ARIZONA COURT OF APPEALS
DIVISION ONE

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| LINDSEY R[redacted],<br><br>Plaintiff/Appellant,<br><br>v.<br><br>ARIZONA DEPARTMENT OF CHILD SAFETY,<br><br>Defendant/Appellee. | Court of Appeals Division One No. [redacted]<br><br>Maricopa County Superior Court Case No.: [redacted] |

**BRIEF OF AMICUS CURIAE NATIONAL ADVOCATES FOR PREGNANT WOMEN, ACADEMY OF PERINATAL HARM REDUCTION, AMERICANS FOR SAFE ACCESS FOUNDATION, NATIONAL PERINATAL ASSOCIATION, NORTH AMERICAN SOCIETY OF PSYCHOSOCIAL OBSTETRICS AND GYNECOLOGY, AMY SCHUMER, ET AL.**
**IN SUPPORT OF PLAINTIFF/APPELLANT'S APPEAL OF HER PLACEMENT ON THE DEPARTMENT OF CHILD SAFETY'S CENTRAL REGISTRY**

Jana L. Sutton
MESCH CLARK ROTHSCHILD
State Bar No. 032040

259 North Meyer Avenue
Tucson, Arizona 85701
Phone: (520) 624-8886
Fax: (520) 798-1037
Email: jsutton@mcrazlaw.com
Attorneys for *Amicus Curiae*

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## IDENTITY AND INTERESTS OF AMICI CURIAE

As described further in Appendix A, *amici* are organizations and individuals with expertise in pediatrics and other areas of medicine, medical and social science research, public health, law, and the lived experience of being pregnant and having hyperemesis gravidarum. Pursuant to Arizona Rule of Civil Appellate Procedure 16(b)(1)(C)(iii), *amici curiae* bring to the Court's attention the troubling and unwarranted departure from medical and scientific understanding apparent in the Arizona Department of Child and Safety ("DCS") Decision and Order in *the Matter of Lindsay R.*, affirmed by the Superior Court, and defended by the State. The legal issue presented in this case, whether a pregnant person commits child neglect and may be placed on the DCS Central Registry ("Central Registry") because she consumed medical marijuana in accordance with Arizona's Medical Marijuana Act ("AMMA"), should not be decided based on medical misinformation or scientifically unsupported presumptions.

*Amici* bring their expertise to this Court and join together to highlight the grave risks to maternal, fetal, and child health and family well-being presented by this case and to bring to this Court's attention constitutional analysis essential to the proper interpretation and application of A.R.S. § 8-201(25)(c) ("Neglect Statute") and AMMA.

## STATEMENT OF FACTS

While the parties disagree about some of the facts—and the relevance of others to the application of the law in this case—key facts of concern to *amici* are not in dispute. Ms. R[redacted] was diagnosed with irritable bowel syndrome, depression, and anxiety prior to her pregnancy. (IRA 40 ¶¶ 9, 11, 14; IRA 41 ¶ 2; Appellant's Opening Brief ("OB") at 5, 7; Appellee's Answering Brief ("AB") at 9.) Prior to and during her pregnancy, Ms. R[redacted] engaged in treatment for those conditions, including use of Buspar, Celexa, Zofran, and medical marijuana. She also ingested caffeine and took the over-the-counter medication Benadryl during her pregnancy. (IRA 40 ¶¶ 9, 11, 14; IRA 41 ¶ 2; OB at 5, 7; AB at 9.) Ms. R[redacted] was a physician-certified, qualifying patient who held a valid, medical marijuana patient registry identification card prior to her pregnancy. (IRA 40 ¶ 9; IRA 41 ¶ 2; IRA 55 at 8; OB at 5; AB at 9.) She was recertified as a qualifying medical marijuana patient in December 2018. (IRA 40 ¶ 19; IRA 41 ¶ 6; OB at 5–6; AB at 10.)

Ms. R[redacted] found out she was pregnant on or about September 2018. (IRA 40 ¶ 1; IRA 41 ¶ 1; OB at 5; AB at 9.) Throughout her pregnancy, she suffered from hyperemesis gravidarum ("HG"). (IRA 40 ¶¶ 11, 17; IRA 41 ¶¶ 2, 4; IRA 55 at 2; OB at 5; AB at 9.) Ms. R[redacted] was admitted to the emergency room twice for acute HG, in November 2018 and February 2019. (IRA 40 ¶ 18; IRA 41 ¶ 5; IRA 55 at 4; OB at 6; AB at 9, 10.) In May 2019, Ms. R[redacted] gave birth to her baby, Silas. (IRA

40 ¶ 1; IRA 41 ¶ 1; IRA 55 at 2; OB at 7; AB at 11.) Silas is now almost two years old and the State has offered no evidence saying that he suffered any adverse health consequences since his discharge from the hospital after birth. (OB at 7.)

In May 2019, DCS informed Ms. R[redacted] that it intended to enter a finding of neglect against her in the Central Registry. (IRA 40 ¶ 3; IRA 41 ¶ 1; IRA 55 at 2; OB at 3; AB at 12.) Ms. R[redacted] appealed. (IRA 40 11 ¶ 11; IRA 55 at 3; OB at 4; AB at 13.) In February 2020, the Administrative Law Judge ("ALJ") issued its decision rejecting DCS's allegations of neglect and declining to enter her name into the Central Registry. (IRA 40 at 11 ¶ 11; IRA 55 at 3; OB at 4; AB at 13.) In March 2020, this decision was overruled by DCS and Ms. R[redacted] was placed on the Central Registry. (IRA 41 ¶¶ 2–3; IRA 55 at 3; OB at 4; AB at 13.) Ms. R[redacted] appealed to the Superior Court, which affirmed DCS's decision on December 10, 2020. (IRA 55 at 13; OB at 4; AB at 15.) This appeal followed.

## SUMMARY OF ARGUMENT

In 2010, Arizona voters passed Proposition 203, AMMA, enabling people to legally access the benefits of medical marijuana. AMMA provides that a "registered qualifying patient . . . is not subject to arrest, prosecution or penalty in any manner, or denial of any right or privilege, including any civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau . . . [f]or the registered qualifying patient's medical use of marijuana pursuant to this chapter . . .

." A.R.S. § 36-2811(B)(1). To qualify for these protections, AMMA presumes that one is "engaged in the medical use of marijuana . . . [if she] [i]s in possession of a registry identification card." A.R.S. § 36-2811(A)(1)(a). Pregnant people clearly qualify for medical use under AMMA, and its protections plainly apply to them. In fact, AMMA requires warning labels explaining potential risks of medical marijuana use during pregnancy and mandates that doctors inform their patients of potential risks; neither provision would exist if medical marijuana were not available to pregnant patients. A.R.S. § 36-2803. Recognizing that AMMA's protections exist for qualifying pregnant patients, the legislature has sought to pass legislation limiting such protections for pregnant people on at least one occasion. HB 2061 (as introduced), 52d Leg., 2d Reg. Sess. (Ariz. 2016), https://www.azleg.gov/legtext/52leg/2r/bills/hb2061h.pdf. The proposed bill faced numerous obstacles[1] and was

[1] Mikel Weisser, *Action Alert: Bad Bill HB2061*, ARIZONA NORML, https://normlinarizona.org/action-alert-bad-bill-hb2061-pregnancy-as-a-disqualifying-mmj-condition/; Ray Stern, *Arizona Lawmakers Want to Force Medical Pot Stores to Warn Pregnant Women about Weed Danger*, PHOENIX NEW TIMES (Feb. 16, 2016), https://www.phoenixnewtimes.com/news/arizona-lawmakers-want-to-force-medical-pot-stores-to-warn-pregnant-women-about-weed-danger-8061617e (noting that HB 2061's proposed ban of pregnant women accessing marijuana pursuant to AMMA would likely run afoul of Arizona's Voter Protection Act, which prevents legislators from making non-beneficial changes to laws approved directly by voters); Howard Fischer, *Mesa's Townsend backs away from medical marijuana proposal*, EAST VALLEY TRIBUNE (Feb. 17, 2016), https://www.eastvalleytribune.com/local/article_f6c6f3ec-d5c7-11e5-b147-d32ceaf22623.html (noting a host of legal problems, including probable violation of physician-patient privacy because the proposed law would overrule any finding by a physician that marijuana was appropriate).

ultimately rescinded by its proponent.[2]

There is no dispute that Ms. R was a qualifying patient in possession of a registry identification card pursuant to AMMA. (IRA 55 at 8; OB at 5; AB at 9.) Thus, there is a presumption that her marijuana use was for a medical purpose. A.R.S. § 36-2811(A)(1)(a). In order to find that Ms. R engaged in child neglect, the State must establish that Ms. R's medical use created an "unreasonable danger to the safety" of Silas by clear and convincing evidence, as required by AMMA: "No person may be denied custody of or visitation or parenting time with a minor, and *there is no presumption of neglect or child endangerment* for conduct allowed under this chapter, *unless the person's behavior creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.* A.R.S. §§ 36-2813(C), (D) (emphasis added).

The Court made no such determination. Instead, the Court ignored AMMA's heightened standard requiring clear and convincing evidence of unreasonable danger. Instead, it referred exclusively to the neglect statute, which defines child neglect as "a determination by a health professional that a newborn infant was exposed prenatally to a drug or substance listed in § 13-3401 and that this exposure was not the result of a medical treatment administered to the mother or the newborn infant by a health professional." A.R.S. § 8-201(25)(c). Under the guise of statutory

[2] Howard Fischer, *supra* note 1.

interpretation, the Court read the term "administered" in such a manner that all pregnant patients—who are permitted to use medical marijuana under the clear language of AMMA—are excluded from AMMA's legal protections, in order to find Ms. R[redacted] guilty of child neglect.[3]

Moreover, even when arguing in the alternative and purporting to follow AMMA's clear mandate requiring proof of unreasonable danger to a minor, the State attempts a feat of linguistic legerdemain—declaring (without support) that AMMA's provisions designed to protect "children" applies to "fetuses" in the context of pregnancy. (AB at 21.) In fact, where the legislature has not specifically included reference to "unborn children," Arizona courts have refused to judicially expand the scope of the law to reach pregnant people and fetuses. *See Reinesto v. Superior Ct.*,

[3] In a remarkable feat of circular logic, the State, admitting that AMMA does not prohibit pregnant women from using medical marijuana, instead seeks to circumvent that prohibition by claiming that AMMA's protections do not extend to exposing "children" to the drug. (AB at 21.) First, the State inappropriately conflates fertilized eggs, embryos, and fetuses with children and "minors," which is unsupported as a matter of fact and Arizona law. *See, e.g.*, *State v. Lockwood*, 222 Ariz. 551, 553 (App. 2009) ("the legislature did not intend a fetus to constitute a 'person' for all purposes… where the legislature intends to protect the unborn, it does so by specific reference to a fetus."); A.R.S. § 13-1103(A) (prohibiting manslaughter of a "person" and of an "unborn child" in different subsections); A.R.S. § 36-329 (providing separately for death certificate for fetal death); A.R.S. § 36-2301.01(D) (defining "viable fetus" not as "human being" but as "unborn offspring of human beings that has reached a [specified] state of fetal development"). Second, if in fact AMMA's protections did not extend to exposing fertilized eggs, embryos, and fetuses to marijuana, that would serve as a blanket prohibition for pregnant women to utilize AMMA; again, even the State admits that AMMA does not create such a prohibition.

182 Ariz. 190, 192–93 (App. 1995) ("The legislature's specific decision to include a reference to an 'unborn child' in [some] contexts . . . and to exclude such a reference [in others] indicates that the legislature did not intend that the child abuse statute apply to situations in which harm to a fetus subsequently affects the newborn."); *In re Appeal in Pima Cty. Juvenile Severance Action No. S-120171*, 183 Ariz. 546, 548 (App. 1995) ("a 'person' or 'child' does not include unborn children"); *see also* A.R.S. § 8-201(6) (defining "child" as "an individual who is under the age of eighteen years"); *State v. Cotton*, 197 Ariz. 584, 587 ¶ 10 (App. 2000) ("[A] legislative determination that a fetus was not to be considered a person within the meaning of the murder statute.").

The DCS and Superior Court decisions were influenced by medically unsupported assumptions about pregnancy, without the benefit of scientific research regarding marijuana, the severity of HG, and the potential benefits of medical marijuana during pregnancy. A person's existing medical conditions do not disappear when they become pregnant and those conditions often require continuing care. Further, pregnancy can cause additional health concerns, such as HG, that create serious risks to both pregnant people and their fetuses. Peer-reviewed scientific research establishes that medical marijuana provides relief to pregnant

patients, including those suffering from HG.[4] Peer-reviewed scientific research does not, however, support claims that prenatal exposure to medical marijuana creates unique risks of harm different in kind or magnitude from thousands of other activities and exposures during pregnancy, nor pose an unreasonable danger to a fetus. As the ALJ explained, "[a]lthough [the] AMMA did not change the definition of 'neglect' in the Department's statutes, it changed parents' and their treating healthcare professionals' healthcare options for alleviating the adverse maternal effects of pregnancy to make a healthy baby's birth more likely." (IRA 40 at 9.)

Further, children will be endangered—not protected—by a decision ignoring AMMA's protections. AMMA was designed to promote public health by facilitating authorized use and preventing punitive responses that undermine patient-provider relationships and deter people from obtaining medical care for themselves and their families. "[T]he purpose of this act is to protect patients with debilitating medical conditions, as well as their physicians and providers, from

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[4] Gideon Koren, *The use of cannabis for hyperemesis gravidarum (HG),* J. OF CANNABIS RESEARCH (2020), https://jcannabisresearch.biomedcentral.com/articles/10.1186/s42238-020-0017-6 (100% of those studied experienced improvement in quality of life (related to nausea and vomiting) with the use of marijuana); Rachel E. Westfall, et al., *Survey of medicinal cannabis use among childbearing women: Patterns of its use in pregnancy and retroactive self-assessment of its efficacy against 'morning sickness'*, COMPLEMENTARY THERAPIES IN CLINICAL PRACTICES (2006), https://www.sciencedirect.com/science/article/abs/pii/S1744388105000939?via%3Dihub (92% of those surveyed rated cannabis as "extremely effective" or "effective" in treating nausea and vomiting in pregnancy).

arrest and prosecution, criminal and other penalties and property forfeiture if such patients engage in the medical use of marijuana." Prop 203, Sec. 2 (2010), *available at* https://apps.azsos.gov/election/2010/info/PubPamphlet/Sun_Sounds/english/prop203.htm. There is a growing body of research that punitive responses, and the fear they perpetuate, actually harm the very children DCS claims it is seeking to protect. *See infra* Section II.B.

The Superior Court upheld DCS's decision to impose not one, but two statutory penalties on Ms. R[redacted]: 1) a finding of neglect; and 2) placement on the Central Registry. (IRA 55 at 12.) It also penalized Ms. R[redacted]'s exercise of her rights under the Arizona and U.S. Constitutions to informed medical decision-making, bodily integrity, and privacy, as well as her right to equal protection of the law under the United States and Arizona Constitutions. U.S. Const., amend. 14; Ariz. Const. art. II, §§ 8, 13; *see, e.g.*, Cruzan *v. Director, Mississippi Dept. of Health*, 497 U.S. 261 (1990); *Rasmussen v. Fleming*, 154 Ariz. 207, 215 (1987). If not reversed, the decision and the resulting penalties for Ms. R[redacted]—and other pregnant qualifying patients under AMMA—will have a detrimental effect on maternal, fetal, and child health in Arizona. Scientific integrity and the health and well-being of Arizona's children and their mothers demand that this Court properly interpret

AMMA, reverse the Superior Court decision, and remove Ms. R[redacted] from the Central Registry.

## I. AMMA Protects All Certified Users of Medical Marijuana, Including Pregnant Patients, and Recognizes the Nature of Pregnancy and the Potential Benefits of Medical Marijuana to People During Pregnancy.

According to the Superior Court, Ms. R[redacted]'s certified medical marijuana use while pregnant constitutes "neglect" under Arizona's Child Safety statute because it did not qualify as medical treatment "administered to the mother." A.R.S. § 8-201 (25). (IRA 55 at 12.) The Court suggested that to "administer" medical marijuana, a certifying physician would have to "direct or supervise" the use of or provide "instructions on how or when to use" the marijuana. (IRA 55 at 11; *see also* IRA 41 at ¶ 3.) Such reasoning overlooks the ways in which medical marijuana is prescribed and used, and ignores the reality that many other medications are prescribed and used on a similar "as needed" basis.[5] Minimizing the significance of Ms. R[redacted]'s health conditions, including HG, and the need to treat health

[5] Mojtaba Vaismoradi et al., *Patient Safety and Pro Re Nata Prescription and Administration: A Systematic Review,* 6 Pharmacy (Basel) 95 (2018), doi: 10.3390/pharmacy6030095 (PRN prescription and administration is a common practice. PRN is an acronym for '*pro re nata*,' authorizing administration of medicine when needed, in the opinion of the nurse or patient administering medications, either at specified times of day or entirely at the nurse's or patient's discretion. Common examples of this are medications for migraines and treatment for erectile dysfunction. Once prescribed, use of these medications are directed by the patient, not "directed or supervised" by the physician.).

conditions during pregnancy, the State erroneously argues that her use of medical marijuana is selfish behavior that wrongfully "prioritiz[ed] her own needs over those of her child." (AB at 27.) As discussed below, this characterization is not supported by the medical realities of pregnancy. Rather, people's existing conditions do not disappear when they become pregnant. Some health conditions, including HG, can create serious risks to both pregnant people and fetuses and must be treated to minimize those risks.

The State argues in the alternative, without evidence, that Ms. R[redacted]'s medical marijuana use "created an unreasonable danger to the safety of a minor" under AMMA. (AB at 27–28.) This argument is unsupported by medical or scientific research about marijuana, pregnancy, or the balance of risks posed by pregnancy, HG, and use of medical marijuana. Research does not support the claim that exposure to medical marijuana creates unique risks of harm different in kind or magnitude from innumerable other activities and exposures during pregnancy, and the State's singular focus on medical marijuana is misguided as a matter of medicine and science.

### A. Pregnant People's Existing Conditions Do Not Disappear When They Become Pregnant and Often Require Continuing Care.

No pregnant person or doctor can guarantee a healthy birth outcome,[6] and

[6] For example, fifteen to twenty percent of all pregnancies result in a miscarriage or a stillbirth regardless of what a pregnant person does or does not do. American

chronic conditions do not disappear simply because a person becomes pregnant.[7] Additionally, recent studies have shown that social determinants of health (such as poverty, racism, and lack of access to adequate healthcare prior to pregnancy) are far more indicative of pregnancy outcomes than anything a pregnant person does or does not do during pregnancy.[8] Chronic, pre-existing conditions must be managed by the pregnant person. Although healthcare providers may assist in that

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College of Obstetricians and Gynecologists, *Early Pregnancy Loss*, November 2018, https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss?utm_source=redirect&utm_medium=web&utm_campaign=otn; Donna L. Hoyert, et al., Centers for Disease Control and Prevention National Vital Statistics System, *Cause of Fetal Death: Data from the Fetal Death Report, 2014*, National Vital Statistics Reports, Vol. 65, No. 7, Oct. 31, 2016, https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_07.pdf.

[7] *See*, *e.g.*, Shona L. Ray-Griffith, et al., *Chronic pain during pregnancy: a review of the literature*, 10 INT'L J. WOMEN'S HEALTH 153 (2018), doi:10.2147/IJWH.S151845.

[8] *See*, *e.g.*, Hallam Hurt & Michel Martin, *Decades Later, Drugs Didn't Hold 'Crack Babies' Back*, NPR (July 31, 2013), https://www.npr.org/templates/story/story.php?storyId=207292639 ("We evaluated our participants every 6 to 12 months, when they were young infants and children. What we found was that the cocaine exposed and the non-exposed didn't differ from each other…" (citing Laura M. Betancourt, et al., *Adolescents with and without Gestational Cocaine Exposure: Longitudinal Analysis of Inhibitory Control, Memory and Receptive Language,* 33, 1 NEUROTOXICOL. TERATOL. 36-46 (2011)); Hallam Hurt & Laura M. Betancourt, *Effect of Socioeconomic Status Disparity on Child Language and Neural Outcome: How Early is Early?*, 79 PEDIATRIC RESEARCH 148 (2016) ("Potentially malleable environmental factors (parenting and home environment) were more influential on [Full Scale IQ] than gestational exposure to cocaine in these 'inner-city achievers.'"); *see also* Tanya Maria Golash-Boza, RACE & RACISMS 333-34, 337 (Oxford U. Press 2015) (disparate birth outcomes for Black women are attributable to racial residential segregation, environmental health, and weathering on the body due to constant exposure to discrimination and inequities in healthcare access and treatment.).

management, they cannot make medical decisions for their pregnant patients.[9] Decisionally capable pregnant patients, just like all decisionally capable patients, have the right to refuse treatment, to disagree with medical advice, and to refuse recommended medical or surgical interventions.[10]

Prior to her pregnancy, Ms. R[redacted] experienced chronic health conditions; she suffered from anxiety, depression, irritable bowel syndrome, and other chronic ailments. (OB at 5, 7; AB at 9.) In order to manage those chronic conditions, Ms. R[redacted] was prescribed Buspar and Celexa, which she used during pregnancy and at the time of the birth. (OB at 7; AB at 9.) She also was certified to use medical marijuana to help manage her conditions. (OB at 5–6.) The lower court's decision and the State's position inappropriately minimize the seriousness of these conditions and improperly characterize Ms. R[redacted]'s decisions about how best to manage them as a form of child neglect. Just as parents traveling on planes should put their oxygen masks on first, a pregnant person not only may, but must, prioritize their own health.

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[9] "The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision." American Medical Association, Policy Statement H-420.969, *Legal Interventions During Pregnancy* (last modified 2018).

[10] "Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected." American College of Obstetricians and Gynecologists Committee on Ethics, Committee Opinion 664, *Refusal of Medically Recommended Treatment During Pregnancy* (2016; reaffirmed 2019). *See infra* Section III.

### B. Pregnancy Can Cause Health Conditions Such as Hyperemesis Gravidarum that Create Serious Risks to Both Pregnant People and Fetuses.

There is no dispute that Ms. R[redacted] had hyperemesis gravidarum ("HG"). A true understanding of HG refutes the State's characterization of her response to it as somehow selfish. (OB at 5; AB at 9.) There are a number of medical conditions that can arise due to a pregnancy, including HG, gestational diabetes, and preeclampsia. Each of these conditions can carry serious risks for the health of the pregnant person and for the outcome of the pregnancy.[11]

HG is a potentially life-threatening condition related to pregnancy that can cause weight loss, malnutrition, severe dehydration, gastrointestinal trauma, and even neurological damage to the fetus, and may cause long-term health issues for pregnant people and fetuses.[12] HG occurs in 0.3-3 percent of all pregnancies and is

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[11] Franzago, et al., *Nutrigenetics, epigenetics and gestational diabetes: consequences in mother and child*, 14 EPIGENETICS 215 (Mar. 2019), doi: 10.1080/15592294.2019.1582277 (consistent evidence shows relationships between gestational diabetes mellitus and subsequent type 2 diabetes, hypertension, dyslipidaemia, vascular dysfunction, atherosclerosis and other markers of cardiovascular risk in the mother, short-term increased risk of macrosomia, shoulder dystocia, birth injury, and prematurity for the infant, and association long-term with changed anthropometric and metabolic functions for the child); Bokslag, et al., *Preeclampsia: short and long-term consequences for mother and neonate*, 102 EARLY HUM. DEV. 47 (Nov. 2016), doi: 10.1016/j.earlhumdev.2016.09.007 (preeclampsia increases risk of low birthweight and stillbirth, as well ask hypertension, ischaemic heart disease, stroke, and venous thromboembolism for the pregnant person).

[12] London, et al., *Hyperemesis Gravidarum: A Review of Recent Literature*, Pharmacology (2017), 100:161-171, doi: 10.1159/000477853; HER Foundation,

the most common cause of hospitalization in the United States during the first half of pregnancy, second only to preterm labor for pregnancy overall.[13] It is much more severe than typical "morning sickness" and can result in such dangerous vitamin deficiencies as to cause neurological damage to the developing fetus.[14] Electrolyte deficiencies due to HG increase the pregnant person's risk of heart and kidney failure and may require nutrition to be delivered intravenously.[15] HG also increases the likelihood of miscarriage[16] and is associated with adverse fetal brain development.[17] HG's symptoms are so severe that most people who suffer from it are forced to take off significant time from work, causing economic instability and added stress,[18]

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*About Hyperemesis Gravidarum*, https://www.hyperemesis.org/about-hyperemesis-gravidarum/.

[13] *Id.* at 162, 165.

[14] Specifically, vitamin B1 deficiency from severe and persistent vomiting can cause Wernicke's encephalopathy, neurological symptoms caused by biochemical lesions of the central nervous system. London, et al., *Hyperemesis Gravidarum: A Review of Recent Literature*, Pharmacology 2017;100:161-171. doi: 10.1159/000477853, at 164-165.

[15] *Id.* at 165, 166.

[16] *Id.*

[17] Koren, et al., *Hyperemesis gravidarum—Is it a cause of abnormal fetal brain development?*, Reproductive Toxicology 79 (2018) 84-88, doi:10.1016/j.reprotox.2018.06.008 ("Offspring exposed to HG were 3.6 fold more likely to report psychological and behavioral disorders.).

[18] Mitchell-Jones, et al., *Association between hyperemesis gravidarum and psychological symptoms, psychosocial outcomes and infant bonding: a two-point prospective case-control multicentre survey study in an inner city setting*, BMJ Open. 2020 Oct 13;10(10):e039715. doi: 10.1136/bmjopen-2020-039715. PMID: 33051235; PMCID: PMC7554497.

which can further negatively impact health outcomes.[19] HG also increases the likelihood of postpartum depression 76-fold.[20] The severe health burdens, risks, and deeply challenging experience of HG are documented in *amicus* Amy Schumer's documentary, *Expecting Amy*.[21]

Effective treatment is crucial to prevent the severe damage to the health of the pregnant person, the developing fetus, and the continuation of the pregnancy. There are several medications that are typically prescribed to treat HG. As with any medication, it may or may not be effective for a particular patient, and the side effects or risks may outweigh the benefits.[22] Ms. R[redacted] was prescribed Zofran, which is

[19] *See*, *e.g.*, Hobel, et al., *Psychosocial stress and pregnancy outcome*, 51 CLIN. OBSTET. GYNECOL. 333 (2008); Wadhwa, et al., *The contribution of maternal stress to preterm birth: issues and considerations*, 38 CLIN PERINATOL. 351 (2011); Cardwell, *Stress: Pregnancy considerations*, 68 OBSTET. GYNECOL. SURV. 119 (2013); Witt, et al., *Maternal stressful life events prior to conception and the impact on infant birthweight in the United States*, 104 AMERICAN J. PUBLIC HEALTH S81 (2014); Kramer, et al., *Socio-economic disparities in pregnancy outcome: why do the poor fare so poorly?*, 14 PED. & PERINATAL EPIDEMIOLOGY 194 (2001), https://doi.org/10.1046/j.1365-3016.2000.00266.x.

[20] London, et al., *Hyperemesis Gravidarum: A Review of Recent Literature*, 100 PHARMACOLOGY 161, 165 (2017), doi: 10.1159/000477853.

[21] *Expecting Amy,* Amy Schumer, It's So Easy Productions, HBO Max, July 9, 2020.

[22] Furthermore, it must be noted that very few medications used by and prescribed to pregnant women have been subject to research on their possible impact on pregnancy. *See*, *e.g.*, Rae Ellen Bichell, *When Pregnant Women Need Medicine, They Encounter a Void*, https://www.npr.org/sections/health-shots/2016/08/08/486907088/when-pregnant-women-need-medicine-they-encounter-a-void.

one of the "mainstays of current hyperemesis gravidarum therapy."[23] However, it briefly fell out of use in the United States due to associations with fetal cardiac malformations.[24] While it is now back in use, the association between Zofran exposure and fetal cardiac malformations exemplifies the many—often troubling and sometimes contradictory—recommendations that pregnant people receive and have to sort through to find the best care for themselves and their pregnancy.[25] Instead of Zofran or other medications, pregnant patients may find relief from medical marijuana, as further discussed below. *See infra* Section I.C.

### C. Research Establishes that Medical Marijuana Provides Relief to Pregnant Patients Including Those Suffering from HG.

Ms. R[redacted] used medical marijuana to manage her health conditions, that included the severe nausea caused by her debilitating and dangerous HG. Contrary to the State's baseless characterization of her use as selfish and suspect, it is supported by medical research and protective of both Ms. R[redacted] and her pregnancy.

Throughout history, marijuana treatments have been used in obstetric and gynecologic practice as a safe and efficacious medicine to treat a range of conditions

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[23] London, et al., *Hyperemesis Gravidarum: A Review of Recent Literature*, 100 PHARMACOLOGY 161, 168 (2017), doi: 10.1159/000477853.
[24] *Id.*
[25] *See, e.g.*, Emily Oster, *Expecting Better: Why the Conventional Pregnancy Wisdom Is Wrong—and What You Really Need to Know*, Penguin Publishing Group (2014).

including dysmenorrhea, dysuria, menopausal symptoms, and HG.[26] Studies show that marijuana is an effective antiemetic, meaning a drug that is effective against vomiting and nausea.[27] Many pregnant women use it to address the symptoms of HG as well as the less severe pregnancy symptoms including headaches, nausea, and loss of appetite.[28] In a peer-reviewed study to determine if marijuana benefited pregnant people, ninety-two percent of patients reported marijuana as "effective" or "extremely effective" for managing nausea and vomiting.[29] Another peer-reviewed

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[26] Russo, *Cannabis Treatment in Obstetrics and Gynecology: A Historical Review*, J. OF CANNABIS THERAPEUTICS (2008), https://www.tandfonline.com/doi/abs/10.1300/J175v02n03_02?src=recsys (reviewing literature on gynecological cannabis use, comparing historical and modern research findings, and concluding that cannabis is an efficacious and safe alternative for treatment of a wide range of conditions in women including dysmenorrhea, dysuria, hyperemesis gravidarum, and menopausal symptoms).

[27] Rachel E. Westfall, et al., *Use of anti-emetic herbs in pregnancy: women's choices, and the question of safety and efficacy*, COMPLEMENTARY THERAPIES IN NURSING & MIDWIFERY (2004), https://www.semanticscholar.org/paper/Use-of-anti-emetic-herbs-in-pregnancy%3A-women's-and-Westfall/14ea31fdd2db80408364f30f7f1d9720479bb4b2 (cannabis' anti-emetic properties are well established in the context of chemotherapy-induced nausea and found slightly more effective than conventional anti-emetic drugs).

[28] Robertson, *Marijuana Use and Maternal Experiences of Severe Nausea During Pregnancy in Hawai'i*, HAWAI'I J. MED. & PUBLIC HEALTH (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4174692/#; *see also* Betsy Dickson, et al., *Recommendations from cannabis dispensaries about first-trimester cannabis use*, 131 OBSTET. GYNECOL. 1031 (2018), doi: 10.1097/AOG.0000000000002619; Young-Wolff, et al., *Self-reported daily, weekly, and monthly cannabis use among women before and during pregnancy*, JAMA NETW. OPEN (2019), 2:e196471, doi:10.1001/jamanetworkopen.2019.6471.

[29] Rachel E. Westfall, et al, *Survey of medicinal cannabis use among childbearing women: Patterns of its use in pregnancy and retroactive self-assessment of its efficacy against 'morning sickness'*, COMPLEMENTARY THERAPIES IN CLINICAL

study of patients suffering from HG found that marijuana consumption was associated with a "highly significant improvement in symptoms" and "a significant increase in quality of life."[30] Both studies pointed to likely benefits, and because of this, the authors encouraged additional research on the subject.[31] Additionally, medicinal marijuana treatment for HG is a cost-effective option that does not require medical insurance, and as the research finds, many patients find it to be more effective and less debilitating than other clinical and pharmaceutical interventions.[32] Nothing in AMMA prevents a certified qualifying patient who experiences both qualifying and non-qualifying conditions from using medical marijuana. A.R.S. § 36-2811(A). Given the potential of medical marijuana to alleviate the severe nausea

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PRACTICES (2006), https://www.sciencedirect.com/science/article/abs/pii/S1744388105000939?via%3Dihub.

[30] Gideon Koren, *The use of cannabis for hyperemesis gravidarum (HG)*, J. OF CANNABIS RESEARCH (2020), https://jcannabisresearch.biomedcentral.com/articles/10.1186/s42238-020-0017-6.

[31] *See supra* notes 29-30.

[32] Wei-Ni Lin Curry, *Hyperemesis Gravidarum and Clinical Cannabis: To Eat or Not to Eat?*, J. OF CANNABIS THERAPEUTICS (2002), https://www.tandfonline.com/doi/pdf/10.1300/J175v02n03_05?needAccess=true ("Hyperemesis gravidarum (HG), a debilitating ailment characterized by severe nausea and vomiting, malnutrition, and weight loss during pregnancy, occurs to 1–2% of pregnant women globally. Although the medical community offers clinical and pharmaceutical intervention, the procedures are: (1) partially effective, if at all, (2) costly and unaffordable without health insurance, (3) questionable in their long-term safety for the fetus, as most have not been scientifically tested, and (4) in more severe cases, physically painful and psychologically disempowering for the pregnant woman. This study unveils the deep suffering endured by women undergoing HG from a folkloristic perspective and proposes the use of medical cannabis as an effective natural remedy for the symptoms of HG.").

caused by HG and improve quality of life, it is inappropriate to characterize Ms. R[redacted]'s use as selfish and amounting to child neglect.

While the research on the use of medicinal marijuana as an effective treatment for HG continues to develop,[33] there is considerable research on the relationship between marijuana and pregnancy. Indeed, the use of marijuana in pregnancy is well-studied[34] and cannot be said to create unreasonable danger[35] to pregnancy. An

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[33] "Research funding, when appropriated, was commonly sought to identify adverse effects from marijuana use. This fact introduces both funding bias and publication bias into the body of literature related to marijuana use." Robertson, et al., *Monitoring Health Concerns Related to Marijuana in Colorado: 2014 Changes in Marijuana Use Patterns, Systematic Literature Review, and Possible Marijuana-Related Health Effects*, COLORADO DEPT. OF PUBLIC HEALTH AND ENVIRONMENT (2015).

[34] Westfall, *Use of anti-emetic herbs in pregnancy*, *supra* note 27 ("The use of Cannabis in pregnancy, on the other hand, is well-studied and does not appear to be contraindicated. Due to the popularity of Cannabis as a recreational drug, considerable amounts of data have been collected on the effects of prenatal exposure."); Torres, et al., *Totality of the Evidence Suggests Prenatal Cannabis Exposure Does Not Lead to Cognitive Impairments: A Systematic and Critical Review*, 11 FRONTIERS IN PSYCHOLOGY 816 (2020), at 24, doi:10.3389/ fpsyg.2020.00816 [*hereinafter* "Torres"].

[35] While A.R.S. § 8-201(25) defines prenatal exposure to a listed drug as neglect, there is no medical or policy support to consider drug exposure neglect. American College of Obstetricians and Gynecologists, *Opposition to Criminalization of Individuals During Pregnancy and Postpartum Period* (2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period (citing Center for Substance Abuse Treatment, *Drug Testing in Child Welfare: Practice and Policy Considerations*, HHS Pub. No. (SMA) 10-4556 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2010) ("In addition, drug tests do not provide sufficient information for substantiating allegations of child abuse or neglect or for making decisions about the disposition of a case (including decisions regarding child

internationally peer-reviewed study found that "[t]he use of Cannabis in pregnancy, on the other hand, is well-studied and does not appear to be contraindicated."[36] In fact, Ms. R's actions are more properly viewed as protective, since the severe nausea caused by HG itself can lead to pregnancy loss if left untreated or ineffectually treated.[37] The alternative would have been to continue to suffer from her various health conditions, including HG, and put herself and her developing pregnancy at risk, an outcome contrary to the child protection interests asserted by the State. *See, e.g., State's Br.*, at 17 ("The Department's primary purpose is to protect children.").

### D. Research Does Not Support the Claim that Medical Marijuana Creates Unique Risks of Harm Different in Kind or Magnitude Compared to Other Activities and Exposures During Pregnancy, Nor Does It Create Unreasonable Danger to a Fetus.

Evidence-based research does not support equating prenatal exposure to medical marijuana to neglect, nor does it support the claim that Ms. R's consumption of medical marijuana for well-recognized health conditions, including HG, created an unreasonable danger to the safety of her child.

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removal, family reunification, or termination of parental rights)"); Susan Boyd, *Gendered Drug Policy*, 68 Int'l J. of Drug Policy 109 (2019), at 14 ("leading medical organizations agree that a positive drug test should not be construed as child abuse or neglect" and that policing on the basis of a positive drug test "poses serious threats to people's health . . . [by] erod[ing] trust in the medical system, making people less likely to seek help when they need it").

[36] Westfall, *Use of anti-emetic herbs in pregnancy*, *supra* note 27.

[37] *Id.*

### 1. Exposure to Medical Marijuana Does Not Establish Harm or Neglect.

Although the state's child neglect law equates any prenatal exposure to selected substances as neglect (A.R.S. § 8-201(25)(c)(iv)), AMMA, consistent with medical and social science research as well as the recommendations of every leading medical group,[38] makes clear that the State may not presume that evidence of exposure to medical marijuana constitutes neglect. A.R.S. § 36-2813(D). Rather, the State must establish an "unreasonable danger . . . by clear and convincing evidence." *Id.* This is consistent with the fact that neither verbally disclosed drug use nor a positive result of a drug test provide any evidence of harm or impairment. As the U.S. Department of Justice explains, "[d]rug tests detect drug use but not impairment. A positive test result, even when confirmed, only indicates that a particular substance is present in the test subject's body tissue. It does not indicate abuse or addiction; recency; frequency, or amount of use; or impairment." U.S. Dept. of Justice, *Drugs, Crime, and the Justice System: A National Report from the Bureau of Justice Statistics* 119 (1992). A positive drug test thus cannot determine whether a person occasionally uses a drug, is addicted, suffers any physical or

[38] American College of Obstetricians and Gynecologists, Opposition to Criminalization of Individuals During Pregnancy and Pospartum Period (2020) ("a positive drug test should not be construed as child abuse or neglect"), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period; *see also infra* Section II.A.

emotional disability from that addiction, or is more or less likely to abuse or neglect their children. *Id.* AMMA recognizes this in the context of medical marijuana, and demands more than evidence of prenatal medical marijuana exposure; it requires a finding by clear and convincing evidence that the exposure causes "unreasonable danger to the safety of the minor." A.R.S. §§ 36-2813(C), (D).

### 2. Research on Marijuana and Pregnancy Does Not Support the Conclusion that Ms. R[redacted] Exposed her Fetus to Unreasonable Danger.

In a recently published, peer-reviewed, systematic, and critical review of the literature from the past 30 years on the effects of prenatal exposure to marijuana, researchers found that "the evidence does not support an association between prenatal marijuana exposure and clinically relevant cognitive defects."[39] Further, as the study (*hereinafter*, "Torres study") concludes,

> a misunderstanding of the relationship between prenatal cannabis exposure and subsequent cognitive function leads to an oversimplification of the complex relationships between socioeconomic factors and the functioning of the individual whether drug use is involved or not . . . leading to punitive policies and enhancing unwarranted stigma. . . . Th[ese] assumption[s] should be reevaluated to ensure that our assumptions do not do more harm than the drug itself.[40]

[39] Torres, *supra* note 34, at 23.
[40] *Id.* at 25.

The scientific literature addressing the relationship between prenatal marijuana exposure and other possible pregnancy outcomes uniformly recognizes that any evidence of the impact of prenatal marijuana exposure on fetal or child development is inconsistent and therefore inconclusive.[41] The findings in this area have been highly variable and all studies address correlations, not causation. The distinction between correlation and causation is essential in both scientific and legal theory. A simple observation of correlation or association—the co-occurrence of two things—does not establish that one *causes* the other, *i.e.*, that the two things have a causal relationship. Several researchers have found no correlation between maternal marijuana consumption and pregnancy outcomes whatsoever,[42] other studies have found a correlation between maternal marijuana use and small negative effects on

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[41] *See, e.g.*, Fergusson, et al., *Maternal use of Cannabis and Pregnancy Outcome*, 109 BJOG: an International Journal of Obstetrics and Gynecology 21, 21–22 (2002); Fried, et al., *Growth of Pubertal Milestones during Adolescence in Offspring Prenatally Exposed to Cigarettes and Marihuana,* 23 NEUROTOXICOLOGY AND TERATOLOGY 431, 432 (2001); P. A. Fried & A. M. Smith, *A Literature Review of the Consequences of Prenatal Marihuana Exposure: An Emerging Theme of Deficiency in Aspects of Executive Function,* 23 NEUROTOXICOLOGY AND TERATOLOGY 1, 8 (2001); English, et al., *Maternal Cannabis Use and Birth Weight: A Meta- Analysis*, 92 ADDICTION 1553, 1558–59 (1997); Dreher, et al., *Prenatal Marijuana Exposure and Neonatal Outcomes in Jamaica: An Ethnographic Study,* 93 PEDIATRICS 254, 254–56 (1994).

[42] *See, e.g.*, Fried et al., *supra* note 41 at 436 (study of 13–16-year-old adolescents, maternal marijuana showed no association between any growth measurement or the timing of pubertal milestones); Astley, et al., *Analysis of Facial Shape in Children Gestationally Exposed to Marijuana, Alcohol, and/or Cocaine,* 89 PEDIATRICS 67, 67–77 (1992) (no association between fetal marijuana exposure and facial dysmorphology).

birth weight or certain developmental markers,[43] and some researchers have found some slight beneficial correlation with birth weight or infant development.[44] None of these are causal.

Methodological difficulties raised by the scientific literature make it impossible to isolate the causal effects of marijuana use from the myriad of complex factors contributing to pregnancy outcomes.[45] Researchers have been unable to control for the effects of exposure to other substances—cigarettes, alcohol, criminalized drugs, and prescription medications—from marijuana intake during pregnancy.[46] For example, ten studies examining the effect of marijuana on birth weight neglected the confounding effects arising from the practice of mixing tobacco

[43] For example, one study indicated a possible correlation between marijuana smoking and a decrease in birth weight, although the author and others recognized no correlation after correcting for confounding factors, such as tobacco smoking and poverty. Fergusson, *supra* note 41 at 23-26. No study has found a correlation with miscarriage or infant mortality. Fried & Smith, *supra* note 41, at 3 (while discussing the problematic issues of the current research Fried & Smith note that the unique variance attributable to prenatal marijuana is typically less than 5% after the variance due to potentially confounding factors is removed).

[44] Dreher, *supra* note 41 at 254–60; Tennes, *Effects of Marijuana on Pregnancy and Fetal Development in Human,* NIDA RES MONOGR. 48-60 (1985); Fergusson, *supra* note 41, at 25 (In contrast to heavy cannabis use, occasional use of cannabis before or during pregnancy did not have detectable adverse effects on birthweight, and appeared to increase mean birth weight, although it was not statistically significant).

[45] *See* English, *supra* note 41, at 155–59; Fried & Smith, *supra* note 41 at 8; Dreher, *supra* note 41, at 255–56.

[46] *See* Fried & Smith, *supra* note 41 at 8; Fergusson, *supra* note 59 at 36.

and marijuana.[47] After adjusting for these as confounding factors, studies have concluded that the association between prenatal marijuana exposure and pregnancy outcomes is statistically insignificant.[48]

Varied social and demographic characteristics amongst the mothers studied exacerbate the difficulty of drawing firm conclusions from the peer-reviewed and published research—even on associations between marijuana use and pregnancy outcomes.[49] Peter Fried, the most published researcher in this field, asserts that any definitive statement of the consequences of prenatal exposure to marijuana would be "problematic, presumptuous, and foolhardy."[50]

Moreover, the suggestion that if Ms. R[redacted] had disclosed her marijuana use to certain medical providers, there was some treatment that could have been provided to Silas is without any foundation in medical science. DCS Dec., Concl. of Law ¶ 3, State's Br. at 27-28. DCS presented no evidence that there was anything

[47] English, *supra* note 41 at 1558.
[48] Torres, *supra* note 34 at 23–24.
[49] Torres, *supra* note 34 at 23 (existing studies do not adjust for sociodemographic factors including maternal cognitive ability, poverty, home environment, preschool and daycare attendance, and other factors which are known correlates to cognitive performance); *id.* at 24 ("A greater understanding is necessary of the fact that many children with prenatal cannabis exposure are also exposed to factors often seen in people with low socioeconomic status, such as poor nutrition, parents with lower levels of education and parents who may also use other substances, including nicotine and alcohol, among a host of other confounding variables."); *id.* at 25 ("mothers who used more cannabis were different people—likely leading different lives—from those using less or no cannabis").
[50] Fried & Smith, *supra* note 41 at 8.

different that would have been done during the pregnancy or at the birth if providers had known that Ms. R had used medical marijuana during pregnancy. In fact, because there is no identified harm from prenatal exposure to medical marijuana use, there is no treatment for it that was denied or delayed and no danger to Silas by not disclosing marijuana use.

Peer-reviewed medical research simply does not provide a basis for presuming that Ms. R 's use of medical marijuana created an "unreasonable danger to the safety of a minor,"[51] or for removing pregnant women from the protections of AMMA. In fact, as addressed above, evidence of potential harm to fetuses of untreated HG is far better established than any claims of harm from prenatal exposure to medical marijuana use.

[51] Even when looking at non-certified, illicit use of drugs, research finds "that many women who use illegal drugs are adequate parents and, like non-drug using parents, adopt strategies to mitigate harm. . . . . [M]ost drug use is unproblematic." Susan Boyd, *Gendered drug policy*, 68 INT'L J. OF DRUG POLICY 109 (2019). *See also* Olsen, et al., *Contraception, punishment and women who use drugs*, 14 BMC WOMENS HEALTH 5 (Jan. 2014), doi: 10.1186/1472-6874-14-5 ("Women's drug use should not automatically be associated with an inability to make informed health care choices or to care for children."); Hepburn, *Drug use in pregnancy*, 49 BR. J. HOSP. MED. 51 (Jan. 1993), PMID: 8431726 (although the lives and relationships of regular, loving families who regularly use illicit drugs do not always conform to mainstream standards, those families practice ways of keeping children safe and loved that are rarely documented); Am. Bar Ass'n, Foster Care Project, Nat'l Legal Resource Center for Child Advocacy & Protection, *Foster Children in the Courts* 206 (Mark Hardin ed., 1983) (many parents "suffer from drug or alcohol dependence yet remain fit to care for a child. An alcohol or drug dependent parent becomes unfit only if the dependency results in mistreatment of the child, or in a failure to provide the ordinary care required for all children").

### E. Because Numerous Factors Are Associated with and Potentially Contribute to Pregnancy Outcomes, the Superior Court's Singular Focus on Medical Marijuana Is Inappropriate.

Although the Superior Court's decision purports not to rely on facts regarding harm or danger of medical marijuana use during pregnancy (Decision at 9 n.2), the Department investigator (ALJ, Findings of Fact ¶ 11), Director (DCS Dec., Concl. Of Law ¶ 3), and the State (State's Br. at 27) attribute "complications after birth," including "jitteriness," trouble breathing, and a possible stroke, to testing positive for marijuana.

The Department investigator and the Director's focus on marijuana use for the conditions of the child at birth lacks medical basis and ignores numerous other factors that may contribute to birth outcomes. Nothing in the ALJ's or Director's findings of fact provide a basis for concluding that medical marijuana caused those conditions. Indeed, assuming that causes are even determinable, the investigator and Director ignored numerous other highly relevant factors.

Jitteriness is extremely common, occurring in almost half of healthy, full-term neonates.[52] This non-specific clinical notation does not indicate anything about baby Silas' prenatal exposure or any harm to him. Instead, DCS used this extremely

[52] Parker, et al., *Jitteriness in Full-Term Neonates: Prevalence and Correlates*, 85 PEDIATRICS 17, 22 (1990), PMID: 2296489.

common neonatal state to imply harm, without presenting any evidence, whether qualified expert testimony or reference to peer-reviewed research.

Further, Ms. R took Buspar and Celexa to manage her anxiety and depression. She also consumed caffeine and Benadryl. Prenatal exposure to caffeine, among other factors, may contribute to jitteriness.[53] Yet the investigator admits that she did not probe the possible effects of any of these drugs nor whether they might be alternate causes of the newborn's "jitters." Appellant's Brief at 7; ALJ, Findings of Fact ¶ 13.

In addition to the prescribed medications Ms. R was taking, Silas was born positive for strep, which is a common, yet serious condition for a newborn and can cause difficulty breathing and fever, and has absolutely no relationship to medical marijuana use.[54] The investigator, Department, and Superior Court noted

[53] *See id.*

[54] Group B Strep is known to be the most common infectious cause of morbidity and mortality in neonates. Puopolo, et al., Committee on Fetus and Newborn, Committee on Infectious Diseases, *Management of Infants at Risk for Group B Streptococcal Disease*, PEDIATRICS (Aug. 2019), doi: 10.1542/peds.2019-1881. *See also* Verani, et al., Division of Bacterial Diseases, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention (CDC), *Prevention of perinatal group B streptococcal disease--revised guidelines from CDC* (2010), 59 MMWR Recomm Rep. 1 (Nov 2010), PMID: 21088663 ("Group B *Streptococcus* remains the leading infectious cause of morbidity and mortality among newborns in the United States."); Ahmadzia & Heine, *Diagnosis and management of group B streptococcus in pregnancy*, 41 OBSTET. GYNECOL. CLIN. NORTH AM. 629 (Dec. 2014), doi: 10.1016/j.ogc.2014.08.009 ("Group B streptococcus infection may cause significant maternal and neonatal morbidity, including sepsis, pneumonia and meningitis.").

these conditions, but chose—without medical or scientific support—to regard them as evidence of "neglect" rather than health conditions many newborns experience and from which, as with Silas, they recover.

## II. Children Will Be Endangered, Not Protected, by a Decision Excluding Pregnant Patients from AMMA's Protections.

According to the State, the purpose of the neglect law and the decision to put Ms. R[redacted] on the Central Registry is to protect children. State's Br. at 17, 19. In support of that purpose, the State asks this Court to uphold the Superior Court's ruling, overriding AMMA's broad coverage and its prohibitions against penalties for lawful use of medical marijuana. The Superior Court and the State are wrong, however, in concluding that ignoring AMMA's protections and allowing a finding of neglect of Ms. R[redacted] protects children, because they improperly rely on specious assumptions surrounding the alleged harm caused by medical marijuana and ignore the deleterious consequences of the penalties they impose.

### A. AMMA's Protection Against Penalties Is Consistent with the Recommendations of Every Leading Medical Organization.

The American Medical Association,[55] American Nurses Association,[56] American Psychological Association,[57] American Psychiatric Association,[58] and the American Academy of Pediatrics[59] unanimously conclude that punitive responses to

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[55] American Medical Association, Policy Statement H-420.962, *Perinatal Addiction -Issues in Care and Prevention* (last modified 2019) ("Transplacental drug transfer should not be subject to criminal sanctions or civil liability . . ."); American Medical Association, Policy Statement H-420.969, *Legal Interventions During Pregnancy* (last modified 2018) ("Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.").

[56] American Nurses Association, Position Statement, *Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders* (2017) ("Contrary to claims that prosecution and incarceration will deter pregnant women from substance use, the greater result is that fear of detection and punishment poses a significant barrier to treatment.").

[57] American Psychological Association, *Pregnant and Postpartum Adolescent Girls and Women with Substance-Related Disorders* (updated: 2020) ("Punitive approaches result in women being significantly less likely to seek substance use treatment and prenatal care due to fear of prosecution and fear of the removal of children from their custody. This places both the mother and her children at greater risk of harm.").

[58] American Psychiatric Association, Position Statement, *Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders* (2019) ("A public health response, rather than a punitive legal approach to substance use during pregnancy is critical.").

[59] American Academy of Pediatrics, Committee on Substance Use and Prevention, Policy Statement, *A Public Health Response to Opioid Use in Pregnancy (*2017) ("The existing literature supports the position that punitive approaches to substance

the issue of pregnancy and drug use are harmful to the health of women and children, and diminish families' healthcare access.

The American College of Obstetricians and Gynecologists ("ACOG") explains, "a positive drug test should not be construed as child abuse or neglect" and punitive responses pose "serious threats to people's health … [by] erod[ing] trust in the medical system, making people less likely to seek help when they need it."[60] For this reason the ACOG Committee on Health Care for Underserved Women has concluded that:

> 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.[61]

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use in pregnancy are ineffective and may have detrimental effects on both maternal and child health . . . .").

[60] ACOG, Opposition to Criminalization of Individuals During Pregnancy and Pospartum Period (2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period.

[61] ACOG, Committee on Health Care for Underserved Women, Committee Opinion No. 473 (Jan. 2011, affirmed 2014), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy-the-role-of-the-obstetrician-gynecologist.

From a public health perspective, imposing a finding of neglect and placing someone on the Central Registry based solely on medical marijuana use is likely to cause real and devastating health consequences by deterring women from seeking prenatal care altogether.[62] The fear of penalties also deters parents from bringing their children in for care, further undermining family health.[63] It creates a disincentive for pregnant women with actual drug dependency problems from having an open and honest relationship with their prenatal health care providers out of fear that disclosure will lead to punitive child welfare interventions.[64] Further, contrary to the intent of AMMA, such penalties undermine the public's ability to take advantage of the benefits of medical marijuana and the legislatively-created permission to use medical solutions that best suit their needs. Finally, imposing the penalty of being on the Central Registry increases numerous risks to family health and well-being as a result of the parents' associated loss of job opportunities, income, and increased stress. *See* infra Section II.C.

### B. Punitive Laws Addressing Pregnancy and Drug Use Increase Risk of Harm to Children Rather Than Protecting Them.

Punitive laws that drive a wedge between patients and their doctors have

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[62] *See supra* notes 55-59, *infra* notes 66-68.
[63] *Id.*
[64] *Id.*; *see also* Wakeman, et al., *When Reimagining Systems of Safety, Take a Closer Look at the Child Welfare System*, HEALTH AFFAIRS (Oct. 7, 2020), doi: 10.1377/hblog20201002.72121.

demonstrable negative impacts on fetal and neonatal health. Empirical research, using Tennessee's fetal assault law as a case study, found that the state's punitive approach to pregnancy and drug use increased the risk of harm to children, finding a statistically significant negative impact on fetal and child health.[65] Another empirical study found higher prevalence of neonatal abstinence syndrome (NAS) in states with punitive policies in effect.[66]

Simply put, punitive responses to drug use during pregnancy, either via the child welfare system or the criminal law system, generate negative health outcomes by deterring prenatal and postnatal care, far outweighing any speculative risks of harm as a result of medical marijuana use.[67]

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[65] Boone & McMichael, *State Created Fetal Harm*, 109 GEORGETOWN L. J. 3 (2021), *e.g.* at 501, 514; *see also* Bach, *Prosecuting Poverty, Criminalizing Care*, 60 WILLIAM & MARY L. REV. 3 (2019); SisterReach, et. al., *Tennessee's Fetal Assault Law: Understanding its impact on marginalized women* (Dec. 14, 2020), https://www.nationaladvocatesforpregnantwomen.org/tennessees-fetal-assault-law-understanding-its-impact-on-marginalized-women/.

[66] Laura J. Faherty et al., *Association of Punitive and Reporting State Polices Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome*, 2 JAMA NETW. OPEN, e 1914078 (2019). *See also,* Haffajee, et al., *Pregnant Women with Substance Use Disorders—The Harm Associated with Punitive Approaches*, N. ENGL. J. MED. (2021), doi: 10.1056/NEJMp2102051; Roberts & Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, 15 MATERN. CHILD HEALTH J. 33 (2011), doi: 10.1007/s10995-010-0594-7.

[67] *See*, *e.g.*, Haffajee, *supra* note 67.

### C. The Specific Penalty in the Case—Placing Ms. R[redacted] on the Central Registry for 25 years—Will Have Devastating Consequences for Her Family's Well-Being.

As the Superior Court acknowledged, being placed on the Central Registry constitutes a penalty violating AMMA's anti-discrimination provisions. (IRA 55 at 7.) While that court acknowledged that there could be "adverse employment consequences" as a result (*id.*), this significantly understates the extent of the harm and the degree to which it can exacerbate economic instability within households. Once placed on the Central Registry, the person's name remains in the system for 25 years, foreclosing many employment opportunities over that time period, particularly in education, healthcare, and child welfare.[68] The education and health services industries are the second largest employers in Arizona[69] and its employees are disproportionally women.[70] This fact is particularly relevant in this case, where

[68] *Faces of Child Welfare: Why we're telling these stories*, AZCENTRAL (2018), https://www.azcentral.com/story/news/local/arizona-child-welfare/2018/05/20/faces-child-welfare-series-arizona-child-protective-services/567345002/.

[69] U.S. Bureau of Labor Statistics, *Economy at Glance – Arizona* (2021), https://www.bls.gov/eag/eag.az.htm#eag_az.f.3 (as of April 2021, 469 100 people are employed within the Education and Health Services sector in Arizona. This is the second largest industry after the Trade, Transportation and Utilities sector).

[70] Data USA, Data USA: Elementary and Secondary Schools & Educational Services, Health Care & Social Assistance – diversity (2021), https://datausa.io/profile/naics/elementary-secondary-schools?compare=educational-services-health-care-social-assistance#demographics (74.1% of workers in the Educational Services, Health

Ms. R[redacted] has previously served as a DCS investigator and more recently worked with [redacted], a home health agency. (OB at 7.) Her placement on the Central Registry would almost certainly bar her from employment in both fields.

Placement on registries like Arizona's can have devastating economic impacts on families, which can lead to associated negative health outcomes for children.[71] Economic instability, as a social determinant of health, is a stronger driver of health status than individual healthcare or lifestyle choices.[72] Thus, preventing employment in the industries in which Ms. R[redacted] is most qualified to work will undermine her ability to support her family for the rest of her working life, risking economic

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Care & Social Assistance Industry Sector are Female, making them the more common gender in the workforce).

[71] Colleen Henry, et al., *The Collateral Consequences of State Central Registries: Child Protection and Barriers to Employment for Low-Income Women and Women of Color*, 64 SOCIAL WORK 373 (Oct. 2019), https://doi.org/10.1093/sw/swz025; Community Legal Services of Philadelphia, *Reform the Child Abuse Registry System in Pennsylvania*: *The child abuse registry unnecessarily blocks low-wage workers from employment, harming children and families* (Nov. 2020), https://clsphila.org/wp-content/uploads/2020/11/Reform-the-Child-Abuse-Registry-update-3.pdf.

[72] World Health Organization, *Social Determinants of Health* (2021) https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 ("The social determinants of health (SDH) are the non-medical factors that influence health outcomes . . . include[ing] economic policies and systems, development agendas, social norms, social policies and political systems. . . . Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health. For example, numerous studies suggest that SDH account for between 30-55% of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector.").

instability and increasing the likelihood of negative health impacts for herself and her children.[73]

## III. All Adults, Including Pregnant People, Are Entitled to Make Health Decisions for Themselves

DCS and the Superior Court assumed that Ms. R[redacted] was under an obligation to disclose certain information, seek out and accept the advice of particular medical providers, and get additional "permission" to do what is legally permissible in Arizona: use medical marijuana. This runs afoul of the constitutional and statutory protections of medical decision-making enjoyed by all patients, including pregnant ones.

The Superior Court found it problematic that, according to its factual findings, Ms. R[redacted] only disclosed her marijuana use and her pregnancy to the certifying physician. (IRA 55 at 9–10.) In its Findings of Fact, DCS concluded that there was no "evidence that any of the emergency room doctors gave her *permission* to continue using medical marijuana." (IRA 41 at ¶ 5 (emphasis added).) While there is a dispute between the parties, and between the ALJ's original findings of fact and those of DCS about what disclosures Ms. R[redacted] made regarding her use of medical marijuana and to whom she made them, it is clear that as a matter of constitutional law, she was under no obligation to make those disclosures nor to obtain permission

[73] *Id.* (*see* Figure 1: Social Determinants of Health).

for her medical and health decisions.

The Arizona Supreme Court has squarely held that Arizona citizens have the right to care for their health and to choose or refuse treatment they deem most appropriate for themselves. *Rasmussen v. Fleming*, 154 Ariz. 207, 215 (1987) (citing Ariz. Const. art. II, § 8). "[Arizona] citizens have rights under that clause to care for their health and to choose or refuse the treatment they deem best for themselves . . . the 'individual's right to chart his or her own plan of medical treatment deserves as much, if not more, constitutionally-protected privacy than does an individual's home or automobile.'" *Simat Corp. v. Arizona Health Care Cost Containment Sys.*, 203 Ariz. 454, 458 n.2 (2002) (quoting *Rasmussen*, 154 Ariz. at 216)). This right to medical decision-making is enshrined in the Arizona Constitution's explicit right to privacy, long-recognized in common law, and supported by the U.S. Constitution. Ariz. Const. art. II, § 8 ("No person shall be disturbed in his private affairs . . . ."); *Rasmussen*, 154 Ariz. at 214–16. Specifically, this

> right to be free from nonconsensual bodily invasions is at the heart of what is known today as the doctrine of informed consent . . . [which] is defeated somewhat if, after receiving all information necessary to make an informed decision, the patient is forced to choose only from alternative methods of treatment and precluded from foregoing all treatment whatsoever. We hold that the doctrine of informed consent—a doctrine borne of the common-law right to be free from nonconsensual physical invasions—permits an individual to refuse medical treatment.

*Rasmussen*, 154 Ariz. at 216. Pregnant people are not excluded from the category, "Arizona citizens."

In fact, all adults are permitted to accept or reject the advice of their medical providers, even if that refusal might cause them harm or even result in their death.[74] All state appellate courts that have considered cases regarding treatment refusals by pregnant patients, and have done so with the benefit of full briefing and *amici* participation, have upheld the pregnant patient's right to refuse medically recommended treatment even when it was believed that such refusals could result in the end of a pregnancy. *See In re Fetus Brown*, 689 N.E.2d 397 (Ill. App. 1997); *In re Baby Boy Doe*, 632 N.E.2d 326, 328, 332 (Ill. App. 1994); *In re A.C.*, 573 A.2d 1235 (Dist. Columbia Ct. App., 1990).

Ms. R[redacted]'s right to decide what medical care to seek, what information to disclose, and what medical advice to accept or reject is consistent not only with the

[74] American Medical Association, Code of Medical Ethics Opinion 1.1.3(d) (Patient have the right "To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention."); American College of Obstetricians and Gynecologists, *Committee Opinion: Refusal of Medically Recommended Treatment During Pregnancy*, No. 664, June 2016 ("Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected."); *Cruzan v. Director, Mississippi Dept. of Health*, 497 U.S. 261 (1990) (a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment under the Due Process Clause); *Rasmussen*, 154 Ariz. at 215.

law but also medical ethics and the recommendations of the American Medical Association ("AMA") and the American College of Obstetricians and Gynecologists ("ACOG"). As the AMA Code of Medical Ethics Opinion 1.1.3(d) explains, patients have the right "to make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention." And ACOG has stated unequivocally that pregnant people's rights to make medical or health decisions for themselves and their fetuses are unwavering, even if such decisions are not advised by the pregnant person's doctors or in direct contravention of that advice.[75] This position recognizes the fact that pregnant people often receive conflicting advice

[75] American College of Obstetricians and Gynecologists, *Committee Opinion: Refusal of Medically Recommended Treatment During Pregnancy*, No. 664, June 2016.

from healthcare providers, social networks,[76] and the media.[77]

The Superior Court's decision to ignore the mandates of AMMA not only violates Ms. R[redacted]'s constitutional rights to privacy and medical decision-making, it also creates a new standard whereby one group of patients, pregnant women, are excluded from AMMA's provisions. This exclusion raises significant equal protection concerns. U.S. Consti., Amend. 14; Ariz. Const. art. II, § 13. The Arizona equal privileges and immunities clause requires rational basis review if the statutory scheme is not predicated on a suspect class, but it requires strict scrutiny where a fundamental right is at stake, such as medical decision-making. *Simat*, 203 Ariz. at 459; *Rasmussen*, 154 Ariz. at 214–16 (citing Ariz. Const., art. II, § 8, and centuries of common law).

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[76] McCarthy, et al., *The pregnancy experience: a mixed methods analysis of women's understanding of the antenatal journey*, 188 IRISH J. OF MED. SCIENCE 555 (2019), https://link.springer.com/article/10.1007/s11845-018-1874-2 ("Just under two thirds of women always understood the information provided in the antenatal setting, which worryingly means that the remainder are unclear on certain aspects of antenatal information provided. Factors involved with this lack of understanding can include information saturation, education level *and conflicting advice from healthcare providers*.") (emphasis added); Schölmerich, et al., *Caught in the middle? How women deal with conflicting pregnancy-advice from health professionals and their social networks*, 35 MIDWIFERY 62 (2016), https://doi.org/10.1016/j.midw.2016.02.012 ("We found that all women faced a misalignment of advice by health professionals and social networks.").

[77] *See, e.g.*, Tara Parker-Pope, Should Pregnant Women Eat More Seafood?, N.Y. TIMES (Oct. 5, 2007), https://well.blogs.nytimes.com/2007/10/05/should-pregnant-women-eat-more-seafood/.

Because Ms. R[redacted]'s fundamental rights to privacy and medical decision-making are implicated, the court must apply strict scrutiny, and whatever the nature of the state's "legitimate" interest in "protecting the fetus" might be, it is not a compelling interest and thus may not be the basis for barring pregnant patients from making their own medical decisions, nor is it more compelling than the state's interest in protecting the health of the pregnant person afflicted by debilitating and life-threatening health conditions.

While the Arizona Supreme Court's decision in *Simat* makes clear that State law excluding pregnant patients from AMMA's benefits and protections should be evaluated under the strict scrutiny standard, such an exclusion also fails under rational basis review. The research shows that penalties for pregnancy and medical marijuana use undermine rather than further any asserted interest in maternal or fetal health. *See supra* Sections I.D.2, II. Therefore, exempting pregnant patients from AMMA's protections bears no rational relationship to any legitimate state purpose.

## CONCLUSION

Ms. R[redacted] had the right—as a matter of both statutory and constitutional law—to benefit from medical marijuana. Marijuana does not create unique risks of harm, and it certainly does not create an "unreasonable danger" to a developing pregnancy. By contrast, it can successfully treat a variety of conditions, including HG, a condition that, left untreated, poses a far greater risk of harm to pregnancy.

Imposing a 25-year penalty on a person for legal medical marijuana use while pregnant—particularly where it was used to mitigate the risk of harm of a severe pregnancy-related condition—creates actual risk of harm to Ms. R[redacted] in the form of long-term economic instability, and will deter other pregnant people from seeking the care they need. This court must remedy these violations of Ms. R[redacted]'s rights, protect the rights and health of pregnant people in Arizona, and reverse the Superior Court decision.

DATED: July 2, 2021

MESCH CLARK ROTHSCHILD

By: /s/ Jana L. Sutton
Jana L. Sutton
*Attorneys for Amicus Curaie*

# APPENDIX A

## STATEMENTS OF INTEREST FOR AMICI CURIAE

### INSTITUTIONAL AMICI

**National Advocates for Pregnant Women** ("NAPW") is a nonprofit organization that advocates for the rights, health, and dignity of all people, focusing particularly on pregnant and parenting women, and those who are most likely to be targeted for state control and punishment. Through litigation, representation of leading medical and public health organizations and experts as amicus, and through organizing and public education, NAPW works to ensure that people do not lose their constitutional, civil, and human rights as a result of pregnancy. The organization also conducts research and has published a peer-reviewed study on prosecutions of and forced medical interventions on pregnant women. NAPW believes that health and welfare problems, including substance use disorders, should be addressed as health issues not as crimes, and promotes policies that actually protect maternal and child health as well as families.

**Academy of Perinatal Harm Reduction** is a source for evidence-based, stigma-free education and support. Our mission is to improve the lives of pregnant and parenting people who use substances. Our collaborative approach provides a fresh framework for multi-disciplinary, critical analysis of the most current research.

**Americans for Safe Access Foundation** ("ASA") was founded in 2002 and now has over 150,000 active supporters in all 50 states. ASA is the largest national member-based organization of patients, medical professionals, scientists and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research. ASA works to overcome political, social and legal barriers by creating policies that improve access to medical cannabis for patients and researchers through legislation, education, litigation, research, grassroots empowerment, advocacy and services for patients, governments, medical professionals, and medical cannabis providers.

**Arizona Attorneys for Criminal Justice** ("AACJ"), the Arizona state affiliate of the National Association of Criminal Defense Lawyers, was founded in 1986 in order to give a voice to the rights of the criminally accused and to those attorneys who defend the accused. AACJ is a statewide not-for-profit membership organization of criminal defense lawyers, law students, and associated professionals dedicated to protecting the rights of the accused in the courts and in the legislature, promoting excellence in the practice of criminal law through education, training and mutual assistance, and fostering public awareness of citizens' rights, the criminal justice system, and the role of the defense lawyer. AACJ has a strong interest in enforcement of the Arizona Medical Marijuana Act, and in furtherance of that interest, it has filed briefs in every major criminal case before the Arizona Supreme Court and also in cases before this court.

**Arizona Center for Women's Advancement** ("ACWA") is Arizona's first think tank and advocacy organization dedicated to women's issues and organizations. ACWA conducts research on the status of women and girls in Arizona and the best practices that effectively address the challenges we identify. ACWA also has an active advocacy arm, which represents women's organizations and interests at the Arizona Legislature. We have helped to lead Arizona's Reproductive Rights Coalition. We also work to assure resources and support for struggling families: pre-natal health care, education, child care, safety net services, pay equity, and more.

**Arizona Justice Alliance** ("AJA") was established in 2012 as a network of groups working on issues related to criminal justice and prison issues. The mission of Arizona Justice Alliance is to identify and recommend changes to Arizona's justice-related laws and practices to preserve and enhance public safety, reduce prison populations, and decrease corrections spending so that state resources can be invested in critical services that prevent crime, protect citizens and fulfill state priorities.

**Arizona National Organization for Women** ("NOW") through legislative, political and educational initiatives works to advance women's rights and address NOW's core issues. NOW's six main issues are: 1. Eliminating discrimination and harassment in the workplace, schools, the justice system, and all other sector of society; 2. securing reproductive justice for all women; 3. Ensuring full civil and

human rights for the LBGTQIA communities; 4. Ending all forms of violence against women; 5. Eradicating racism, sexism and homophobia; 6. Promoting equality and justice in our society. This lawsuit comes squarely within NOW's priority number 2.

**Central Arizona National Lawyers Guild** is an association dedicated to the need for basic change in the structure of our judicial, political, and economic system. We seek to unite the lawyers, law students, legal workers, and jailhouse lawyers of Central Arizona in an organization which shall function as an effective political and social force in the service of the people, to the end that human rights shall be regarded as more sacred than property interests. Our aim is to bring together all those who regard adjustments to new conditions as more important than the veneration of precedent; who recognize the importance of safeguarding and extending the rights of workers, women, farmers, and minority groups upon whom the welfare of the entire nation depends; who seek actively to eliminate racism; who work to maintain and protect our civil rights and liberties in the face of persistent attacks upon them; and who look upon the law as an instrument for the protection of the people, rather than for their repression.

**Do Less Harm LLC** is Dr Mishka Terplan's solo organization focused on education related to addiction medicine and the provision of expert testimony for pregnant and parenting individuals involved in the criminal justice system where drugs are part of the charge and conviction.

**Doctors for Cannabis Regulation** ("DFCR") serves as a global voice for physicians and other health professionals who support cannabis legalization and science-based regulation. DFCR promotes public education, research, and advocacy to support legislative changes necessary for improved public health, social justice, and consumer protections.

**Drug Policy Alliance** ("DPA") is a 501(c)(3) nonprofit organization that leads the nation in promoting drug policies that are grounded in science, compassion, health, and human rights. Established in 1994, DPA is a non-partisan organization with tens of thousands of members nationwide. DPA is dedicated to advancing policies that reduce the harms of drug use and drug prohibition and to seeking solutions that

promote public health and public safety. DPA is actively involved in the legislative process across the country and strives to roll back the excesses of the drug war, block new, harmful initiatives, and promote sensible drug policy reforms. The organization also regularly files legal briefs as amicus curiae, including in other cases pertaining to pregnant women who use drugs.

**Ibis Reproductive Health** is an international nonprofit organization with a mission to improve women's reproductive autonomy, choices, and health worldwide. Our core activity is clinical and social science research on issues receiving inadequate attention in other research settings and where gaps in the evidence exist. Our agenda is driven by women's priorities and focuses on increasing access to safe abortion, expanding contraceptive access and choices, and integrating HIV and comprehensive sexual and reproductive health services. We partner with advocates and other stakeholders who use our research to improve policies and delivery of services in countries around the world.

**If/When/How: Lawyering for Reproductive Justice** organizes the legal profession, provides direct legal support and uses litigation and policy strategies to transform the law so that everyone has the rights and resources to determine if, when, and how to create and sustain a family. If/When/How works to dismantle policies and practices that punish people for addressing their reproductive health care needs. Such punishment undermines individual and community health, and needlessly destroys families. If/When/How joins to urge the court to rectify the harm, rooted in stigma and misinformation about pregnancy and cannabis, that has been caused by the proceeding below.

**Inez Casiano National Organization for Women** was founded in 2016 with six core issues: 1. Eliminating discrimination and harassment in the workplace, schools, the justice system, and all other sector of society; 2. securing reproductive justice for all women; 3. Ensuring full civil and human rights for the LBGTQIA communities; 4. Ending all forms of violence against women; 5. Eradicating racism, sexism and homophobia; 6. Promoting equality and justice in our society. This issue comes squarely in priority number 2. This chapter has consistently advocated for reproductive justice in many different ways.

**Legal Action Center** ("LAC") is a national public interest law firm, with offices in New York and Washington, D.C., that performs legal and policy work to fight discrimination against and promote the privacy rights of individuals with criminal records, substance use disorders, and/or HIV/AIDS. LAC has done a tremendous amount of policy advocacy work to expand treatment opportunities for people with substance use disorders and to oppose legislation and other measures that employ a punitive approach, rather than a public health approach, to addiction. LAC has also represented individuals and substance use disorder treatment programs who face discrimination based on inaccurate and outmoded stereotypes about the disease of addiction.

**Movement for Family Power** works to end the Foster System's policing and punishment of families and to create a world where the dignity and integrity of all families is valued and supported. One cannot fight against the policing of families without squarely attacking mass child removals, family separation tactics, and surveillance that is waged on Black/Latinx/Indigenous and low income mothers through drug war policies.

**NARAL Pro-Choice Arizona** is the Arizona chapter of NARAL Pro-Choice America, an organization whose network of state affiliates and chapters are dedicated to protecting and expanding reproductive freedom for all people. NARAL Pro-Choice Arizona represents more than 50,000 members statewide. For more than 50 years, NARAL has worked to guarantee that every person has the right to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion. Ensuring that pregnant people can make these decisions free from punishment is a critical piece of our mission.

**National Coalition for Child Protection Reform** (NCCPR) is an organization of professionals from the fields of law, psychology, social work, and journalism who are dedicated to improving child welfare systems through public education and advocacy. NCCPR is a tax-exempt non-profit organization founded at a 1991 conference at Harvard Law School. NCCPR is incorporated in Massachusetts and headquartered in Alexandria, Virginia. Further information about the organization is available on its website, www.nccpr.org

**National Council of Jewish Women Arizona** is a grassroots organization that advocates for social justice within a reproductive justice framework. We are key members of the Arizona Reproductive Rights Coalition working to block legislation that would criminalize pregnancy and restrict access to the full spectrum of reproductive healthcare. Along with our National organization, our fundamental mission is to protect reproductive, constitutional and human rights and freedoms.

**National Perinatal Association** ("NPA") is a non-profit that works to give voice to the needs of pregnant people, infants, their families, and their healthcare providers so that collectively we can have the greatest positive impact on perinatal care in the United States. Additionally, NPA brings together people who are interested in perinatal care to share to listen and learn from each other. Our diverse membership is comprised of healthcare providers, parents & caregivers, educators, and service providers - all driven by their desire to support and advocate for babies and families at risk across the country.

**National Women's Health Network** ("NWHN") was founded in Washington, DC, in 1975 to improve the health of all women by developing and promoting a critical analysis of women's health issues. NWHN advocates for healthcare policies and programs that meet the needs of women and their families and works to defend women's sexual and reproductive health and autonomy against threats that seek to undermine women's ability to make the best decisions regarding their own health.

**North American Society of Psychosocial Obstetrics and Gynecology** ("NASPOG")'s mission is to promote the study and clinical application of the neurobiologic and psychosocial aspects of women's health and well-being across the life span. The NASPOG's aim is broadly defined to include the psychological, psychophysiological, public health, socio-cultural, ethical and other aspects of such functioning and behavior. Membership is comprised of approximately 200 individuals drawn from the fields of obstetrics and gynecology, psychiatry, psychology, nursing, social work, anthropology, and other related disciplines.

**Pima County Defender's Office** is the second largest indigent defense agency in Arizona tasked with defending those accused of felony offenses. The office

represents many thousands of clients every year in criminal cases, in juvenile delinquency cases, and in dependency and termination proceedings in Pima County Juvenile Court. Its lawyers represent many parents who are approved under AMMA to use medical marijuana, and many of these cases involve attempts by the Department of Child Safety to forbid parents from using medical marijuana, despite state law to the contrary.

**Women's Law Project** ("WLP") is a nonprofit public interest legal organization working to defend and advance the rights of women, girls, and LGBTQ+ people in Pennsylvania and beyond. Throughout its history, the WLP has played a leading role in the struggle to eliminate discrimination against people based on pregnancy and reproductive capacity, representing people and amici curiae in cases involving the improper application of state criminal, child abuse, and drug delivery statutes to pregnant people and to new mothers who have used substances during or after pregnancy. The WLP believes that it is both unjust and counterproductive to impose punitive sanctions on pregnant people for conduct affecting their own pregnancies.

**INDIVIDUAL AMICI****

**Ashley Bennett, MD** is a pediatrician and child rights advocate. Dr. Bennett works to promote health equity and centers the best interests of children in decisions. Dr. Bennett opposes all policies that cause harm to infants, including those that harm the mother-baby dyad.

**Monica J Casper, PhD** is Professor Emerita at the University of Arizona and the Dean of the College of Letters and Professor of Sociology at San Diego State University. Dr Casper is a sociologist of women's health, specifically reproduction, and a bioethicist. She has written widely on reproductive justice and politics, with a forthcoming book on racial disparities in infant mortality. Evidence is clear that punitive policies harm women and children, whereas policies that embrace pregnant women's autonomy support health and life.

**Wendy Chavkin, MD, MPH** is a professor of public health and obstetrics-gynecology at Columbia University's medical center. She has conducted research, published extensively, served on national commissions and testified before Congress and state legislatures about policies regarding drug use during pregnancy.

**Debra DeBruin, PhD** is the Interim Director, Center for Bioethics, Maas Family Chair in Bioethics, Associate Professor, Director of Graduate Studies, Center for Bioethics Associate Professor, College of Liberal Arts Department of Philosophy at the University of Minnesota. She is a bioethics scholar who works on ethical issues related to coercive interventions in pregnancy, which include legal actions taken against individuals for alleged behavior during their pregnancies.

**Deborah Frank, MD** is a Professor of Child Health and Well Being at Boston University School of Medicine and has published numerous peer reviewed articles on prenatal exposure to marijuana, cocaine, alcohol, and tobacco and also on malnutrition and its impact during gestation and the well-being of the child after birth. She has been a pediatrician for more than 40 years.

**Caitlin Gerdts, PhD, MHS** is the Vice President for Research at Ibis Reproductive Health. Caitlin leads the development and implementation of Ibis's research agenda, and serves on the Senior Management Team. Caitlin's methodologic expertise is in

study design and implementation, impact evaluation, and causal inference methods; she has authored and co-authored over 20 peer-reviewed publications. Prior to joining Ibis, Caitlin served as an Epidemiologist with Advancing New Standards in Reproductive Health (ANSIRH) at the University of California, San Francisco. She received her undergraduate degree in Human Biology from Stanford University; a Masters in Health Sciences (MHS) in Population, Family, and Reproductive Health from the Johns Hopkins Bloomberg School of Public Health; and a PhD in Epidemiology from the University of California, Berkeley.

**Gabrielle Goodrick, MD** is the Medical Director of Camelback Family Planning in Arizona and a physician. She trained in Family Medicine at Phoenix Baptist Hospital and worked at Planned Parenthood for 5 years before opening her own private office. She supports people's choices concerning their health and that of their children because pregnant people along with their healthcare providers must be given the choice to make the best medical decisions for a good birth outcome. Dr Goodrick opposes any policy that hinders a person's choice concerning their health and that of their children.

**Gregg E Gorton, MD, DLFAPA** is a board-certified psychiatrist with expertise in addiction (board-certified) who--during his 36-year clinical and academic career--has been Associate Clinical Professor of Psychiatry at the University of Pennsylvania Perelman School of Medicine, Associate Professor of Psychiatry & Human Behavior at Jefferson Medical College, and Clinical Associate Professor of Psychiatry & Behavioral Science at Temple University Lewis Katz School of Medicine. He is a native Arizonan currently residing in Patagonia, Arizona, who has a career-long interest in medical ethics, addiction treatment, and psychological trauma, all of which have been subjects of his professional publications.

**Erika Goyer** is a Family Advocate with the National Perinatal Association and the co-founder of the Academy of Perinatal Harm Reduction. They are a parent advocate, health educator, peer-to-peer support specialist, and community-based service provider who works with high-risk and underserved populations. Working under grants from the Health Resources and Services Administration (HRSA), Maternal Child Health Bureau (MCHB), and Children with Special Health Care Needs (CSHCN) programs they collaborate with community groups, universities, corporations, national organizations, and state agencies to improve outcomes for

families of premature infants, babies born with special health care needs, children with special educational and developmental needs, and pregnant and parenting people affected by substance dependence.

**Carl Hart, PhD** is the Ziff Professor of Psychology in the Departments of Psychology and Psychiatry at Columbia University. Professor Hart has published numerous scientific articles in the area of neuropsychopharmacology. His research investigates the behavioral and neuropharmacological effects of psychoactive drugs in humans. Professor Hart has also published multiple books, including "*High Price: A Neuroscientist's Journey of Self-Discovery That Challenges Everything You Know About Drugs and Society,*" which won the 2014 PEN/E.O. Wilson Literary Science Writing Award. His most recent book, "*Drug Use for Grown-ups: Chasing Liberty in the Land of Fear,*" is changing the national conversation on drug use. Professor Hart has appeared on multiple podcasts, radio and television shows. His essays have been published in several popular publications including *The New York Times*, *Scientific American*, *The Nation*, *Ebony*, and *Folha de S. Paulo* (Brazil's leading newspaper).

**Hytham M. Imseis, MD** is a Maternal-Fetal Medicine Specialist practicing in Charlotte, North Carolina. His career has been dedicated to caring for and advocating for pregnant women. He is very involved in the medical education of Obstetrician/Gynecologists across the United States for which he has won many teaching awards. He has served on the Women's Executive Board and the Ethics Committee at his hospital and has served as the Medical Director of the Mountain Area Perinatal Substance Abuse Program and the Mountain Area Health Education Teen Pregnancy Clinic. Dr. Imseis has published research articles in the American Journal of Obstetrics and Gynecology and in Obstetrics and Gynecology and currently reviews manuscripts for publication predominantly in the American Journal of Obstetrics and Gynecology and in Ultrasound in Obstetrics and Gynecology. Dr. Imseis also currently serves on the Board of Directors of National Advocates for Pregnant Women.

**Atsuko Koyama, MD, MPH** is a triple board-certified pediatrician specializing in pediatric emergency medicine and adolescent medicine. As an emergency room physician, she cares for pregnant women with hyperemesis gravidarum, which if

untreated can seriously compromise a woman's pregnancy. As a pediatrician, she advocates for the well-being of infants and children and their families. She opposes policies and procedures that penalize pregnant women for medically indicated treatments and interfere with a mother's ability to care for her family.

**Mary Faith Marshall, PhD, HEC-C, FCCM** is the Director of the Center for Health Humanities and Ethics and Director of the Program in Biomedical Ethics at the University of Virginia School of Medicine, and co-founder of the Studies in Reproductive Ethics and Justice program at the University of Virginia School of Medicine. She was a member of the American College of Obstetricians and Gynecologists Committee on Ethics for eleven years, and is the first author of its Opinion #664, Refusal of Medically Recommended Treatment During Pregnancy. She is a member of the editorial board of the American Journal of Bioethics.

**Danielle Raiman Plummer, PharmD,** is a medication expert, patient advocate, three-time survivor of Hyperemesis Gravidarum (HG), and is on the Board of Directors for the HER Foundation, a nonprofit that provides support, groundbreaking research, advocacy, and education on hyperemesis. Dr Plummer is passionate about creating personalized treatment plans using pharmacogenetics through her consulting business and blog to support women currently suffering with hyperemesis gravidarum, www.hgpharmacist.com. She is passionate about improving treatment options for HG, both medically and socially.

**Dianne Post, JD** is an Arizona-based attorney who has worked in over 14 countries to design and implement fundamental legal, policy and programmatic reform on issues related to gender equality. Post works with vulnerable populations, especially women and children, in developing, transitional and developed countries to achieve their human rights and freedom from violence. Post is a gender expert in violence against women and children. She works with governments, foreign aid agencies, and other partners to create, reform or implement laws, train actors in the government and criminal justice sectors and empower vulnerable populations.

**Mical Raz, MD, PhD, MSHP** is the Charles E. and Dale L. Phelps Professor in Public Policy and Health at the University of Rochester, and is a board-certified physician in internal medicine at University of Rochester Medical Center. She completed her residency in Internal Medicine at Yale New Haven Hospital in 2015,

followed by a Robert Wood Johnson Clinical Scholars Fellowship at the University of Pennsylvania. Dr Raz's research interests lie in child welfare reform and her written scholarship has received numerous awards. Her latest book "Abusive Policies: How the American Child Welfare System Lost its Way" was published in late 2020.

**Amanda Reiman, PhD, MSW** was a professor at UC Berkeley for over ten years where she taught courses on substance abuse treatment and social work as a profession. She has been conducting social science research with cannabis for almost 20 years. There is no evidence that medical cannabis use is associated with child neglect. However, there is a great deal of research showing the negative impacts of removing a child from the home without substantiated claims of abuse or neglect. Family disruption in this case, would be the most harmful outcome for all involved.

**Louise Roth, MA, PhD**, is a Professor of Sociology at the University of Arizona. Dr Roth's work explores how organizations and laws influence justice and quality of life for women. Her research uses mixed methods to analyze the effects of organizational and legal structures on gender inequality in employment and on maternity care practices. Her book, *The Business of Birth: Malpractice and Maternity Care in the United States* and related articles in Social Problems and the Journal of Health and Social Behavior, Roth uses quantitative data on the effects of state-level laws and qualitative data from in-depth interviews with obstetricians, midwives, malpractice attorneys, hospital administrators, and health insurance executives to understand the relationship between the legal environment and birth outcomes like early induction and cesarean delivery.

**Lisa Sangoi, JD** is the co-founder and co-director for the Movement for Family Power. Lisa is committed to working in service of growing a movement for child welfare and foster system reform and abolition. Lisa has had the honor of working on a number of campaigns to roll back laws, policies and practices that punish women and mothers. She has also had the privilege of providing legal representation to women targeted by the child protection and criminal legal systems through trial and appellate advocacy. Given the intersection of the drug war and the child welfare system, Lisa spends quite a bit of time learning about drug use, pregnancy and

parenting, and she regularly consults on related child welfare cases and legislation throughout the country.

**Amy Schumer** was diagnosed with hyperemesis gravidarum during her pregnancy. Schumer is an award-winning comedian and the executive producer of the HBO Max documentary miniseries "Expecting Amy" which follows her pregnancy and her experience with hyperemesis gravidarum. Through the documentary series she highlights how debilitating the condition can be.

**Lois Shepherd, JD** is the Wallenborn Professor of Biomedical Ethics at the School of Medicine's Center for Health Humanities and Ethics and a Professor of Law and Public Health Sciences. She is an expert in the fields of health law and bioethics. Joining the faculty of the University of Virginia in 2008, she has a primary appointment in the School of Medicine's Department of Public Health Sciences and a secondary appointment in the School of Law. She is based in the Center for Health Humanities and Ethics, where she directs the Center's programs in medicine and law and is a co-director of Studies in Reproductive Ethics and Justice.

**Mishka Terplan MD, MPH, FACOG, DFASAM** is board certified in both obstetrics and gynecology and in addiction medicine. His primary clinical, research and advocacy interests lie along the intersections of reproductive and behavioral health. He is Associate Medical Director at Friends Research Institute, Deputy Chief Clinical Officer at the Department of Behavioral Health, District of Columbia, and adjunct faculty at the University of California, San Francisco where he is a Substance Use Warmline clinician for the National Clinician Consultation Center. Dr.Terplan has active grant funding and has published over 120 peer-reviewed articles with emphasis on health disparities, stigma, and access to treatment. He has spoken at local high schools and before the United States Congress and has participated in expert panels at CDC, SAMHSA, ONDCP, OWH, FDA and NIH primarily on issues related to gender and addiction.

** Individuals have joined as amici in their personal capacities; institutional affiliations are noted for identification purposes only.