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IN THE SUPREME COURT OF THE STATE OF MONTANA

No. DA 23–287

PLANNED PARENTHOOD OF MONTANA, et al.,

Plaintiffs and Appellees,

v.

STATE OF MONTANA, et al.,

Defendants and Appellants.

On appeal from the Montana First Judicial District Court, Lewis and Clark County
Cause No. ADV 23–299, the Honorable Mike Menahan, Presiding

BRIEF OF AMICI CURIAE LEGAL VOICE, MONTANA COALITION AGAINST DOMESTIC & SEXUAL VIOLENCE, ASIAN PACIFIC INSTITUTE ON GENDER-BASED VIOLENCE, COALITION ENDING GENDER-BASED VIOLENCE, THE NATIONAL DOMESTIC VIOLENCE HOTLINE, AND SEXUAL VIOLENCE LAW CENTER.

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

CASES

OTHER AUTHORITIES

INTRODUCTION[1]

Abortion care is essential medical care for survivors of intimate partner violence ("IPV"), whose abusive partners exert control by limiting access to healthcare and forcing pregnancy. Perpetrators of IPV maintain relationship power by undermining their partners' economic security, health, safety, and autonomy over reproductive decisions. Survivors of color, including those from Native American communities, are particularly affected. As difficult as it is for survivors of IPV to escape abusive relationships and exercise reproductive autonomy, systemic inequities faced by survivors of color—in access to healthcare, employment, housing, education, and many other resources—make it more challenging.[2]

Survivors of IPV are more likely to be forced into unintended pregnancy; need abortions; and risk being trapped in violent co-parenting relationships if they cannot access abortion care. The consequences of such entrapment range from escalating violence during pregnancy to death.[3] The risks are even greater for survivors from

[1] Please see the statement of amici in the motion to appear as amicus.
[2] 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).
[3] 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.

marginalized communities, who already experience disproportionately higher rates of unintended pregnancy[4] and associated increased health risks.[5]

Regulations on abortion care for Medicaid beneficiaries will compound control that abusers already exert over Medicaid-eligible survivors, forcing more pregnant IPV survivors to carry pregnancies to term against their will, significantly risking their lives and health.

ARGUMENT

A. Survivors of IPV are at a greater risk of unintended pregnancy, threatening health and safety.

1. Many Montanans experience IPV.

Nearly half of United States women experience IPV, which the World Health Organization defines as "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours."[6] Almost *60 million* American women[7] report that they have experienced sexual violence, physical

[4] 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).
[5] 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.
[6] World Health Org., *Violence Against Women* (Mar. 9, 2021), https://www.who.int/news-room/fact-sheets/detail/violence-against-women; *see also* World Health Org., *Understanding and Addressing Violence Against Women: Intimate Partner Violence* 1 (2012), http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf.
[7] Though many gender identities experience IPV, this brief specifically references "women" where the underlying research focuses on women.

violence, and/or stalking by an intimate partner during their lifetimes.[8] The numbers are even starker for women of color: More than half of all multi-racial, Native, and Black people in the U.S. report experiencing IPV in their lifetimes.[9] IPV is also disproportionately high for Asian and Latina immigrant women who face additional structural barriers, including language difficulties, immigration status, and lack of resources to utilize the legal system, all layered on overall challenges of assimilation.[10]

Women in Montana suffer IPV at rates even higher than the national average: More than 41 percent report experiencing sexual violence, 24.1 percent report experiencing attempted or completed rape, and 29 percent report experiencing unwanted sexual contact.[11] Indigenous women in Montana experience disproportionately higher rates of sexual abuse and domestic violence—a pattern

[8] Ruth W. Leemis et al., Ctr. for Disease Control & Prevention, *The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence* 4 (2022), https://www.cdc.gov/violenceprevention/pdf/nisvs/NISVSReportonIPV_2022.pdf.
[9] *Id.* at 7.
[10] *See also* Jamila K. Stockman et al., *Intimate Partner Violence and Its Health Impact on Disproportionately Affected Populations, Including Minorities and Impoverished Groups*, 24 J. Women's Health 62, 62 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302952/pdf/jwh.2014.4879.pdf.
[11] 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.

dating back to colonization and forced placement of indigenous children in boarding schools.[12]

2. Abusers use coercive control to create conditions for unwanted pregnancy, exacerbated by systemic inequities.

Physical abuse is only one aspect of IPV. Abusers also exert "coercive control" by isolating survivors, monitoring their whereabouts and relationships,[13] limiting their financial resources by sabotaging employment or restricting access to money,[14] limiting transportation and travel from home,[15] and threatening to harm or kidnap children, *inter alia*.[16] This coercion limits survivors' access to resources needed to escape the abuse and positions the abuser to use violence with relative impunity because of the survivors' compromised support system, economic security, and safety protections.

Poverty and unobtainable resources heighten the difficulty for survivors to escape IPV. Fleeing abuse requires money—for hotel rooms, gas, food, and

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[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/.
[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, 2132 (1993), https://scholar.smu.edu/cgi/viewcontent.cgi?article=2322&context=smulr.
[14] *See id.* at 2121–22; Julie Goldscheid, *Gendered Violence and Work: Reckoning with the Boundaries of Sex Discrimination Law*, 18 Colum. J. Gender & L. 61, 75–77 (2008), https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1162&context=cl_pubs; Leigh Goodmark, *A Troubled Marriage: Domestic Violence and the Legal System* 42 (2012).
[15] *See* Goldscheid, *supra* note 14, at 75; Goodmark, *supra* note 14, at 4.
[16] Fischer et al., *supra* note 13, at 2121–22, 2131–32.

childcare, among other things. Longer-term costs include mental and physical healthcare, stable housing, legal representation, and finding flexible employers to accommodate leave for court appearances and safety-related needs. But many IPV survivors lose their jobs as a direct consequence of their abuse.[17]

Survivors from marginalized communities face systemic inequities that exacerbate coercive control conditions by further limiting their access to resources necessary to seek safety from abuse, especially in Montana. For instance, 31.8 percent of Native American women in Montana are impoverished, compared to 13.6 percent of their White counterparts.[18] Native American women and Hispanic women make 66.9 cents and 53.7 cents on the dollar, respectively, in Montana compared to White men.[19] Many Montanan women of color also lack healthcare: 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.[20] People of color are even more likely to be impoverished if they are

[17] Ellen Ridley et al., Me. Dep't Lab. & Fam. Crisis Servs., *Domestic Violence Survivors at Work: How Perpetrators Impact Employment* 1, 4 (Oct. 2005), https://www1.maine.gov/labor/labor_stats/publications/dvreports/survivorstudy.pdf.
[18] 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.
[19] *Id.*
[20] *Id.*

LGTBQ+, disabled, or non-citizens.[21] And women from these communities are more likely to experience IPV.[22] The COVID-19 pandemic only exacerbated existing economic inequities and coercive control experienced by IPV survivors, as abusers further limited survivors' access to resources by leveraging lockdown policies to justify increased surveillance and control of their partners.[23] With limited access to stable income, affordable healthcare, and higher education, it is nearly impossible to summon necessary resources to escape abusive relationships.[24]

3. Abusers coerce and force victims into unwanted pregnancies.

Abusers frequently use "reproductive coercion" and rape to force victims into unwanted pregnancies to increase dependency and thwart the survivor's escape.[25] Reproductive coercion describes a spectrum of conduct used to force pregnancy, ranging from rape to threats of physical harm to sabotaging a partner's birth

[21] Bianca D.M. Wilson et al., UCLA Williams Inst., *LGBT Poverty in the United States: Trends at the Onset of COVID-19*, 3–4 (2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Poverty-COVID-Feb-2023.pdf.
[22] *See supra* § I.A.
[23] Minna Lyons & Gayle Brewer, *Experiences of Intimate Partner Violence during Lockdown and the COVID-19 Pandemic*, 37 J. Fam. Violence 969, 972–73 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7908951/pdf/10896_2021_Article_260.pdf.
[24] Ranji, *supra* note 12.
[25] Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 Contraception 316, 320 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896047/pdf/nihms164544.pdf; *see also* Ann M. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 Soc. Sci. & Med. 1737, 1737–38 (2010), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/socscimed201002009.pdf; Sanctuary for Fams., *Access to Abortion – A Lifeline for Survivors of Domestic Violence* (June 24, 2022), https://sanctuaryforfamilies.org/abortion-domestic-violence/.

control.[26] Abusers interfere with their partners' contraceptive use by discarding or damaging contraceptives, unconsented removal of prophylactics during sex, forcibly removing internal use contraceptives, or retaliating against or harming their partners for contraceptive use.[27]

Reproductive coercion is widespread, particularly for IPV survivors: The Centers for Disease Control and Prevention ("CDC") reports that 10.3 million American women have had a partner attempt to impregnate them against their will or refused a condom.[28] When Amicus 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.[29] IPV survivors are almost three times more likely to report that their partner made it difficult for them

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[26] Miller et al., *supra* note 25, at 316–17; Moore et al., *supra* note 25, at 1738; *see also* Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411, 1–2 (2013, reaffirmed 2022), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion.pdf.

[27] 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 25, at 316–17; 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 1 (2015), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0118234&type=printable.

[28] M.C. Black et al., Ctr. for Disease Control & Prevention, *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* 48 (2011).

[29] Nat'l Domestic Violence Hotline, *1 in 4 Callers to the National Domestic Violence Hotline Report Birth Control Sabotage and Pregnancy Coercion* (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, 605–06 (2010).

to use birth control.[30] Survivors of IPV "face compromised decision-making regarding, or limited ability to enact, contraceptive use and family planning…."[31] As a result, they are significantly less likely to be able to use contraceptives.[32]

It is thus hardly surprising that reproductive coercion in abusive relationships dramatically increases risk of unintended pregnancy.[33] Marginalized communities already experience disproportionately high rates of unintended pregnancy,[34] largely due to a lack of access to sexual health information,[35] health insurance,[36] and affordable contraceptives,[37] compounded with a history of coercion by and mistrust

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[30] Elizabeth Miller & Jay G. Silverman, *Reproductive Coercion and Partner Violence: Implications for Clinical Assessment of Unintended Pregnancy*, 5 Expert Rev. Obstetrics & Gynecology 511 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3282154/pdf/nihms250246.pdf.
[31] Miller et al., *supra* note 25, at 316–17; *see also* Coker, *supra* note 27, at 151.
[32] *See* Megan Hall et al., *Associations between Intimate Partner Violence and Termination of Pregnancy: A Systemic Review and Meta-Analysis*, 11 PLoS Med. 1, 10 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3883805/pdf/pmed.1001581.pdf; *see also* Maxwell et al., *supra* note 27.
[33] Elizabeth Miller et al., *Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 Contraception 457, 457 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872678/pdf/nihms185106.pdf.
[34] 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), https://pubmed.ncbi.nlm.nih.gov/26616306/.
[35] Amaranta D. Craig et al., *Exploring Young Adults' Contraceptive Knowledge and Attitudes: Disparities by Race/Ethnicity and Age*, 24 Women's Health Issues 281, 285–87 (2014), https://www.teachtraining.org/wp-content/uploads/2013/10/Exploring-young-adults-contraceptive-knowledge-and-attitudes.pdf.
[36] Latoya Hill et al., Kaiser Fam. Found., *Health Coverage by Race and Ethnicity, 2010–2022* (Jan. 11, 2024), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.
[37] Usha Ranji et al., Kaiser Fam. Found., *Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities* (Nov. 14, 2019), https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/.

of state and medical institutions.[38] That's particularly true in Montana: Rates of teen pregnancy in Big Horn County, where the Crow Reservation is located, is more than three times the overall rate in Montana.[39] Experts attribute this difference to a shortage in and historical mistrust in reproductive health providers, a lack of transportation and sexual health education, confidentiality concerns, and other systemic factors.[40]

4. IPV survivors in rural areas face greater isolation and unique barriers.

Women in rural areas experience more frequent and severe rates of IPV and face additional challenges.[41] On average, they have to drive beyond 25 miles to access domestic violence intervention programs.[42] Additionally, rural emergency departments have fewer resources to address IPV, so even someone who has managed to find care may still be without support needed to address the underlying problem.[43] Nearly 44 percent of Montana lives in rural areas where these barriers

[38] Marcela Howell et al., In Our Own Voice: Nat'l Black Women's Reprod. Just. Agenda, *Contraceptive Equity for Black Women* 2–3 (2020), http://blackrj.org/wp-content/uploads/2020/04/6217-IOOV_ContraceptiveEquity.pdf.
[39] Ranji et al., *supra* note 37.
[40] Howell et al., *supra* note 38.
[41] Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources*, 20 J. Women's Health 1743, 1747 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064/.
[42] *Id*. at 1748.
[43] Danielle M. Davidov et al., *Comparison of Intimate Partner Violence and Correlates at Urgent Care Clinics and an Emergency Department in a Rural Population*, 20 Int'l J. Env't Res. & Pub. Health 4554, at 2 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10002050/.

further isolate survivors from necessary resources and highlight measures like direct-to-patient telehealth that reduce barriers to accessing reproductive healthcare, including medication abortion care.

Women living on tribal lands face particular challenges in accessing healthcare, which again can exacerbate conditions for abuse and resulting unwanted pregnancy. Many Montana counties encompassing Indian Reservations are federally designated Medically Underserved Communities with few primary care providers, high infant mortality, high poverty or a high elderly population.[44] The Crow Indian Reservation is one example.[45] "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."[46] Among those barriers is that, "In many parts of the reservation, the nearest healthcare provider is an hour drive away; yet, transportation is not readily available in this low-income, rural community…."[47]

Rural Montanan IPV survivors outside of tribal reservations also face difficulty accessing healthcare. Of Montana's 56 counties, "45 are considered

[44] *MUA Find*, Health Res. & Servs. Admin., https://data.hrsa.gov/tools/shortage-area/mua-find (last visited Mar. 22, 2022).
[45] Ranji, *supra* note 12.
[46] *Id.*
[47] *Id.*

frontier based on having population densities of less than 6 persons per square mile."[48] Geographic isolation and long distances between towns and healthcare organizations are barriers to heath care access.[49] More than half of "Montanans travel [beyond] five miles each way to get to a doctor's office; 13% travel [beyond] 30 miles; 7% travel [beyond] 50 miles."[50] Many of Montana's isolated, rural communities lack public transportation, making access to local primary care and out-of-town specialty medical services problematic.[51] Restricting access to any existing resources make escaping abuse nearly impossible for IPV survivors in rural Montana.

B. IPV survivors need meaningful access to abortion care but face heightened barriers.

Meaningful access to abortion care, while important to all women, is particularly critical for IPV survivors; especially those whose unintended pregnancies resulted from reproductive coercion or rape. Because pregnancy termination undermines abusers' control, abusers are motivated to prevent it Consequently, survivors face increased barriers to obtaining abortion care.

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[48] 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.
[49] *Id.*
[50] *Id.* at 12.
[51] *Id.*

Dozens of studies have found a strong association between IPV and the decision to terminate a pregnancy.[52] One found that 10.8 percent of women seeking abortions reported IPV within the past year.[53] A survivor may choose to terminate a pregnancy that results from rape or coercion,[54] or out of fear of increased violence and/or being trapped in the relationship if the pregnancy continues.[55] Among other risks, having children with an abusive partner exacerbates risks of poverty and homelessness upon leaving the abuser.[56]

Indeed, abortion care is lifesaving healthcare for many survivors of IPV because coercive control often extends to prenatal care. Where every pregnancy

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[52] *See* Hall et al., *supra* note 32 (identifying 74 studies from the United States and around the world that demonstrated a correlation between IPV and abortion).
[53] *See* Audrey F. Saftlas et al., *Prevalence of Intimate Partner Violence Among an Abortion Clinic Population*, 100 Am. J. Pub. Health 1412, 1413 (2010), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2009.178947; *see also* Gigi Evins et al., *Prevalence of Domestic Violence Among Women Seeking Abortion Services*, 6 Women's Health Issues 204 (1996) (stating that, of the 51 women who sought an abortion at the University of North Carolina's abortion clinic during a two-month period in 1994, 31.4 percent had experienced physical or sexual abuse their entire lives; 21.6 percent had been abused in the previous year, and 7.8 percent been abused during their current pregnancy).
[54]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).
[55] 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).
[56] 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.

carries risk, unintended pregnancies have significantly greater health risks,[57] including pregnancy complications and poor birth outcomes such as miscarriage or stillbirth.[58] These problems are compounded for IPV survivors. Abusers often prevent survivors from making or keeping medical appointments or from having private conversations with healthcare providers.[59] Thus, IPV survivors are less likely to receive prenatal care and more likely to miss medical appointments than pregnant people in non-violent relationships, which increases risks of further harm.[60] Pregnant people experiencing IPV are also at high risk of depression, post-traumatic stress disorder, and having babies preterm and with low birth weight.[61]

Survivors of color are further burdened by transgenerational racism and poverty, making them especially vulnerable to pregnancy-related complications.[62] "Native American women in Montana are seven times more likely to die from

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[57] 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).
[58] *Id*.
[59] Nat Stern et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 Geo. J. Gender & L. 613, 633 (2014).
[60] Gunnar Karakurt et al., *Mining Electronic Health Records Data: Domestic Violence and Adverse Health Effects*, 3 J. of Fam. Violence 79–87 (2016).
[61] Jeanne L. Alhusen, *Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes*, 24 J. Women's Health 100, 101 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4361157/pdf/jwh.2014.4872.pdf.
[62] 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).

pregnancy-related causes than White women.[63] Moreover, Black, American Indian, Alaskan Native, Native Hawaiian, and Pacific Islander women are more likely to have preterm births and low birth weights.[64] Asian American and Pacific Islander women are at greater risk of severe maternal morbidities and maternal mortality.[65] Immigrant women are at higher risk because they tend to receive less prenatal care, in part due to exclusionary health insurance laws and policies.[66]

Not only do pregnant people in abusive relationships face increased health risks, IPV is common during pregnancy.[67] Approximately 324,000 pregnant women are abused in the U.S. each year.[68] The abuse may worsen during pregnancy, even leading to homicide.[69]

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[63] *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.
[64] *Id.*
[65] Maryam Siddiqui et al., *Increased Perinatal Morbidity and Mortality Among Asian American and Pacific Islander Women in the United States*, 124 Anesthesia & Analgesia 879, 881 (2017).
[66] Sheela Maru et al., *Utilization of Maternal Health Care Among Immigrant Mothers in New York City, 2016–2018*, 98 J. Urban Health 711, 721–723 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8688674/pdf/11524_2021_Article_584.pdf.
[67] 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).
[68] Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 518: Intimate Partner Violence*, 119 Obstetrics & Gynecology 1, 2 (2012, reaffirmed 2022), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence.
[69] *Id.*

In fact, homicide is the leading cause of maternal death in the U.S.[70] Women who are pregnant or post-partum are more than twice as likely to die by homicide in the U.S. than by any other cause of maternal mortality.[71] In 2020, the homicide rate for pregnant and post-partum women was 35 percent higher than other women of reproductive age.[72] Risks are even greater for people of color and young women: Pregnancy-associated homicide is highest among Black women and women under age 25.[73] And staggering numbers of murdered and missing indigenous women suggests that homicide is responsible for even more indigenous pregnancy-related deaths than researchers can document.[74]

Meaningful access to abortion care is absolutely critical to IPV survivors' ability to escape abuse. If a survivor is coerced into pregnancy and has a child with the abuser, escaping that abusive relationship becomes increasingly difficult.[75] The survivor must navigate the legal system to obtain custody and ensure protective

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[70] Hall et al., *supra* note 32. *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/ (intimate partner violence contributes to 45.3 percent of pregnancy-related homicides).
[71] *Id.* at 764.
[72] Maeve Wallace, *Trends in Pregnancy-Associated Homicide, United States*, 2020, 112 Am. J. Pub. Health 1333, 1334 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9382166/pdf/AJPH.2022.306937.pdf.
[73] *Id.*; Emiko Petrosky et al., *Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence — United States, 2003–2014*, 66 Morbidity & Mortality Weekly Rep. 741, 743 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657947/pdf/mm6628a1.pdf.
[74] Heck, *supra* note 70. *See also,* Ranji, *supra* note 12.
[75] *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).

parenting arrangements, commonly without legal representation.[76] The Access to Justice 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 IPV survivors.[77] Nationwide, abusive parents are more likely to seek child custody than non-abusive parents, and when they do, they succeed more than 70 percent of the time.[78]

Simultaneously, the child welfare system wrongly punishes survivors—especially survivors of color—for failure to protect their children from IPV.[79] Children of Black survivors are overrepresented in the child welfare system.[80] And before Congress passed the Indian Child Welfare Act (ICWA) in 1978,

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[76] 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).
[77] *Id*.
[78] 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.
[79] 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).
[80] 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.

"approximately 75-80% of Indian families living on reservations lost at least one child to the foster care system."[81] These effects linger: In 2015, American Indian and Alaskan Native children nationwide remained in foster care at twice the rates of their White counterparts.[82] This "damned if you do, damned if you don't" response by legal systems undermine rights of survivors and provides abusive partners with another weapon of control.[83]

C. The Medicaid regulations at issue will have grave consequences for the lives and health of IPV survivors.

Despite the significance of abortion care for IPV survivors, meaningful access to such healthcare is challenging because of subjection to coercive control and, often, reproductive coercive control. By reducing access to abortion care for Medicaid beneficiaries, the regulations at issue threaten grave consequences for the health and well-being of many survivors of IPV.

Combined with the barriers that survivors of IPV already face in accessing abortion care, further restricting access to abortion care for Medicaid beneficiaries will prevent some survivors from obtaining care altogether. Being forced to carry

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[81] *ICWA History and Purpose*, Mont. DPHHS, https://dphhs.mt.gov/cfsd/icwa/icwahistory (last visited Mar. 23, 2022).
[82] 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.
[83] *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).

an unintended pregnancy to term exposes survivors of IPV to a high likelihood of further violence, including homicide, and significant health risks. Indeed, it could cost some pregnant people—especially Indigenous women—their lives.[84]

Barriers to accessing abortion care are more severe for survivors of IPV. These obstacles may include having to navigate the violence to sneak away from a partner to obtain an abortion, for example."[85] Further, finding money, childcare, and transportation—all without a violent partner knowing—takes time.[86] 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.

Physical injuries and past sexual assault trauma can also interfere with future medical care, limiting options for abortion care. For example, amici have worked with survivors who experienced internal scarring and medical complications from rape, which limited surgical interventions for medical needs, including abortion. Obstetric and gynecological care, particularly procedures that require instruments such as non-medication abortions, can be psychologically difficult due to sexual

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[84] *See 2019-2020 Maternal Mortality Scorecard: Montana*, *supra* note 63, 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.").

[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] Ushma D. Upadhyay, et al., *Denial of Abortion Because of Provider Gestational Age Limits*, 104 Am. J. of Pub. Health 1687 (2014).

assault trauma.[87] Meeting the reproductive health needs of rape and sexual assault survivors requires specialized, trauma-informed medical options.

If the regulations are permitted to go into effect, many survivors of IPV simply will not be able to access abortion care at all and will be forced to bear the burden of higher risks of negative health outcomes and further reproductive control

Federal courts have recognized the importance of access to abortion care for survivors of IPV. *See, e.g.*, *Robinson v. Attorney General*, 957 F.3d 1171, 1180–81 (11th Cir. 2020) (summarizing unchallenged district court factual finding of undue burden based, in part, on expert testimony about abortion delays leading to increased IPV). This Court should likewise recognize that, for many survivors of IPV, access to abortion care is critical to their health and safety because being forced to carry an unintended pregnancy to term increases survivors' risks of suffering further violence, including homicide, and poses significant risks to their health, well-being, and safety.

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[87] *See* Erica Sharkansky, U.S. Dep't of Veterans Affs., *Sexual Trauma: Information for Women's Medical Providers* (2014), https://www.ptsd.va.gov/professional/treat/type/sexual_trauma_women.asp; Carol K. Bates et al., *The Challenging Pelvic Examination*, 26 J. Gen. Internal Med. 651, 654–55 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101979/pdf/11606_2010_Article_1610.pdf; Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 825: Caring for Patients Who Have Experienced Trauma*, Obstetrics & Gynecology 94, 96 (2021); *cf.* Sobel et al., *Pregnancy and Childbirth After Sexual Trauma: Patient Perspectives and Care Preferences*, 132 Obstetrics & Gynecology 1461, 1463 (2018).

CONCLUSION

The right to abortion is vital to the ability to participate equally in "the economic and social life of the Nation." *Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, at 856 (1992).* For IPV survivors, the stakes are even higher. Reducing access to abortion care will enable abusers to exert even greater, more dangerous control. It is not an exaggeration to say that abortion access may mean the difference between life and death.

Amici urge this Court to support the efforts of survivors to break free of abuse and reclaim control of their lives rather than compounding the control that abusers already exert and further undermining survivors' constitutional right to reproductive decision-making at the moment when it is most critical. *Amici* request that this Court affirm the Order Granting Preliminary Injunction.

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Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify this brief 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 5,000 words, excluding the cover page, tables, and certificates.

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