IN THE SUPREME COURT OF THE STATE OF NEVADA

Case No. 83224

Jerry Howell, in his capacity as warden of the Florence McClure Women's Correctional Center,

Appellant/Cross-Respondent,

v.

Patience Marie Frazier,

Respondent/Cross-Appellant.

On Appeal from the Sixth Judicial District Court of the State of Nevada in and for the County of Humboldt

No. CV 022510

BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN SOCIETY OF ADDICTION MEDICINE, NEVADA STATE MEDICAL ASSOCIATION, NEVADA PUBLIC HEALTH ASSOCIATION, PHYSICIANS FOR REPRODUCTIVE HEALTH, ACADEMY OF PERINATAL HARM REDUCTION, ADVOCACY AND RESEARCH ON THE REPRODUCTIVE WELLNESS OF INCARCERATED PEOPLE, PROJECT SANA, DANIEL GROSSMAN, MD, AND SARAH ROBERTS, DrPH IN SUPPORT OF RESPONDENT/CROSS-APPELLANT (FOR AFFIRMANCE)

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NRAP 26.1 Disclosure

The undersigned counsel of record hereby certifies that the following are non-governmental entities that must be disclosed under NRAP 26.1(a).

- American College of Obstetricians and Gynecologists
- American Society of Addiction Medicine
- Nevada State Medical Association
- Nevada Public Health Association
- Academy of Perinatal Harm Reduction
- Physicians for Reproductive Health
- Advocacy and Research on the Reproductive Wellness of Incarcerated People
- Project SANA

- Daniel Grossman, MD
- Sarah Roberts, DrPH

They are entities with no parent corporations. Dr. Grossman and Dr. Roberts are individuals.

The above *amici* did not appear in the underlying action and have submitted to this Court a motion for leave to file this brief. They are represented in the current action, as amicus curiae, by Robert L. Eisenberg, of the firm of Lemons, Grundy, & Eisenberg, and Farah Diaz-Tello of If/When/How (pending *pro hac vice* admission).

DATED this 28th day of April, 2022.

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Interest of Amici Curiae[1]

Amici curiae are medical and public health experts whose research, clinical practice, and advocacy include a focus on reproductive health and policy approaches to public health concerns that promote the well-being of pregnant people.

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women. With more than 62,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care. ACOG has appeared as amicus curiae in courts throughout the country. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, as a leading provider of authoritative scientific data regarding pregnancy, childbirth, and abortion.

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[1] No counsel of a party authored this brief in whole or part, and no person other than *amici* or their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

The American Society of Addiction Medicine (ASAM) represents more than 7,000 physicians, clinicians, and associated professionals who prevent, treat, and promote remission and recovery from the disease of addiction. ASAM members are dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, and supporting research and prevention of addiction. ASAM is committed to reducing potential drug-related harms at every reasonable opportunity and shares concern for the health and welfare of children and pregnant persons.

The Nevada State Medical Association (NSMA) is a professional organization that has been representing Nevada physicians since 1875. As the longest-standing voice of professional medicine in the state, NSMA advocates for high quality health care for all Nevadans, and represents physicians at the state and local levels of government, as well as before the U.S. Congress and the Nevada Legislature. NSMA works to eliminate barriers to healthcare, including reproductive healthcare, and represents the Nevada Section of the American Congress of Obstetricians and Gynecologists in policy matters before the Nevada Legislature. NSMA joins to emphasize the importance of removing criminal penalties for conduct affecting the outcome of a pregnancy so that all Nevadans are able to access pregnancy-related care.

The Nevada Public Health Association (NPHA) is Nevada's leading group of public health professionals and public health partners. With more than 300 members statewide, NPHA's mission is to serve as the voice for public health in Nevada in order to improve health and achieve health equity in our state. NPHA's vision is a healthy Nevada. In keeping with its mission and vision, a key element of NPHA's advocacy agenda is protecting and promoting maternal, child, and adolescent health in Nevada, including advocacy for increased access to reproductive services and evidence-based care for women. NPHA supports the decriminalization of self-managed abortion and non-punitive responses to substance use in pregnancy.

Physicians for Reproductive Health (PRH) is a nonprofit organization that organizes, mobilizes, and amplifies the voices of medical providers to advance sexual and reproductive health, rights, and justice. Its programs combine education, advocacy, and strategic communications to ensure access to abortion care and equitable, comprehensive health care. PRH believes this work is necessary for all people to live freely, with dignity, safety, and security.

The Academy of Perinatal Harm Reduction (APHR) provides evidence-based, stigma-free education and support to help people who use drugs have healthy pregnancies and births, while mitigating the harms associated with substance use and exposure. Drawing from a growing body of evidence on how to

effectively support pregnant people and parents who use drugs, APHR affirms people's lived experiences and fosters community to realize creative solutions for well-being.

Advocacy and Research on Reproductive Wellness of Incarcerated People (ARRWIP) is a research group based at Johns Hopkins School of Medicine. The ARRWIP team situates its work at the intersections of reproductive health, reproductive justice, and mass incarceration in the U.S. Its research addresses reproductive health care issues for people experiencing incarceration. Working with key stakeholders, including directly impacted people and policy makers, ARRWIP aims to contribute to meaningful change in recognizing the full humanity and value of incarcerated people's reproductive lives. ARRWIP strongly opposes actions that criminalize health care, and people who are pregnant for their actions to access necessary health care. (Institutional affiliation provided for identification purposes only.)

Project SANA, the Self-Managed Abortion Needs Assessment Project, is an interdisciplinary research group at the University of Texas at Austin examining how and why people self-manage their abortions in the United States. Project SANA's findings have illuminated the role of state policy in driving the need for self-management and the experiences of those who manage their own care. (Institutional affiliation provided for identification purposes only.)

Daniel Grossman, MD, FACOG, is an obstetrician-gynecologist and researcher based at the University of California, San Francisco, where he is the Director of Advancing New Standards in Reproductive Health (ANSIRH). His research includes both clinical and social science studies aimed at improving access to contraception and abortion in the U.S., Latin America, and sub-Saharan Africa. As an investigator with the Texas Policy Evaluation Project (TxPEP), he has studied changes in abortion access and rates of self-induced abortion in response to abortion restrictions, and has published extensively on the importance of harm reduction in post-abortion care and miscarriage management. (Institutional affiliation provided for identification purposes only.)

Sarah Roberts, DrPH, is a Professor and Legal Epidemiologist at Advancing New Standards in Reproductive Health (ANSIRH) at the University of California, San Francisco. She studies the ways that policies and the health care system punish, rather than support, structurally vulnerable pregnant people, including pregnant people who use alcohol and drugs and pregnant people seeking abortion. Dr. Roberts' current research focuses on evaluating impacts of state-level pregnancy-specific alcohol and drug policies and understanding health care provider reporting practices in the contexts of self-managed abortion and of birthing people’s use of alcohol and drugs. Previously, Dr. Roberts has led research about public health approaches to abortion, and the impacts of state-level

restrictive abortion policies. She has published more than 90-peer reviewed manuscripts and has received grant funding from multiple private foundations as well as the National Institutes of Health and other government agencies. (Institutional affiliation provided for identification purposes only.)

Amici's collective decades of research, service, and advocacy surrounding the matters of general public interest raised by this case make them well-situated to lend perspective that can assist this Court.

Introduction

Patience Frazier was criminally prosecuted for experiencing a stillbirth under NRS 200.220, a century-old criminal statute originally intended to imprison women for having abortions. In her cross-appeal, Ms. Frazier challenges NRS 200.220 on the grounds that it violates constitutional due process and equal protection guarantees. Her challenge will mark the first reported opportunity a Nevada appellate court has had to consider the validity of the law. In assessing the validity of NRS 200.200, this Court will have to examine the law's intended purpose, its justifications, and its real-world ramifications for the many other Nevadans who experience adverse pregnancy outcomes. Understanding the harms that people face when they are criminalized for ending or losing a pregnancy is critical to the Court's adjudication of the issues under consideration.

On this point, *amici*, as experts in perinatal care and the troubling consequences that arise from punitive responses to pregnancy outcomes, have insights that can assist this Court. In brief, *amici* seek to provide context that will demonstrate that neither losing a pregnancy nor having an abortion is a proper justification for imposing criminal penalties.

Amici further wish to inform the court of the unmistakable trend – dating as far back as the common law – of prohibiting the imposition of criminal penalties on people for acts or omissions that might affect their own pregnancies. This trend reflects the recognition that criminalization of reproductive outcomes has devastating, even life-threatening, consequences. It prevents people from seeking medical care when they need it, subjects them to cruel and humiliating investigations in the midst of medical emergencies, and consigns them to stigma and condemnation in their communities. Worse, the harms of criminalization are disproportionately borne by people who are already marginalized due to their race and socioeconomic disadvantage, compounding the effects of a legal scheme that singles people out for sex-based criminalization.

Argument

Punishing people for reproductive outcomes violates their fundamental rights by inserting punitive state proceedings into some of the most intimate aspects of their lives and creating inherently discriminatory legal standards that

punish people on the basis of their capacity to become pregnant.[2] The U.S. and Nevada constitutions protect against such incursions against dignity, forbidding the state from depriving people of their rights to liberty, equality, and due process without appropriate justification. When the state seeks to enforce laws that transgress these rights, courts are called to evaluate the state's asserted interest in the law's enforcement, whether that interest warrants restraint of an individual's rights, and whether the state's purpose is served by the enforcement of the law. *See Youngberg v. Romeo*, 457 U.S. 307, 321 (1982); *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997). No law similarly criminalizing a pregnant woman for causing a miscarriage has survived constitutional challenge. *See McCormack v. Hiedeman*, 694 F.3d 1004, 1015–18 (9th Cir. 2012); *Henrie v. Derryberry*, 358 F. Supp. 719, 724–25 (N.D. Okla. 1973). But regardless of the form of constitutional scrutiny applied, NRS 200.220 fails. Criminalizing people who experience pregnancy losses or end their pregnancies thwarts, rather than advances, any interest the state might raise in protecting maternal or infant health and hinders the fair administration of law.

[2] People with a range of gender identities can become pregnant, including transgender men or non-binary individuals. The harms that emerge from prosecuting people based on their pregnancy outcomes apply irrespective of a person's gender identity.

I. Prosecuting people for reproductive health outcomes harms individual and public health by deterring them from seeking healthcare.

Medical authorities, including *amici*, are unanimous in their opposition to laws or practices that criminalize people for the circumstances or outcomes of their pregnancies. Whether the charge is for self-managing an abortion outside of the formal medical system or for an act or omission believed to have increased risk to a fetus, prosecuting people for ending or losing pregnancies defies tenets of sound medical practice, ethics, and science.

By imposing criminal penalties for people who end or lose their pregnancies, NRS 200.220 directly contradicts the guidance provided by experts dedicated to advancing maternal, fetal, and infant well-being. For decades, medical and public health associations have issued increasingly dire warnings about the consequences of criminalizing people who self-manage abortions, use criminalized drugs during pregnancy, or otherwise experience an adverse pregnancy outcome. Their opposition to this practice is rooted in a commitment to maternal, fetal, and infant well-being, and in the understanding the threat of punishment makes healthcare unsafe and inaccessible.

Amicus the American College of Obstetricians and Gynecologists (ACOG), the nation's leading authority on the care of pregnant patients, has long held that criminalization of pregnancy outcomes is both unjust and hazardous to maternal and infant health. It recently took an unequivocal public stance, adopting a 2020

policy statement urging the elimination of laws or practices criminalizing acts alleged to be harmful to a patient's own pregnancy."[3] Such criminalization, ACOG observes, "violates the pillars of medical ethics," depriving patients of their autonomy, discriminating on the basis of gender, and flouting the mandates of beneficence and non-maleficence.[4] Laws that seek to impose control upon pregnancy through the use of the criminal legal system are "counterproductive to the overarching goal of improving maternal and neonatal outcomes."[5] ACOG cites "fear of interrogation, arrest, and prosecution while seeking health care services and medical treatment" as a barrier to care.[6]

A. Criminalizing pregnant people who use drugs during pregnancy creates barriers to healthcare for those who could most benefit from it.

The State interpreted NRS 200.220's prohibition of "any drug" used "with the intent to terminate [the accused's] pregnancy after the 24th week of pregnancy" to authorize the criminal prosecution of women who use controlled substances and experience stillbirths. This interpretation of the law puts it in direct opposition to

[3] Am. Coll. of Obstetricians & Gynecologists, *Statement of Policy: Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*, Dec. 2020, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period.
[4] *Id.*
[5] *Id.*
[6] *Id.*

the policy recommendations of every expert in the field of perinatal care: the admonition against penalizing acts believed to increase risk to a pregnancy applies equally – perhaps especially – in the case of substance use.

As the U.S. Supreme Court has recognized, the threat of being reported to law enforcement when receiving pregnancy-related care "may have adverse consequences because it may deter patients from receiving needed medical care." *See, e.g., Ferguson v. City of Charleston*, 532 U.S. 67, 78 n. 14 (2001), *citing Whalen v. Roe*, 429 U.S. 589, 599-600 (1977). Lack of prenatal care, regardless of whether a person uses controlled substances, is associated with worse pregnancy outcomes.[7] For this reason, experts in care in the perinatal period all reject policies that punish patients for the circumstances and outcome of their pregnancies, and instead emphasize the importance of a health-focused approach that encourages open communication with clinicians.

ACOG's Committee on Underserved Women explains that "use of the legal system to address perinatal alcohol and substance abuse is inappropriate." [8] Nor

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[7] *See* Anthony M. Vintzileos et al., *The Impact of Prenatal Care on Neonatal Deaths in the Presence and Absence of Antenatal High-Risk Conditions*, 186(5) Am. J. Obstetrics & Gynecology 1011, 1013-14 (2002); Susan H. Friedman et al., *Disposition and Health Outcomes Among Infants Born to Mothers with No Prenatal Care*, 33 Child Abuse & Neglect 116 (2009).

[8] 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* 2 (2011, *reaff'd* June 2019).

should use of controlled substances lead to "civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing."[9] Imposing punishment casts addiction, inaccurately, as a failure of will rather than "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences."[10] As a result, the Committee calls upon obstetrician-gynecologists to advocate against state policies that harm maternal and fetal health by creating such barriers to care, and to instead encourage supportive, treatment-focused approaches.[11]

ACOG is joined in this perspective by virtually every other major medical association. ACOG's Committee on Obstetric Practice joined with the American Society of Addiction Medicine to issue a statement outlining the importance of a health-systems approach to substance use in pregnancy, noting that "a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families."[12] The American Academy of Pediatrics considers punitive approaches to substance use "ineffective" and warned that they "may have

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[9] *Id*. at 1.
[10] Am. Soc'y Addiction Med., *Definition of Addiction* (2019), https://www.asam.org/quality-care/definition-of-addiction;
[11] Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion 473*, *supra* note 8 at 2.
[12] Am. Coll. of Obstetricians & Gynecologists, Comm. on Obstetric Practice & Am. Soc'y Addiction Med., *Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy* (2012, *reaff'd* 2021).

detrimental effects on both maternal and child health" in reaffirming a longstanding position that such measures are "are not in the best interest of the health of the mother-infant dyad."[13]

The American Medical Association (AMA), too, has adopted a series of policies over several years in opposition to punitive interventions during pregnancy, calling criminal sanctions for actions believed to have harmed a woman's own fetus "inappropriate,"[14] and noting that "[t]ransplacental drug transfer should not be subject to criminal sanctions or civil liability."[15] In 2020, the AMA reconfirmed its position, which it has taken for more than 30 years, to "oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment."[16]

Public health experts like the American Public Health Association have also spoken out against measures that criminalize people based on pregnancy or pregnancy outcomes. In a 2013 policy statement opposing such measures, APHA

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[13] Am. Acad. of Pediatrics, Comm. on Substance Use and Prevention, *Policy Statement, A Public Health Response to Opioid Use in Pregnancy* (2017).
[14] Am. Med. Ass'n, *Policy 420.969: Legal Interventions During Pregnancy* (1990, *reaff'd* 2018).
[15] Am. Med. Ass'n, *Policy 420.962: Perinatal Addiction – Issues in Care and Prevention* (1992, *reaff'd* 2019).
[16] Am. Med. Ass'n, *Policy H-420.970: Treatment Versus Criminalization: Physician Role in Drug Addiction During Pregnancy* (1990, *reaff'd* 2020).

noted that "no compelling or public health justification" has been offered to support laws that would subject pregnant people to arrest and prosecution based on acts with respect to a fetus.[17]

In sum, there is unanimous accord among the nation's leading medical and public health organizations that any interest the state may have in protecting maternal and fetal well-being is undermined when pregnant patients fear arrest because of pregnancy outcomes. This is not to suggest that the state has no role to play in ensuring maternal and fetal health. To the contrary, pregnancy can be a motivator for a pregnant person to address problematic substance use,[18] and an opportunity for the state to provide supportive services, as it does when pregnant patients are addicted to other harmful substances like nicotine.[19] Furthermore, access to quality prenatal care is a protective factor in pregnancy,[20] as is drug

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[17] Am. Pub. Health Ass'n, *Policy No. 20139, Renouncing the Adoption or Misapplication of Laws to Recognize Fetuses as Independent of Pregnant Women* (2013).

[18] *See e.g.*, Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. Drug Issues 285 (2003); M.L. Poland et al., *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 Drug Alcohol Dependence 199 (1993); Mishka Terplan et al., *Methamphetamine Use Among Pregnant Women*, 113 Obstetrics & Gynecology 1289, 1290 (2009).

[19] *See, e.g.*, Washoe County Health District, *Baby & Me Tobacco Free*, https://www.washoecounty.gov/health/programs-and-services/cchs/chronic-disease-prevention/be-tobacco-free/baby-and-me.php (describing a free smoking cessation program, including financial incentives offered to pregnant Nevadans).

[20] Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 Health & Just. 1, 2–8, 14 (2015) (pregnant drug users delayed or avoided prenatal care out of fear of criminal punishment, though they were

treatment.[21] If the state wishes to advance any interest in the protection of the health of pregnant women and their infants, the way forward is clear: it must remove, not erect, barriers. And the importance of unfettered access to healthcare is just as critical to the health of women who end their pregnancies as it is to those who carry to term.

B. Criminal penalties endanger people who self-manage abortions by impeding their ability to access to medical support without delay.

In addition to jeopardizing the health of pregnant patients who use controlled substances by imposing felony charges in the event of a pregnancy loss,

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likelier to experience positive birth outcomes when they received prenatal care); P. Moran et al., *Substance Misuse During Pregnancy: Its Effects and Treatment*, 20 Fetal & Maternal Med. Rev. 1, 16 (2009); Andrew Racine et al., *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 J. Am. Med. Ass'n 1581, 1585-86 (1993) (finding that prenatal care reduces the risk of low-birthweight babies among women who use drugs); Edward F. Funai et al., *Compliance with Prenatal Care in Substance Abusers*, 14(5) J. Maternal Fetal Neonatal Med. 329, 329 (2003); Cynthia Chazotte et al., *Cocaine Use During Pregnancy and Low Birth Weight: The Impact of Prenatal Care and Drug Treatment*, 19(4) Seminars in Perinatology 293, 293 (1995); Sheri Della Grotto et al. *Patterns of Methamphetamine Use During Pregnancy: Results from the Infant Development, Environment, and Lifestyle (IDEAL) Study*, 14 Maternal Child Health J. 519 (2010).

[21] *See, e.g,* Patrick J. Sweeney et al., *The Effect of Integrating Substance Abuse Treatment with Prenatal Care on Birth Outcomes*, 20(4) J. Perinatology 219, 223 (2000) (indicating significantly better pregnancy outcomes when women received drug treatment and prenatal care.); N.C. Goler et al., *Substance Abuse Treatment Linked with Prenatal Visits Improves Perinatal Outcomes: A New Standard*, 28 J. Perinatology 597, 602 (2008) ("[Women] will only get better if they receive appropriate support that they can access without . . . stigmatization or fears of criminal investigation.").

NRS 200.220 explicitly criminalizes women who self-manage an abortion. This, too, is in direct contradiction of the warnings issued by medical experts, who are — in the midst of legislative attacks on the constitutionally-protected right to abortion — sounding the alarm of the potentially dangerous consequences of imposing legal penalties for people unable to access abortion care through legal channels.

1. Increasing restrictions to abortion care are driving an increase in self-managed abortion.

In many states across the country, there has been a rapid escalation in attempts to restrict access to abortion care. In 2021 alone, 108 abortion restrictions were enacted, more than any other year since *Roe v. Wade* was decided.[22] And as access to clinic-based abortions is restricted, people looking for accessible alternatives are increasingly turning to self-managed abortion. [23] While it is difficult to count abortions that take place outside of the medical system, research

[22] Elizabeth Nash, Guttmacher Institute, *State Policy Trends 2021: The Worst Year for Abortion Rights in Almost Half a Century* (Dec. 2021), https://www.guttmacher.org/article/2021/12/state-policy-trends-2021-worst-year-abortion-rights-almost-half-century.

[23] *See* Heidi Moseson et al., *Self-Managed Abortion: A Systematic Scoping Review* 3, UCSF (Nov. 4, 2019), http://escholarship.org/uc/item/1mj5832t ("Regardless of the legal climate, people may seek alternative models of abortion provision, such as self-managed abortion, when they cannot or do not want to access facility-based abortion care.").

suggests that it is a relatively common occurrence.[24] In a one-month period, there were more than 210,000 unique internet searches for terms related to self-managed abortion. [25] One online service that mails abortion pills to pregnant people internationally received more than 57,000 U.S.-based requests—from all fifty states—for medication to self-manage abortion between 2018 and 2020.[26]

Unsurprisingly, demand for self-managed abortion is higher in states with abortion restrictions: 76% of U.S.-based requests came from states that heavily restrict abortion.[27] In Texas, requests to an online telemedicine service jumped 1180% in the weeks following the enactment of Senate Bill 8, which makes abortion inaccessible for most pregnant people after six gestational weeks.[28] Nevada, despite being characterized as having a "supportive" policy climate, had a

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[24] Lauren Ralph et al., *Prevalence of Self-Managed Abortion Among Women of Reproductive Age in the United States,* 3(12) J. Am. Med. Ass'n Network Open e2029245 (estimating 7% of U.S. women will attempt to self-manage an abortion in their lives).

[25] *See* Jenna Jerman et al., *What are People Looking for When They Google "Self-Abortion"?,* 97 Contraception 510, 512 (2018) (62% of 1235 respondents indicated that they were searching because they were pregnant and did not want to be).

[26] Abigail R.A. Aiken et al., *Factors Associated with Use of an Online Telemedicine Service to Access Self-Managed Medical Abortion in the US,* 4 JAMA Network Open e2111852, at 1 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780272.

[27] Abigail R.A. Aiken et al., *Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States,* 110(1) Am. J. Pub. Health 90, 92 (2020).

[28] Abigail R.A. Aiken et al., *Association of Texas Senate Bill 8 with Requests for Self-Managed Medication Abortion,* (5)2 JAMA Network Open e221122 (2022).

density of requests similar to that of "hostile" states like Kentucky and Texas.[29] This reflects the fact that people who self-manage their abortions may experience barriers to care other than legal restrictions, such as distance to the nearest clinic (likely to affect rural Nevadans who live a great distance from the nearest provider), or the cost of care.[30] Thus, even in states that protect abortion rights, it is still imperative to ensure that people who self-manage can do so safely.

2. Criminalization needlessly imperils people who self-manage abortions.

The need to ensure that people can access care without hesitation has led medical associations to oppose laws like NRS 200.220 that criminalize self-managed abortion. While the abortion pills mifepristone and misoprostol have made abortion so safe that their self-directed use is recommended as an option by the World Health Organization within the first 12 weeks of pregnancy, it is important that abortion-seekers have "the support of trained health workers and access to a health-care facility and to referral services if they need or desire it."[31] And — as Ms. Frazier's case bears out — some people may yet resort to unsafe or

[29] Aiken et al., *supra* note 27, at T. 2.
[30] *See* Abigail R.A. Aiken et al., *Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States,* 110 Am. J. Pub. Health 90, 94–95 (2020).
[31] World Health Org., Human Reproduction Programme, *Abortion Care Guideline* 98 (2022).

ineffective means.[32] In such situations, patients "may need life-saving critical care for sepsis, hemorrhage, pelvic-organ injury, or toxic exposures."[33] Health care providers recognize that "women's legal safety — their risk of prosecution — may be the biggest threat to their well-being."[34]

As the American College of Obstetricians and Gynecologists has explained, "[t]he threat of prosecution may result in negative health outcomes by deterring women from seeking needed care[.]"[35] The American Medical Association shares this position, because criminalizing pregnancy outcomes "increases patients' medical risks and deters patients from seeking medically necessary services[.]"[36] Similarly, the American Public Health Association adopted a policy admonishing that "threat of prosecution, including the risk of being reported by one's doctor, impedes the public health priority of maintaining trust in

[32] *See* Moseson et al., *supra* note 23, at 3 (discussing methods used to end pregnancies outside of medical setting).
[33] Lisa Harris & Daniel Grossman, *Complications of Unsafe & Self-Managed Abortion*, 382(11) New England J. Med. 1029, 1029 (2020).
[34] *Id.*
[35] Am. Coll. of Obstetricians & Gynecologists, *Position Statement: Decriminalization of Self-Induced Abortion* (Dec. 2017), https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2017/decriminalization-of-self-induced-abortion.
[36] Am. Med. Ass'n, *Oppose the Criminalization of Self-Induced Abortion H-5.980* (2018) ("No person should be subject to legal action for decisions they make about ending a pregnancy.").

the health care system and ensuring access to information and medical care for people who self-manage."[37]

The harms to health created by inserting the fear of criminal prosecution into seeking post-abortion care are not hypothetical. People in the U.S. who fear arrest avoid the healthcare system, even in the absence of a law that would criminalize them. For example, people who could die from a drug overdose are still unlikely to seek medical care for fear of arrest, even when laws encourage them to seek such care.[38] The same is true of people who fear being criminalized for their pregnancy outcomes.[39] Unfortunately, based on the experiences of individuals criminalized for their pregnancy outcomes in the U.S., the fears that drive people away from medical care are well-founded.

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[37] Am. Pub. Health Ass'n, *Policy No. 20217, Decriminalization of and Support for Self-Managed Abortion* (Oct. 26, 2021) https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Decriminalization-of-and-Support-for-Self-Managed-Abortion.

[38] Stephen Koester et al., *Why Are Some People Who Have Received Overdose Education and Naloxone Reticent to Call Emergency Medical Services in the Event of Overdose?*, 48 Int'l J. Drug Pol'y 115, 116 (2017).

[39] Sarah C.M. Roberts, *Women's Perspective on Screening for Alcohol and Drug Use in Prenatal Care*, 20 Women's Health Issues 193, 198 (2010) (finding that women who feared legal consequences based on substance use in pregnancy avoided or disengaged from care); Sarah C.M. Roberts & Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, 15(3) Maternal & Child Health J. 333 (2011).

II. Prosecutions based on reproductive outcomes are irreconcilable with scientific evidence.

The imposition of penalties for abortions or stillbirths is based on the faulty presumption that pregnancy lends itself to legal processes to determine guilt or innocence. The precepts of the criminal legal system are inapt to the context of pregnancy: it is frequently impossible to determine the cause of a pregnancy outcome. Where the stakes are as high as they are under NRS 200.220, the legal process warrants a level of certainty that science is simply unable to provide. Furthermore, the inability to reliably point to a specific cause of a particular pregnancy outcome exacerbates due process concerns by leaving NRS 200.220 susceptible to arbitrary and discriminatory interpretation.

A. The cause of a stillbirth can be difficult, frequently impossible, to discern.

Among the theories pursued by the State was the notion that Ms. Frazier's use of methamphetamine caused her pregnancy loss. I A.A. 35, 39. As every medical expert presented in the case testified, the available evidence did not support this theory, nor would it be possible to conclusively determine with the available evidence. II R. App. 321-323, 328-333. In fact, this is the case in a substantial percentage of stillbirths.

Stillbirth is the unfortunate outcome of one of every 160 pregnancies each year.[40] Fetal deaths are unique in their inexplicability: the most frequently cited cause is "unspecified."[41] Studies have found that as many as 66% of stillbirths are unexplained.[42] That is to say that medicine frequently cannot offer an explanation – it can only offer risk factors and known associations. But, critically, associations are distinct from causation.[43]

For instance, as was presented in the court below, methamphetamine use among pregnant individuals has not been associated with obstetric outcomes that can lead to perinatal death, such as preterm delivery, placental abruption, or stillbirth.[44] It has been associated with reduced fetal growth[45] and low birth

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[40] Stillbirth Collaborative Research Network Writing Group, *Cause of Death Among Stillbirths,* 306(22) J. Am. Med. Ass'n 2459 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4562291/.
[41] D.L. Hoyert & E.C.W Gregory, Ctrs. for Disease Control & Prevention, Div. of Vital Stats., *Cause of Fetal Death: Data from the Fetal Death Report, 2014,* Nat'l Vital Stats. Rep., Oct. 31, 2016, vol. 67(7), at 4 (rates of reported stillbirth with an unspecified cause of death "ranged from 18.3% to 75.4%").
[42] Jason Gardosi et al., *Classification of Stillbirth by Relevant Condition at Death (ReCoDe): Population Based Cohort Study*, 331(7525) British Med. J. 1113, 1114 Nov. 12, 2005).
[43] R.M. Silver et al., *Work-Up of Stillbirth: A Review of the Evidence*, 196(5) Am. J. Obstetrics & Gynecology 433 ("[C]"onditions may be associated with stillbirth without directly causing them.").
[44] Rizwan Shah et al., *Prenatal Methamphetamine Exposure and Short-Term Maternal and Infant Medical Outcomes,* 29(5) Am. J. Perinatology 391 (2012).
[45] Corie B. Miller & Tricia Wright, *Investigating Mechanisms of Stillbirth in the Setting of Prenatal Substance Use.* 8(4) Academic Forensic Pathology 865 (2018).

weight.[46] But low birth weight is also associated with other factors, such as maternal age, race and ethnicity, and even education level.[47] The notion that in-utero substance exposure is uniquely or inevitably harmful in a way that can be singled out from other risk factors is not supported by evidence-based research.[48]

The evidentiary deficiencies that plagued the prosecution against Ms. Frazier are inherent to criminalization of pregnancy outcomes generally. Other courts that have had the opportunity to hear from medical experts have similarly questioned the basis of prosecutorial claims of fetal harm from substance use. For instance, South Carolina's Supreme Court freed a woman who had been incarcerated based on an allegation that her use of cocaine caused a stillbirth. *McKnight v. State*, 661 S.E.2d 354 (S.C. 2008). In a unanimous decision, the court noted that the trial counsel's failure to call expert witnesses who could have discussed "recent studies

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[46] Diana Nguyen et al., *Intrauterine Growth of Infants Exposed to Prenatal Methamphetamine: Results from the Infant Development, Environment, and Lifestyle Study*, 157(2) J. of Pediatrics 337 (2010).
[47] A.W.G. Ratnasiri, *Recent Trends, Risk Factors, and Disparities in Low Birth Weight in California, 2005-2014: A Retrospective Study*, 4(15) Maternal Health, Neonatology & Perinatology 1 (2018).
[48] Ashley H. Schempf & Donna M. Strobino, *Illicit Drug Use and Adverse Birth Outcomes: Is It Drugs or Context?*, 85 J. Urban Health 858 (2008); Emmalee S. Bandstra et al., *Prenatal Drug Exposure: Infant and Toddler Outcomes*, 29 J. Addictive Diseases 245 (2010); Ashley H. Schempf, *Illicit Drug Use and Neonatal Outcomes: A Critical Review*, 62 Obstetric & Gynecological Survey 749, 750 (2007); Barbara L. Thompson et al., *Prenatal Exposure to Drugs: Effects on Brain Development and Implications for Policy and Education*, 10 Nature Revs. Neuroscience 303, 303 (2009).

showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor" constituted ineffective assistance of counsel. *Id.* at 358 n.2. This observation calls into question not only the process in a single case, but whether a prosecution is ever justifiable given the many factors, both controllable and uncontrollable, that can affect the outcome of a pregnancy.

The desire to explain — and assign liability to — the inexplicable can lead to counterproductive results when it is combined with stigma ascribed to people who use drugs. Popular media have been periodically captivated by claims of "epidemics" or "crises" of harm to pregnancies caused by criminalized drugs.[49] While these claims lack scientific validity, they have led to real harm in the form of widespread attempts to prosecute women who use drugs, in spite of science, and frequently in spite of the law.

B. Attempts by prosecutors across the country to criminalize pregnancy losses demonstrate the risk of arbitrary enforcement.

Prosecutors have sought, largely unsuccessfully, to criminalize pregnancy outcomes. Since 1973, more than 1,200 people suspected of having caused their

[49] *See* Susan Okie, *The Epidemic that Wasn't*, N.Y. Times, Jan. 26, 2009 (acknowledging the inaccuracy of pervasive media accounts of so-called "crack babies" in the 1980s and 90s); Deborah A. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure*, 285 J. Am. Med. Ass'n 1613, 1624 (2001) (noting the correlation between other factors, such as poverty, tobacco, and alcohol, with symptoms previously attributed to cocaine).

own miscarriages or allegedly risking harm to their pregnancies have been arrested for offenses ranging from feticide to child abuse to poisoning.[50] The circumstances vary. These individuals may have used a criminalized drug during pregnancy and given birth to a healthy baby, *see Ex parte Hicks*, 153 So. 3d 53, 55 (Ala. 2014) (upholding felony chemical endangerment conviction, noting that the baby was "doing fine" since birth). Pregnant people may have expressed ambivalence about their pregnancy while seeking help for falling down a flight of stairs,[51] or had a precipitous birth at home that ended in a stillbirth, *see Commonwealth v. Pugh*, 969 N.E.2d 672, 677 (Mass. 2012) (reversing manslaughter conviction for breech delivery that ended in stillbirth).

Prosecutors have even attempted to punish people for their pregnancy outcomes when it results from violence against them. Marshae Jones lost her pregnancy after another person shot her in the stomach.[52] Compounding the trauma

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[50] *See* Farah Diaz-Tello, *Roe Remains for Now… Will it Be Enough*, Human Rights (Sept. 7, 2020), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/health-matters-in-elections/roe-remains-for-now-will-it-be-enough/; *See also* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Pol., Pol'y & L. 299, 309 (2013).

[51] *See* Kevin Hayes, *Did Christine Taylor Take Abortion into Her Own Hands?*, CBS News (Mar. 2, 2010), http://www.cbsnews.com/news/did-christine-taylor-take-abortion-into-her-own-hands (woman arrested for attempted feticide after falling down stairs while pregnant).

[52] Vanessa Romo, *Woman Indicted for Manslaughter After Death of Her Fetus, May Avoid Prosecution*, NPR (Jun. 28, 2019),

of being shot and losing a pregnancy, the state of Alabama indicted Ms. Jones for homicide and incarcerated her on a $50,000 bond. Though the prosecutor eventually dismissed the indictment, Ms. Jones should never have been indicted in the first place: Alabama's homicide statute specifically prohibits homicide charges against "any woman with respect to her unborn child." Ala. Code § 13A-6-1.

Frequently, the rush to judgement that animates these prosecutions undermines their legal integrity, leading to reversal on appeal.[53] But even when courts affirm that the law does not permit punishing people for pregnancy outcomes, the wait for vindication on appeal lasts months or years, causing

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https://www.npr.org/2019/06/28/737005113/woman-indicted-for-manslaughter-after-death-of-her-fetus-may-avoid-prosecution.

[53] *See, e.g., Patel v. State*, 60 N.E.3d 1041, 1045–46, 1056–62 (Ind. Ct. App. 2016) (overturning feticide conviction based on alleged self-managed abortion); *Bynum v. State*, 546 S.W.3d 533, 536, 541–43 (Ark. Ct. App. 2018) (finding that defendant was "clearly prejudiced" by introduction of evidence of her use of abortion pills, noting that using such pills to end a pregnancy is not criminalized); *Arms v. State*, 471 S.W.3d 637, 641–43 (Ark. 2015) (overturning conviction of poisoning crime as applied between a woman and her fetus); *State v. Louk*, 786 S.E.2d 219, 228 (W. Va. 2016) (overturning conviction for child neglect resulting in death based on overdose during pregnancy); *People v. Jorgensen*, 41 N.E.3d 778, 781–82 (N.Y. 2015) (overturning manslaughter conviction of woman involved in car accident whose baby died shortly after emergency delivery); *State v. Stegall*, 828 N.W.2d 526, 529–33 (N.D. 2013) (holding child endangerment statute does not apply to acts by pregnant people in relation to their pregnancies, regardless of birth outcome); *but see Ex parte Ankrom & Kimbrough*, 152 So. 3d 397, 421 (Ala. 2013) (permitting child endangerment charges for prenatal exposure to controlled substances); *Whitner v. State*, 492 S.E.2d 777, 778 (S.C. 1997) (extending criminal child abuse laws to reach acts that affect a viable fetus), *State v. Green*, 474 P.3d 886, 891 (Okla. Crim. App. 2020) (holding that a child neglect statute may apply to a fetus).

irrevocable damage to the people who are caught in unlawful criminal proceedings. Such harms are irreconcilable with the guidance of health experts and the well-being of pregnant people.

III. Nearly every other state has adopted healthcare, rather than criminalization, as the response to adverse pregnancy outcomes.

On its face, NRS 200.220 defies the urgent warning of medical experts that criminalizing pregnancy outcomes is counterproductive by imposing felony jail terms upon a person who uses "any drug, medicine or substance" to end their pregnancy. While the swath it cuts is much broader, the law's target is people who have abortions. In a nation that has recognized the right to abortion as constitutionally protected for nearly a half-century, *Roe v. Wade*, 410 U.S. 113 (1973), and in a state that has protected abortion rights through NRS 442.250, a voter-approved law, since 1990, this notion seems nonsensical and archaic in its opposition to public health guidance.

The health-promoting principles espoused by medical experts, including *amici*, have long been reflected by statutes and court decisions refusing to criminalize people who have abortions, even prior to *Roe*. 430 U.S. 151 ("[B]y statute or judicial interpretation, the pregnant woman herself could not be prosecuted for self-abortion or for cooperating in an abortion performed upon her

by another.").[54] The Florida Supreme Court recognized the prohibition against criminalizing people for their pregnancy outcomes as a "centuries-old principle of the common law [. . .] grounded in the wisdom of experience[.]" *State v. Ashley*, 701 So. 2d 338, 342 (Fla. 1997). Similarly, the Court of Appeals of Georgia noted that applying its criminal abortion law to a woman who engaged in a self-injurious act would risk criminalizing ingesting nicotine, alcohol, or controlled substances. *Hillman v. State*, 503 S.E.2d 610, 612–13 (Ga. Ct. App. 1998) ("[A] pregnant woman who suffers a late term miscarriage could be subjected to criminal investigation, indictment, and prosecution long before a jury is asked to determine whether she intentionally did anything to cause the miscarriage. This is a patently unjust approach.").

Today, Nevada stands alone in retaining a felony statute explicitly criminalizing causing a miscarriage.[55] In recent years, several states have taken

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[54] *See also*, *State v. Carey*, 56 A. 632, 636 (Conn. 1904) ("an operation on the body of a woman quick with child, with intent thereby to cause her miscarriage, was an indictable offense, but it was not an offense in her to so treat her own body."); *State v. Barnett*, 437 P.2d 821, 822 (Or. 1968) ("[T]he acts prohibited are those which are performed upon the mother rather than any action taken by her.").

[55] *Cf.*, Ala. Code § 26-23B-6 (2011) ("...[n]o penalty shall be assessed against the woman upon whom the abortion is performed…"); Ark. Code Ann. § 20-16-1407(b) (2013) ("A penalty may not be assessed against the woman upon whom the abortion is performed…"); Kan. Stats. Ann. § 65-6703(e) (1998) ("A woman upon whom an abortion is performed shall not be prosecuted…"); Ky. Rev. Stats. § 311.782(6) (2017) ("A pregnant woman on whom an abortion is intentionally performed...is not guilty of violating subsection (1)..."); Reiss. Rev. Stats. Neb. § 28-3, 108 (2010) ("...[n]o penalty shall be assessed against the woman upon whom

steps to repeal[56] or reform[57] laws that have been used to criminalize pregnancy outcomes to bring them into conformity with the recommendations of medical and public health experts. Others have reinforced existing protections for reproductive health by passing measures guaranteeing a non-punitive approach to pregnancy outcomes.[58] Indeed, the prosecutions contemplated by NRS 200.220 are the exact type of prosecution these health-focused reforms seek to avoid.

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the abortion is performed…"); Ohio Rev. Code Ann. § 2919.17(I) (2011) ("A pregnant woman upon whom an abortion is performed or induced or attempted to be performed or induced in violation...of this section...is not guilty of violating…this section"); *Cf.* S.C. Code Ann. § 44-41-80(b) (defining misdemeanor "soliciting unlawful abortion"); Okla. Stat. Ann. tit. 21, § 862 (defining misdemeanor "[s]ubmitting to or soliciting" abortion) *held unconstitutional in Henrie v. Derryberry*, 358 F. Supp. 719, 724–25 (N.D. Okla. 1973).

[56] S.B. 240, Reg. Sess. § 5 (N.Y. 2019) (repealing "self-abortion" crimes); S.B. 1457, 55th Leg. Reg. Sess. (Ariz. 2021) (repealing "solicitation of miscarriage" crime); H.B. 31, 151st Gen. Assem. (Del. 2021) (repealing "self-abortion" crime); 2018 Mass. Acts Ch. 155 (repealing criminal abortion law); 2019 R.I. Acts Ch. 27 (repealing feticide law)

[57] Ind. Pub. L. 203-2018 (amending feticide law to explicitly prohibit prosecution of pregnant people).

[58] Wash. H.B. 1851 (2022) ("The state shall not penalize, prosecute, or otherwise take adverse action against an individual based on their actual, potential, perceived, or alleged pregnancy outcomes."); 2019 Vt. Acts & Resolves No. 47 ("No State or local law enforcement shall prosecute any individual for inducing, performing, or attempting to induce or perform the individual's own abortion"); 2019 Ill. Pub. Act 101-0013 ("The State shall not [. . .] prosecute, punish, or otherwise deprive any individual of the individual's rights for any act or failure to act during the individual's own pregnancy, if the predominant basis for such prosecution, punishment, or deprivation of rights is the potential, actual, or perceived impact on the pregnancy or its outcomes or on the pregnant individual's own health."; D.C. Law 23-90 § 2(a)(3)(2020), ("The District shall not [. . .] Penalize an individual for [s]eeking, inducing, or attempting to induce, the

IV. Criminalizing pregnancy outcomes perpetuate harms that jeopardize the fair administration of law.

In addition to the public health harms and legal deficiencies discussed above, this Court should consider the erosion of sex equality and perpetuation of racially-disparate harm that attends the criminalization of pregnancy outcomes. Ms. Frazier experienced some of this; indeed it was her public expression of grief over the loss she experienced, however inopportune or unexpected the pregnancy might have been, that led to her being arrested and the memorial she erected for the fetal remains exhumed and used as evidence against her. I R. App. 140-42. The humiliation continued even through the habeas proceeding. At the evidentiary hearing, the State spent a significant amount of time asking fact and expert witnesses to look at grainy pictures of Ms. Frazier and judge her body shape to decide whether she "looked pregnant" or was "petite," often to their palpable discomfort. *E.g.*, IV A.A. 201-02. Heartbreakingly, her experience is not unique – instead it is characteristic of the fundamentally flawed approach of using criminal prosecutions to address healthcare matters.

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individual's own abortion; or [a]ny act or omission during the individual's pregnancy based on the potential or actual impact on the individual's health or pregnancy.").

A. Abortion stigma leads to cruel and discriminatory treatment within and outside the legal system.

Because criminalization of pregnancy outcomes draws law enforcement into a private and sensitive health matter, it yields legal processes that are uniquely invasive and humiliating. Because it involves a highly politically-fraught health matter that touches on people's religious beliefs and attitudes about sex equality, the stigma related to abortion only intensifies the degradation the accused suffers.

The harmfulness of prosecutions for pregnancy outcomes is evident from their inception, in which a medical emergency is converted into a law enforcement investigation. Like Bei Bei Shuai in Indiana, patients may be interrogated while "[g]rief stricken and under heavy sedation" from labor or an obstetric emergency.[59] Like Purvi Patel, they may have recorded "confessions" extracted by police without *Miranda* warnings, in the middle of the night while in post-operative recovery from "sedation and severe blood loss."[60] Or, like Kenlissia Jones after she

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[59] Ed Pilkington, *Indiana Prosecuting Chinese Woman for Suicide Attempt That Killed Her Foetus*, The Guardian (May 30, 2012), https://www.theguardian.com/world/2012/may/30/indiana-prosecuting-chinese-woman-suicide-foetus (although Bei Bei Shuai was so distraught after the death of her infant following her suicide attempt that she was "instantly transferred to the mental health wing," a detective was dispatched to the maternity ward to question her "within half an hour of her baby's death").

[60] *See* Amy Gastelum, *Purvi Patel Faces 20 Years in Prison for Feticide and Child Neglect*, The World (Mar. 31, 2015), https://www.pri.org/stories/2015-03-30/purvi-patel-faces-20-years-prison-feticide-and-child-neglect; *Patel*, 60 N.E.3d at 1047.

delivered a 5-month gestation fetus en route to the emergency room, they may be transferred directly from the hospital to jail, still bleeding, and held without bond.[61]

But the harm does not end with the investigation phase. In fact, it often continues even in the event of legal vindication. The U.S. Supreme Court has recognized that even when charges are dropped, the mere fact of an arrest causes ongoing harm. *See, e.g.*, *Michelson v. United States*, 335 U.S. 469, 482 (1948) ("Arrest without more may nevertheless impair or cloud one's reputation."); *Utah v. Strieff*, 579 U.S. 232, 253 (2016) (even the innocent "experience the 'civil death' of discrimination by employers, landlords, and whoever else conducts a background check") (Sotomayor, J., dissenting). Given the Internet's indelible record, cruel and degrading treatment is ongoing, as the names, mugshots, and private medical information of people criminalized for self-managing abortion remain online in perpetuity. As a result, the accused face stigma, ostracism, and threats. Jennie McCormack, despite her successful challenge to the law used against her for self-managing an abortion, was "turned [] into a pariah" and forced to quit her job at a dry cleaner because "clients said they didn't want her handling

[61] *Official: 5-Month-Old Fetus Lived 30 Minutes After 'Abortion Pill' Delivery*, WALB News (Jun. 8, 2015), https://www.walb.com/story/29263746/official-5-month-old-fetus-lived-30-minutes-after-abortion-pill-delivery/.

their clothes."[62] When Kasey Dischman, who nearly lost her pregnancy after a life-threatening drug overdose, was arrested, "[r]eaders of the local paper were calling for Ms. Dischman to be sterilized, hung with piano wire or shot in the back of the head."[63]

B. Criminalization of pregnancy outcomes compounds health disparities and overpolicing experienced by people of color.

The compounding nature of discrimination on the bases of race and sex yields disproportionate criminalization and punishment among pregnant people of color. People of color and low-income people are exponentially more likely to be arrested, charged, prosecuted, convicted, and more heavily punished than are white, wealthier women.[64] They are also more likely, due to persistent health

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[62] *See* Kim Murphy, *Idaho Woman's Case Marks a Key Abortion Challenge*, L.A. Times (Jun. 16, 2012), http://www.latimes.com/archives/la-xpm-2012-jun-16-la-na-idaho-abortion-20120617-story.html.

[63] N.Y. Times Ed. Bd., *The Mothers Society Condemns*, N.Y. Times (Dec. 28, 2018), http://www.nytimes.com/interactive/2018/12/28/opinion/abortion-law-poverty.html.

[64] Ashley Nellis, *The Color of Justice: Racial and Ethnic Disparity in State Prisons*, The Sentencing Project (Jun. 14, 2016), https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/ (Black people are more than five times likelier than white people to be imprisoned; Latinos are 1.4 times as likely); *see also* Lakota People's Law Project, *Native Lives Matter* 6 (Feb. 2015), https://s3-us-west-1.amazonaws.com/lakota-peoples-law/uploads/Native-Lives-Matter-PDF.pdf (Native American women are imprisoned at six times the rate of white women).

disparities, to experience adverse pregnancy outcomes that place them under scrutiny of the legal system.[65]

Unsurprisingly, then, criminalizing people for their pregnancy outcomes disproportionately impacts people of color. One study found that, among women seeking medical care related to pregnancy, women of color were significantly more likely to be reported to law enforcement *by the very people they turned to for help* than were white women.[66] Axiomatically, this results in disproportionate punishment. In Florida, where Black people constitute only 15% of the population, they accounted for 75% of arrests related to pregnancy.[67] In South Carolina, where Black people constitute only 30% of the population, they accounted for 74% of arrests related to pregnancy.[68] This is likely to be exacerbated in Nevada where stillbirths are twice as common among Indigenous women, and 1.5 times as common among Black women, as they are among white women.[69]

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[65] Samantha Artiga et al., *Kaiser Family Foundation*, *Racial Disparities in Maternal and Infant Health: An Overview*, Nov. 10, 2020, https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/.
[66] *See* Paltrow & Flavin, *supra* note 50, at 326–27.
[67] *Id.* at 311.
[68] *Id.*
[69] March of Dimes, *Peristats: Late Fetal Mortality by Race – Nevada, 2015-2017 Average,* Feb. 2020, https://www.marchofdimes.org/peristats/data?top=6&lev=1&stop=375&ftop=377&reg=99&sreg=32&obj=1&slev=4 (The rate of later fetal mortality per 1000 live births/fetal deaths was 2.8 for white women, 4.4 for Black women, and 6.9 for American Indian/Alaska Native women.)

Conclusion

Ms. Frazier's tragic case presents the first opportunity for a Nevada appellate court to weigh the constitutionality of NRS 200.220, a law unique in our country in its harshness in punishing what is, at its heart, a health concern. The State resurrected it from what appears to be a century of disuse to prosecute a woman who was a victim of circumstance in a moment in which medical and public health experts are amplifying their warnings that the health and well-being of pregnant people are at grave risk. These perspectives, and the harm to maternal health they portend, are relevant as this Court assesses whether NRS 200.220 continues to advance any valid state interest, if it ever did at all. *Amici* ask this Court to find that it does not.

Dated this 28th day of April, 2022.

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Certificate of Compliance

1. I hereby certify that his proposed brief complies with the formatting requirements of NRAP 32(A)(4), the typeface requirements of NRAP 32(a)(5) and the type-style requirements of NRAP 32(a)(6) because this brief was prepared in a proportionally-spaced typeface (14-point Times New Roman font) using Microsoft Word.
2. I further certify that this amicus brief complies with the page-or type-volume limitations of NRAP 29(e) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), it is proportionally spaced, has a typeface of 14 points or more, and contains 8,332 words. The word limitation for this brief is governed by NRAP 29(e), which allows one-half the maximum length authorized for Frazier's brief, and NRAP 28.1(e)(2)(B)(i), which allows 18,500 words for Frazier's combined answering brief and opening brief (because this case includes a cross-appeal). Therefore, this amicus brief has a word limit of 9,250 words.
3. I hereby certify that I have read this amicus curiae brief, and to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose.
4. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(1), which requires every assertion

in the brief regarding matters in the record to be supported by a reference to the page and volume number, if any, of the transcript or appendix where the matter relied on is to be found.

5. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

DATED this 28th day of April, 2022.

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Certificate of Service

Pursuant to NRCP 5(b), I certify that I am an employee of Lemons, Grundy & Eisenberg, and on this date, I filed and served a true and correct copy of the foregoing ***Brief of Amici Curiae American College of Obstetricians and Gynecologists, American Society of Addiction Medicine, Nevada State Medical Association, Nevada Public Health Association, Physicians for Reproductive Health, Academy of Perinatal Harm Reduction, Advocacy and Research on the Reproductive Wellness of Incarcerated People, Project SANA, Daniel Grossman, MD, and Sarah Roberts, DrPH in Support of Respondent/Cross-Appellant (For Affirmance),*** via the court's electronic filing and service system, which will send a notice of electronic filing to the following:

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