outrage often substitutes for

scientific justification in discussions of drug and alcohol use by pregnant women.[10] Thus it is highly likely that there will be widely divergent views as to what degree of use is "habitual" or "severe," whether there is any risk to a pregnancy or a future child from that use, and what degree of risk is "substantial." Moreover, what constitutes "self-control," or its absence, is almost entirely in the eye of the beholder or—as is the case under the Act—the enforcer.

As the Supreme Court and the Seventh Circuit have made clear, a law delegating unfettered discretion to those enforcing it to determine to whom, and on what grounds, the law should be applied cannot survive due process vagueness review. *See Grayned v. City of Rockford*, 408 U.S. 104, 108-09 (1972) ("A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application"); *Record Head Corp.*, 682 F.2d at 678 (A law is unconstitutionally vague when it "leaves to the arresting or prosecuting authorities the job of determining, essentially without legislative guidance, what the prohibited offense is."). The Act does exactly this by inviting arbitrary and discriminatory enforcement under its standardless terms at all stages of proceedings under its auspices, from initial jurisdiction over pregnant women (or a woman hosting fertilized eggs prior to pregnancy) under Section 48.133, to their arrest, *see, e.g.,* Wis. Stat. § 48.193, detention, *see, e.g.,* Wis. Stat. § 48.205, involuntary treatment, *see., e.g.,* Wis. Stat. § 48.347, adjudication as abusers, *see* 48.981(3)(c)(5m), and eventual loss of their newborns. *See* Wis. Stat. §§ 48.347(7) & Wis. Stat. § 48.415(2)(a).

The opportunity for arbitrary and discriminatory enforcement extends beyond police officers to a host of health care providers, social workers, and legal system actors who are

[10] *See*, *e.g* David C. Lewis et al., *Open Letter to the Media*, (Feb. 25, 2004) (Appendix 4); David C. Lewis et al., *Open Letter From Doctors, Scientists & Specialists Urging Major Media Outlets Not to Create "Meth Baby" Myth*, (July 27, 2005) (Appendix 5); Robert G. Newman, et, al, *Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women*, (March 11, 2013) (Appendix 7).

granted enormous discretion by the Act to determine who should be subject to state custody and control, and what deprivation of a woman's constitutional liberties the enforcers believe should be inflicted. With its undefined, open-ended terminology the Act violates "the requirement that a legislature establish minimal guidelines to govern law enforcement." *Kolender v. Lawson*, 461 U.S. 352, 358 (1983). Instead of providing such constitutionally required guidelines, the Act's "standardless sweep" simply allows its multiple enforcers "to pursue their personal predilections." *Smith v. Goguen*, 415 U.S. 566, 575 (1974). Thus, the Act is unconstitutional on its face because it is void for vagueness in violation of the Due Process Clause.

III. PLAINTIFF IS LIKELY TO SUCCEED ON THE MERITS OF HER CLAIM THAT THE ACT IS UNCONSTITUTIONAL UNDER THE EQUAL PROTECTION CLAUSE

The Act targets pregnant women for unequal treatment and infringes numerous fundamental rights. Subjecting pregnant women to select burdens violates their right to equal protection of the laws, in furtherance of no compelling, important, or even legitimate state interest. First, when state laws directed at a class of people infringe the fundamental rights of the targeted group, these laws violate the Equal Protection Clause unless they can satisfy strict scrutiny. *Shapiro v. Thompson,* 394 U.S. 618, 638 (1969). As described above, the Act strips Wisconsin pregnant women of a host of fundamental rights, in service of no compelling interest. For that reason, the Act violates the Equal Protection Clause and is facially unconstitutional.

The Act also specifically targets Wisconsin citizens on the basis of gender, and thus is also subject to heightened, or "intermediate" scrutiny under the Equal Protection clause. *See U.S. v. Virginia*, 518 U.S. 515, 555 (1996) ("all gender-based classifications today warrant heightened scrutiny") (citation omitted); *Hayden v. Greensburg Community School Corporation*, 743 F.3d 569, 577 (7th Cir. 2014) ("Gender is a quasi-suspect class that triggers intermediate scrutiny in the equal protection context."). The Act fails this level of scrutiny, because it is not substantially

related to an important governmental objective. *See Craig v. Boren*, 429 U.S. 190, 197-8 (1976).

Finally, the Act does not afford pregnant women targeted under the Act with the same procedural protections guaranteed by Wisconsin's Mental Health Act to individuals facing involuntary civil commitment. This arbitrary denial is not rationally related to any legitimate governmental interest, and thus the Act cannot withstand rational basis review. *See Cleburne v. Cleburne Living Center*, 473 U.S. 432, 440 (1985).

A. The Act Violates Pregnant Women's Rights To Equal Protection By Infringing On Their Fundamental Rights In Service Of No Compelling Interest

As described in Section I, the Act violates numerous recognized fundamental rights, including rights to freedom from bodily restraint, bodily integrity, medical decision-making, and procreative freedom. These impositions are also invalid under the Equal Protection Clause, which requires strict scrutiny of any state classification that infringes fundamental rights. *Shapiro v. Thompson*, 394 U.S. 618 (1969) (state exclusion of new residents from receiving welfare violated the new residents fundamental right to travel); *see also M.L.B. v. S.L.J.* 519 U.S. 102 (1996) (failure to provide a transcript for indigent parent whose parental rights were terminated precluded her from appealing the termination, thus violating the Equal Protection Clause by burdening her fundamental right to care, custody and control of her children). As in these cases, the fundamental rights burdened by the Act require its justification by a compelling state interest. *Shapiro*, 394 U.S. at 638. As set forth in Section I, no compelling interest justifies the Act's incursions into the fundamental constitutional rights of pregnant women, nor is the Act narrowly tailored to achieve the interests it purports to advance. Accordingly, the Act violates the rights of Ms. Loertscher —and all Wisconsin women whose liberties are infringed by the Act— to equal protection of the laws.

B. The Act Targets People With The Capacity To Become Pregnant: Women

The Act's provisions apply only to "expectant mothers." *See, e.g.,* Wis. Stat. § 48.205(1m) (authorizing holding an "adult expectant mother" in custody). While the term is undefined, it applies only to people that could be "expectant mothers," namely, women.[11] Indeed, it applies to Wisconsin women even *before* they are pregnant, as the Act defines an "unborn child" as existing from the moment of fertilization (as noted above, pregnancy is a post-fertilization event that may or may not happen) (*See* PFOF 177 & 178); Wis. Stat. § 48.02(19).

The Act's targeting of "expectant mothers" translates directly into obligations and potential penalties on Wisconsin women who have the capacity to become pregnant, risks that Wisconsin men with procreative capacity will never face. In addition to the numerous deprivations of civil rights permitted by the Act, this law requires all Wisconsin women to be ever vigilant, and correct, concerning whether they might be pregnant or carrying a fertilized egg—the latter a biological event that cannot be detected by any medical test. (PFOF 178). If they are not, Wisconsin women might consume controlled substances (including common prescription and over-the-counter drugs) or alcohol while pregnant or carrying a fertilized egg, and thereby become subject to the Act with its attendant losses of liberty and other deprivations of constitutional rights. (This is exactly what happened to Ms. Loertscher—her use of drugs and

[11] In *Geduldig v. Aiello,* 417 U.S. 484 (1974), the Supreme Court held that a state benefit scheme for employee disability that excluded coverage for pregnancy did not discriminate on the basis of gender, reasoning that not every classification on the basis of pregnancy is necessarily discriminatory in violation of the Equal Protection clause. *Id.* at 497, n.20. Shortly after the Supreme Court extended this reasoning to a claim against a private employer brought under Title VII of the Civil Rights Act in *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125 (1976), Congress enacted the Pregnancy Discrimination Act ("PDA"), to expressly overrule *Gilbert* and affirm Congress' understanding that, under Title VII, discrimination based on pregnancy is sex discrimination. *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669 (U.S. 1983). Although *Geduldig* concerned the Equal Protection Clause rather than Title VII, its questionable holding has been only rarely relied upon in the decades since. But this is not a case where state employment benefits are at stake between otherwise similarly situated employees; rather, this is a case where women's civil rights are burdened in ways that no man would ever face. Here, the Act distinguishes between the people who have the capacity to become pregnant (women) and those who cannot (men). Accordingly, *Geduldig v. Aiello*, whatever vitality its reasoning retains, is inapposite.

alcohol before she was pregnant and before she knew she was pregnant became the basis for the multiple deprivations the state subjected her to under the Act.)[12] In short, the Act imposes unique obligations and potential penalties only on those with the capacity to become pregnant.

Wisconsin men, who lack the capacity to become pregnant, face no similar deprivation of their constitutional rights for procreating and using alcohol or controlled substances. Alcohol use by adults is legal in Wisconsin, and controlled substances other than those enumerated in Schedule I are also legally available in the state. *See* Wis. Stat. § 961.01 *et seq.* Moreover, while the State criminalizes illegal possession of controlled substances with the intent to sell them, mere use of these substances alone is not itself criminalized. *See* Wis. Stat. § 961.41. Thus the Act exposes all Wisconsin women capable of becoming pregnant to a significant risk of deprivation of their fundamental rights, and holds them to a different standard of conduct than state law requires of Wisconsin men who are capable of procreating.

C. The Act's Gender-Based Classification Is Not Substantially Related To The Achievement Of An Important Governmental Objective

The Supreme Court has made clear that "the party seeking to uphold a statute that classifies individuals on the basis of their gender must carry the burden of showing an 'exceedingly persuasive justification' for the classification." *Mississippi Univ. for Women v. Hogan,* 458 U.S. 718, 724 (1982). This burden may be met only by demonstrating that the classification serves "important governmental objectives," and that the discriminatory means employed in furtherance of those objectives are "substantially related to the achievement of those objectives." *Id*. Defendants cannot meet this burden, as singling out pregnant women for the massive intrusions permitted by the Act are not justified by any interest.

First, as discussed above in Section I.B, the Act does not advance any purported state

[12] As noted in Section II, *supra*, the child maltreatment determination issued by the TCDHS cited Ms. Loertscher's preconception conduct as one of the bases for the determination that she had maltreated her fetus. (PFOF 166).

interest in maternal, fetal, or child health, *because* threats of arrest, detention, and loss of parental rights are likely to deter women from approaching medical personnel with candor about private matters during pregnancy, or even seeking prenatal care at all. Similarly, as explained above, the Act targets women who have allegedly used substances during their pregnancy, even though the substances targeted by the Act are not more or even as dangerous to fetal health as other prenatal exposures, including lack of prenatal care—the very thing the Act makes more likely by undermining women's trust in their health care providers.

Moreover, the Act's usurpation of a woman's fundamental right to make her own medical decisions and to determine what course of treatment is best for herself and her pregnancy is not only contrary to accepted standards of medical treatment and medical ethics, it also actually increases risks of negative health outcomes for pregnant women and the fertilized eggs, embryos, and fetuses that they carry and sustain. (*See* PFOF 190 & 191). For example, the Act authorizes appointment of a GAL as the independent representative of the fertilized egg, embryo, or fetus, *see* Wis. Stat. § 48.235, and requires that the interests of the fertilized egg, embryo or fetus "shall always be of paramount consideration," *see* Wis. Stat. § 48.01(1). The Act thus presumes that a GAL—who is not required to hold any special qualifications in obstetrics and gynecology, prenatal care, or drug treatment, and has no statutory obligation to consult with any experts in those fields—is in a better position than the woman, who carries the pregnancy and its attendant risks, to decide what is best for the fetus she carries. In carrying out their duties, GALs have no statutory obligation to consider the impact of their decisions on the health of the pregnant women carrying the fetuses the GALs represent.

But this Court need not look very far to see the ways in which the Act harms maternal and fetal health. Ms. Loertscher's situation demonstrates precisely what the Act was designed to

do. Ms. Loertscher voluntarily sought medical help for her severe hypothyroidism, depression and associated mental health symptoms, and severe head and neck pain. (PFOF 33-36). She sought this care for the purpose of protecting both her health and, in the event that her then-suspected pregnancy might be confirmed, the health of her pregnancy. (PFOF 36). Taking immediate steps to safeguard her health and the health of her pregnancy is what any rational state actor interested in furthering fetal health would want a pregnant woman in Ms. Loertscher's situation to do. Rather than support her in this endeavor, the State's response under the Act was to interrupt her chosen course of treatment with state efforts to collect medical information that could be and then was used to invoke the Act.

Under the Act's authority, Defendants ordered Ms. Loertscher detained in the hospital where she had sought treatment, and then ordered her moved to a behavioral drug treatment facility in the absence of any evidence she had an actual substance use disorder. (PFOF 68, 69, 90, 91, 168 & 171). When she declined to accept this forced treatment, state actors ultimately placed her in jail[13]—as state law authorizes for any woman deemed non-compliant with a court order issued under the Act. *See* Wis. Stat. §§ 785.01-785.04.

In effect, the Act treats the woman, once pregnant, as automatically subject to deprivation of core constitutional liberties. This alone should confirm the Act's unconstitutionality as sex discrimination. But this course of action also profoundly undermines state interests, because it is

[13] Predictably, once the state jailed Ms. Loertscher, the threats to her health increased dramatically. *See, e.g.,* Rachel Roth and Sara Ainsworth, "*If They Hand You a Paper, You Sign It": A Call To End the Sterilization of Women in Prison*, 26 Hastings Women's L.J. 7, 27 (2015) (noting that prison is a dangerous place to be pregnant, "as demonstrated in numerous lawsuits brought by women whose experiences of substandard or total denial of care resulted in miscarriages, stillbirths, or the deaths of their newborn babies."). Ms. Loertscher was put in solitary confinement for a day and a half (PFOF 150-152); denied her prescription medication for hypothyroidism, a condition that heightens risk of miscarriage (PFOF 11, 139-141); denied access to any prenatal care and forced to miss scheduled appointments with her OB GYN (PFOF 138, 142 & 143); treated with deliberate indifference by jail staff and the jail doctor when she exhibited troubling pregnancy symptoms (PFOF 143 & 147); and subjected to extreme and needless stress (PFOF 148-151). While the specifics of her incarceration may have been unique to this case, incarceration is authorized for any woman deemed in contempt of a court order infringing her fundamental rights under the Act.

diametrically opposed to the interests of a woman's health, the wellbeing of her pregnancy, and, potentially, to the wellbeing of her future child. (*See, e.g.*, PFOF 190 & 191). In short, what happened to Ms. Loertscher under the Act demonstrates that the Act is not "substantially related" to furthering any type of governmental interest in the health of a pregnancy or the health of a child resulting from that pregnancy. Because there is no "exceedingly persuasive" justification for this gender-based discrimination, the Act is unconstitutional under the Equal Protection Clause.

D. There Is No Rational Basis For Denying Pregnant Women The Same Procedural Protections Afforded Individuals Facing Civil Commitment Under Wisconsin's Mental Health Act

The Act also violates Equal Protection because it restrains pregnant women's liberty without affording them the same procedural protections as individuals who are involuntarily committed under Wisconsin's Mental Health Act. *See* Wis. Stat. § 51.01 *et seq*. Wisconsin Statute Section 51.20 sets out procedures for civil commitment on the basis of drug or alcohol use, mental illness, or other factors, when an individual is demonstrated by clear and convincing evidence to be a danger to herself or others. The Mental Health Act provides important procedural protections to individuals threatened with civil commitment that are not available to pregnant women similarly threatened with involuntary confinement and medical treatment under the Act, including the right to immediate appointment of counsel without regard to indigency, and the protections afforded by the requirement that qualified state-appointment experts examine the individual and provide reliable scientific testimony at the hearing to determine whether the statutory requirements have been met.

Denying pregnant women the same procedural protections guaranteed all other Wisconsin citizens facing involuntary confinement and forced medical treatment is not rationally related to any legitimate state interest, and thus violates the constitutional right to equal

protection under even the lenient rational basis test. *See Cleburne v. Cleburne Living Center*, 473 U.S. 432, 439 (1985) ("The Equal Protection Clause of the Fourteenth Amendment commands that no State shall deny to any person within its jurisdiction the equal protection of the laws, which is essentially a direction that all persons similarly situated should be treated alike.").

The Wisconsin Mental Health Act provides for the appointment of counsel *immediately* upon the filing of a petition for commitment, without regard to proof of indigency. Wis. Stat. § 51.20(3) ("At the time of the filing of the petition the court *shall* assure that the subject individual is represented by adversary counsel by referring the individual to the state public defender, who *shall* appoint counsel for the individual without a determination of indigency[.]") (emphasis added). By contrast, under the Act, pregnant women are not guaranteed counsel until a fact-finding hearing at which they face involuntary placement outside their home. If the state seeks to restrain a pregnant woman's liberty and medical-decision making without attempting to place her outside the home, she is not entitled to the appointment of counsel at all. *See* Wis. Stat. § 48.23(2m). Additionally, appointment of counsel under the Act is limited to individuals who can prove indigency as statutorily defined. Wis. Stat. § 48.23(4). By the time a pregnant woman is appointed counsel under the Act, if she even qualifies for the appointment, she may have been held in custody for up to 30 days, *see* Wis. Stat. § 48.305, and will have faced an initial "plea hearing" at which she must make crucial decisions about defending herself, including invoking or waiving her right to a jury trial and entering a plea on her own behalf—all without the benefit of legal representation, *see* Wis. Stat. § 48.30(1) &(2).

In fact, Ms. Loertscher faced that proceeding without legal representation, despite having repeatedly expressed her desire for counsel (*see* PFOF 73); the GAL appointed to represent Ms. Loertscher's fetus appeared at the plea hearing and entered a plea on behalf of her fetus

admitting all the allegations against Ms. Loertscher. (PFOF 125). Denying a pregnant woman facing involuntary commitment, confinement, and forced medical treatment the representation guaranteed to other individuals facing involuntary civil commitment cannot be rationally related to any legitimate state interest in protecting her health or the health of her pregnancy.

Wisconsin's Mental Health Act also provides for the automatic appointment of two experts (psychiatrists and/or psychologists) to personally examine the individual subject to involuntary commitment, and requires that the appointed experts "shall have specialized knowledge determined by the court to be appropriate to the needs of the subject individual." Wis. Stat. § 51.20(9)(a)(1). Additionally, an individual facing involuntary commitment has a right to retain an additional expert, or to petition the court for the appointment of an additional expert if the individual is indigent. *See* Wis. Stat. § 51.20(9)(3). By contrast, the Act makes no such provision for the appointment of experts and does not require expert testimony at the fact-finding hearing determining whether a woman should be subject to the Act. *See* Wis. Stat. § 48.31.

However, the Act requires proof not only of "habitual" controlled substance or alcohol use by a pregnant woman deemed to lack "self-control," but also evidence of some (undefined) degree of harm or risk of harm to a fetus or child resulting from that use. *See* Wis. Stat. § 48.133. Yet establishing whether exposure to a particular drug during pregnancy is causally related to harm to a fetus or child requires reliable, scientifically grounded expert testimony. *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993), concerned this exact issue: the plaintiffs in that case alleged that Merrell Dow's antinausea drug, Bendectin, had caused birth defects when taken during pregnancy. *Id*. at 582. The Supreme Court held that proof of causation must be established by "reliable" expert testimony based on scientific knowledge:

> The adjective "scientific" implies a grounding in the methods and procedures of science. Similarly, the word "knowledge" connotes more than subjective belief or

> unsupported speculation. The term applies to any body of known facts or to any body of ideas inferred from such facts or accepted truths on good grounds.

Id. at 590.[14] Wisconsin has adopted the *Daubert* standard for determining the scientific reliability of expert testimony. *See* Wis. Stat. § 907.02.

Establishing by clear and convincing evidence that a pregnant woman's use of controlled substances or alcohol poses a "substantial risk" of harm to her fertilized egg, embryo, or fetus, or to her future child, necessitates the use of reliable, scientifically grounded expert testimony every bit as much as establishing that the standards have been met for involuntary commitment under the Mental Health Act. Yet before an individual may be involuntarily committed, he or she must have been examined by at least two, and potentially three, qualified experts who will assist the court in determining whether the standards for involuntary commitment have been met; the Act provides no such safeguard of evidentiary reliability for a pregnant woman who, once subjected to the Act, faces loss of her liberty, and even the loss of her future child.

As the Supreme Court has made clear, "[e]qual protection of the laws is not achieved through indiscriminate imposition of inequalities." *Sweatt v. Painter*, 339 U.S. 629, 635 (1950). By requiring under the rational basis test that a "classification bear a rational relationship to an independent and legitimate legislative end, [courts] ensure that classifications are not drawn for the purpose of disadvantaging the group burdened by the law." *Romer v. Evans*, 517 U.S. 620, 633 (1996). Accordingly, a state "may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *Cleburne*, 473 U.S. at 446.

[14] Ultimately, the Ninth Circuit on remand determined that Plaintiffs' proffered testimony was insufficiently reliable under the new evidentiary standard announced by the Supreme Court to allow them to establish a triable issue of fact as to whether Bendectin had caused their birth defects. *See Daubert v. Merrell Dow Pharm., Inc.*, 43 F.3d 1311 (9th Cir.1995).

In this case, denying pregnant women the procedural protections afforded individuals facing civil commitment under Wisconsin's Mental Health Act bears no relationship to furthering maternal and fetal health. Indeed, arbitrarily denying pregnant women the same protections afforded other state citizens facing involuntary confinement and forced medical treatment under Wisconsin's Mental Health Act suggest a separate, non-legitimate purpose for the Act: the establishment of separate rights for fertilized eggs, embryos, and fetuses as part of a long-term plan to overturn *Roe v. Wade. See, e.g.*, Nora Caplan-Bricker, *How the "Crack Baby" Scare Armed the Pro-Life Cause*, New Republic, October 29, 2013, http://www.newrepublic.com/article/115396/how-crack-baby-scare-armed-pro-life-cause; Lynn D. Wardle, *Restricting Abortion Through Legislation*, *in* To Rescue The Future 101, 108 (Dave Andrusko ed., 1983) (describing how state legislatures can contribute to overturning *Roe v. Wade*, identifying one method as enacting legislation "to extend the maximum permissible protection for the unborn"); Mark S. Kende, *Michigan's Proposed Prenatal Protection Act: Undermining a Women's Right to an Abortion*, 5 Am. U. Gender & L. 247, 249 (1996) (describing a bill that would treat fetuses as persons, and punish a third party who injures a fetus, as having "received great support from 'Right to Life' groups").

But regardless of the true legislative intent of the Act, its denial to pregnant women of the procedural protections afforded other similarly situated individuals under the Mental Health Act cannot survive rational basis review under the equal protection clause. As the Supreme Court has made clear: "A law declaring that in general it shall be more difficult for one group of citizens to seek aid from the government is itself a denial of equal protection of the laws in the most literal sense. The guaranty of equal protection of the laws is a pledge of the protection of equal laws." *Romer*, 517 U.S. at 633. Because the Act violates this fundamental pledge to Wisconsin's

citizens, its violates the Equal Protection Clause.

IV. PLAINTIFF HAS NO ADEQUATE REMEDY AT LAW AND WILL SUFFER IRREPARABLE HARM IF THE ACT IS NOT ENJOINED

Ms. Loertscher has demonstrated that the Act is invalid on its face and that its enforcement violates her constitutional rights. Injunctive relief is necessary to protect her from irreparable injuries arising from these constitutional violations. It is well established that, for the purposes of obtaining injunctive relief, a plaintiff has no adequate remedy at law when an award of monetary damages would not adequately make her whole for the harm she has suffered. *See, e.g., Roland Machinery Co. v. Dresser Industries, Inc.*, 749 F.2d 380, 386 (7th Cir. 1984). The Seventh Circuit has also made clear that monetary damages alone cannot remedy infringements of vital constitutional liberties. *See Ezell v. City of Chicago*, 651 F.3d 684, 699 (7th Cir. 2011). Thus, in cases such as this one seeking preliminary injunctive relief from the violation of constitutional liberties, the inadequate remedy at law and irreparable harm factors converge. *See, e.g., id*; *American Civil Liberties Union of Illinois v. Alvarez*, 679 F.3d 583, 589 (7th Cir. 2012). Indeed, once a constitutional violation is established, no further showing of irreparable injury is necessary. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976) (loss of constitutional "freedoms… unquestionably constitutes irreparable injury"); *Ezell*, 651 F.3d at 699 (7th Cir. 2011) (holding that the infringement of constitutional rights by a facially invalid law causes irreparable harm); *Preston v. Thompson*, 589 F.2d 300, 303 n.3 (7th Cir. 1978) ("The existence of a continuing constitutional violation constitutes proof of an irreparable harm.").

Absent preliminary injunctive relief from this Court, the violation of Ms. Loertscher's constitutional rights will continue. She is currently deprived of the ability to make her own medical decisions, and is forced to submit to regular drug testing and to continued supervision by TCDHS personnel, all under threat of being held in contempt of court if she fails to comply with

any of these conditions. (PFOF 156 & 157). And, critically, Ms. Loertscher faces undergoing the impending birth of her first child, due January 29, 2015, (PFOF 7), under the supervision of state actors authorized to enforce the Act against her and supplant her own medical decision-making with their own; these actors include a GAL who remains appointed under the Consent Decree, and who is empowered by the Act to potentially override her decisions regarding her own health and the health of her child during the birthing process, if he unilaterally decides that his own decisions are in the best interests of the fetus. *See, e.g,* Wis. Stat. §§ 48.235(3)(b)(2) (GAL to assert "best interests of the …unborn child at every stage of the proceeding"); 48.235(4m)(4) & (5) (authorizing GAL to petition court for revision or extension of dispositional orders, which may include forced medical treatment); 48.235 (4m)(8) (authorizing GAL to "[p]erform any other duties consistent with this chapter.").

The danger to Ms. Loertscher is acute, because the GAL is not required to consider her interests at all when overriding her medical decisions about childbirth. Indeed, the GAL is constrained by statute to consider *only* the best interests of the fertilized egg, embryo, or fetus. *See* Wis. Stat. § 48.01 ("the best interests of the… unborn child shall always be of paramount consideration"); Wis. Stat. § 48.235(3) (GAL shall be an advocate for "best interests of …unborn child for whom the appointment is made").

Under the terms of the Act Ms. Loertscher also potentially faces loss of her newborn, if the GAL or other state actors decide to petition for a change in custody or even termination of her parental rights under the Act. *See* Wis. Stat. §§ 48.347(7), 48.345, 48.415(2)(a). Finally, unwanted intrusion by *anyone* during childbirth, whether the person is a state actor or not, inherently violates the privacy and dignity of the birthing process, one of the most momentous occasions in any parent's lifetime. Such harms are profound and irreparable. Accordingly, urgent

preliminary injunctive relief is warranted.

V. ENJOINING THE CHALLENGED ACT WILL NOT HARM THE PUBLIC INTEREST

As set out above, Ms. Loertscher has demonstrated a strong likelihood that she will win on the merits of her facial constitutional challenge to the Act. Thus, the balance of harms need not weigh significantly in her favor. *See*, *e.g.*, *Planned Parenthood of Wis., Inc. v. J.B. Van Hollen*, 738 F.3d 786, 795 (7th Cir. 2013) ("[T]he more likely it is the plaintiff will succeed on the merits, the less the balance of irreparable harms need weigh towards its side."). Nonetheless, the balance of harms favor enjoining enforcement of the Act.

As the Seventh Circuit has repeatedly held, the public interest is served, not harmed, by enjoining enforcement of an unconstitutional law. *See Alvarez*, 679 F.3d at 589-90 ("if the moving party establishes a likelihood of success on the merits, the balance of harms normally favors granting preliminary injunctive relief because the public interest is not harmed by preliminarily enjoining the enforcement of a statute that is probably unconstitutional"); *Preston*, 589 F.2d at 303 n.3 (noting that remedying a constitutional violation "certainly would serve the public interest"); *Joelner v. Vill. of Washington Park*, 378 F.3d 613, 620 (holding that there can be no irreparable harm to the state "when it is prevented from enforcing an unconstitutional statute because it is always in the public interest to protect [constitutional] liberties.") (citations omitted). Because the Act is unconstitutional on its face, enjoining its enforcement serves the public interest.

CONCLUSION

For the foregoing reasons, the Court should grant Plaintiff's Motion for Preliminary Injunction.

Dated this 7th day of January, 2015.

Respectfully submitted,

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APPENDIX

1. Gordan Malaise Drafter's Note From the Legislative Reference Bureau, November 12, 1997

2. Memorandum from Linda Hisgen to Directors, County Departments of Human Services and Directors, County Departments of Social Services re 1997 Wisconsin Act 292, July 23, 1998

3. Kenneth A. De Ville, Loretta M. Kopelman, Journal of Law, Medicine & Ethics, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy*,27 (1999): 332-42

4. David C. Lewis et al., Open Letter to the Media, (Feb. 25, 2004), http://www.advocatesforpregnantwomen.org/articles/crackbabyltr.htm

5. David C. Lewis et al., Open Letter From Doctors, Scientists & Specialists Urging Major Media Outlets Not to Create "Meth Baby" Myth, (July 27, 2005), http://advocatesforpregnantwomen.org/%2522Meth%2522%20Open%20Letter%20-%202005.pdf

6. The American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, Obstetrics & Gynecology, Vol. 117, No. 1, January 2011

7. Robert G. Newman, et, al, Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women, (March 11, 2013), http://advocatesforpregnantwomen.org/Open%20Letter%20to%20the%20Media%20and%20Policy%20Makers%20Regarding%20Alarmist%20&%20Inaccurate%20Reporting%20on%20Prescription%20Opiate%20Use%20by%20Pregnant%20Women%20-%20March%202013.pdf

8. Medical Groups Position Statements

APPENDIX 2

Paltrow

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF CHILDREN AND FAMILY SERVICES

1 WEST WILSON STREET
P.O. BOX 8916
MADISON WI 53708-8916

DATE: July 23, 1998

TO: Directors, County Departments of Human Services
Directors, County Departments of Social Services

FROM: Linda Hisgen, Director
Bureau of Programs and Policies

RE: 1997 Wisconsin Act 292

Attached is a copy of 1997 Wisconsin Act 292, which creates a form of maltreatment called "unborn child abuse" and specific responsibilities and authority for county social/human services departments to intervene in such cases. Act 292 makes changes in Chapters 48, 46, 51, 146, 757, 808, 813, 904, 905 and 938. We will be reviewing this legislation with the Bureau of Substance Abuse Services and the Division of Health in order to develop helpful guidelines and reasonable standards as to how to proceed in these cases. In the meantime, however, this legislation has been enacted and became effective on July 1, 1998. We encourage you and your staff to review the attached act and determine how you will proceed.

Act 292 is fairly extensive. In summary, it does the following:

- Creates a new category of abuse, "unborn child abuse", which is defined under s. 48.02(1)(am) in the following way: "When used in referring to an unborn child, serious physical harm inflicted on the unborn child, and the risk of serious physical harm to the child when born, caused by the habitual lack of self-control of the expectant mother of the unborn child in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree."
- Defines an "unborn child" to be a "human being from the time of fertilization to the time of birth."
- Provides for interventions to protect unborn children that parallel the protections for children throughout Chapter 48. Interventions include such actions as the receipt and investigation of referrals, taking and holding an expectant mother in custody, filing juvenile court actions, determining if unborn child abuse has occurred, preparing dispositional reports and providing services and supervision. Procedures vary depending upon whether the subject is an adult or a child.
- Provides for the unborn child to be represented by a guardian ad litem when the expectant mother is taken into custody and not released and when there is court action.
- Other than in cases of Chapter 51 commitments, places responsibility with the public child welfare system for placement and supervision of the expectant mother and developing and overseeing treatment.

Act 292 creates a new area of responsibility for child welfare, and, as such, there are no existing protocols, policies, assessment tools or guidelines that define child welfare's role. As mentioned above, we expect to explore the development of appropriate policies and practice with a team of people representing child welfare, substance abuse and the medical profession. In the interim, you may wish to do the same in your own community.

In determining how you will fulfill the requirements of Act 292, we recommend you consider the following:

- What referrals will be accepted for investigation? Will only reports from credible reporters that can present information to support reasonable suspicion for all the elements in the definition of "unborn child abuse" be accepted? Or will all allegations be accepted for investigation, including anonymous reports and reports of one-time drug or alcohol use?

- How will referrals be investigated? Solely through evaluations and reports from AODA and medical professionals? If a woman refuses an evaluation, what level of evidence is necessary to support a court petition that could result in a court-ordered evaluation? In addition, pregnancy tests cannot be required, except through a court order.

- How will the case finding decision be made? All of the following must be proven to a preponderance of the evidence:
  - the woman or girl is pregnant
  - serious physical harm was inflicted on the unborn child
  - there is a risk of serious physical harm to the child when born
  - that the harm or risk of harm is caused by the habitual lack of self-control of the expectant mother in the use of alcohol beverages, controlled substances or controlled substance analogs
  - that the habitual lack of self-control is exhibited to a severe degree

  The first bullet would have to be determined medically or by the woman's/girl's statement. The second bullet would have to be determined by a medical professional, but in some cases would have to be done on speculation, since fetal impact research is not conclusive. The third bullet could be a social work decision in part, based on how the woman/girl is expected to function once the child is born. However, it also requires an AODA assessment. The fourth and fifth bullets also require assessments and conclusions by AODA and medical professionals.

- The bases for taking adult women into custody vary. In some instances, just the belief that the woman is pregnant and habitually lacks self-control in AODA use exhibited to a severe degree is sufficient. No expectation of an emergency or need for immediate intervention is required. In other instances, the fact that the woman refused AODA services is required. In developing policy in this area, consideration should be given to identifying the purpose and need for taking the adult woman into custody and whether any other less restrictive solution is an option.

- Counties will have to determine if they want their staff taking adult pregnant women into physical custody, particularly since they are likely to be somewhat out of control if conditions are such that they need to be taken into custody. What if a woman resists? Although Act 292 states that the unborn child's best interests are paramount, it also states that provisions of the chapter that protect unborn children shall be construed to apply "to the extent that application … is constitutionally permissible…" Counties may wish to be cautious about having individual staff determine what might be "constitutionally permissible". If counties decide to allow staff to take adult women into custody, there should be clear guidelines and protocols and training for the affected staff with the assistance from law enforcement and 51 personnel that are already trained and experienced in these areas.

- A woman can be released to an adult relative or friend or she can be counseled and released on her own. Protocols should be developed for when adult women will be released to adult friends or relatives and the basis for which the person releasing the woman would determine that the friend/relative is appropriate. (Consider the possibility of domestic violence when an adult woman is released to a partner, since AODA, pregnancy and domestic violence are frequently linked.)

- A woman may also be held in a licensed community-based residential facility. County agencies will need an understanding with those facilities about referrals. Counties are financially responsible for the cost of care and supervision of women placed in facilities.

- Act 292 allows a woman to be taken into custody and held for 48 hours and, if no petition is filed, held for an additional 72 hours upon authorization of the court. Under Chapter 51, if an adult is detained on an emergency basis, a decision must be made within 24 hours by the treatment facility whether that person should be detained. It the decision is made to detain, the period cannot exceed 72 hours from when the person was delivered to the facility. If a woman is taken into custody under Act 292 but held in a facility that operates under Chapter 51 statutes, which timeframe applies? County agencies may wish to confer with local counsel, the local court system and 51 facility staff as to how to proceed in these cases.

- An expectant mother can be "placed" at the home of a "suitable" adult following a dispositional hearing. This presumably makes that adult the physical custodian of the woman. It is unclear what the job of the physical custodian in these situations is. Counties may need to confer with colleagues in the 51 system for assistance in defining the role of this person and for assistance in developing criteria for determining who is "suitable" in this role in order to make appropriate recommendations to the court.

- Act 292 requires counties to provide and/or arrange for the needed services in these cases. Counties will need to determine how these service needs will be met. For counties where the social services and 51 departments are separate, the issues may be more complex than for counties with humans services departments. Additional service questions include the availability of treatment resources designed for women and of support services, such as transportation or child care, to assure that treatment can be accessed by the woman.

- The law modified s.48.981(7) to allow "a person having physical custody of the expectant mother of an unborn child" to have access to the CPS record. Basically, this means that person could have access upon demand against the wishes of the woman. Since the physical custodian need not be a person with a legal or professional relationship to the woman, counties may wish to seek legal guidance about releasing information under this section.

- Counties are required to report statistical data to the state on all referrals of unborn child abuse. Our current data system is not set up to accept and interpret this data. We will advise you when we have the ability to do so. In the meantime, we ask that you use the CFS-40 to log data on these cases and write "unborn child abuse" across the top of the form. We will send a brief memo describing these procedures in the very near future.

I hope the above information provides some assistance in considering county child welfare responsibilities under Act 292. We expect additional questions to arise and will answer them as best we can.

Attachment

cc: Susan Dreyfus, DCFS
Sinikka McCabe, DSL
Phil McCullough, BSAS
Diane Waller, OSF
Area Administration Teams

APPENDIX 3

Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy

Kenneth A. De Ville, Loretta M. Kopelman

In the summer of 1998, the Wisconsin State legislature amended its child protection laws.[1] Under new child abuse provisions, Wisconsin judges can confine pregnant women who abuse alcohol or drugs for the duration of their pregnancies. South Dakota enacted similar legislation almost simultaneously. The South Dakota statute requires mandatory drug and alcohol treatment for pregnant women who abuse those substances and classifies such activity as child abuse. In addition, the South Dakota legislation gives relatives the power to commit pregnant women involuntarily for two days; a court order can place the pregnant women in custody for up to nine months.[2] These recent legislative "successes" follow scores of failed attempts by legislators in other states to establish fetal protection laws aimed at women who use and abuse drugs and alcohol during pregnancy.[3] Barbara Lyons, of the Wisconsin Right to Life Committee, boldly predicts that, by passing fetal protection laws, "Wisconsin has become a national model for this sort of legislation."[4]

Indeed, the legislative urge to protect fetuses has not abated. In the 1999 legislative session, at least a dozen fetal protection statutes were proposed, including an additional nine that would punish women criminally for their behavior during pregnancy.[5] But even if a morally and socially justifiable fetal protection law is possible, it would have to be carefully conceived, drafted, and implemented. Our examination of the new Wisconsin statute reveals flaws in conceptualization and structure that render it morally suspect, constitutionally vulnerable, and a potential danger to both women and their future children.

Wisconsin's action, and legislative initiatives like it, is not surprising. The image of newborns injured by prenatal substance abuse sometimes seems to cry out for decisive action. In addition, infants and children harmed in utero cost society valuable and scarce social, educational, and economic resources. Despite these observations, and the state's interest in promoting the health of future citizens, such fetal protection policies remain an extraordinarily complicated class of legislation. By their very nature, fetal protection laws intrude on the most protected right in Western culture—the right to be free from bodily restraint. It is true that individual liberty can sometimes be circumscribed when the risk of harm to other individuals or society is both severe and likely. That case, however, is frequently difficult to make. Even though substance abuse poses a risk of harm to the child who will be born,[6] its magnitude and probability is highly uncertain.[7] Fetal injury stemming from substance abuse varies dramatically, and frequently unpredictably, from nonexistent to minor to tragic.[8] Finally, there may be a range of less restrictive and more effective remedies to aid the fetus without infringing on the interests of the pregnant woman. For these reasons and others, it is prudent to be skeptical, perhaps even suspicious, when evaluating fetal protection legislation in general.[9] The empirical evidence does not yet exist to justify state intrusion on an individual's liberty interests in the ways that most proposed and enacted fetal protection legislation demands, such as that in Wisconsin and South Dakota.

The Wisconsin law

The new Wisconsin fetal protection legislation revises significantly the state's child abuse law. The purpose of the Wisconsin bill, according to its framers, is "to provide a just and humane program of services to children and unborn children and the expectant mothers of those unborn children."[10] The statute defines "unborn child" as a "human

Journal of Law, Medicine & Ethics, 27 (1999): 332–42.

being from the time of fertilization to the time of birth," and stresses that provisions of the law are intended to "apply throughout an expectant mother's pregnancy."[11] "[U]nborn children," this statute states, "have certain basic needs," including the need to "develop physically to their potential and the need to be free from physical harm." To protect these basic needs, when "an expectant mother of an unborn child suffers from a habitual lack of self-control" in the use of alcoholic beverages or controlled substances "to a severe degree," a court may "determine that it is in the best interests of the unborn child for the expectant mother to be ordered to receive treatment, including inpatient treatment."[12] This treatment may include, but is not limited to, medical, psychological, or psychiatric treatment, as well as alcohol or other drug abuse treatment or other services that the court finds necessary and appropriate. In construing and implementing the legislation, "the best interests of the child or unborn child shall always be a paramount consideration," and the law should be "liberally construed to effectuate" the expressed legislative purposes.[13]

Related, revised legislation specifically frees health professionals to disclose confidential information obtained within the health care relationship. Under Wisconsin statutory law, "[a] patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made or information obtained or disseminated for purposes of diagnosis or treatment."[14] Under new legislation, however, this standard does not apply when "the examination of the expectant mother of an abused unborn child creates a reasonable ground for an opinion ... that the physical injury inflicted on the unborn child was caused by the habitual lack of self-control of the expectant mother of the unborn child in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree."[15] Thus, health professionals, social workers, counselors, and a variety of other professionals "having reason to suspect that an unborn child has been abused or reasons to believe that an unborn child is at substantial risk of abuse" are directed to report that suspicion to child welfare agency or local law enforcement officials.[16]

The statute directs the relevant child welfare agency or law enforcement officials to determine whether the "unborn child" is in immediate danger and to "take any necessary action," including confinement of the pregnant woman, to protect the unborn child.[17] An "expectant mother" can be taken into custody for up to forty-eight hours without a hearing by a law enforcement officer who "believes on reasonable grounds" that there is a substantial risk to the unborn child.[18]

At a full adversarial hearing before a judge, or jury if requested, the statute requires that a guardian ad litem be appointed to represent the fetus, to serve as an advocate for "the best interest of the unborn child."[19] The judge (or jury) will consider evidence, including the social history of the pregnant woman, the gestational age of the "unborn child," and dispositional recommendations from the child welfare agency. Hearsay evidence may be admitted.[20] In determining what measures to take, the court must order the "least restrictive" disposition or treatment option that is consistent with the well-being of the unborn child.[21] A court can order mandatory commitment and treatment for a pregnant woman who "habitually" lacks self-control toward drugs and alcohol to a severe degree, when there is a "substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered unless the expectant mother receives prompt and adequate treatment."[22] If she refuses voluntary treatment, or has not made a good faith effort to participate in such programs, then a court may place a woman in custody for involuntary treatment.[23] She may be held in custody, as long as necessary to protect the unborn child, in the home of an adult relative or friend, a private or public residential substance abuse treatment facility, or in a hospital.[24] Alternatively, the court can release the woman, order counseling or some other form of outpatient supervision,[25] and "impose reasonable restrictions on her travel," "association with other persons or places of abode," or conduct "which may be necessary to ensure the safety of the unborn child and of the child when born."[26]

Analysis

The new Wisconsin policy is not a newly drafted, free-standing law devoted specifically to the complicated issue of fetal health. Instead, it is a revision of the state's existing child abuse and protection laws. This modification followed a 1997 Wisconsin Supreme Court ruling, *Angela M.W. v. Kruzicki*, which declared that the then current child abuse laws could not be used to confine a pregnant woman who had tested positive for cocaine.[27] (With the exception of South Carolina, other state courts that have considered the matter have maintained that unmodified, existing child protection laws could not be used to take pregnant women into custody for the benefit of their fetuses.[28]) Soon after the *Kruzicki* decision, the Wisconsin State legislature amended the statute to permit such detentions under child abuse law. The state legislature's decision to approach the issue of fetal protection through the mechanism of child abuse law creates a series of interlocking problems—conceptual, symbolic, and practical—which severely undermine the wisdom, workability, and justice of the new policy.

Words matter

> "When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean—neither more nor less."

> "The question is," said Alice, "whether you can make words mean different things."
> "The question is," said Humpty Dumpty, "which is to be master—that's all."[29]

Humpty Dumpty's glib assertion has special meaning in the context of legislative enactments, especially Wisconsin's fetal protection statute. Legislative enactments give words content and power. Throughout the lengthy and detailed fetal protection statute, the legislature repeatedly employs two central terms: "unborn child" and "expectant mother." A statute's language, the legislators' choice of terms, can reflect the underlying ideology that inspired the law and have a practical impact on how the policy is implemented.

"Pregnant woman" or "expectant mother"

Consider the exclusive use in the Wisconsin law of the term "expectant mother" instead of, for example, "pregnant woman." The former focuses on the status of the individual as "mother" with its attendant socially assumed duties—a potentially meaningful shift in perspective. Nationally, fetal protection policies and enforcement efforts frequently converge on the actions of the pregnant woman and fail fully to appreciate and regulate, for example, male responsibilities during pregnancy.[30] Equality before the law is a fundamental political and constitutional principle in democratic societies.[31] Policy-makers and the public should be skeptical of measures that reserve punitive action for one segment of society while neglecting analogous wrongs perpetrated by another segment of society.

Future fathers, for example, also have a duty to safeguard the interests of the child to be born. Fathers and other men sometimes play a central role in encouraging or assisting in drug use by pregnant women and are arguably culpable in other damage caused to future children. Domestic violence during pregnancy endangers both mother and future child.[32] In addition, second-hand exposure to crack cocaine, marihuana, and tobacco smoke may present at least marginal potential dangers to pregnant women and their fetuses.[33] The pregnant woman's actions may frequently pose a greater immediate risk of harm, but that is not always the case. One commentator speculates that attempts at fetal protection focus on women, in part, because our culture views child-bearing and child-rearing as largely female responsibilities.[34] This cultural assumption is reinforced in the Wisconsin fetal protection statute by referring to pregnant women in language that emphasizes not their autonomy and individuality, but that highlights their social role and presumptive duties to their fetuses and society, that is, their status as expectant mothers. Embodied in law, such an approach might be expected to focus on maternal duty and devalue individual rights—as we ultimately see is the case with Wisconsin's new legislation. Even if widespread cultural expectations underlie this language and current fetal protection approaches, it is insufficient justification in a society that is based on the aspiration that all citizens should be treated equally.

One solution to this apparent inequity is to assure that fetal protection policies target individuals based on the degree of risk they create for future persons, not on their social role or gender. Fetal protection policies that affect pregnant women, however, may still require a higher burden of justification. Fetal protection policies targeting male offenders frequently affect only their freedom of action, involving in many cases activity that is already illegal (such as domestic abuse). In contrast, fetal protection policies affecting pregnant women typically require confinement and imposition on the pregnant woman's bodily autonomy and freedom.

"Fetus" or "unborn child"

Given the current pro-choice–pro-life debate in the United States, there is obvious symbolic significance in the choice of the term "unborn child" over other available descriptions. In dicta, the U.S. Supreme Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey* suggested that the state may have some interest in potential life even at the previability stage.[35] Neither it, nor any other constitutional ruling, however, even has implied that the fetus itself possesses constitutional rights of any sort. Under *Roe v. Wade*, *Casey*, and other relevant reproductive rights jurisprudence, the interests of the state in potential life are balanced against the considerable liberty rights of the woman.[36] It is not until the fetus reaches viability that the state's interests increase to the point where it can prohibit abortion. Even then, no fetal rights are implicated. It is the state's interest in future life, not fetal rights, that is balanced against the rights of the woman.[37] Without legislative action in specifically defined areas, there can be no assertion that the fetus possesses legal rights or that the child who will be born possesses legal rights. The fetus or future person might possess some manner of interests that deserve moral consideration; but there has never been a consensus on what those interests are, and if and how they should be protected by law.

By defining a fetus from conception as a "child," the Wisconsin legislation blurs the significant difference between the previously unenforceable interests possessed by the fetus and the very real interests possessed by an ex utero child. In doing so, the legislative language changes the legal calculus from one that balances a woman's rights against state interests, to one that balances a woman's rights against a child's rights—a significant and very real transformation with concrete implications. The new Wisconsin law underscores the creation of independent fetal interests by its provisions for the appointment of an independent guardian ad

litem to advocate for the "best interests" of the "unborn child" in child abuse proceedings.

Finally, the redefinition by the legislature of "fetus" into "child" is consistent with the grand strategy of pro-life advocates. *Roe* and its jurisprudential progeny refused to declare that fetuses were "persons" deserving protection under the Fourteenth Amendment of the U.S. Constitution. Such a declaration might have profoundly undermined the legal status of abortion. Consequently, one facet of the long-term, end-game strategy of pro-life forces has included an attempt to have fetuses declared "children" or "persons" in as many legal contexts as possible, including child abuse laws, civil wrongful death actions, and criminal homicide and assault statutes. Abortion opponents hope to argue that because state law, in a variety of situations and jurisdictions, treats fetuses as persons, that Fourteenth Amendment jurisprudence should similarly recognize the reality of fetal personhood.[38]

The selection and use of terms such as "unborn child" and "expectant mother," then, have more than symbolic importance. They have practical, rhetorical, and political power as well. Rephrasing the statutes may moderate some of the force of the language, but the potential impact on pregnant women is the same if the structure of the legal remedy employed does not fully protect their interests.

Choice of remedies

Child abuse law allows social intervention into the normally private and protected sphere of family life. Society sanctions broad parental control over children based on the assumption that parents are the persons best suited and most inclined to act in the best interests of their children. Parental authority is also based on the notion that self-determination encompasses the freedom to raise one's children as one chooses. This freedom, though not as definitive as the notion of individual bodily autonomy, is represented in the parents' Fourteenth Amendment constitutional liberty interest in bringing up children according to the dictates of their own consciences. Child abuse laws are a recognition that those parental rights are not absolute. Coercive state interference with parental prerogatives, for the good of the state and the good of the child, is justified when there is "clear and convincing evidence" that parents' actions or decisions represent likely and serious harm to the child.[39]

By defining a fetus from conception as a "child," the Wisconsin statute attempts to extend the child abuse model described above to deal with maternal substance use. Such an approach is conceptually unfounded and misguided. The state's power to take custody of an abused or neglected child implicitly balances the well-being of the child against the parental right to raise one's child as one chooses. Parental autonomy and family privacy are important, but not transcendent liberties. Thus, the focus of state child protection activities, when a minor is endangered, is understandably on the well-being of the child.[40]

In contrast, when child abuse laws are used to protect fetuses, the nature of the relevant interests and personal liberties shifts significantly. When the state takes custody of an abused child, it interferes with the parental right to raise one's child as one chooses. But when the state takes custody of an "unborn child" by confining the mother for mandatory substance abuse treatment, it abrogates the mother's right to bodily autonomy, to mobility, to freedom of association, to individual liberty. The Supreme Court, for example, describes the involuntary civil commitment of an individual as a "massive deprivation of liberty" and demands that the confinement procedures and standards strike a balance between the rights of the individual and the legitimate concerns of the state.[41]

Thus, the Wisconsin legislature's use of the child abuse model to confine pregnant women does not account for this shift in interests that occurs when the state confines an adult individual, as opposed to that which occurs when the state takes temporary custody of an adult individual's child. At most, the child protection model balances the well-being of the "child" against the parental rights (as opposed to the more robust[42] physical liberty rights) of the parent. As a result, the child abuse approach maintains the focus on the "child" rather than fully recognizing and considering the other rights at stake. If any involuntary maternal confinement policy can be justifiably enacted, it would, at minimum, have to take full account of the liberty interests of the individuals confined against their will. The child abuse model, *by its very nature*, fails to fulfill this criteria.

If the state can demonstrate legitimate concerns regarding the effect of maternal behavior on fetal well-being, it *may* have grounds to consider intervention. However, the state's concerns must be balanced against the physical liberty interests of the woman and subjected to the scrutiny that other similar state actions must face. The child abuse model cannot provide these protections.

Limiting liberty and empirical certitude

The Wisconsin approach to maternal substance use is flawed in another critical respect. It does not guarantee the evidentiary certainty and protection that is typically required when individual rights are abrogated. Interference with the liberty of competent adults requires satisfying a heavy burden of proof in regards to the magnitude of harm threatened and the probability that it will occur. For example, the standard of evidence constitutionally required to confine an individual involuntarily, even to prevent harm to one's self or others, ranges from "clear and convincing" to "clear, unequivocal and convincing" evidence.[43] Similarly, even the abrogation of parental prerogatives under the child abuse model requires clear and convincing evidence that the child

is likely to suffer serious harm. This standard is purposefully set high to protect individual rights. Under either formulation, child protection or involuntary commitment, the state's right to intervene depends on the quality of the evidence. That is, the justification for interventions varies with the probability and magnitude of the predicted harm, in this case that the behavior of the pregnant woman will result in serious fetal injury. The current state of empirical evidence regarding substance abuse does not generally support such a demonstration, especially for one of the most targeted groups—women who use cocaine.

The dangers of the use and abuse of alcohol during pregnancy is the best documented of any substance. In the 1970s, researchers identified a specific pattern of disabilities in children born to some alcoholic women, which they identified as fetal alcohol syndrome (FAS). Currently, FAS affects 0.29 to 0.48 per 1,000 children born in the United States, or about 1,200 children born annually.[44] In addition, prenatal alcohol abuse is one of the leading causes of mental retardation and has been linked to a wide range of mental and physical disabilities.[45] Even moderate alcohol intake during pregnancy has been linked to a range of postnatal injury and deficits, both intellectual and behavioral. However, the likelihood and nature of the impact of alcohol use during pregnancy remains highly uncertain. Typically, the more a woman drinks during pregnancy, the greater the risk posed to the resulting child. But, the studies illuminating the precise nature of the link between alcohol use and fetal injury are sometimes confounded by factors such as maternal intelligence, paternal effects, medication usage, and other variables. Moreover, different levels of alcohol use affect different women and their fetuses differently, as the result of such factors as genetic predispositions, environment, dose frequency, lifestyle, prenatal care, and other comorbid factors. Some studies have failed to find an effect of lower levels of alcohol usage, further undermining the efficacy of other studies and illustrating the potential difficulty in monitoring women's alcohol consumption during pregnancy.[46] Even studies of children born to alcoholic women show that only 10 to 40 percent suffer from FAS, though a high percentage may suffer from other disabilities.[47] Finally, according to a review of the literature on prenatal exposure to alcohol, "there is often little reliable information about the degree of alcohol exposure" during the pregnancy.[48]

None of this discussion is intended to discount the dangers of alcohol use during pregnancy. Such observations, though, should underscore the uncertainty of the potential harm. Not all children born to women who drink are injured, nor are they injured in the same way or degree.[49] Thus, it may be difficult, if not impossible to establish a clearly defined threshold beyond which the risk to the resulting child will justify, as a matter of standing policy, coercive intervention or criminal prosecution.

Studies involving the prenatal use of drugs such as marijuana, amphetamines, and barbiturates are even more equivocal. They clearly suggest that they may be harmful and should be avoided, but the exact impact on the fetus of these substances remains unclear.[50] The greatest public concern and the bulk of the fetal protection efforts have been focused on pregnant women who use cocaine. Although cocaine has been linked to a range of injuries, many serious, in many studies it has been difficult to determine which birth injuries are related to the drug's use and which are related to other coexisting risk factors. In addition, many of the original studies that spurred fears of a generation of "crack babies" were flawed in a number of ways, leading one researcher to remark that "the emergence of medical knowledge on the reproductive effects of cocaine is a fascinating example of difficult methodological hurdles 'simplified' in an unacceptable, nonscientific manner to derive at [sic] premature conclusions."[51] Similarly, as substance abuse researcher Daniel Neuspiel observes, "Early studies and anecdotal reports of adverse effects of cocaine use in pregnancy have fueled a mythology of severe risk among both professionals and the general public.... Even though recent studies ... have generally reported either less or no effects of gestational cocaine, this mythology persists."[52] Even the documented effects of maternal cocaine use vary dramatically from individual to individual, with many resulting infants showing no long-term injury.[53] In fact, not only do medical researchers disagree about the impact of cocaine use during pregnancy, but also, according to one specialist, "[c]ocaine-exposed babies are not neurologically impaired to the degree initially reported, even when they are exposed through most of the pregnancy."[54] According to Linda LaGasse, Ronald Seifer, and Barry Lester's recent examination of existing evidence on the topic, "recent studies do not support the case for devastating consequences, but rather suggest there are subtle deficits amenable to intervention."[55]

Women who use or abuse alcohol and drugs during pregnancy clearly increase the risk of injury to their fetuses. The scientific evidence is sufficient to counsel women against substance use and abuse and to provide treatment services to those women who want to forgo those substances during their pregnancies. But given current levels of knowledge regarding substance abuse and fetal harm, the risk of fetal injury will rarely be sufficient to meet the clear and convincing evidence standard that is required when the state wishes to deprive an individual of his/her liberty. And, as important, the disparate effects of substance use and the influence of comorbidity factors frustrate efforts to establish a justifiable threshold of alcohol and drug use that will trigger a particular coercive state intervention.

The Wisconsin law, then, increases the probability that individual women could be confined without sufficiently strong evidence that the fetus will likely suffer serious harm. Recall that, under the statute, any person, including a health

care professional, a social worker, or a counselor, may report a woman if he/she has "reason to suspect" or "reasons to believe" that an unborn child is at substantial risk of abuse. A physician may report a pregnant woman who tests positive for drugs or alcohol, but no such test results, or series of tests results, are required to trigger child abuse and confinement proceedings.[36] On receiving a report of suspected abuse, a law enforcement or child protection agency official may confine the pregnant woman if there are "reasonable grounds" to believe that her "habitual and severe" use of substances substantially endangers the health of the unborn child. At the woman's full adversarial hearing, potentially subjective social history evidence and hearsay evidence (usually considered suspect by courts[37]) may be introduced. The judge is empowered to confine the woman for treatment if there is a "substantial risk" that the unborn child's health is seriously threatened by the "habitual and severe" substance use.

These statutory provisions represent relatively low evidentiary standards and thus insufficient procedural safeguards given the nature of the potential deprivation of liberty faced by the pregnant women who are targets of this legislation. Women may be reported on "suspicions" of substance abuse and confined by law enforcement officials who have "reasons to believe" that the abuse has been "habitual and severe." At a full hearing, hearsay evidence is admissible, but no medical testimony is specifically required. No expert witness, for example, is required to establish the probability or magnitude of harm represented by the woman's behavior. Judges must merely believe that a woman's "habitual and severe" substance use creates a substantial risk that the "unborn child" will be injured before they can order a woman confined or into treatment against her will. Given popular misconceptions regarding the probability and magnitude of the harm posed by substance use on fetal health, judges' ability to estimate accurately the risk posed to the fetus should be questioned. Health professionals are given no guidance as to what constitutes a legitimate "suspicion" sufficient to report. "Habitual and severe" substance use is never defined and means substantially different things to different potential informants. It is never clear on what grounds a judge is to determine whether the woman's actions create a substantial risk to the unborn child.

These ambiguous yet pivotal features of the Wisconsin fetal protection law do not seem to be an oversight, but are consistent with the overall tenor and underlying meaning of the law. For example, the focus of the legislation is to protect the "unborn child," defined as a "human being from the time of conception." This definition, aimed at protecting the fetus, leaves health professionals, law enforcement officials, and judges (as well as other mandatory reporters of child abuse) little latitude except to determine that their primary duty is to protect the fetus. In contrast, key terms that are central to the protection and liberty of the pregnant woman are left vague and without content, in effect increasing the discretion left to those who report, arrest, and decide the fate of pregnant women and the nature of the duty to protect the fetus.

Statutory ambiguity

By their very nature, statutes must grant some discretion to those individuals who are responsible for implementing them. But when statutory ambiguity allows discretion in decisions that threaten individual liberty, more substantial safeguards are warranted. Nowhere is this more true than in the Wisconsin statute's provision allowing confinement of a woman if her actions represent a "substantial risk" to the unborn child. Given that the scientific evidence regarding substance use and pregnancy is unclear, and that, in any event, it is not required, judges (or juries) are left with a potentially perilous degree of discretion. Risk, especially medical risk, is a profoundly complex notion, subject to a broad range of factors. It is shaped not only by available evidence, but also by personal values and experiences, institutional roles, and professional training. Risk perception, not surprisingly, varies elastically from individual to individual and from group to group.[38] The legislation may allow decision-makers to base their judgments of "substantial" and "risk," not on the complicated and sometimes equivocal medical and scientific evidence regarding maternal substance use, but rather on their view of what constitutes appropriate behavior for an "expectant mother." As noted, a substantial disparity exists between the public image of substance-abusing mothers and the scientific evidence currently available regarding fetal injury. Consequently, decision-makers in this process may sometimes rely on their intuitions of how expectant mothers should behave, rather than on the clear, convincing, and competent scientific evidence that is otherwise required and should be present when limiting the liberty of competent adult individuals.

Although the most disconcerting aspect of the Wisconsin legislation involves its potential burdens on pregnant women's freedom of movement, other commonly recognized liberties are endangered. For example, a woman could be forced or coerced into medical treatment against her desires if a judge or jury decides that her fetus is at risk of injury. Her presumptive right to confidential medical advice or other counseling is explicitly suspended, and her physician or other medical caregiver is expected to report her to state authorities. A woman's right to make reproductive decisions for herself, without undue interference from the state, is also implicated. Consider a woman facing a hearing and potential involuntary confinement under the Wisconsin statute. A statutorily mandated guardian ad litem is appointed to protect the best interests of the unborn child. Can the women, in the course of the hearings, choose to terminate her pregnancy? What will be the role, voice, and

weight of opinion of the guardian ad litem under these circumstances? Given current abortion rights law, it seems unlikely that the woman could be prevented from pursuing an abortion if her pregnancy has not reached the statutorily defined cut-off point in the state. That issue, however, is not addressed in the statute.

But the woman who wishes to continue, rather than to terminate her pregnancy, faces perhaps a greater threat to reproductive liberty. A woman brought before a court under this statute might have to submit to any of a wide range of limitations on her freedom of movement, freedom of association, right to privacy, and right to choose or refuse medical treatment if she wishes to continue her pregnancy. If she chooses to continue her pregnancy, she remains under the authority of the court. Such a choice regarding the loss of liberty may place a considerable burden on the woman's right to reproduce. This burden might be exacerbated by parallel legislation passed in Wisconsin to protect fetuses. The law provides criminal penalties for anyone who causes harm or death to an unborn child.[39] Once again, it is unclear if the law can or will be used against a woman who is deemed to have injured a fetus; but its existence and the threat of prosecution may undermine a woman's decision to continue her pregnancy if she fears postnatal prosecution.

Finally, many observers contend that coercive fetal protection policies will fail to accomplish their stated goal—the health of future children. Commentators generally agree that the most effective substance abuse policies are those that provide pregnant women with access to education, counseling, and treatment without fear of prosecution or confinement. Most pregnant women who use controlled substances wish to avoid harm to their future children.[40] According to a 1999 literature survey in the *Journal of Substance Abuse Treatment*, there is little empirical evidence that residential, inpatient substance abuse treatment for pregnant women is more effective than other treatment approaches.[41] But growing evidence suggests that mandatory inpatient drug treatment programs for pregnant women may aggravate the problems they are trying to solve because they encourage women to avoid prenatal medical care of any kind for fear of incarceration and/or the loss of their children.[42] Such a course of action risks leading to higher levels of neonatal morbidity rather than lower levels, as the policy presumably intends.

We and others have argued elsewhere that coercive and involuntary measures aimed at pregnant women who use and abuse drugs and alcohol are unlikely to work and unfairly single out one group—young women—while ignoring equal or similar harm from others.[43] Such measures also threaten important civil liberties and have the potential to erode trust in medical clinical professions. Equally troublesome, past fetal protection initiatives have appeared to focus on women of color as their primary concern.[44] African-American and other minority women may have been singled out disproportionately because of skewed media portrayals that cast them as the primary abusers of substances during pregnancy.[45] The Wisconsin law contains some safeguards that may mitigate its practical impact on the liberties of pregnant women. Judges are required to select the least restrictive alternative possible to protect the unborn child when choosing among the various available statutory remedies. The Wisconsin statute specifically states that inpatient detention may only be used when a woman has refused voluntary substance abuse treatment or has failed to make a good faith effort to participate in such treatment.

In implementing this statute, law enforcement and child protection officials and judges may choose to focus their attention only on the isolated, worst-case examples of maternal substance abuse. Given the level of public outrage on this issue, the poor data, the spare safeguards, the ambiguous language, and the overall latitude granted decision-makers by the policy, it is equally likely that the statute will be applied inconsistently and in ways that undermine the liberty interests of pregnant women. The very framing of a statute as one of child abuse may presage its future application.

Are there any acceptable coercive interventions?

Given that the Wisconsin and South Dakota statutes are fraught with practical, moral, and symbolic difficulties, are *any* coercive remedies justifiable? Clearly, some individual instances of maternal substance abuse (both hypothetical and real) are so egregious that they would justify intervention on an ad hoc basis. Intervention might also become more defensible in the future, if better information becomes available showing a clear and convincing likelihood of substantial and avoidable harm posed by women who use drugs and alcohol when they are pregnant. But is it possible to craft a social policy—a broadly applied legal remedy—that provides a formal way of dealing with egregious cases while at the same time protecting the interests of pregnant women whose behavior, although unwise, does not threaten the health of future persons in a clear and certain way?

Some observers contend that if *any* coercive fetal protection policy is defensible, it must be modeled on the civil commitment model, similar to that employed in the mental health context. Such an approach, they suggest, comes closer to "achieving the proper balance between an individual's right to freedom and society's need to protect public health and safety."[46] Indeed, in the most comprehensive review and analysis of fetal protection policies to date, Lawrence Nelson and Mary Faith Marshall attack the child abuse model and conclude that the civil commitment approach, expanded and applied judiciously, is the most appropriate currently available means to intervene in the lives of pregnant women who may be injuring themselves and their future children with substance abuse.[47]

The civil commitment model *might* be the most defensible coercive approach to fetal protection and *might* be justifiable if it is appropriately conceived and applied. However, we will try to show that such an amended form of the civil commitment model, in its likely application, threatens to result in many of the same vagaries and unwarranted infringements on the rights of women that characterize other coercive fetal protection policies and should therefore not be pursued at this time. Policy-makers, law enforcement officials, and health care providers should instead focus their efforts on enhancing voluntary education, counseling, and treatment programs for pregnant women who use controlled substances.

The current civil commitment remedy for incompetent adults already exists in a number of jurisdictions, and it is justifiably applicable to a narrow range of women who abuse controlled substances during pregnancy. In many states, individuals who represent a danger to themselves, or who are unable to care for themselves, as a result of substance abuse may be involuntarily confined and treated for substance abuse under the state's civil commitment statute. In some cases, these statutes, without revision, might also legitimately apply to incompetent women who abuse substances while they are pregnant.[68] In such instances, the pregnant woman should be afforded the same procedural safeguards as nonpregnant individuals confined under the statute. The criteria for confining a pregnant woman who represents a danger to herself because of substance abuse should differ in no way from the relevant jurisdiction's standards for confining nonpregnant individuals who endanger themselves through drug or alcohol abuse. Moreover, investigation and enforcement efforts must proceed evenhandedly—the woman should be singled out for treatment and confinement, not because she is pregnant, but because she represents a risk of harm to herself.

The legitimacy of the intervention, under currently existing involuntary commitment statutes, rests on the reason the state sanctions involuntary confinement. The justification of the pregnant woman's commitment is her own lack of decision-making capacity and threats to her own well-being (or perhaps, in some cases, that of other live-born human beings who might be endangered by her actions). Fetal health may incidentally benefit from the woman's confinement and treatment under these circumstances, but it need not if she were given powerful medications early on in pregnancy. Moreover, current involuntary commitment statutes were not framed with fetal health in mind, and thus fetal protection would be improper grounds on which to deny an individual liberty. Action under such statutes, appropriately and honestly applied, does not unjustifiably infringe on the woman's autonomy, because she has been found incapable of making decisions on her own behalf and is being confined to protect her own interests, not those of another being.

Many of the same problems that arise for child abuse laws would also arise if existing involuntary commitment statutes were expanded (or adapted) to restrict competent women to protect fetal life or the health of children who will be born. First, current civil commitment statutes, like most child abuse laws, were not intended by their drafters to protect fetal life or future children. Thus, if policy-makers wish to protect future life from in utero injury using the civil commitment model, a revised involuntary commitment statute needs to be constructed.[69] As noted earlier, *Casey* declared that the state has some legitimate interest in protecting potential life, even at the previability stage of fetal development. In both personal injury and criminal law, a legal duty to avoid harming future (that is, fetal) life has been widely, albeit not universally, recognized. Likewise, it may be possible to construct a reasonable involuntary commitment statute designed to protect future children from substance abuse.

Second, like Wisconsin's revised child abuse laws, a model expanded involuntary commitment statute might authorize the confinement of a pregnant woman when her abuse of controlled substances threatens "serious, likely and permanent harm to a future person." But because this wording might be misread to include all *possible* descendants, such a statute, at minimum, should further define "future person" as an existing fetus that the woman "intends" to carry to full term. The woman's statement on whether she "intends" to carry the fetus to term should serve as a "rebuttable presumption," or even a "conclusive presumption," of the status of the fetus. This requirement is of central importance because if the woman does not intend to complete her pregnancy, then the state has no constitutionally justifiable interest in the protection of a future person.[70]

Third, such an expanded statute, if enacted, should protect the rights and interests of the pregnant woman by the consistent application of a clear and convincing evidence standard. But this would limit the expansion of such laws to all but incompetent persons. Clear and convincing evidence is generally considered that degree of proof "which will produce in the mind of the trier of facts a firm belief or conviction as to the allegations sought to be established."[71] For example, the trier of fact (probably a judge) in a case involving a pregnant woman would be required to determine whether clear and convincing evidence exists that: the woman intended to bring the fetus to term; the woman's actions threaten "serious, likely and permanent harm" to a future person; and that the confinement and treatment chosen are the least restrictive means available. Finally, the woman should be entitled to the procedural protections ordinarily guaranteed in other involuntary commitment proceedings including: notice; an adversarial hearing; representation by counsel; and the provision of beneficial treatment during confinement in the least restrictive environment practicable.

The clear and convincing evidence standard, if honestly applied by judges, should safeguard the current rights of the pregnant woman, and is consistent with the standard employed in other situations where serious deprivations of liberty are involved. This measure is flexible and adaptable to the wide range of substance abuse cases. Judges and prosecutors could fairly apply new medical and scientific information regarding the effects of substance abuse during pregnancy as it becomes available.

If applied fairly and consistently by prosecutors and judges, this approach to the commitment of pregnant women who abuse controlled substances is likely to result in the mandatory confinement of only a very few women in the most egregious instances of substance abuse. Currently, it is clear that the use of virtually any type of controlled substance use during pregnancy is unwise. But given the state of existing prenatal and perinatal knowledge, it will rarely be demonstrable prospectively—by clear and convincing evidence—that the resulting child in any individual case is likely to be severely and permanently harmed by substance abuse. A comprehensive model statute designed to allow the involuntary commitment of pregnant women who abuse substances would still require considerable elaboration even if the general outlines and necessary limits of such a statute are already clear. The civil commitment model seems superior to a child abuse model, like Wisconsin's law, because it does not redefine the fetus as an unborn child.

Nonetheless, we cannot support the enactment of fetal protection statutes at this time. Even with safeguards, redefining the fetus as a future person at risk of harm is, on balance, unwise. Too great a danger remains, given the bias and scant evidence that we have described, that social demand and prosecutorial and judicial discretion may lead to inappropriate enforcement decisions and abuses and may represent unwarranted infringements on the rights of women without generating significant benefit for those women or their children. It is possible, of course, that involuntary commitment statutes would only be used in the egregious and very rare case. But the history of fetal protection efforts in the last decade suggests otherwise. Over the past decade, prosecutors, judges, and health professionals have been willing to intervene coercively even in the absence of specific statutes or law allowing them to do so. This "rough justice" is likely to continue in the most flagrant cases of substance abuse even in the absence of any new laws authorizing such interventions. A new law codifying and expanding the state's enforcement reach over pregnant women, through either the involuntary commitment model or the child abuse model, might not stem the practice of rough justice. Instead, it could have the obverse effect, unofficially endorsing and encouraging increased state oversight into other areas of the pregnant woman's life. As a result, expanded and voluntary educational and counseling efforts remain the more justified and appropriate clinical, social, and legal response to the problem of substance abuse during pregnancy.

Conclusion

Wisconsin's approach to fetal protection is marred by a series of conceptual, symbolic, and practical problems. The use of the child abuse model, by its very nature, fails to fulfill the state's duty to assess fairly and impartially the liberties of individuals confined against their will. Wisconsin's fetal protection law collapses an issue involving individual maternal liberty into a revamped child abuse law, complicating the already intricate medical, moral, and social problem of substance use during pregnancy. Instead of approaching the issue warily, the Wisconsin legislature has extended traditional child abuse protection not only to viable fetuses, but also to the very point of conception. It is unclear if the statute will withstand the legal and constitutional challenges that may follow or become a model for other state legislative action. In the meantime, pregnant women in Wisconsin will remain subject to the vagaries of an ill-conceived and ambiguous statute and the decision-makers who apply it. Attempts to expand involuntary commitment measures raise similar problems.

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11. *Id.* §§ 48.01–.02.
12. *Id.* § 48.01(1)(a)(am).
13. *Id.* §§ 48.01–.02.
14. *Id.* § 905.04(2).
15. *Id.* § 905.04(4)(e)(3).
16. *Id.* § 48.981(1)–(3).
17. *Id.* § 48.981(3)(b).
18. See *id.* §§ 48.193, .981(3).
19. *Id.* §§ 48.213, .235.
20. See *id.* § 48.299(4)(b).
21. See *id.* § 48.355.
22. *Id.* §§ 48.133, .19(8).
23. See *id.* §§ 48.205, .345, .347.
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42. In moral theory and in law, physical liberty is typically treated with more deference than other liberty rights because it is the liberty most closely associated solely with one's own interests. In contrast, parents' right to direct the upbringing of their child affects not only the parents, but also the child.
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53. See D.R. Neuspiel et al., "Maternal Cocaine Use and Infant Behavior," *Neurotoxicology and Teratology*, 13 (1991): 229–33; Bell and Lau, *supra* note 7; Hulse et al., *supra* note 7; Plessinger and Woods, *supra* note 8; and Eyler et al., *supra* note 8.
54. J.R. Woods Jr., "Translating Basic Research on Drugs and Pregnancy into the Clinical Setting," in Wetherington and Roman, *supra* note 38, 187–95, at 190.
55. L.L. LaGasse, R. Seifer, and B.M. Lester, "Interpreting Research on Prenatal Substance Exposure in the Context of Multiple Confounding Factors," *Clinics in Perinatology*, 26 (1999): 39–54, at 39.

56. See Wis. Stat. § 146.0255(2) (1998).

57. See J. Kaplan and J.R. Waltz, *Evidence: Cases and Materials* (Mineola: Foundation Press, 6th ed., 1987): 81–96.

58. See L. Handwerker, "Medical Risk: Implicating Poor Pregnant Women," *Social Science Medicine*, 8 (1994): 663–75.

59. See Wis. Stat. §§ 940.06–.25 et seq.

60. See M. Rosenbaum and K. Irwin, "Pregnancy, Drugs, and Harm Reduction," in Wetherington and Roman, *supra* note 38, at 309–18.

61. See E.M. Howell, N. Heiser, and M. Harrington, "A Review of Recent Findings on Substance Abuse Treatment for Pregnant Women," *Journal of Substance Abuse Treatment*, 16 (1999): 195–219.

62. See A.M. Cole, "Legal Interventions During Pregnancy: Court-Ordered Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *JAMA*, 264 (1990): 2663–70.

63. See De Ville and Kopelman, *supra* note 9; and Solomon, *supra* note 30.

64. See D.E. Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right to Privacy," *Harvard Law Review*, 104 (1991): 1419–82; L.J. Chasnoff, H.J. Landress, and M.E. Barret, "The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida," *N. Engl. J. Med.*, 322 (1990): 1202–06; D.R. Neuspiel, "Racism and Perinatal Addiction," *Ethnicity & Disease*, 6, nos. 1–2 (1996): 47–55; and P.H. Jos, M.F. Marshall, and M. Perlmutter, "The Charleston Policy on Cocaine Use During Pregnancy, A Cautionary Tale," *Journal of Law, Medicine & Ethics*, 23 (1995): 120–28.

65. See D. Humphries, "Crack Mothers at 6," *Violence Against Women*, 6, no. 1 (1998): 45–61.

66. J.M. Wilson, "Compelled Hospitalization and Treatment During Pregnancy: Mental Health Statutes as Models for Legislation to Protect Children from Prenatal Drug and Alcohol Exposure," *Family Law Quarterly*, 25 (1991): 149–70, at 150.

67. See L.J. Nelson and M.F. Marshall, *Ethical and Legal Analyses of Three Coercive Policies Aimed at Substance Abuse By Pregnant Women* (Princeton: Robert Wood Johnson Foundation, Substance Abuse Policy Research Program, Grant 030790, 1997): at 95–111.

68. See S.A. Garcia and I. Keilitz, "Involuntary Civil Commitment of Drug-Dependent Persons with Special Reference to Pregnant Women," *MPDLR*, 15 (1991): 418–37.

69. Wilson, *supra* note 66, at 166.

70. The intentionality requirement, of course, would allow pregnant women to avoid involuntary commitment for potentially injurious substance abuse throughout the first two trimesters of their pregnancies by merely informing the court that they did not intend to carry the fetus to term. At the same time, however, if the pregnancy has progressed past the point of a legal abortion, then the issue of whether the woman "intends" to carry the fetus to term becomes irrelevant. She would be legally precluded from deciding otherwise.

71. H.C. Black, *Black's Law Dictionary* (St. Paul: West Publishing, 5th ed., 1979): at 227.

APPENDIX 4

Date: February 25, 2004

Contact: David C. Lewis, M.D.
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Top Medical Doctors and Scientists Urge Major Media Outlets to Stop Perpetuating "Crack Baby" Myth

Signatories from Leading Hospitals and Research Institutes in US and Canada Agree That Term Lacks Scientific Basis and Is Dangerous to Children

Letter Sent to Washington Post, Arizona Republic, LA Weekly, Charleston Post and Courier, Amarillo Globe-News and Other Media Using These Terms

On February 25, 2004 thirty leading medical doctors, scientists and psychological researchers released a public letter calling on the media to stop the use of such terms as "crack baby" and "crack addicted baby and similarly stigmatizing terms, such as "ice babies" and "meth babies." This broad group of researchers agrees that these terms lack scientific validity and should not be used.

Motivated by a New Jersey case in which the label was used to explain away apparent efforts by the parents to starve some of their adopted foster children, these leading doctors and researchers collaborated to write a consensus statement requesting that the media stop using such terms.

Members of the consensus group agree "These pejorative labels result in damaging stigma that hurts the children all of us are working so hard to protect."

The full text of this letter with a complete list of signatories is attached. It is also available at: http://www.jointogether.org/sa/files/pdf/sciencenotstigma.pdf

Open Letter to the Media

February 25, 2004

To Whom It May Concern:

As medical and psychological researchers with many years of experience studying addictions and prenatal exposure to psychoactive substances, we are writing to request that the terms "crack baby" and "crack addicted baby" be dropped from usage. These terms and similarly stigmatizing terms, such as "ice babies" and "meth babies," lack scientific validity and should not be used.

Despite the lack of a medical or scientific basis for the use of these pejorative and stigmatizing labels, they have been repeatedly used in the popular media, in a wide variety of contexts and across the country. Just a few examples include the Washington Post ("She taught a class of about eight kids, ages 3 to 6, in Charlottesville when her husband, Rob, was attending business school at the University of Virginia. Some of the children just had speech delays; others were *crack babies*.") Ylan Q. Mui, Including Ashley, Washington Post Magazine (Nov. 9, 2003, at W22); LA Weekly (California) ("Some widows take up tennis, or volunteer to be museum docents or to hold *crack babies* down at County hospital") Michelle Huneven, Atwater Rising (Sept. 12, 2003 pg. 38); The Arizona Republic ("But the number of removals was rising in the four months before that, up 13 percent after the 2001 death of a *crack baby* was made public last summer.") Karina Bland, CPS Taking More Children; New Effort May Stir Trouble Experts Say (July 5, 2003 pg. 1A); The Post and Courier (Charleston, SC) ("The defendants had asked the Supreme Court to again consider the issue of whether the women knew their urine was being screened for drugs, as part of a 1989 policy designed to stop the *crack baby* epidemic.") Herb Frazier, Supreme Court Won't Review MUSC Case; Trial Will Determine Damage Awards for 10 Pregnant Women on Cocaine, (June 17, 2003, pg. 3B); Amarillo Globe-News, Jim McBride, Women Indicted in '*Crack Baby*' Case (Feb. 6, 2004, pg. 1A) (italics added throughout).

Throughout almost 20 years of research, none of us has identified a recognizable condition, syndrome or disorder that should be termed "crack baby." Some of our published research finds subtle effects of prenatal cocaine exposure in selected developmental domains, while other of our research publications do not. This is in contrast to Fetal Alcohol Syndrome, which has a narrow and specific set of criteria for diagnosis.

The term "crack addicted baby" is no less defensible. Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. By definition, babies cannot be "addicted" to crack or anything else. *In utero* physiologic dependence on opiates (**not** addiction), known as Neonatal Narcotic Abstinence Syndrome, is readily diagnosed, but no such symptoms have been found to occur following prenatal cocaine exposure.

That these concerns are not merely academic is vividly illustrated by the fact that the media's use of these terms has led to a situation in which children can be starved and abused and the "crack baby" label can be used to excuse the results. The *New York Times'* coverage of the New Jersey

family that allegedly starved four of their adopted sons provides a compelling and tragic example of how the stereotype of the "crack baby" is not only scientifically inaccurate, but potentially dangerous to the children to whom it is applied. On October 28, 2003, Lydia Polgreen, in "Uneven Care Not Unusual in Families, Experts Say," reported that the family used this label as an explanation for the children's apparent lack of growth: "In the Jacksons' case, the couple told friends, neighbors and people who went to their church that the four brothers had been born addicted to crack cocaine and had an eating disorder." Several days later, in another story on the same children, "Amid Images of Love and Starvation, a More Nuanced Picture Emerges" (November 2, 2003), Leslie Kaufman and Richard Lezin Jones reported that "if anyone asked about the little ones, they were told that the children had some fetal alcohol and crack baby syndromes, and that's why they would never grow."

While these references are indirect quotes from sources, another *New York Times* story that used this term and the many uses of the term by other media outlets validated this usage. In "In Home That Looked Loving, 4 Boys' Suffering Was Unseen" (October 28, 2003), the *New York Times* reported that "Michael, the youngest, was *born a crack baby* before being taken in" (italics added).

We are deeply disappointed that American and international media continues to use a term that not only lacks any scientific basis but endangers and disenfranchises the children to whom it is applied.

We would be happy to furnish an extensive bibliography if requested or to send representatives to meet with the staff or editorial boards of your paper, journal, or station and to give you more detailed technical information. Please feel free to contact Dr. David C. Lewis, M.D., 404-444-1818, david_lewis@brown.edu, Professor of Alcohol and Addiction Studies at Brown University, who has agreed to coordinate such requests on our behalf and who can provide you with contact information for the researchers listed below in alphabetical order.

Sincerely,

Robert E. Arendt, PhD
Research Director
The Buckeye Ranch

Emmalee S. Bandstra, M.D.
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Director, Perinatal Chemical Addiction Research and Education (CARE) Program

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Maureen Black, Ph.D
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Lynn T. Singer, Ph.D
Interim Provost and University Vice-President
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Barry Zuckerman, M.D.
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Department of Pediatrics
Boston University School of Medicine
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APPENDIX 5

FOR IMMEDIATE RELEASE
July 27, 2005

Contact: David C. Lewis, M.D.,
(401) 444-1818

Top Medical Doctors, Scientists & Specialists Urge Major Media Outlets Not to Create "Meth Baby" Myth

Signatories from Leading Hospitals and Research Institutes In US and Abroad Agree That Term Lacks Scientific Basis as Does the Claim That Treatment Does Not Work

Letter Sent to CBS National News, Minneapolis Star Tribune, New York Times, Los Angeles Times. Chicago Tribune, Sunday Oklahoman and Other Media Perpetuating Such Myths

On July 25, 2005 more than 90 leading medical doctors, scientists, psychological researchers and treatment specialists released a public letter calling on the media to stop the use of such terms as "ice babies" and "meth babies." This prestigious group agrees that these terms lack scientific validity and should not be used.

Motivated by news coverage using alarmist and unjustified labels and new legislative proposals suggesting punishment rather than treatment, these leading doctors, researchers, and specialists collaborated to write a consensus statement requesting that media coverage of the subject and legislative proposals addressing it be "based on science not presumption or prejudice."

Members of the consensus group agree "The use of stigmatizing terms, such as 'ice babies' and 'meth babies' lack scientific validity" and that the use of "such labels harms the children to which they are applied" by "lowering expectations for their academic and life achievements, discouraging investigation into other causes for physical and social problems the child might encounter, and leading to policies that ignore factors, including poverty, that may play a much more significant role in their lives. Members also agree that "the suggestion that treatment will not work for people dependent upon methamphetamines, particularly mothers, also lacks any scientific basis."

The letter calls on the media to stop the use of pejorative terms and also urges the media to stop its practice of relying on people who lack scientific experience or expertise for their information about the effects of prenatal exposure to methamphetamine and about the efficacy of treatment.

The full text of this letter with a complete list of signatories is attached. It is also available at:
http://www.jointogether.org/y/0,2521,577769,00.html

Contact: David C. Lewis, M.D., Professor of Medicine and Community Health
Donald G. Millar Distinguished Professor of Alcohol & Addiction Studies Brown University, Phone: 401-444-1818, E-Mail: David_Lewis@brown.edu

Those interested in Methamphetamine issues can also learn more at the First National Methamphetamine, HIV and Hepatitis Conference, *Science and Response in 2005*, August 19th and 20th, 2005 in Salt Lake City, http://www.harmredux.org/conference2005.html

Date: July 27, 2005

Contact: David C. Lewis, M.D.
Professor of Medicine and Community Health
Donald G. Millar Distinguished Professor of Alcohol & Addiction Studies Brown University
Phone: 401-444-1818
E-Mail: David_Lewis@brown.edu

To Whom It May Concern:

As medical and psychological researchers, with many years of experience studying prenatal exposure to psychoactive substances, and as medical researchers, treatment providers and specialists with many years of experience studying addictions and addiction treatment, we are writing to request that policies addressing prenatal exposure to methamphetamines and media coverage of this issue be based on science, not presumption or prejudice.

The use of stigmatizing terms, such as "ice babies" and "meth babies," lack scientific validity and should not be used. Experience with similar labels applied to children exposed parentally to cocaine demonstrates that such labels harm the children to which they are applied, lowering expectations for their academic and life achievements, discouraging investigation into other causes for physical and social problems the child might encounter, and leading to policies that ignore factors, including poverty, that may play a much more significant role in their lives. The suggestion that treatment will not work for people dependant upon methamphetamines, particularly mothers, also lacks any scientific basis.

Despite the lack of a medical or scientific basis for the use of such terms as "ice" and "meth" babies, these pejorative and stigmatizing labels are increasingly being used in the popular media, in a wide variety of contexts across the country. Even when articles themselves acknowledge that the effects of prenatal exposure to methamphetamine are still unknown, headlines across the country are using alarmist and unjustified labels such as "meth babies."

Just a few examples come from both local and national media:

- CBS NATIONAL NEWS, "Generation of Meth Babies" (April 28, 2005) at CBSNews.com
- ARKANSAS NEWS BUREAU, Doug Thompson, "Meth Baby Bill Survives Amendment Vote" (Mar. 5, 2005)
- CHICAGO TRIBUNE, Judith Graham, "Only Future Will Tell Full Damage Speed Wreaks on Kids" ("At birth, meth babies are like 'dishrags'") (Mar. 7, 2004)
- THE LOS ANGELES TIMES, Lance Pugmire, "Meth Baby Murder Trial Winds Up" (Sept.5. 2003 at B3)
- THE SUNDAY OKLAHOMAN, "Meth Babies" (Oklahoma City, OK; May 23, 2004 at 8A)
- APBNEWS.COM, "Meth Infants Called the New "Crack Babies" (June 23, 2000).

Other examples include an article about methamphetamine use in the MINNEAPOLIS STAR TRIBUNE that lists a litany of medical problems allegedly caused by methamphetamine use during pregnancy, using sensationalized language that appears intended to shock and appall rather than inform, "…babies can be born with missing and misplaced body parts. She heard of a meth baby born with an arm growing out of the neck and another who was missing a femur." Sarah McCann, "Meth ravages lives in northern counties" (Nov. 17, 2004 at N1). In May, one Fox News station warned that "meth babies" "could make the crack baby look like a walk in the nursery." Cited in "The Damage Done: Crack Babies Talk Back," Mariah Blake, COLUMBIA JOURNALISM REVIEW Oct/Nov 2004.

Although research on the medical and developmental effects of prenatal methamphetamine exposure is still in its early stages, our experience with almost 20 years of research on the chemically related drug, cocaine, has not identified a recognizable condition, syndrome or disorder that should be termed "crack baby" nor found the degree of harm reported in the media and then used to justify numerous punitive legislative proposals.

The term “meth addicted baby” is no less defensible. Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. By definition, babies cannot be “addicted” to methamphetamines or anything else. The news media continues to ignore this fact.

- A CNN report was aired repeatedly over the span of a month, showing a picture of a baby who had allegedly been exposed to methamphetamines prenatally and stating: “This is what a meth baby looks like, premature, hooked on meth and suffering the pangs of withdrawal. They don't want to eat or sleep and the simplest things cause great pain.” CNN, “The Methamphetamine Epidemic in the United States,” Randi Kaye. (Aired Feb. 3, 2005 – Mar. 10 2005).

- One local National Public Radio station claims that “In one Minnesota County, there is a baby born addicted to meth each week.” (Found at http://news.minnesota.publicradio.org/features/2004/06/14_hetlandc_methfostercare/ from June 14, 2004).

In utero physiologic dependence on opiates (not addiction), known as Neonatal Narcotic Abstinence Syndrome, is readily diagnosable and treatable, but no such symptoms have been found to occur following prenatal cocaine or methamphetamine exposure.

Similarly, claims that methamphetamine users are virtually untreatable with small recovery rates lack foundation in medical research. Analysis of dropout, retention in treatment and re-incarceration rates and other measures of outcome, in several recent studies indicate that methamphetamine users respond in an equivalent manner as individuals admitted for other drug abuse problems. Research also suggests the need to improve and expand treatment offered to methamphetamine users.

Too often, media and policymakers rely on people who lack any scientific experience or expertise for their information about the effects of prenatal exposure to methamphetamine and about the efficacy of treatment. For example, a NEW YORK TIMES story about methamphetamine labs and children relies on a law enforcement official rather than a medical expert to describe the effects of methamphetamine exposure on children. A police captain is quoted stating: "Meth makes crack look like child's play, both in terms of what it does to the body and how hard it is to get off.” (Fox Butterfield, Home Drug-Making Laboratories Expose Children to Toxic Fallout, Feb 23, 2004 A1)

We are deeply disappointed that American and international media as well as some policy makers continue to use stigmatizing terms and unfounded assumptions that not only lack any scientific basis but also endanger and disenfranchise the children to whom these labels and claims are applied. Similarly, we are concerned that policies based on false assumptions will result in punitive civil and child welfare interventions that are harmful to women, children and families rather than in the ongoing research and improvement and provision of treatment services that are so clearly needed.

We would be happy to furnish additional information if requested or to send representatives to meet with policy advisors, staff or editorial boards to provide more detailed technical information. Please feel free to contact David C. Lewis, M.D., 401-444-1818, David_Lewis@brown.edu, Professor of Medicine and Community Health, Brown University, who has agreed to coordinate such requests on our behalf and who can provide you with contact information for the experts listed below in alphabetical order.

1. Lily Alvarez, Kern County Mental Health Behavioral Health System Administrator, Kern County Mental Health Department, Bakersfield, CA
2. M. Douglas Anglin, Ph.D., Professor in Residence, UCLA Integrated Substance Abuse Programs, Los Angeles, CA
3. Robert E. Arendt, Ph.D., Associate Professor of Pediatrics, Ohio State University, Grove City, OH
4. Robert L. Balster, Ph.D., Butler Professor of Pharmacology and Toxicology; Director, Institute for Drug and Alcohol Studies, Virginia Commonwealth University, Richmond, VA
5. Marjorie Beeghly, Ph.D., Assistant Professor of Pediatrics, Harvard Medical School & Senior Research Associate, Children’s Hospital- Boston, Child Development Unit, Boston, MA
6. Marylou Behnke, M.D., Professor, Department of Pediatrics, University of Florida, College of Medicine, Gainesville, FL
7. Adam Bisaga, M.D., Research Psychiatrist, Columbia University & Addiction Psychiatrist, New York State Psychiatric Institute, New York, NY
8. Maureen Black, Ph.D., Professor, Department of Pediatrics, University of Maryland Hospital for Children, Baltimore, MD
9. Susan Blacksher, Executive Director, California Association of Addiction Recovery Resources, Sacramento, CA
10. Elizabeth R. Brown, M.D., Director of Neonatology & Associate Professor of Pediatrics, Boston University School of Medicine & Boston Medical Center, Boston, MA
11. Theresa L. Cannon, Executive Vice President, Behavioral Health Services, Inc., Gardena, CA

12. Wendy Chavkin, M.D., M.P.H., Professor of Clinical Public Health and Obstetrics and Gynecology, Mailman School of Public Health & College of Physicians and Surgeons, Columbia University, New York, NY
13. Claire D. Coles, Ph.D., Professor, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine & Director, Fetal Alcohol Center, Marcus Institute, a Division of the Kennedy Krieger Institute at Emory University, Atlanta, GA
14. Jay Davidson, L.C.S.W., C.A.D.C., President and CEO, The Healing Place, Louisville, KY
15. Nancy Day, Ph.D., Professor of Psychiatry and Epidemiology, University of Pittsburgh School of Medicine, Pittsburgh, PA
16. Eric Denner, Licensed Marriage and Family Therapist, San Francisco General Hospital Trauma Recovery Center, San Francisco, CA
17. Chris Derauf, M.D., Associate Professor of Pediatrics, University of Hawaii School of Medicine, Honolulu, HI
18. Christine Dickinson, Chemical Dependency Specialist and Proposition 36 Coordinator, Tarzana Treatment Centers, Northridge, CA
19. Fonda Davis Eyler, Ph.D., Professor of Pediatrics, University of Florida Health Science Center, Gainesville, Fl
20. Jennifer Feiock, Program Director, Alcohol Drug Council, High Gain Project, Santa Monica, CA
21. Gabriele Fischer, Ph.D., Professor, Medical University of Vienna, Department of Psychiatry, Drug Addiction Clinic, Vienna, Austria
22. Deborah A. Frank, M.D., Professor of Pediatrics, Boston University, School of Medicine, Boston, MA
23. Peter Fried, Ph.D., Professor, Department of Psychology, Carleton University, Ottawa, Ontario, Canada
24. Judith M. Gardner, Ph.D., High Risk Infant Development Follow-up Program, New York State Institute for Basic Research in Developmental Disabilities, New York, NY
25. Jim Gilmore, Director of Residential/Outpatient Services, Behavioral Health Services, Inc., Gardena, CA
26. Penny Grant, M.D., Associate Professor of Pediatrics, University of Oklahoma Health Sciences Center, Tulsa, OK
27. John Timothy Gray, M.A., Alcohol and Drug Corrections Specialist, Communicare, Inc., Elizabethtown, KY
28. Christine Grella, Ph.D., Research Psychologist, UCLA Integrated Substance Abuse Programs, Los Angeles, CA
29. Irina Gromov, M.D., Ph.D., Medical Director, Matrix Alliance Recovery Systems, Dallas, TX
30. John H. Hannigan, Ph.D., Professor of Obstetrics, Psychology and Cellular and Clinical Neurobiology, Wayne State University, C.S. Mott Center for Human Growth and Development, Detroit, MI
31. Wm. Frees Haning, III, M.D., FASAM, Director of Addiction Psychiatry/Addiction Medicine Program & Associate Dean for Graduate Affairs, University of Hawaii, John A. Burns School of Medicine, Honolulu, HI
32. Nancy Haug, Ph.D., Assistant Professor, San Francisco General Hospital, San Francisco, CA
33. Lance R. Heffer, Psy.D., Mental Health Director, Special Programs, Communicare, Inc., Elizabethtown, KY
34. Brandon Hurley, M.P.H., Prevention Specialist, Bluegrass Prevention Center, Lexington, KY
35. Hallam Hurt, M.D., Associate Professor of Pediatrics, Neonatology, Department of Pediatrics, University of Pennsylvania School of Medicine, Children's Hospital of Philadelphia, Philadelphia, PA
36. Joseph L. Jacobson, Ph.D., Professor, Department of Psychiatry and Behavioral Neurosciences, Wayne State University, School of Medicine, Detroit, MI
37. Sandra W. Jacobson, Ph.D., Professor, Department of Psychiatry and Behavioral Neurosciences, Wayne State University, School of Medicine, Detroit, MI
38. Karol Kaltenbach, Ph.D., Director, Maternal Addiction Treatment Education and Research, Jefferson Medical College, Thomas Jefferson University, Philadelphia, PA
39. Jonathan Kamien, Ph.D., Research Scientist, Friends Research Institute, Los Angeles, CA
40. Stephen R. Kandall, M.D., F.A.A.P., Professor of Pediatrics, Emeritus, Albert Einstein College of Medicine, Raleigh, NC
41. Bernard Z. Karmel, Ph.D., Infant Development, New York State Institute for Basic Research in Developmental Disabilities, New York, NY
42. Elizabeth C. Katz, Ph.D., Research Scientist, Friends Social Research Center, Baltimore, MD
43. Dennis Kenmore, Program Coordinator & Instructor, Alcohol Drug Council, Santa Monica, CA
44. Jane A. Kennedy, D.O., Associate Clinical Professor of Psychiatry, University of Colorado Medical School, Denver, CO
45. John R. Knight, M.D., Associate Professor of Pediatrics, Harvard Medical School & Director, Center for Adolescent Substance Abuse Research, Children's Hospital, Boston, MA
46. Gideon Koren, M.D., F.R.C.P.C., Professor of Pediatrics, Pharmacology, Pharmacy, Medicine, and Medical Genetics, University of Toronto; Senior Scientist, The Hospital for Sick Children, Clinical Pharmacology Department; Director, Motherisk Program, The Ivey Chair in Molecular Toxicology, University of Western Ontario, Canada
47. Thomas Kosten, M.D., Professor of Psychiatry and Medicine, Yale School of Medicine, West Haven, CT
48. Donald J. Kurth, M.D., FASAM, President, California Society of Addiction Medicine, Alta Loma, CA
49. Linda LaGasse, Ph.D., Assistant Professor of Pediatrics, Brown University, Providence, RI
50. Barry Lester, Ph.D., Professor of Psychiatry and Pediatrics, Brown Medical School, Director, Infant Development Center, Providence, RI
51. Joreen Long, Deputy Director, Alcohol Drug Council, High Gain Project, Santa Monica, CA
52. Paul R. Marques, Ph.D., Senior Research Scientist, Pacific Institute for Research and Evaluation, Calverton, MD
53. Jane C. Maxwell, Ph.D., Research Professor, The University of Texas at Austin, Austin, TX

54. Linda Mayes, M.D., Arnold Gesell Professor, Child Psychiatry, Pediatrics, and Psychology, Yale Child Study Center, Yale University School of Medicine, New Haven, CT
55. Nena Messina, Ph.D., Associate Research Criminologist, UCLA Integrated Substance Abuse Programs, Los Angeles, CA
56. Jan Moffitt, Executive Director, Central Texas Council on Alcoholism and Drug Abuse, Harker Heights, TX
57. Connie E. Morrow, Ph.D., Research Associate Professor and Licensed Psychologist,Associate Director, Perinatal CARE Program, Department of Pediatrics, University of Miami, Coral Gables, FL
58. Debra A. Murphy, Ph.D., Research Psychologist, UCLA Department of Psychiatry, Los Angeles, CA
59. Michael A. Nader, Ph.D., Professor of Pharmacology, Wake Forest University, Winston-Salem, NC
60. Prasanna Nair, M.D., M.P.H., Professor of Pediatrics, University of Maryland School of Medicine, Baltimore, MD
61. Daniel R. Neuspiel, M.D., M.P.H., Associate Chairman of Pediatrics, Beth Israel Medical Center, New York, NY
62. Robert G. Newman, M.D., Director, The Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center, New York, NY
63. Noosha Niv, Ph.D., Post-Doctoral Fellow, National Institute on Drug Abuse, Los Angeles, CA
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APPENDIX 6

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

COMMITTEE OPINION

Number 473 • January 2011

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist

Abstract: Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse. Obstetrician–gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their states. They are encouraged to work with state legislators to retract legislation that punishes women for substance abuse during pregnancy.

A disturbing trend in legal actions and policies is the criminalization of substance abuse during pregnancy when it is believed to be associated with fetal harm or adverse perinatal outcomes. Although no state specifically criminalizes drug abuse during pregnancy, prosecutors have relied on a host of established criminal laws to punish a woman for prenatal substance abuse (1). As of September 1, 2010, fifteen states consider substance abuse during pregnancy to be child abuse under civil child-welfare statutes, and three consider it grounds for involuntary commitment to a mental health or substance abuse treatment facility (1). States vary in their requirements for the evidence of drug exposure to the fetus or newborn in order to report a case to the child welfare system. Examples of the differences include the following: South Carolina relies on a single positive drug test result, Florida mandates reporting newborns that are "demonstrably adversely affected" by prenatal drug exposure, and in Texas, an infant must be "addicted" to an illegal substance at birth. Most states focus only on the abuse of some illegal drugs as cause for legal action. For instance, in Maryland, the use of drugs such as methamphetamines or marijuana may not be cause for reporting the pregnant woman to authorities (2). Some states also include evidence of alcohol use by a pregnant woman in their definitions of child neglect.

Although legal action against women who abuse drugs prenatally is taken with the intent to produce healthy birth outcomes, negative results are frequently cited. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse (3–5). Legally mandated testing and reporting puts the therapeutic relationship between the obstetrician–gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient (6, 7). In one study, women who abused drugs did not trust health care providers to protect them from the social and legal consequences of identification and avoided or emotionally disengaged from prenatal care (8). Studies indicate that prenatal care greatly reduces the negative effects of substance abuse during pregnancy, including decreased risks of low birth weight and prematurity (9). Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.

Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing (6). These approaches treat addiction as a moral failing. Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes. Substance abuse reporting during pregnancy may dissuade women from seeking prenatal care and may unjustly single out the most vulnerable, particularly women with low incomes and women of color (10). Although the type of drug may differ, individuals from all races and socioeconomic strata have similar rates of substance abuse and addiction (11).

Pregnant women who do not receive treatment for drug dependence cannot be assumed to have rejected treatment (12). The few drug treatment facilities in the United States accepting pregnant women often do not provide child care, account for the woman's family responsibilities, or provide treatment that is affordable. As of 2010, only 19 states have drug treatment programs for pregnant women, and only nine give priority access to pregnant women (1).

Obstetrician–gynecologists have important opportunities for substance abuse intervention. Three of the key areas in which they can have an effect are 1) adhering to safe prescribing practices, 2) encouraging healthy behaviors by providing appropriate information and education, and 3) identifying and referring patients already abusing drugs to addiction treatment professionals (13). Substance abuse treatment programs integrated with prenatal care have proved to be effective in reducing maternal and fetal pregnancy complications and costs (14).

The use of the legal system to address perinatal alcohol and substance abuse is inappropriate. Obstetrician–gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their states. In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions. These approaches should include the development of safe, affordable, available, efficacious, and comprehensive alcohol and drug treatment services for all women, especially pregnant women, and their families.

Resource

Guttmacher Institute. Substance abuse during pregnancy. State Policies in Brief. New York (NY): GI; 2010. Available at: http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf. Retrieved September 10, 2010.

This report lists policies regarding prosecution for substance abuse during pregnancy and drug abuse treatment options for pregnant women for each state. It is updated monthly.

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Substance abuse reporting and pregnancy: the role of the obstetrician–gynecologist. Committee Opinion No. 473. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:200–1.

APPENDIX 7

Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women

March 11, 2013

To whom it may concern:

A substantial increase has been noted in the number of pregnant women and newborns who test positive for illegal as well as legal opiates, including those utilized as prescribed as well as those misused and/or diverted. A great deal of experience has been gained over the course of almost 50 years regarding the effects of prenatal opiate exposure on expectant mothers and their babies, and guidelines have been established for optimal care of both. And yet, reporting in the popular media continues to be overwhelmingly inaccurate, alarmist and decidedly harmful to the health and well-being of pregnant women, their children, and their communities.

As medical and psychological researchers and as treatment providers with many years of experience studying and treating prenatal exposure to psychoactive substances, as well as treatment providers and researchers with many years of experience studying addictions and addiction treatment, we are writing to urge that policies addressing prenatal exposure to opiates, and media coverage of this issue, be evidence-based rather than perpetuate and generate misinformation and prejudice.

No newborn is born "addicted"

Popular media repeatedly and inaccurately describe children exposed to various drugs *in utero* as "addicted," a term that is incorrect and highly stigmatizing. Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. In fact, babies cannot be born "addicted" to anything regardless of drug test results or indicia of physical dependence. Evidence of physiologic dependence on (not addiction to) opiates has been given the name neonatal abstinence syndrome (NAS), a condition that is diagnosable and treatable. And yet, as the following examples demonstrate, news reports typically and inaccurately describe newborns as addicted (emphasis added).

- "In Broward County, there has been an alarming jump in the number of babies born to pill-using mothers; *babies who are themselves born addicted*." (KTHV Television, *More Pill-Using-Mothers Delivering Addicted Babies*, July 29, 2011)
- "There's a growing epidemic of *babies being born addicted to prescription drugs* ingested by young mothers…" (Bradentown Herald, *Prescription-Abuse Babies a Growing 'Crisis' in Manatee, Say Advocates*, Nov. 9, 2011)
- "The number of *babies born addicted* to the class of drugs that includes prescription painkillers has nearly tripled in the past decade…" (USA Today, *Addicted Infants Triple in a Decade*, May 1, 2012)

- "In the past decade, the number of *babies born addicted to opiates* has tripled." (The Huffington Post, *More Babies Born Addicted to Painkillers, Multiple Reports Show Growing Epidemic*, July 13, 2012)
- "Once, every hour in the U.S. a *baby is born addicted to the painkillers* that swallowed up its mother." (WKYC Television, *Tiniest Victims of Ohio's Painkiller Epidemic*, Aug. 1, 2012)
- "10 percent of the *babies born are addicted to opiates*." (WSAZ News Channel, *Scioto County and Portsmouth Make Strides in the War on Drugs*, Oct. 31, 2012)
- "A new study showing a major increase in Tennessee *babies born addicted to drugs* has prompted the state Health Department to require hospitals to report that information." (WFPL News, *Tennessee Requiring Hospitals to Report Babies Born Addicted to Drugs*, Dec. 5, 2012)

In addition to labeling newborns addicted when they are not, major news outlets have also drawn parallels between children born to women who have used opiates during their pregnancy and those who, a decade ago, were branded "crack babies." For example, Brian Williams began an NBC news report by saying, "For those of us who were reporters back in the 1980s, it was an awful new trend we were covering at the time, and it was the first time our viewers were hearing about the young, innocent infants. A generation of crack babies, born addicted to drugs because of their mothers' habit. Sadly, a new generation has meant a new habit – prescription pain meds, Oxycontin, Vicodin; other powerful drugs in that same category. And now we are seeing the infants born to mothers abusing these drugs." (NBC News, *Prescription Drug Addiction Among Pregnant Women Becoming 'Monstrous Tidal Wave'*, July 5, 2012) An ABC news report likewise claimed: "The increasing numbers of women who abuse prescription painkillers while pregnant are delivering the crack babies of the 21st century, specialists say." (ABC News Medical Unit, *Newborns Hooked on Mom's Painkillers Go Through Agonizing Withdrawal*, Nov. 14, 2011) And The Wall Street Journal described newborns exposed prenatally to cocaine and methadone treatment as "reminiscent of the 'crack babies' of the 1980s and 1990s." (Wall Street Journal, *Pain Pills' Littlest Victims*, Dec. 28, 2012)

In more than 20 years of research, none of the leading experts in the field have identified a recognizable condition, syndrome, or disorder that should be termed "crack baby" (See Open Letter To the Media, February 25, 2004). Rather than learning from its alarmist and false reporting about pregnant women and cocaine use (e.g., New York Times, *The Epidemic That Wasn't*, Jan. 26, 2009), media outlets have now irresponsibly revived the term "crack baby" and created new, equally unfounded and pejorative labels such as "oxy babies" or "oxy tots." (FoxNews, 'Oxytots' Victims of Prescription Drug Abuse, October 28, 2011; The Examiner, *"Oxytots": A National Disgrace*, Oct. 30, 2011)

Equally unjustified is the suggestion that some women who become pregnant and carry their pregnancies to term give birth not to babies but rather to "victims." As noted above, a story in The Wall Street Journal was headlined *Pain Pills' Littlest Victims*. (Wall Street Journal, Dec. 28, 2012) Another recent article in USA Today referred to newborns prenatally exposed to prescription opiates as "the tiniest victims." (USA Today, *Kentucky Sees Surge in Addicted Infants*, Aug. 27, 2012) Of course, where there are victims, there also are perpetrators – in this case, pregnant women and mothers. None of these women – whether receiving methadone or

other opiates for the management of pain, obtaining federally-recommended treatment of dependence, or misusing opiates and experiencing a dependency problem – may fairly be characterized as perpetrators or victimizers.

The most respected and objective authorities in the U.S. and throughout the world, including the World Health Organization, have determined that drug addiction is not a "bad habit" or willful indulgence in hedonism, but a chronic medical condition that is treatable but – as yet – not curable. Demonizing pregnant women creates an environment where punishment rather than support is the predominant response, and will inevitably serve to discourage women from seeking care.

Long-term implications for offspring misrepresented

News media also typically report or suggest that "those born dependent on prescription opiates … are entering a world in which little is known about the long-term effects on their development." (New York Times, *Newly Born, and Withdrawing from Painkillers*, April 9, 2011) And yet, when controlling for factors such as economic status, access to healthcare, and concomitant medical problems, including use of nicotine products and alcohol, decades of studies reported in the professional literature have failed to demonstrate *any* long-term adverse sequelae associated with prenatal exposure to opiates, legal or illegal. On the other hand, it is not an exaggeration to state that labels such as "victim" or "tiny addict" or "born addicted" carry with them severe negative consequences, both medical and social. Children so labeled are at substantial risk of stigma and discrimination in educational contexts starting at the pre-school level. They may be subject to medical misdiagnosis and unnecessary, detrimental separation from loving and supportive families as a result of ill-informed and inappropriate child welfare interventions.

It should be clear from the above that we are not preoccupied with semantic niceties, but deeply concerned about reporting that, very literally, threatens the lives, health, and safety of children.

Neonatal abstinence syndrome, when it occurs, is treatable and has not been associated with long-term adverse consequences

Both the occurrence and severity of NAS have been shown to be affected by a variety of factors that are unrelated to possible pharmacological effects of prenatal exposure to opiates. For example, a 2006 study demonstrated that babies who stayed in their mothers' room while in hospital (i.e., "rooming in") rather than being placed in neonatal intensive care units (NICU) had less need for treatment of NAS, shorter length of hospital stay, and significantly greater likelihood of being discharged home in the custody of their mothers. Similarly, a 2010 study found that only 11% of babies who boarded with their mothers required treatment of NAS compared to more than four times as many who were placed in an NICU.

Moreover, it has long been known that NAS, when it occurs, can be treated effectively. NAS can be evaluated and managed with scoring systems and treatment protocols that have been available for decades in standard textbooks and in numerous articles in the professional literature. Appropriate care, which may include breastfeeding and "comfort care" (e.g.,

swaddling and skin-to-skin contact between mother and baby), is often sufficient to prevent or minimize signs of distress in the baby. There simply is no reason why babies should as stories report "go through agonizing withdrawal" or demonstrate "…merciless screams, jitters and unusually stiff limbs." News reports describing newborns suffering suggest lack of appropriate medical training and the failure to provide optimal medical care rather than inevitable, untreatable, effects of prenatal exposure to opiates. (e.g., The Gadsen Times, *Our View: Addicted at Birth*, Nov. 15, 2011; PBS Newshour, *Painkiller 'Epidemic' Deepens in U.S.*, Nov. 2, 2011; Knoxville News Sentinel, *Drug-addicted Babies Difficult to Treat*, Nov. 1, 2011)

Media misinformation and stigmatizing characterizations discourage appropriate, federally recommended treatment

Recent reporting also frequently dangerously mischaracterizes methadone maintenance treatment as harmful and unethical. For example, a CNN story irresponsibly portrays a woman's decision to follow recommended treatment as a form of abuse:

> **Narrator 1**: Guided by her doctor, April did what she thought was best for her baby and stayed on methadone for her entire pregnancy. The end result? Mariah was born dependent on drugs.
> **Narrator 2**: What did that feel like to know that your use of methadone had caused her so much suffering?
> **April Russell**: Oh it's, I mean, I can't explain it. I mean, it killed me. I mean, still today I mean it's, it's hard (April starts to cry). But, (stops talking due to crying), sorry.

(CNN video broadcast, *One Baby Per Hour Born Already in Withdrawal*, April 12, 2012) Similarly, NBC News reported that a pregnant woman in treatment "can't save her baby from going through withdrawal. Because methadone is another form of medication similar to painkillers, there is a good chance her baby will be born addicted to that drug." (NBC News, July 5, 2012) And The New York Times reported that "those who do treat pregnant addicts face a jarring ethical quandary: they must weigh whether the harm inflicted by exposing a fetus to powerful drugs, albeit under medical supervision, is justifiable." (New York Times, April 9, 2011)

The evidence for the efficacy of methadone maintenance treatment – most particularly its use in the care of pregnant women – has been overwhelmingly consistent for almost half a century. The highest U.S. government authority on drug abuse treatment, the Substance Abuse and Mental Health Services Administration, summed it up in a pamphlet it produced several years ago and continues to distribute. It is directed to pregnant, opiate-dependent women and states in unusually clear and concise terms: "If you're pregnant and using drugs such as heroin or abusing opioid prescription pain killers, it's important that you get help for yourself and your unborn baby. Methadone maintenance treatment can help you stop using those drugs. It is safe for the baby, keeps you free of withdrawal, and gives you a chance to take care of yourself … Methadone maintenance treatment can save your baby's life." Recently, buprenorphine treatment has also been used effectively to treat opiate addiction in pregnant women.

There are, however, enormous financial, regulatory, and cultural barriers to this treatment that

are exacerbated by misinformed and inaccurate news reporting. Indeed, we are aware of numerous cases in which judges and child welfare workers have sought to punish as child abusers pregnant women and mothers who are receiving methadone maintenance treatment.

Conclusion

It is deeply distressing that US media continue to vilify mothers who need and those who receive treatment for their opiate dependence, and to describe their babies in unwarranted, highly prejudicial terms that could haunt these babies throughout their lives. Such reporting, judging, and blaming of pregnant women draws attention away from the real problems, including barriers to care, lack of medical school and post-graduate training in addiction medicine, and misguided policies that focus on reporting women to child welfare and law enforcement agencies for a treatable health problem that can and should be addressed through the health care system. It fosters inappropriate, punitive, expensive, and family-disruptive responses by well-meaning but misinformed criminal justice and child protective agencies, creating a reluctance on the part of healthcare professionals to recommend and offer the services that evidence clearly indicates are best for their patients.

We would be happy to furnish additional information, including references to research material discussed. Please feel free to contact Dr. Robert Newman (rnewman@icaat.org), who will coordinate response to such requests.

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APPENDIX 8

AMERICAN MEDICAL ASSOCIATION

"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." Report of American Medical Association Board of Trustees, Legal Interventions During Pregnancy, 264 JAMA 2663, 267 (1990). *See also* American Medical Association, *Treatment Versus Criminalization: Physician Role in Drug Addiction During Pregnancy*, Resolution 131 (1990) ("therefore be it . . . resolved that the AMA oppose legislation which criminalizes maternal drug addiction").

AMERICAN ACADEMY OF PEDIATRICS

"The [Academy] is concerned that [arresting drug addicted women who become pregnant] may discourage mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment." American Academy of Pediatrics, Committee on Substance Abuse, Drug Exposed Infants, 86 Pediatrics 639, 641 (1990).

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

"Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing. Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes." American College of Obstetricians and Gynecologists Committee on Ethics, Committee Opinion 473, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (Jan. 2011).

"Pregnant women should not be punished for adverse perinatal outcomes. The relationship between maternal behavior and perinatal outcome is not fully understood, and punitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses. American College of Obstetricians and Gynecologists Committee on Ethics, Committee Opinion 321, *Maternal Decision Making, Ethics, and the Law* (Nov. 2005).

AMERICAN PUBLIC HEALTH ASSOCIATION

"Recognizing that pregnant drug-dependent women have been the object of criminal prosecution in several states, and that women who might want medical care for themselves and their babies may not feel free to seek treatment because of fear of criminal prosecution related to illicit drug use . . . [the Association] recommends that no punitive measures be taken against pregnant women who are users of illicit drugs when no other illegal acts, including drug-related offenses,

have been committed." American Public Health Association, Policy Statement No. 9020, *Illicit Drug Use by Pregnant Women*, 8 Am. J. Pub. Health 240 (1990).

AMERICAN NURSES ASSOCIATION

"The American Nurses Association recognizes alcohol and other drug problems as treatable illnesses. 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." American Nurses Association, Position Statement on Opposition to Criminal Prosecution of Women for Use of Drugs While Pregnant and Support for Treatment Services for Alcohol and Drug Dependent Women of Childbearing Age (Apr. 5, 1991).

AMERICAN SOCIETY OF ADDICTION MEDICINE

"Criminal prosecution of chemically dependent women will have the overall result of deterring such women from seeking both prenatal care and chemical dependency treatment, thereby increasing, rather than preventing harm to children and to society as a whole." American Society of Addiction Medicine, *Policy Statement on Chemically Dependent Women and Pregnancy* (Sept. 1989).

MARCH OF DIMES

"Punitive approaches to drug addiction may be harmful to pregnant women because they interfere with access to appropriate health care. Fear of punishment may cause women most in need of prenatal services to avoid health care professionals." March of Dimes, *Statement on Maternal Drug Abuse* (1990).

AMERICAN PSYCHIATRIC ASSOCIATION

The APA states, "policies of prosecuting pregnant and/or postpartum women who have used either alcohol or illegal substances during pregnancy, on grounds of 'prenatal child abuse'[and their] subsequent incarceration, either in jails, prisons or in locked psychiatric unit both deprives the mother of her liberty and seriously disrupts the incipient or nascent maternal-infant bond….Such policies are likely to deter pregnant addicts from seeking wither prenatal car or addiction treatment, because of fear of prosecution and/or civil commitment." American Psychiatric Association, Position Statement, *Care of Pregnant and Newly Delivered Women Addicts*, APA Document Reference No. 200101 (March 2001).

AMERICAN PSYCHOLOGICAL ASSOCIATION

Resolves that the APA "[a]ffirms its view that alcohol and drug abuse by pregnant women is a public health problem and that laws, regulations and policies that treat chemical dependency

primarily as a criminal justice matter requiring punitive sanctions are inappropriate." Further "[a]ffirms the use of health care strategies to foster the welfare of chemically dependent women and their children by expanding access to prenatal care and to reproductive health care generally." American Psychological Association, *Resolution on Substance Abuse by Pregnant Women* (Aug 1991).

NATIONAL PERINATAL ASSOCIATION

"NPA opposes punitive measures that deter women from seeking appropriate care during the course of their pregnancies. . . . NPA supports comprehensive drug treatment programs for pregnant women that are family-centered and work to keep mothers and children together whenever possible. The most successful treatment models will include access to quality prenatal and primary medical care, child development services, crisis intervention, drug counseling, family planning, family support services, life skills training, mental health services, parent training, pharmacological services, relapse strategies, self-help groups, stress management, and vocational training." National Perinatal Association, Position Statement, *Substance Abuse Among Pregnant Women* (updated as of December 2013).

NATIONAL ASSOCIATION FOR PERINATAL ADDICTION RESEARCH AND EDUCATION

"From a health-care perspective, it appears likely that criminalization of prenatal drug use will be counterproductive. It will deter women who use drugs during pregnancy from seeking the prenatal care which is important for the delivery of a healthy baby . . . . The threat of criminal prosecution alone will not deter women in most instances from using drugs during pregnancy. These women are addicts who become pregnant, not pregnant women who decide to use drugs and become addicts." National Association for Perinatal Addiction Research and Education, *Criminalization of Prenatal Drug Use: Punitive Measures Will Be Counterproductive* (1990).

NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE

"[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 best interests of infants and children by involving the sanctions of the criminal law in the case of a health and medical problem." National Council on Alcoholism and Drug Dependence, Policy Statement, *Women, Alcohol, Other Drugs and Pregnancy* (1990).

ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

"The threat of criminal prosecution prevents many women from seeking prenatal care and early intervention for their alcohol or drug dependence, undermines the relationship between health and social service workers and their clients, and dissuades women from providing accurate and essential information to health care providers. The consequence is increased risk to the health

and development of their children and themselves." Association of Maternal and Child Health Programs, Law and Policy Committee, *Statement Submitted to the Senate Finance Committee Concerning Victims of Drug Abuse: Resolution on Prosecution* (1990).

COALITION ON ALCOHOL AND DRUG DEPENDENT WOMEN AND THEIR CHILDREN

"The criminal prosecution of addicted women solely because they are pregnant is both inappropriate and counterproductive. There is no evidence that a policy of criminal prosecution will either prevent prenatal drug exposure or improve children's health. Rather, prosecution of alcoholic and drug dependent women will very likely deter them from seeking both prenatal care and treatment for their addiction, resulting in increased risks to the health and well-being of women and their children." Coalition on Alcohol and Drug Dependent Women and their Children, *Statement Opposing Prosecution* (1990).

NATIONAL ORGANIZATION ON FETAL ALCOHOL SYNDROME

"At NOFAS, we believe that a legal approach will only deter women with an alcohol problem from seeking prenatal care . . ." "NOFAS supports increased access to treatment services for pregnant women. Pregnant women who are alcohol dependent seldom receive the proper treatment and therapy they need." National Organization on Fetal Alcohol Syndrome, Policy Statement, *Pregnant Women Who Drink Alcohol Need Treatment, Not Prison* (March 23, 2004).

CENTER FOR THE FUTURE OF CHILDREN

"A woman who uses illegal drugs during pregnancy should not be subject to special criminal prosecution on the basis of allegations that her illegal drug use harms the fetus." Center for the Future of Children, 1 The Future of Children at 16 (1991) ("[w]e believe that requiring health providers to report pregnant women to law enforcement for prosecution will reduce the likelihood that these women will seek medical care during pregnancy").

SOUTHERN LEGISLATIVE SUMMIT ON HEALTHY INFANTS AND FAMILIES

"[S]tates should adopt, as preferred methods, prevention, intervention, and treatment alternatives rather than punitive actions to ameliorate the problems related to perinatal exposure to drugs and alcohol." Southern Legislative Summit on Healthy Infants and Families, Policy Statement 8 (Oct. 1990). *See also* Association of Family and Conciliation Courts, *Maternal Substance Abuse Policy Recommendations* (1992) ("criminalization of maternal substance abuse is not in the best interests of the child").

NATIONAL ASSOCIATION OF PUBLIC HILD WELFARE ADMINISTRATORS

The National Association of Public Child Welfare Administrators has stated that "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." National Association of Public Child Welfare Administrators, *Guiding Principles for Working With Substance-Abusing Families and Drug-Exposed Children: The Child Welfare Response* (1991).