IN THE SUPREME COURT OF THE STATE OF MONTANA

DA 21-0521

PLANNED PARENTHOOD OF MONTANA, and JOEY BANKS, M.D., on behalf of themselves and their patients,

Plaintiffs and Appellees,

v.

STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General,

Defendant and Appellant.

BRIEF OF *AMICI CURIAE* OF THE ASIAN PACIFIC INSTITUTE ON GENDER-BASED VIOLENCE; ASPEN; CAMINAR LATINO; CUSTER NETWORK AGAINST DOMESTIC ABUSE, INC.; DISTRICT 4 HUMAN RESOURCES DEVELOPMENT COUNCIL; DOMESTIC AND SEXUAL VIOLENCE SERVICES; IDAHO COALITION AGAINST SEXUAL & DOMESTIC VIOLENCE; LATINOS UNITED FOR PEACE AND EQUITY; LEGAL VOICE; MONTANA COALITION AGAINST DOMESTIC & SEXUAL VIOLENCE; NATIONAL COALITION AGAINST DOMESTIC VIOLENCE; NATIONAL NETWORK TO END DOMESTIC VIOLENCE; RICHLAND CO. COALITION AGAINST DOMESTIC VIOLENCE; SAFE IN THE BITTERROOT; SAFE SPACE; SANDERS COUNTY COALITION FOR FAMILIES; SEXUAL ASSAULT COUNSELING CENTER; UJIMA, INC.; VICTIM-WITNESS ASSISTANCE SERVICES; WA STATE COALITION AGAINST DOMESTIC VIOLENCE; YWCA GREAT FALLS; AND YWCA MISSOULA IN SUPPORT OF APPELLEES

On Appeal from the Montana Thirteenth Judicial District Court, Yellowstone County, The Honorable Michael G. Moses, Presiding

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INTRODUCTION[1]

The State's defense of the abortion restrictions at issue in this case reflects a privileged view of reality that disregards the lived experience of survivors of intimate partner violence ("IPV")[2]—especially survivors of color. The suggestion that these restrictions somehow benefit pregnant people is at best grossly ignorant of the reality on the ground for pregnant people—even more so for survivors of IPV. Montana should be providing support to survivors that enable them to regain control over their lives and working to make up for the centuries of racial and gender oppression that have left survivors of color especially vulnerable to IPV and unintended pregnancy, not doubling down on that oppression by further restricting their reproductive autonomy.

Abortion care is essential for survivors of IPV, whose abusive partners seek to exert control over them in part by limiting access to health care and forcing pregnancy. Perpetrators of IPV maintain power within their relationships by undermining their partners' economic security, health, safety, and autonomy to make reproductive decisions. Survivors of color, including those from Native American communities, are particularly impacted. As difficult as it is for survivors of IPV to escape abusive relationships and exercise their reproductive autonomy, systemic inequities faced by survivors of color—in access to healthcare, employment, housing, education, and many other resources—make it even more so.[3]

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[1] Please see the statement of amici in the motion to appear as amicus.

[2] "Intimate partner violence" is abuse in intimate relationships. *See* Claudia Garcia-Moreno et al., World Health Org., Understanding and Addressing Violence Against Women: Intimate Partner Violence 1 n.1 (2012), http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf.

[3] Natalie J. Sokoloff & Ida Dupont, *Domestic Violence at the Intersections of Race, Class, and Gender: Challenges and Contributions to Understanding Violence Against Marginalized Women in Diverse Communities*, 11 Violence Against Women 38, 44 (2005).

Not only do survivors of IPV face increased barriers to accessing care, they also are more likely to be forced into unintended pregnancy; to need abortions; and risk being trapped in violent relationships if they are unable to access abortion care. The consequences of such entrapment range from heightened abuse during pregnancy to being killed.[4] Here again, the risks are even greater for survivors from marginalized communities, who already experience disproportionately high rates of unintended pregnancy[5] and increased health risks associated with unintended pregnancy.[6]

If the injunction is lifted, the State's new abortion restrictions will compound the control that abusers already exert over survivors. Added barriers to abortion will force a significant number of pregnant people to carry their pregnancies to term against their will, at great risk to their lives and health.

ARGUMENT

A. Survivors of IPV are at a greater risk of unintended pregnancy, which creates significant risks for survivors' health and safety.

1. Many Montanans experience IPV.

IPV "has been defined by the World Health Organization (WHO) as 'behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors,' encompassing both current and past

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[4] Alexia Cooper & Erica L. Smith, U.S. Dep't of Just., Bureau of Just. Stats., *Homicide Trends in the United States, 1980-2008, Annual Rates for 2009 and 2010* at 10 (2011), http://bjs.gov/content/pub/pdf/htus8008.pdf.

[5] Theresa Y. Kim et al., *Racial/Ethnic Differences in Unintended Pregnancy: Evidence from a National Sample of U.S. Women*, 50 Am. J. Preventative Med. 427, 427 (2016).

[6] Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, Commonwealth Fund (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries.

intimate partners."[7] IPV affects nearly one third of women in the United States,[8] with 43.6 million women reporting that they experienced sexual violence, physical violence, and/or stalking by an intimate partner during their lifetimes.[9]

Women in Montana suffer IPV at rates even higher than the national average.[10] During their lifetimes, more than 41 percent report experiencing contact sexual violence, 24.1 percent report experiencing attempted or completed rape, and 29.0 percent report experiencing unwanted sexual contact.[11] Indigenous women in Montana in particular, have experienced disproportionately high rates of sexual abuse and domestic violence dating back to colonization and the forced placement of indigenous children in boarding schools.[12]

2. Survivors of IPV experience disproportionately high rates of forced pregnancy resulting from "coercive control," systemic inequities, and reproductive coercion.

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[7] Megan Hall et al., *Associations between Intimate Partner Violence and Termination of Pregnancy: A Systemic Review and Meta-Analysis*, 11 PLoS Med. e1001581 (2014), https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001581&type=printable.

[8] Michele C. Black et al., Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Injury Prevention & Control, *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* 2 (2011), http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[9] Sharon G. Smith et al., Ctrs. for Disease Control & Prevention, *The National Intimate Partner & Sexual Violence Survey: 2015 Data Brief - Updated Release* 9 (2018), https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf.

[10] Sharon G. Smith et al., Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Injury Prevention & Control, *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report* 35 (2017), https://www.cdc.gov/violenceprevention/pdf/nisvs-statereportbook.pdf.

[11] *Id.*

[12] Usha Ranji et al., Kaiser Fam. Found., *Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities: Crow Tribal Nation, MT* (2019), https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-crow-tribal-reservation-mt/.

(i) Abusers use "coercive control" to create the conditions for unwanted pregnancy, and systemic inequities exacerbate those conditions.

Physical abuse is only one aspect of intimate partner violence. Abusers also exert control over survivors by isolating them from family and friends and monitoring their whereabouts and relationships,[13] limiting their access to financial resources, tracking their use of transportation and time away from home,[14] and threatening to harm or kidnap children, among other things.[15] This "coercive control" limits survivors' access to the resources necessary to escape the abusive relationship. Economic control is another aspect of "coercive control" and may include sabotaging employment or restricting access to money.[16] Together, these actions position the abuser to use violence with relative impunity because the survivor's support system, economic security, and resources to seek safety from abuse are compromised.

Survivors from marginalized communities face systemic inequities that exacerbate the conditions for coercive control by further limiting their access to the resources necessary to seek safety from abuse. It takes money to flee an abusive relationship—for hotel rooms, gas, food, and childcare, for example. But 31.8 percent of Native American women in Montana live in poverty, compared to 13.6 percent of their white counterparts.[17] In Montana, Native American women make

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[13] Karla Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 SMU L. Rev. 2117, 2126–27 (1993).
[14] *Id.* at 2121–22, 2131–32; *see also* Leigh Goodmark, *A Troubled Marriage: Domestic Violence and the Legal System* 42 (2012).
[15] Fischer et al., *supra* note 13, at 2122–23.
[16] Julie Goldscheid, *Gender Violence and Work: Reckoning with the Boundaries of Sex Discrimination Law*, 18 Colum. J. Gender & L. 61, 75–77 (2008).
[17] Inst. for Women's Pol'y Rsch., Status of Women in the States: The Economic Status of Women in Montana (2018), https://statusofwomendata.org/wp-content/themes/witsfull/factsheets/economics/factsheet-montana.pdf.

66.9 cents on the dollar and Hispanic women make 53.7 cents on the dollar compared to white men.[18] Many Montanan women of color also lack healthcare and educational resources: While 87.9 percent of nonelderly white women in Montana have health insurance, only 57.2 percent of Native American women and 76.2 of Hispanic women are covered.[19] Only 15.5 percent of Native American women in Montana have a Bachelor's Degree or higher, half the rate for white women.[20] With limited access to stable jobs and income, affordable healthcare, and higher education, it is nearly impossible to summon the resources necessary to escape abusive relationships.[21]

Women living in Indian Country face particular challenges in accessing health care, which again can exacerbate conditions for abuse and resulting unwanted pregnancy. Many Montana counties that encompass Indian Reservations are federally designated Medically Underserved Communities, meaning they have few primary care providers, high infant mortality, high poverty or a high elderly population.[22] The Crow Indian Reservation in Montana is one example.[23] "Although Montana maintains many policies that protect access and coverage for reproductive health services, Crow women living on the reservation face sociodemographic, systemic, and cultural barriers that prevent many from readily accessing services."[24] Among those barriers is a practicality of living in rural Montana: "In many parts of

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[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] Ranji, *supra* note 12.
[22] *MUA Find*, Health Res. & Servs. Admin., https://data.hrsa.gov/tools/shortage-area/mua-find (last visited Mar. 22, 2022).
[23] Ranji, *supra* note 12.
[24] *Id.*

the reservation, the nearest health care provider is an hour drive away; yet, transportation is not readily available in this low-income, rural community . . . ."[25]

Rural IPV survivors outside of Indian Country also face difficulty accessing healthcare. Of Montana's 56 counties, "45 are considered frontier based on having population densities of less than 6 persons per square mile."[26] Geographic isolation and the long distances between towns and health care organizations are often barriers to heath care access in Montana.[27] More than half of "Montanans travel more than five miles each way to get to a doctor's office; 13% travel more than 30 miles; 7% travel more than 50 miles."[28] Many of Montana's isolated, rural communities lack public transportation, so access to local primary care as well as out-of-town specialty medical services is a problem.[29]

(ii) Abusers coerce and force victims into unwanted pregnancies, putting those survivors at risk.

Abusers also use "reproductive coercion" and rape to force victims into unwanted pregnancies.[30] "Reproductive coercion" describes a spectrum of conduct, ranging from rape to threats of physical harm to sabotaging a partner's birth control, used primarily to force pregnancy.[31] Abusers may interfere with their partners'

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[25] *Id.*
[26] Montana Dep't of Pub. Health & Human Servs, *Montana's Rural Health Plan 2021*, at 9 (2021), https://dphhs.mt.gov/assets/qad/FlexGrantStateRuralHealthPlan.pdf.
[27] *Id.*
[28] *Id.* at 12.
[29] *Id.*
[30] Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 Contraception 316 (2010); *see also* Anne M. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 Soc. Sci. & Med. 1737 (2010).
[31] Miller et al., *supra* note 30, at 316–17; Moore et al., *supra* note 30, at 1738; *see also ACOG Committee Opinion No. 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411, 411–15 (2013).

contraceptive use by discarding or damaging contraceptives, removing prophylactics during sex without consent, forcibly removing internal use contraceptives, or retaliating against or threatening harm.[32] A key motivation for forcing pregnancy is to increase dependency and make it harder for the survivor to escape. Beyond the physical violence, survivors of IPV "face compromised decision-making regarding, or limited ability to enact, contraceptive use and family planning . . . ."[33] So, survivors of IPV are significantly less likely to be able to use contraceptives as compared to their non-victimized counterparts.[34] It is hardly surprising, therefore, that the presence of reproductive coercion in abusive relationships dramatically increases the risk of unintended pregnancy.[35] When the National Domestic Violence Hotline surveyed over 3,000 women seeking help, more than 25 percent reported that their abusive partner sabotaged birth control and tried to coerce pregnancy.[36]

Again, systemic inequities further compound the risks associated with reproductive coercion. Marginalized communities generally already experience

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[32] Ann L. Coker, *Does Physical Intimate Partner Violence Affect Sexual Health? A Systematic Review*, 8 Trauma, Violence, & Abuse 149, 151–53 (2007); *see also* Miller et al., *supra* note 30, at 319; *see also* Lauren Maxwell et al., *Estimating the Effect of Intimate Partner Violence on Women's Use of Contraception: A Systematic Review and Meta-Analysis*, 10 PLoS One e0118234 (2015), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0118234&type=printable.

[33] Miller et al., *supra* note 30, at 316–17; *see also* Coker, *supra* note 32, at 151–53.

[34] Hall et al., *supra* note 7; *see also* Maxwell et al., *supra* note 32.

[35] Elizabeth Miller et al., Editorial, *Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 Contraception 457, 457 (2010).

[36] *1 in 4 Callers to the National Domestic Violence Hotline Report Birth Control Sabotage and Pregnancy Coercion*, Nat'l Domestic Violence Hotline (Feb. 15, 2011), https://www.thehotline.org/news/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion/; *see also* Heike Thiel de Bocanegra et al., *Birth Control Sabotage and Forced Sex: Experiences Reported by Women in Domestic Violence Shelters*, 16 Violence Against Women 601–12 (2010).

disproportionately high rates of unintended pregnancy,[37] largely due to a lack of access to sexual health information,[38] health insurance, and affordable contraceptives.[39] That's true in Montana: The rate of teen pregnancy in Big Horn County, where the Crow Reservation is located, is more than three times that of the overall rate in Montana. Experts attribute this difference to a shortage in reproductive health providers, lack of transportation, lack of sexual health education in schools, confidentiality concerns, and historical mistrust of healthcare providers, among other systemic factors.[40]

B. Survivors need meaningful access to abortion.

Countless studies have found a strong association between IPV and pregnancy termination.[41] A survivor may choose to terminate a pregnancy that results from rape or coercion,[42] or out of fear of increased violence and/or being trapped in the relationship if the pregnancy continues.[43] While research shows that having a baby with the abuser is likely to result in increased violence,[44] "having an abortion was associated in a reduction over time in physical violence . . . ."[45] A survivor of IPV

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[37] Kim et al., *supra* note 5, at 427.
[38] Amaranta D. Craig et al., *Exploring Young Adults' Contraceptive Knowledge and Attitudes: Disparities by Race/Ethnicity and Age*, 24 Women's Health Issues e281, e287 (2014) (citations omitted).
[39] Ranji et al., *supra* note 12.
[40] *Id.*
[41] *See* Hall et al., *supra* note 7 (identifying 74 studies from the United States and around the world that demonstrated a correlation between IPV and abortion).
[42] Melisa M. Holmes et al., *Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 Am. J. Obstetrics & Gynecology 320, 322 (1996) (50 percent of women pregnant through rape had abortions).
[43] Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 1, 2, 5 (2014).
[44] *Id.* at 5.
[45] *Id.*

also may terminate a pregnancy to avoid exposing a child to violence.[46] And many survivors have children whom they already struggle to protect.[47] Having a child, or another child, with an abusive partner increases the risks of poverty and homelessness upon leaving the abuser.[48]

Abortion is lifesaving medical care for many survivors. Every pregnancy carries some level of risk. Unintended pregnancies, however, have significantly greater health risks,[49] including pregnancy complications and poor birth outcomes, including miscarriage or stillbirth.[50] These problems are compounded for survivors of IPV. It is common for abusers to prevent survivors from making or keeping medical appointments or from having private conversations with health care providers.[51] As a result, survivors of IPV are less likely to receive prenatal care and more likely to miss doctors' appointments than pregnant people in non-violent relationships.[52]

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[46] Karuna S. Chibber et al., *The Role of Intimate Partners in Women's Reasons for Seeking Abortion*, 24 Women's Health Issues e131, e134 (2014).
[47] *See, e.g.*, Joan S. Meier, *Domestic Violence, Child Custody, and Child Protection: Understanding Judicial Resistance and Imagining the Solutions*, 11 Am. U. J. Gender Soc. Pol'y & L. 657 (2003).
[48] Carmela DeCandia et al., Nat'l Ctr. on Fam. Homelessness, *Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness, The National Center on Family Homelessness* 4 (2013), https://www.air.org/sites/default/files/downloads/report/Closing%20the%20Gap_Homelessness%20and%20Domestic%20Violence%20toolkit.pdf.
[49] Judith McFarlane, *Pregnancy Following Partner Rape: What We Know and What We Need to Know*, 8 Trauma, Violence, & Abuse 127, 130 (2007); *see also Public Health Impact: Unintended Pregnancy*, America's Health Rankings: United Health Foundation, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/unintended_pregnancy/state/U.S (last visited Mar. 23, 2022).
[50] McFarlane, *supra* note 49, at 130.
[51] Nat Stern et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 Geo. J. Gender & L. 613, 633 (2014).
[52] Gunnar Karakurt et al., *Mining Electronic Health Records Data: Domestic Violence and Adverse Health Effects*, 3 J. of Fam. Violence 79–87 (2016).

Survivors of color are further burdened by the effects of transgenerational racism and poverty on their health, making them especially vulnerable to pregnancy-related complications.[53] For example, "Black and American Indian/Alaska Native women have the highest maternal mortality rate compared with Asian/Pacific Islander, white and Hispanic women",[54] and "American Indian/Alaskan Native women in Montana are seven times more likely to die from pregnancy-related causes than white women."[55]

Not only do pregnant people in abusive relationships face increased health risks associated with pregnancy itself, the violence they suffer is likely to increase both in frequency and intensity during pregnancy.[56] In fact, the leading cause of maternal death in the U.S. is homicide.[57] And the staggering number of murdered and missing indigenous women suggests that homicide may be responsible for even more pregnancy-related deaths among indigenous women than researchers have been able to document.[58]

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[53] Cynthia Prather et al., *Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity*, 2 Health Equity 249, 253 (2018).
[54] *Public Health Impact: Maternal Mortality*, America's Health Rankings: United Health Foundation, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/MT?edition-year=2019 (last visited Mar. 23, 2022); *see also* Jennifer L. Heck et al., *Maternal Mortality Among American Indian/Alaska Native Women: A Scoping Review*, 30 J. Women's Health 220–29 (2021), https://pubmed.ncbi.nlm.nih.gov/33211616/.
[55] *2019-2020 Maternal Mortality Scorecard: Montana*, Soc'y for Maternal•Fetal Med. (2019), https://s3.amazonaws.com/cdn.smfm.org/mortality_records/75-:state_slug.pdf.
[56] Beth A. Bailey, *Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management*, 2 Int'l J. Women's Health 183 (2010); *see also* Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 JAMA 1915, 1918 (1996).
[57] Hall et al.,. *supra* note 7. *See also* Heck et al., *supra* note 54 (intimate partner violence contributes to 45.3 percent of pregnancy-related homicides).
[58] Heck, *supra* note 54. *See also,* Ranji, *supra* note 12.

If a survivor who is coerced into pregnancy goes on to have a child with the abuser, it becomes even more difficult to sever that abusive relationship.[59] The abused parent must navigate the legal system to obtain custody and ensure protective parenting arrangements, commonly without legal advice or representation.[60] A commission formed by this Court found that

> [m]any DV victims are forced to make their way through the court system on their own without legal advice, representation or support at a time when they are least able to do it themselves. The power imbalance inherent in a domestic violence relationship makes it more difficult for victims of domestic violence to represent themselves, particularly if the abuser has representation. The results can be the loss of custody of the victim's children and the loss of her home.

Indeed, there is "little access to any level of legal assistance across the State," even for survivors of intimate partner violence.[61]

Violent partners have learned to use this system to their advantage. Victims of domestic violence need representation in court because often their abuser is represented by an attorney and the abuser uses the legal system to continue the abuse.[62] Nationwide, abusive fathers are more likely to seek child custody than non-abusive fathers, and when they do, they succeed in gaining it more than 70 percent of the time.[63]

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[59] *See, e.g.*, Naomi R. Cahn, *Civil Images of Battered Women: The Impact of Domestic Violence on Child Custody Decisions*, 44 Vand. L. Rev. 1041, 1051 (1991).
[60] Carmody and Assocs., *The Justice Gap in Montana: As Vast as Big Sky Country* 24 (2014), https://courts.mt.gov/External/supreme/boards/a2j/docs/justicegap-mt.pdf (prepared for the Access to Justice Commission of the Montana Supreme Court).
[61] *Id.*
[62] *Id.*
[63] Am. Bar Ass'n Comm'n on Domestic Violence, *10 Custody Myths and How to Counter Them*, 4 ABA Comm'n on Domestic Violence Quarterly E-Newsletter, July 2006, at 3, https://xyonline.net/sites/xyonline.net/files/ABACustodymyths.pdf.

At the same time, the child welfare system wrongly punishes survivors—especially survivors of color—for failure to protect their children from IPV.[64] This "damned if you do, damned if you don't" response undermines the rights of survivors and provides abusive partners with another weapon of control.[65] Again, marginalized communities experience this even more often. Children of Black survivors are overrepresented in the child welfare system.[66] And before Congress passed the Indian Child Welfare Act (ICWA) in 1978, "approximately 75-80% of Indian families living on reservations lost at least one child to the foster care system."[67] These effects linger: In 2015, American Indian and Alaskan Native children around the country were still in foster care at twice the rates of their white counterparts.[68]

C. The restrictions at issue will have grave consequences for the lives and health of IPV survivors, especially the most marginalized.

Combined with the barriers that survivors of IPV already face in accessing abortion care, the proposed restrictions will prevent some survivors from obtaining care altogether. Being forced to carry an unintended pregnancy to term exposes survivors of IPV to a high likelihood of further violence, including homicide, and

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[64] Leigh Goodmark, *Law is the Answer? Do We Know That for Sure?: Questioning the Efficacy of Legal Interventions for Battered Women*, 23 St. Louis Univ. Pub. L. Rev. 7, 23 (2004).

[65] *Nicholson v. Williams*, 203 F. Supp. 2d 153, 248, 250 (E.D.N.Y. 2002) (New York City's policy of removing children from their homes solely because their mothers suffered domestic violence violated the Fourteenth Amendment).

[66] National Conf. of State Legs., *Disproportionality & Race Equity in Child Welfare* (2021), https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx.

[67] *ICWA History and Purpose*, Mont. DPHHS, https://dphhs.mt.gov/cfsd/icwa/icwahistory (last visited Mar. 23, 2022).

[68] Jason R. Williams et al., *A Research and Practice Brief: Measuring Compliance with the Indian Child Welfare Act*, Casey Fam. Programs (2014), https://www.casey.org/media/measuring-compliance-icwa.pdf.

poses significant health risks. Indeed, it could cost some pregnant people—especially indigenous women—their lives.[69]

The restrictions set forth in HB 171—requiring that a medical abortion take place in person; that there be an in-person examination prior to providing the medication; that a provider obtain the state's version of "informed consent" 24 hours before administering the medication; and that the provider schedule a follow up appointment—serve no purpose other than to force pregnant people to make multiple unnecessary trips to access care that is safe and straightforward.[70]

Forcing anyone to make unnecessary trips to access healthcare is especially problematic in Montana, where it takes many residents a significant amount of time to travel to any large town or city.[71] For those living in more remote parts of the state, including those living in Indian Country, the travel required will be even greater.[72] If this was not burdensome enough, many people do not have a running car or money for car insurance or gas, and public transportation is extremely limited.[73] Justice Sotomayor highlighted these challenges during her questioning in *Whole Woman's Health v. Hellerstedt* regarding similar limitations in another rural state:

> Justice Sotomayor: . . . The medical abortion, that doesn't involve any hospital procedure. A doctor prescribes two pills, and the women take the pills at home, correct?

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[69] *See 2019-2020 Maternal Mortality Scorecard: Montana*, *supra* note 55, https://s3.amazonaws.com/cdn.smfm.org/mortality_records/75-:state_slug.pdf ("American Indian/Alaskan Native women in Montana are seven times more likely to die from pregnancy-related causes than white women.").
[70] Nat'l Acads. of Scis., Eng'g & Med., *The Safety and Quality of Abortion Care in the United States* 10 (2018).
[71] Carmody and Assocs., *supra* note 60.
[72] Montana Dep't of Pub. Health & Human Servs., *supra* note 26, at 12.
[73] *Id.*

> Ms. Toti: Under Texas law, she must take them at the facility, but that's otherwise correct.
>
> Justice Sotomayor: I'm sorry. What? She has to come back two separate days to take them?
>
> Ms. Toti: That's correct, yes.
>
> **Justice Sotomayor: All right. So now, from when she could take it at home, now she has to travel 200 miles or pay for a hotel to get these two days of treatment?**[74]

Again, these burdens are more severe for survivors of IPV. In-home medical abortion is often a survivor's only option because she must obtain care without the abuser finding out. "[I]ntimate partner violence may drive some pregnant people to medication abortion at home to avoid detection by abusive partners for ending a pregnancy."[75] "[C]onsistent evidence [finds] that women in violent relationships were more likely not to tell their partner about their decision to terminate."[76] Requiring a survivor to travel potentially hundreds of miles and stay overnight to obtain an ultrasound, initial a list of irrelevant consents, take two pills, and participate in follow-up care casts "serious doubt as to whether" that pregnant person has access to abortion at all.[77] Between these restrictions and the many barriers to access to care that survivors of IPV already face, some simply will not be able to access care at all.

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[74] Transcript of Oral Argument at 20:19–21:6, Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016) (No. 15-274) (emphasis added).
[75] Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and at-Home Reproductive Care*, 32 Const. Comment 341, 373 (2017).
[76] Hall et al., *supra* note 7; *see also* Cynthia K. Sanders, *Economic Abuse in the Lives of Women Abused by an Intimate Partner: A Qualitative Study*, 21 Violence Against Women 3 (2015).
[77] Lindgren, *supra* note 74, at 373.

Federal courts agree. The reality of intimate partner violence was central to the Supreme Court's decision to strike down the spousal notification requirement in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[78] The Court reasoned that "there are millions of women in this country who are the victims of regular physical and psychological abuse at the hands of their husbands. Should these women become pregnant, they may have very good reasons for not wishing to inform their husbands of their decision to obtain an abortion."[79] Requiring them to notify their spouses anyway was an undue burden to obtaining care.[80] More recently, the trial court in *Whole Women's Health All. v. Rokita* observed that the burdens of accessing abortion care "intensify for women experiencing intimate partner violence, who often face the necessity of hiding their pregnancies from their perpetrators."[81]

And obtaining an abortion requires significant resources, which survivors often lack. "Transportation and abortion costs also restrict abortion access. Public funding for an abortion is severely restricted and abortions generally cost hundreds of dollars to obtain, due to both the costs of the abortion itself and the costs required for the thousands of women who must travel to see an abortion provider."[82] Abortion patients disproportionately work in jobs with low wages and little flexibility (if they are working at all).[83] Obtaining abortion services under HB 171 requires a survivor

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[78] 505 U.S. 833, 888 (1992).
[79] *Id.* at 893.
[80] *Id.* at 893–94.
[81] Findings of Fact and Conclusions of Law at 28, Whole Women's Health All. v. Rokita, No. 1:18-cv-01904-SEB-MJD (S.D. Ind. Aug. 10, 2021), ECF No. 425.
[82] A. Rachel Camp, *Coercing Pregnancy*, 21 Wm. & Mary J. Women & L. 275, 311 (2015).
[83] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 Am. J. Pub. Health 1904, 1907 (2017); Lisa R. Pruitt & Marta R. Vanegas, *Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law*, 30 Berkeley J. Gender L. & Just. 76, 82 (2015).

to locate a provider, find transportation and lodging, gather financial resources, arrange childcare for existing children, take time off from work, and comply with the newly imposed waiting period—all without an abusive partner knowing and while suffering the cognitive, psychological, and physiological effects of significant trauma.[84]

The 20-week ban set forth in HB 136 will further constrain survivors' chances of accessing care. Evidence suggests that IPV "may affect the timing of abortions."[85] For example, "women reporting both IPV and male partner conflict histories were also more likely to seek abortions in the second trimester or later than 20 weeks."[86] And at least one study has found that "women later in their second trimester (over 16 versus 13–15 weeks' gestation) at the time of [pregnancy termination] were more likely to report IPV."[87] A survivor's delay in seeking an abortion may result from the complexities associated with pregnancies occurring in the context of IPV and are connected to existing barriers to care. "These barriers may include having to navigate the violence to sneak away from a partner to obtain an abortion, for example."[88] Further, finding money, childcare, and transportation—all without a violent partner knowing—takes time.[89] Given these realities, the 20-week ban will force many survivors to self-manage their care without wanted or needed medical support or carry to term pregnancies that may be coerced. These pregnancies in turn trap them in abusive relationships and threaten their health and safety.

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[84] H.B. 171, 67th Leg. (Mont. 2021), https://leg.mt.gov/bills/2021/HB0199/HB0171_1.pdf.
[85] Gretchen Ely & Nadine Murshid, *The Association Between Intimate Partner Violence and Distance Traveled to Access Abortion in a Nationally Representative Sample of Abortion Patients,* 36 J. of Interpersonal Violence NP663, NP666 (2017).
[86] *Id.*
[87] Hall et al, *supra* note 7, at 11.
[88] Ely & Murshid, *supra* note 83, at NP666.
[89] Ushma D. Upadhyay, et al., *Denial of Abortion Because of Provider Gestational Age Limits*, 104 Am. J. of Pub. Health 1687 (2014).

CONCLUSION

The right to abortion is vital to the ability to participate equally in "the economic and social life of the Nation." *Casey*, 505 U.S. at 856. For survivors of IPV, the stakes are even higher. The loss of a meaningful abortion right will enable abusers to exert even greater, more dangerous control over them. It is not an exaggeration to say that a survivor's ability to have an abortion may mean the difference between life and death. This is especially true for survivors of color.

States should support the efforts of survivors to break free of abuse and reclaim control of their lives. But here the State does the opposite, compounding the control that abusers already exert over survivors and further undermining survivors' constitutional right to reproductive decision-making at the moment when it is most critical. For the foregoing reasons, *Amici* request that this Court affirm the Order Granting Preliminary Injunction.

DATED this 24th day of March, 2022.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify this Motion to Appear as Amici is printed with a proportionately spaced Times New Roman typeface in 14 point font, is double spaced, and the word count calculated by the word processing software does not exceed 4,938 words, excluding the cover page, tables, and certificates.

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