IN THE SUPREME COURT OF THE STATE OF MONTANA

DA 24-147

PLANNED PARENTHOOD OF MONTANA, and SAMUEL DICKMAN, 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/LATINOS UNITED FOR PEACE AND EQUITY; DISTRICT 4 HUMAN RESOURCES DEVELOPMENT COUNCIL; DOMESTIC AND SEXUAL VIOLENCE SERVICES OF CARBON COUNTY; IDAHO COALITION AGAINST SEXUAL & DOMESTIC VIOLENCE; LEGAL VOICE; MONTANA COALITION AGAINST DOMESTIC & SEXUAL VIOLENCE; NATIONAL NETWORK TO END DOMESTIC VIOLENCE; SAFE IN THE BITTERROOT; SANDERS COUNTY COALITION FOR FAMILIES; SEXUAL VIOLENCE LAW CENTER; UJIMA, THE NATIONAL CENTER ON VIOLENCE AGAINST WOMEN IN THE BLACK COMMUNITY; VICTIM-WITNESS ASSISTANCE SERVICES; AND WA STATE COALITION AGAINST DOMESTIC VIOLENCE IN SUPPORT OF APPELLEES

On appeal from the Montana Thirteenth Judicial District Court, Yellowstone County Cause No. DV 21-999, the Honorable Kurt Krueger, Presiding

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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 healthcare access and forcing pregnancy. IPV survivors are more likely to be forced into pregnancy; need abortions; and risk being trapped in violent co-parenting relationships without abortion care. The consequences of such entrapment range from escalating violence during pregnancy to death.[2] The risks increase for survivors from marginalized communities already experiencing disproportionately higher rates of unintended pregnancy[3] and associated increased health risks.[4]

IPV survivors thus need meaningful access to abortion care, but they face heightened barriers because IPV perpetrators maintain relationship power by undermining their partners' economic security, health, safety, and autonomy over reproductive decisions. Survivors of color, including those from Native American

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

[2] 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), https://bjs.ojp.gov/content/pub/pdf/htus8008.pdf.

[3] 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://www.sciencedirect.com/science/article/abs/pii/S0749379715006297.

[4] 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.

communities, are particularly affected. Systemic inequities faced by survivors of color—in access to healthcare, employment, housing, education, and many other resources—make it more challenging to escape abusive relationships and exercise reproductive autonomy.[5]

If the challenged regulations are permitted to go into effect, many survivors of IPV will not be able to access abortion care and will be forced to bear the burden of negative health outcomes and be subjected to reproductive control. The restrictions will thus have grave consequences for the lives and health of IPV survivors, especially those most marginalized. For these reasons, *amici* urge this Court to affirm the judgment of the District Court.

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, defined by the World Health Organization as "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual

[5] 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), https://irp.cdn-website.com/25448aaa/files/uploaded/Domestic-Violence-at-the-Intersections-of-Race-Class-Gender.pdf.

coercion, psychological abuse and controlling behaviours."[6] Almost *60 million* American women[7] report having experienced sexual violence, physical violence, and/or stalking by an intimate partner.[8] The numbers are even starker for women of color: Over half of all multi-racial, Native, and Black women in the U.S. report experiencing IPV.[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, all layered on overall challenges of assimilation.[10]

Women in Montana suffer IPV at rates even higher than the national average: Over 41 percent report experiencing sexual violence, 24.1 percent report

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[6] World Health Org., *Violence Against Women* (Mar. 25, 2024), 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 references "women" where the underlying research focuses on women.

[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/nisvs/documentation/nisvsreportonipv_2022.pdf?CDC_AAref_Val=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.

experiencing attempted or completed rape, and 29 percent report experiencing unwanted sexual contact.[11] Indigenous women in Montana experience even higher rates of sexual abuse and domestic violence—a pattern 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,[15] and threatening to harm or kidnap

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[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://stacks.cdc.gov/view/cdc/46305.

[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* (Nov. 14, 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.

children, *inter alia*.[16] This coercion limits survivors' access to resources needed to escape abuse and positions the abuser to use violence with relative impunity because of the survivors' compromised support system, economic security, and safety.

Poverty makes it harder for survivors to escape IPV. Fleeing abuse requires money—for hotel rooms, gas, food, childcare, and more. 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. 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. 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 and Hispanic women make 66.9 cents and 53.7 cents on the dollar, respectively, 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 and 76.2

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[16] Fischer et al., *supra* note 13, at 2121–22, 2131–32.
[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.*

percent of Hispanic women are covered.[20] People of color are even more likely to be impoverished if they are 2SLGBTQIA+, disabled, or non-citizens.[21] And women from these communities are more likely to experience IPV.[22] Limited access to stable income, affordable healthcare, and higher education can make it nearly impossible to escape abusive relationships.[23]

3. Abusers coerce and force victims into unwanted pregnancies.

Abusers use "reproductive coercion" and rape to force victims into unwanted pregnancies, increasing dependency and thwarting the survivor's escape.[24] Reproductive coercion includes rape, threats, and sabotaging a partner's birth control by, for example, discarding or damaging contraceptives, unconsented removal of

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[20] *Id.*

[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* § A(1).

[23] Ranji et al., *supra* note 12.

[24] 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/socscimed20100 2009.pdf; *Access to Abortion – A Lifeline for Survivors of Domestic Violence*, Sanctuary for Fams. (June 24, 2022), https://sanctuaryforfamilies.org/abortion-domestic-violence/.

prophylactics during sex, forcibly removing internal use contraceptives, or retaliating against partners for contraceptive use.[25]

Reproductive coercion is widespread, particularly for IPV survivors: The Centers for Disease Control and Prevention reports that 10.3 million American women have had a partner attempt to impregnate them against their will or refuse a condom.[26] In one survey of over 3,000 women seeking help from a domestic violence hotline, more than 25 percent reported that their abusive partner sabotaged their birth control and tried to coerce pregnancy.[27] IPV survivors are almost three

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[25] Ann L. Coker, *Does Physical Intimate Partner Violence Affect Sexual Health? A Systematic Review*, 8 Trauma, Violence, & Abuse 149, 151–53 (2007); Miller et al., *supra* note 24, at 316–17; Moore et al., *supra* note 24, 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; 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.

[26] M.C. Black et al., Ctr. for Disease Control & Prevention, *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* 48 (2011), https://www.ojp.gov/ncjrs/virtual-library/abstracts/national-intimate-partner-and-sexual-violence-survey.

[27] *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

times more likely to report that their partner made it difficult for them to use birth control.[28] IPV survivors "face compromised decision-making regarding, or limited ability to enact, contraceptive use and family planning…."[29] They are thus significantly less likely to be able to use contraceptives.[30]

Reproductive coercion in abusive relationships dramatically increases risk of unintended pregnancy.[31] Marginalized communities already experience disproportionately high rates of unintended pregnancy,[32] largely due to a lack of

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Violence Against Women 601, 605–06 (2010), https://www.researchgate.net/publication/43133992_Birth_Control_Sabotage_and_Forced_Sex_Experiences_Reported_by_Women_in_Domestic_Violence_Shelters.

[28] 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.

[29] Miller et al., *supra* note 24, at 316–17; *see also* Coker, *supra* note 25, at 151.

[30] *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 25.

[31] 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.

[32] Kim et al., *supra* note 4, at 427.

access to sexual health information,[33] health insurance,[34] and affordable contraceptives,[35] compounded by a history of coercion by, and mistrust of, state and medical institutions.[36] That's particularly true in Montana: Rates of teen pregnancy in Big Horn County, located on the Crow Reservation and the Northern Cheyenne Reservation, are over three times Montana's overall rate.[37] Experts attribute this difference to shortages in, and historical mistrust of, reproductive health providers, lack of transportation and sexual health education, confidentiality concerns, and other systemic factors.[38]

[33] 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.ncbi.nlm.nih.gov/pmc/articles/PMC4119871/pdf/nihms584501.pdf.

[34] 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/.

[35] Ranji et al., *supra* note 12.

[36] 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.

[37] Ranji et al., *supra* note 12.

[38] Howell et al., *supra* note 36.

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 additional challenges.[39] On average, they have to drive over 25 miles to access domestic violence intervention programs.[40] Additionally, rural emergency departments have fewer resources to address IPV, so even someone managing to find care may nonetheless receive insufficient support.[41] Nearly 44 percent of Montanans live in rural areas where these barriers further isolate survivors from necessary resources, necessitating direct-to-patient telehealth to reduce barriers to reproductive healthcare, including medication abortion care.[42]

Women living on Tribal lands face particular challenges in accessing healthcare, exacerbating conditions for abuse and unwanted pregnancy. Many Montana counties encompassing Indian Reservations are federally designated Medically Underserved Communities with few primary care providers and high

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[39] 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/.
[40] *Id.* at 1748.
[41] 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/.
[42] *See* Mont. Leg., *Counting Rural Montana* (Feb. 19, 2020), https://www.leg.mt.gov/information-legislators/census-2020/.

infant mortality and poverty rates.[43] The Crow Reservation is one example.[44] "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."[45] To illustrate: "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…."[46]

IPV survivors outside of Tribal lands also face difficulty accessing healthcare. Of Montana's 56 counties, "45 [have] population densities of less than 6 persons per square mile."[47] Geographic isolation and long distances to healthcare organizations are barriers to healthcare access.[48] More than half of "Montanans travel [over] five miles each way to get to a doctor's office; 13% travel [over] 30 miles; [and] 7% travel [over] 50 miles."[49] Many of Montana's rural communities lack public

[43] *MUA Find*, Health Res. & Servs. Admin., https://data.hrsa.gov/tools/shortage-area/mua-find (last visited Aug. 12, 2024).
[44] Ranji et al., *supra* note 12.
[45] *Id.*
[46] *Id.*
[47] Montana Dep't of Pub. Health & Human Servs, *Montana's Rural Health Plan 2021*, at 9 (2021), https://dphhs.mt.gov/assets/oig/FlexGrantStateRuralHealthPlan.pdf.
[48] *Id.*
[49] *Id.* at 12.

transportation, limiting access to local primary care and out-of-town specialty medical services.[50]

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

Meaningful access to abortion care, while important to all women, is critical for IPV survivors, especially those carrying unintended pregnancies resulting from reproductive coercion or rape. Pregnancy termination undermines abusers' control, so abusers are motivated to prevent it. Consequently, survivors face increased barriers to abortion care.

Dozens of studies have found a strong association between IPV and the decision to terminate pregnancies.[51] One found that 10.8 percent of women seeking abortions reported IPV within the past year.[52] A survivor may choose to terminate

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[50] *Id.*

[51] *See* Hall et al., *supra* note 30 (identifying 74 studies demonstrating correlation between IPV and abortion).

[52] *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), https://pubmed.ncbi.nlm.nih.gov/8754670/ (stating that, of 51 women seeking an abortion at the University of North Carolina's abortion clinic during two months in 1994, 31.4 percent had experienced physical or sexual abuse; 21.6 percent had been abused in the previous year, and 7.8 percent had been abused during their current pregnancy).

a pregnancy resulting from rape or coercion,[53] or out of fear of increased violence and/or being trapped in the relationship if the pregnancy continues.[54] Among other risks, having children with an abusive partner exacerbates risks of poverty and homelessness upon leaving the abuser.[55]

Indeed, abortion care is lifesaving healthcare for survivors of IPV because coercive control often extends to controlling prenatal care. Every pregnancy carries risk, but unintended pregnancies have significantly greater health risks,[56] including pregnancy complications and poor birth outcomes like miscarriage or stillbirth.[57] These problems compound for IPV survivors. Abusers often prevent survivors from

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[53]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), https://pubmed.ncbi.nlm.nih.gov/8765248/ (50 percent of women pregnant through rape had abortions).

[54] 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), https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-014-0144-z.

[55] 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.

[56] Judith McFarlane, *Pregnancy Following Partner Rape: What We Know and What We Need to Know*, 8 Trauma, Violence, & Abuse 127, 130 (2007), https://pubmed.ncbi.nlm.nih.gov/17545570/; *see also Public Health Impact: Unintended Pregnancy*, Am.'s Health Rankings: United Health Found., https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/unintended_pregnancy/state/U.S (last visited Aug. 12, 2024).

[57] *Id.*

making or keeping medical appointments or from having private conversations with healthcare providers.[58] Thus, IPV survivors are less likely to receive prenatal care and more likely to miss medical appointments, which increases risks of further harm.[59] Pregnant people experiencing IPV are also at high risk of depression, post-traumatic stress disorder, and having babies preterm and with low birth weight.[60]

Survivors of color are further burdened by transgenerational racism and poverty, making them especially vulnerable to pregnancy-related complications.[61] Native American women in Montana are seven times more likely to die from pregnancy-related causes than White women.[62] Black, American Indian, Alaskan Native, Native Hawaiian, and Pacific Islander women are more likely to have preterm births and low birth weights.[63] Asian American and Pacific Islander women

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[58] Nat Stern et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 Geo. J. Gender & L. 613, 633 (2014), https://ir.law.fsu.edu/cgi/viewcontent.cgi?article=1454&context=articles.
[59] Gunnar Karakurt et al., *Mining Electronic Health Records Data: Domestic Violence and Adverse Health Effects*, 3 J. of Fam. Violence 79–87 (2016), https://pubmed.ncbi.nlm.nih.gov/28435184/.
[60] Jeanne L. Alhusen et al., *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.
[61] 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), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6167003/pdf/heq.2017.0045.pdf.
[62] *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.
[63] *Id.*

are at greater risk of severe maternal morbidities and mortality.[64] Immigrant women are at higher risk because they receive less prenatal care, partially due to exclusionary health insurance laws and policies.[65]

IPV is also common during pregnancy.[66] Approximately 324,000 pregnant women are abused in the U.S. each year.[67] The abuse may worsen during pregnancy, even leading to homicide.[68] In fact, homicide is the leading cause of death in pregnant women in the U.S.[69] Pregnant or postpartum women are more than twice

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[64] 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), https://journals.lww.com/anesthesia-analgesia/fulltext/2017/03000/increased_perinatal_morbidity_and_mortality_among.30.aspx.

[65] 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.

[66] Beth A. Bailey, *Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management*, 2 Int'l J. Women's Health 183 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2971723/pdf/ijwh-2-183.pdf; *see also* Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 JAMA 1915, 1918 (1996), https://jamanetwork.com/journals/jama/article-abstract/404271.

[67] Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 518: Intimate Partner Violence*, 119 Obstetrics & Gynecology 1, 2 (2012, reaffirmed 2022), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2012/02/intimate-partner-violence.pdf.

[68] *Id.*

[69] Hall et al., *supra* note 30. *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),

as likely to die by homicide in the U.S. than by any other cause of maternal mortality.[70] In 2020, the homicide rate for pregnant and post-partum women was 35 percent higher than other reproductive-age women.[71] Pregnancy-associated homicide is highest among Black women and women under age 25.[72] Staggering numbers of murdered and missing Indigenous women suggest that homicide is responsible for even more Indigenous pregnancy-related deaths than researchers can document.[73]

Meaningful access to abortion care is critical to IPV survivors' ability to escape abuse. If an IPV survivor is coerced into pregnancy and has a child, escaping that abusive relationship becomes increasingly difficult.[74] The survivor must obtain

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https://www.liebertpub.com/doi/epdf/10.1089/jwh.2020.8890 (intimate partner violence contributes to 45.3 percent of pregnancy-related homicides).

[70] *Id.* at 764.

[71] 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.

[72] *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.

[73] Heck, *supra* note 69. *See also* Ranji et al., *supra* note 12.

[74] *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), https://scholarship.law.vanderbilt.edu/cgi/viewcontent.cgi?article=2491&context=vlr.

custody and ensure protective parenting arrangements, commonly without legal representation.[75] 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.[76] Nationwide, abusive parents are more likely to seek child custody than non-abusive parents; when they do, they succeed over 70 percent of the time.[77]

The child welfare system wrongly punishes survivors—especially survivors of color—for failure to protect their children from IPV.[78] Children of Black

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[75] Carmody & 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.
[76] *Id.*
[77] 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.
[78] 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), https://scholarship.law.slu.edu/cgi/viewcontent.cgi?article=1318&context=plr.

survivors are overrepresented in the child welfare system.[79] And before Congress passed the Indian Child Welfare Act in 1978, "approximately 75-80% of Indian families living on reservations lost at least one child to the foster care system."[80] These effects linger: In 2015, American Indian and Alaskan Native children nationwide remained in foster care at twice the rates of their White counterparts.[81]

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

Together with the barriers that IPV survivors already face in accessing abortion care, the proposed restrictions will prevent some survivors from obtaining care altogether. Obtaining an abortion *without* the proposed laws is already a barrier for many, and obstacles are more severe for IPV survivors, [82] including sneaking away from a partner to obtain an abortion.[83] Further, finding money, childcare, and

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[79] *Disproportionality & Race Equity in Child Welfare*, Nat'l Conf. of State Legs. (Jan. 26, 2021), https://www.ncsl.org/human-services/disproportionality-and-race-equity-in-child-welfare.

[80] *ICWA History and Purpose*, Mont. DPHHS, https://dphhs.mt.gov/cfsd/icwa/icwahistory (last visited Aug. 20, 2024).

[81] Jason R. Williams et al., Casey Fam. Programs, *A Research and Practice Brief: Measuring Compliance with the Indian Child Welfare Act* (Mar. 2015), https://www.casey.org/media/measuring-compliance-icwa.pdf.

[82] A. Rachel Camp, *Coercing Pregnancy*, 21 Wm. & Mary J. Women & L. 275, 311 (2015), https://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=1402&context=wmjowl.

[83] 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

transportation—all without a violent partner knowing—takes time.[84] Forced unnecessary trips to access healthcare are especially problematic in Montana, where it may take significant time to travel to resourced towns.[85] Between these restrictions and pre-existing barriers for IPV survivors, some will be unable to access care at all.

Justice Sotomayor highlighted these challenges during her questioning in *Whole Woman's Health v. Hellerstedt*:

> Justice Sotomayor: . . . The medical abortion, that doesn't involve any hospital procedure. A doctor prescribes two pills, and the women take these pills at home, correct?
>
> 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?[86]**

(2017), https://journals.sagepub.com/doi/abs/10.1177/0886260517734861?src=getftr&journalCode=jiva.

[84] Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits*, 104 Am. J. of Pub. Health 1687 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4151926/pdf/AJPH.2013.301378.pdf.

[85] Carmody & Assocs., *supra* note 75.

[86] Transcript of Oral Argument at 20:19–21:6, *Whole Women's Health v. Hellerstedt*, 579 U.S. 582 (2016) (emphasis added).

HB 171 reflects Justice Sotomayor's critique by requiring all medical abortions to take place in person; an in-person examination prior to providing medication; 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. These burdens serve no purpose other than to impose multiple, unnecessary trips to access safe, straightforward care.[87]

In-home medical abortion is often a survivor's only option to obtain care. "[I]ntimate partner violence may drive some pregnant people to medication abortion at home to avoid detection by abusive partners for ending a pregnancy."[88] "[C]onsistent evidence [finds] that women in violent relationships were more likely not to tell their partner about their decision to terminate."[89] Requiring survivors to travel potentially hundreds of miles, stay overnight for an ultrasound, provide

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[87] Nat'l Acads. Of Scis., Eng'g & Med., *The Safety and Quality of Abortion Care in the United States* 10 (2018), https://nap.nationalacademies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states.

[88] Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and at-Home Reproductive Care*, 32 Const. Comment 341, 373 (2017), https://conservancy.umn.edu/server/api/core/bitstreams/fcead1ec-53e4-49ef-9038-a03bbad6f1df/content.

[89] Hall et al., *supra* note 30; *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), https://journals.sagepub.com/doi/abs/10.1177/1077801214564167?journalCode=vawa.

irrelevant consents, take two pills, and participate in follow-up care casts "serious doubt" about access to abortion at all.[90]

Physical injuries and past sexual assault trauma can also interfere with future medical care, limiting abortion care options. For example, *amici* have worked with survivors who experienced internal scarring and medical complications from rape, limiting surgical options, including for abortion. Obstetric and gynecological care, particularly non-medication abortions, can be psychologically difficult due to sexual assault trauma.[91] Meeting the reproductive health needs of rape and sexual assault survivors requires specialized, trauma-informed resources.

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[90] Lindgren, *supra* note 88, at 373.

[91] *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), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/04/caring-for-patients-who-have-experienced-trauma.pdf; *cf.* Lauren Sobel et al., *Pregnancy and Childbirth After Sexual Trauma: Patient Perspectives and Care Preferences*, 132 Obstetrics & Gynecology 1461, 1463 (2018), https://journals.lww.com/greenjournal/abstract/2018/12000/pregnancy_and_childbirth_after_sexual_trauma_.19.aspx.

The 20-week ban in HB 136 will further decrease survivors' chances of accessing care because IPV "may affect the timing of abortions."[92] 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."[93] And "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."[94] As a result, a 20-week ban would force survivors to self-manage their care without necessary medical support, or carry coerced pregnancies to term, trapping them in abusive relationships and further threatening their health and safety.

HB 140, which requires doctors to ask patients if they want to view an ultrasound or listen to a heartbeat, would further limit many IPV survivors' access to essential care because an ultrasound may be especially traumatic for IPV survivors who have experienced sexual assault.[95] Faced with a medical provider—an authority figure—making three offers to view and listen to the ultrasound and forcing them to

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[92] Ely & Murshid, *supra* note 83.
[93] *Id.*
[94] Hall et al., *supra* note 30, at 11.
[95] Nina M. Carroll & Amy Banks, *Health Care for Female Trauma Survivors*, Up to Date (2022), https://medilib.ir/uptodate/show/110594 (noting that transvaginal ultrasounds can be traumatizing to IPV survivors); *see also When Rape and Medicine Collide*, Bos. Area Rape Crisis Ctr. (Apr. 11, 2012), https://barcc.org/blog/details/when-rape-and-medicine-collide-a-survivors-story (explain that "transvaginal ultrasound[s]" are "typically the only ultrasound option for many women who are electing to have an abortion early on during their pregnancy").

attest whether they chose to do so on a stigmatizing form, these individuals may feel they have no choice but to experience medical trauma or forgo an abortion.

Federal courts recognize the importance of access to abortion care for survivors of IPV. *See, e.g.*, *Robinson v. Att'y Gen.*, 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 IPV survivors, access to abortion care is critical to health and safety: Being forced to carry an unintended pregnancy to term increases survivors' risks of further violence, including homicide, and poses risks to their health, well-being, and safety.

CONCLUSION

Abortion care is vital to the safety and well-being of those who need it. For IPV survivors, it is even more essential and 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. *Amici* request that this Court affirm the District Court.

Respectfully submitted this 20th day of August, 2024.

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Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify this brief is double spaced, except for footnotes, quoted, and indented material, is printed with a proportionately spaced Times New Roman typeface in 14-point font, and the word count calculated by the word processing software is 4990 words, excluding the cover page, tables, and certificates.

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