No. 17-2879

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

FREDERICK W. HOPKINS,
Plaintiff-Appellee,

v.

LARRY JEGLEY, et al.,
Defendants-Appellants

On Appeal from the United States District Court for the Eastern District of Arkansas (Hon. Kristine Baker)

BRIEF OF *AMICI CURIAE* NATIONAL ASSOCIATION OF SOCIAL WORKERS, ARKANSAS ABORTION SUPPORT NETWORK, PENNSYLVANIA COALITION AGAINST RAPE, AND PROFESSOR MARGARET DREW IN SUPPORT OF APPELLEE

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TABLE OF CONTENTS

Page

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 9

I. The Challenged Laws Will Cause Significant Harm to Rape Survivors 10

A. Recent Studies Document the Widespread Incidence of Rape and Sexual Assault 12

B. Rape Victims Are At Heightened Risk of Unintended Pregnancy And May Already Face Delays in Accessing Abortion 14

C. The Challenged Laws Would Impose Undue Burdens On Rape Survivors' Access to Abortion 17

II. The Challenged Laws Pose Severe Risks to the Life and Health of Pregnant Victims of Domestic Violence 22

A. Recent Studies Document the Extent and Dynamics of Domestic Violence 22

B. Many Domestic Violence Victims Face Problems Accessing Abortion Due to Abuser Coercion 23

C. The Challenged Laws Will Harm Women in Abusive Relationships 27

III. The Disclosure and Tissue Disposal Mandates Especially Burden Pregnant Minors' Access to Abortions 29

A. Pregnant Minors Seek Abortions at Higher Rates than Older Women 29

B. Pregnant Minors Already Face Delays and Barriers to Accessing Abortions 30

C. The Challenged Laws Will Impose Undue Burdens on Minors' Access to Abortion 31

CONCLUSION 34

CERTIFICATE OF COMPLIANCE 37

CERTIFICATE OF SERVICE 38

TABLE OF AUTHORITIES

Page(s)

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae submit this brief in support of Appellee to highlight the dangers and burdens that the four laws at issue will impose on three vulnerable populations in Arkansas: rape survivors, victims of domestic abuse, and minors seeking to terminate their pregnancies.

Amicus curiae National Association of Social Workers supports its members' work to enhance the well-being of individuals, families, and communities. NASW's members provide services and support to rape survivors, victims of domestic violence, and adolescents considering terminating their pregnancies. NASW also advocates the adoption of policies that promote assistance for victims of crime and supports research on the effects of crime on victims.

Amicus curiae Arkansas Abortion Support Network provides financial assistance to pregnant people who are seeking abortion,

[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), no counsel for a party authored this brief in whole or in part. No person or entity, other than amicus, its members, or its counsel, has made a monetary contribution to the preparation or submission of this brief. Pursuant to Fed. R. App. P. 29(a), the parties have consented to the filing of this brief.

but are unable to cover the entire cost of the procedure and other associated expenses. AASN has worked with many clients who are rape survivors and/or escaping domestic violence. In many cases, access to abortion has been integral for Arkansans working to take back control of their lives and escape abuse.

The mission of *amicus curiae* Pennsylvania Coalition Against Rape is to work to eliminate all forms of sexual violence and to advocate for the rights and needs of victims of sexual assault. Founded in 1975, PCAR works to end sexual violence and advocates for the rights and needs of sexual assault victims. PCAR partners with a network of rape crisis programs to bring help, hope and healing around issues of sexual violence.

Amicus curiae Professor Margaret Drew is Associate Professor and Director of Clinics and Experiential Learning at the University of Massachusetts Law School, where she directs the Human Rights at Home Clinic. Professor Drew has represented survivors of intimate partner violence and sexual assault since 1981. Among her clients are women who have been abused and denied control over reproductive decisions that are vital to their health

and independence. Based upon her nationally recognized research and experience, she has concluded that reproductive autonomy is an essential element in ending gender-based violence.

SUMMARY OF ARGUMENT

The challenged Arkansas laws undercut or eliminate medically safe options and will severely restrict or end access to abortions in Arkansas. If allowed to go into effect, the four statutes will impose particularly severe burdens on rape victims, victims of domestic violence, and minors seeking to terminate unwanted pregnancies.

H.B. 1566, the Tissue Disposal Mandate, requires that disposal of any embryonic or fetal tissue comply with state laws governing final disposition of human remains, which give "parents" the right to make decisions about disposition. Thus, a rape victim must notify her rapist, a victim of domestic violence her abuser, and a minor her parents *and* the parents of her sexual partner if he is a minor.

H.B. 1032, the D&E Ban, bans dilation and evacuation, the safest and most common method of terminating a pregnancy start-

ing early in the second trimester. Indeed, it is the exclusive procedure now in use in Arkansas for terminating pregnancies in the second trimester.[2]

H.B. 1434, the Medical Records Mandate, requires that the physician must "request," and make "reasonable" efforts to obtain, the woman's medical records relating to her "entire pregnancy history," imposing significant cost and delay. Victims of domestic violence and minors also face significant risk that their confidentiality will be breached, giving their abusers and parents an opportunity to learn of, and interfere with, their decisions.

H.B. 2024, the Local Disclosure Mandate, requires the physician to report to local police all abortions performed for women between ages 14 to 16, and to preserve all embryonic or fetal tissue as "evidence," even where no crime is suspected—*i.e.*, the vast majority of instances in which teenagers have sex. Not only is such disclosure likely to be highly embarrassing to an adolescent, but

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[2] CENTER FOR HEALTH STATISTICS, ARKANSAS DEPARTMENT OF HEALTH, *Induced Abortions by Probable Post-Fertilization (PPF) and Type of Procedure - Arkansas Occurrences – 2016* (2016), http://www.healthy.arkansas.gov/images/uploads/pdf/2016_ITOP_Report.pdf.

unnecessary disclosure to local law enforcement—members of her local community—may deter a minor from seeking time-sensitive health care with potentially serious consequences.

The District Court found that these four laws would impose practical and financial burdens that are not justified by the State's interests in enacting them. They ban the only method of second-trimester abortions available in Arkansas; impose delay and expense in the form of unnecessary and impermissibly undefined record-gathering obligations that raise confidentiality concerns; impermissibly resurrect third-party notice requirements; and needlessly and dangerously invade the privacy of minors.

In evaluating these laws, this Court should be particularly mindful of their impact on rape survivors, victims of domestic violence, and minors.

1. The laws will have a profound, detrimental effect on rape survivors. More than 20% of Arkansas women are raped during their lifetimes.[3] One out of every 19 or 20 rapes results in an un-

[3] CENTERS FOR DISEASE CONTROL AND PREVENTION, *The National Intimate*

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wanted pregnancy.[4] The Tissue Disposal Mandate will effectively eliminate the non-invasive medication abortion option and will require "reasonable efforts" to notify third parties, including a woman's violent partner. The D&E Ban's prohibition will make safe, legal second-trimester abortions unavailable to all women, including victims of rape. The Medical Records Mandate will impose potentially indefinite delays on these vulnerable populations and invade the privacy of those for whom access to confidential medical care is especially critical. These laws will inflict unnecessary and significant emotional and physical harm on women who have already endured substantial trauma.

2. The challenged laws will exacerbate the barriers to accessing abortion that victims of domestic violence already confront. More than half of all victims of sexual assault in Arkansas are at-

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Partner and Sexual Violence Survey: 2010-2012 State Report 33 (2017), https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf ("*The National Intimate Partner and Sexual Violence Survey*").

[4] J. Gottschall et al., *Are Per-Incident Rape-Pregnancy Rates Higher than Per-Incident Consensual Pregnancy Rates?*, 14 HUMAN NATURE 1, 4 (2003).

tacked by intimate partners, family members, or acquaintances.[5] Sexual assaults are closely associated with domestic violence, and abusive partners often attempt to dominate women's reproductive choices, using sexual violence as a means of control. The Constitution protects all women against compulsory notification of their partners that they are seeking abortions. As the Supreme Court recognized in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U. S. 833, 877-78 (1992), victims of domestic violence and rape may face "the gravest danger" if they seek to terminate a resulting pregnancy against the wishes of their husbands. *Id.* at 897. The Tissue Disposal Mandate requires notice of a planned termination in circumstances that are just as grave as those identified in *Casey.* Similarly, the Medical Records Mandate invades the woman's privacy and risks disclosure to her abuser that she is seeking an abortion. Finally, elimination of the medication option will deprive such victims of their ability to terminate their pregnancies discreetly, potentially exposing them to further abuse.

[5] *The National Intimate Partner and Sexual Violence Survey*, *supra* note 3, at 45-47.

The additional burdens imposed by the challenged laws will hit these vulnerable women especially hard.

3. The challenged laws also would impose particular harm on minors. The Local Disclosure Mandate requires local police notification for every abortion patient between 14 and 16 years old (even though Arkansas defines statutory rape as sex with a person under age 14.[6]) The Tissue Disposal Mandate requires notice to third parties for every abortion patient under age 18 (either to her parents or to her partner if he is at least 18), and the Medical Records Mandate creates further risk of disclosure to their parents. As the Supreme Court held, such blanket third-party notification requirements are unconstitutional. *See Casey* (spousal notification); *Bellioti v. Baird*, 443 U.S. 622 (1979) (parental notification). Further, the Tissue Disposal Mandate's elimination of medication abortions, the D&E Ban, and the imposition of increased delay and cost will heavily impact minors who lack the resources to overcome these new and unnecessary burdens.

[6] Ark. Code Ann. § 5-14-103(a)(3)(A).

ARGUMENT

Women seeking abortions in Arkansas already face significant barriers to access. Arkansas law requires two in-person office visits and a 48-hour waiting period for all abortions, with the period triggered by the woman's initial in-office consultation and state-mandated counseling.[7] Arkansas also bans most abortions at 20 weeks after the last menstrual period, and prohibits public funding for entities that provide or refer parties for abortions.[8]

These burdens fall disproportionately on poor, young women who are already the least likely to be able to afford health care services or the costs associated with travel to clinics to obtain the services they need. Arkansas has the second highest teen birth rate in the nation[9] and one of the highest percentages of women living in poverty.[10] Poor women are almost twice as likely to be

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[7] Ark. Code Ann. § 20-16-1703.

[8] Ark. Code Ann. §§ 20-16-1405, 20-16-1602, 20-16-1504.

[9] K. Kost et al., *Pregnancies, Births and Abortions Among Adolescents and Young Women In the United States, 2013: National and State Trends by Age, Race and Ethnicity* 7, GUTTMACHER INSTITUTE (Aug. 2017), https://www.guttmacher.org/sites/default/files/report_pdf/us-adolescent-pregnancy-trends-2013.pdf.

[10] NAT'L WOMEN'S LAW CENTER, *Women and Poverty, State by State* (Sept.

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victims of sexual assault than women in higher income brackets.[11] And many of these assaults are committed by abusive domestic partners.[12]

The challenged laws will materially exacerbate the barriers to abortion access for these vulnerable groups.

I. The Challenged Laws Will Cause Significant Harm to Rape Survivors

Sexual assault and rape are disturbingly prevalent in the U.S. and in Arkansas in particular. Certain populations are especially vulnerable: college-aged women, racial and ethnic minorities, low-income women, women with developmental disabilities, and women in rural areas. The trauma of rape is compounded when the rape results in pregnancy.

Access to abortion is critical for rape victims. Rape inherently involves violation of the victim's liberty by her rapist. For many

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14, 2017), http://nwlc.org/resources/women-and-poverty-state-state.

[11] M. Planty et al., *Female Victims of Sexual Violence, 1994-2010 4,* BUREAU OF JUSTICE STATISTICS, UNITED STATES DEPARTMENT OF JUSTICE (2013), http://www.bjs.gov/content/pub/pdf/fvsv9410.pdf (data for women in households with income less than $25,000).

[12] *Id.*

rape victims, a rape-related pregnancy may increase her sense that her liberty has been violated, whether the pregnancy lasts weeks or months. Eliminating the least invasive methods of abortion and requiring notification to the rapist will cause further harm. Enforcement of the challenged laws will heavily burden many rape survivors, removing safe options, increasing costs excessively, imperiling their health and safety, and in all likelihood cutting off the access of many victims to abortion services altogether.

A. Recent Studies Document the Widespread Incidence of Rape and Sexual Assault

The Centers for Disease Control and Prevention estimate that "nearly 1 in 5 women has been raped in her lifetime."[13] In Arkansas, approximately 21.4% of women have been the victims of rape or attempted rape at some point in their lifetimes.[14]

These numbers represent only reported rapes. Recent studies suggest that only about 35% of rapes are reported.[15] Non-reporting often occurs because women regard rape as a personal matter or fear retaliation.[16] Victims often do not disclose the rape even to their own families.[17]

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[13] *The National Intimate Partner and Sexual Violence Survey*, *supra* note 3, at 1.

[14] *Id.* at 33.

[15] P. Tjaden et al., *Extent, Nature, and Consequences of Rape Victimization: Findings From the National Violence Against Women Survey 33*, BUREAU OF JUSTICE STATISTICS, UNITED STATES DEPARTMENT OF JUSTICE (2006), https://www.ncjrs.gov/pdffiles1/nij/210346.pdf ("Only 19.1 percent of the women . . . who were raped since their 18th birthday said their rape was reported to the police"); *see also* Planty, *supra* note 11, at 7 ("36% of rape or sexual assault victimizations reported to police in 2005-10"); J. Truman et al., *Criminal Victimization, 2014* 7, BUREAU OF JUSTICE STATISTICS, UNITED STATES DEPARTMENT OF JUSTICE (2015), http://www.bjs.gov/content/pub/pdf/cv14.pdf (reported rapes or sexual assault account for around 35% of total rapes).

[16] R. Bachman, *Violence Against Women: A National Crime Victimization*

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Women who are racial and ethnic minorities are at heightened risk of sexual assault. According to CDC, while about 20% of women of color experience rape at some point in their lives, "[m]ore than one-quarter of women (26.9%) who identified as American Indian or as Alaska Native and 1 in 3 women (33.5%) who identified as multiracial non-Hispanic reported rape victimization in their lifetime."[18]

Low-income women, regardless of race or ethnicity, are almost twice as likely as women in higher income brackets to experience rape and other sexual victimization because of their environment, including unsafe housing, and transportation, and lack of access to resources.[19] "In 2005-10, females in households earning less than

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Survey Report 9, BUREAU OF JUSTICE STATISTICS, UNITED STATES DEPARTMENT OF JUSTICE (1994), https://www.bjs.gov/content/pub/pdf/FEMVIED.PDF.

[17] NAT'L VICTIM CENTER AND CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MED. U. OF S.C., *Rape in America: A Report to the Nation* 9 (1992), http://tinyurl.com/hh53lkz (finding that some rape victims reported concerns about their family knowing that they have been sexually assaulted).

[18] *The National Intimate Partner and Sexual Violence Survey*, *supra* note 3, at 3, 20.

[19] Planty, *supra* note 11, at 4; D. Greco et al., *Poverty and Sexual Violence, Poverty and Sexual Violence: Building Prevention and Intervention Re-*

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$25,000 per year experienced 3.5 rapes or other sexual assaults per 1,000 females," compared to 1.9 per 1,000 or less for households with higher earnings.[20]

B. Rape Victims Are At Heightened Risk of Unintended Pregnancy And May Already Face Delays in Accessing Abortion

Even without the additional pressures of a resulting pregnancy, rape is "one of the most severe of all traumas, causing multiple, long-term negative outcomes,"[21] and each victim's response and recovery are deeply personal. Many rape victims suffer from an array of severe psychological and physical effects, including posttraumatic stress disorder, depression, substance abuse, suicidality, repeated sexual victimization, and chronic physical health problems.[22] Many rape victims experience PTSD following

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sponses 8, PENNSYLVANIA COALITION AGAINST RAPE (2007), http://tinyurl.com/qjr69b3.

[20] Planty, *supra* note 11, at 4.

[21] R. Campbell, *The Psychological Impact of Rape Victims' Experiences with the Legal, Medical, and Mental Health Systems*, 63 AM. PSYCHOLOGIST 702, 703 (2008) (citing D. Kilpatrick et al., *Mental Health Needs of Crime Victims: Epidemiology and Outcomes*, 16 J. TRAUMATIC STRESS 119, 126-30 (2003)).

[22] *Id.; see also* M. Koss et al., *Depression and PTSD in Survivors of Male*

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the assault. Symptoms continue for months or years, with study estimates ranging from 32% to 90%, compared to the prevalence of PTSD symptoms in the general population of 9%–15%.[23] Women who have been raped are also three times more likely to suffer from depression and four to nine times more likely to contemplate suicide than those who have not experienced a sexual assault.[24]

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Violence: Research and Training Initiatives to Facilitate Recovery, 27 PSYCHOL. OF WOMEN Q. 130, 133 (2003); K. Basile & S. Smith, *Sexual Violence Victimization of Women: Prevalence, Characteristics, and the Role of Public Health and Prevention*, 5 AM. J. LIFESTYLE MED. 407, 410 (2011); N. Sarkar et al., *Sexual Assault on Woman: Its Impact on Her Life and Living in Society*, 20 SEXUAL & RELATIONSHIP THERAPY 407 (2005); L. Chen et al., *Sexual Abuse and Lifetime Diagnosis of Psychiatric Disorders: Systematic Review and Meta-Analysis*, 85 MAYO CLINIC PROC. 618 (2010).

[23] Koss, *supra* note 22, at 133 (internal citations omitted); M. Munro, *Barriers to Care for Sexual Assault Survivors of Childbearing Age: An Integrative Review*, 2 WOMEN'S HEALTHCARE 19, 19 (2014), http://np-womenshealthcare.com/wp-content/uploads/2014/10/SA-Surv_N14.pdf.

[24] *Id.*; E. Krug et al., *World Report on Violence and Health* 163, WORLD HEALTH ORGANIZATION (2002), http://www.who.int/violence_injury_prevention/violence/world_report/en/introduction.pdf; *see also* J. Tomasula et al., *The Association Between Sexual Assault and Suicidal Activity in a National Sample*, 27 SCH. PSYCHOL. Q. 109, 115 (2012).

Pregnancy can add to the psychological and physical challenges inflicted by rape.[25] Between five and eight percent of rape victims nationwide become pregnant as a result of rape annually.[26]

Many women who become pregnant through rape choose to terminate their pregnancies.[27] As many as 50% of rape-related pregnancies are terminated by induced abortion,[28] compared to 18% of all pregnancies.[29] For rape victims, additional barriers to access stem from struggles inherent in recovery from rape, including post-attack trauma, such as PTSD. Struggles to obtain medical care add to victims' psychological stress and dissuade women from obtaining the medical care they would otherwise seek out.

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[25] A. Lathrop, *Pregnancy Resulting from Rape,* 27 JOGNN 25 (1998).

[26] *See* 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) (national rape-related pregnancy rate is 5.0% per rape among victims of reproductive age); Gottschall, *supra* note 4, at 4 (finding that the overall per-incident pregnancy rate following rape may be as high as nearly 8%).

[27] R. Perry et al., *Prevalence of Rape-Related Pregnancy as an Indication for Abortion at Two Urban Family Planning Clinics*, 91 CONTRACEPTION 393, 393 (2015).

[28] Holmes, *supra* note 26, at 322.

[29] *State Facts About Abortion: Arkansas*, GUTTMACHER INSTITUTE (Jan. 2018), http://www.guttmacher.org/pubs/sfaa/arkansas.html.

While dealing with the trauma of rape, victims have a small window to address a resulting pregnancy. In at least one-third of cases, rape victims do not realize they are pregnant until they have already entered the second trimester,[30] when early medication abortions are no longer an option.[31]

C. The Challenged Laws Would Impose Undue Burdens On Rape Survivors' Access to Abortion

The challenged laws will lengthen the time rape survivors seeking abortion carry their pregnancies, invade their privacy, increase the cost of terminating their pregnancies, eliminate their safe, legal options for second-trimester abortions, and increase the chances that they cannot terminate their pregnancies at all.

The Tissue Disposal Mandate unduly burdens rape victims in three ways. First, by imposing requirements for tissue disposition—including that the provider "ensure" disposal in accordance

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[30] Holmes, *supra* note 26, at 322.

[31] J. Trussell et al., *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy* 1, 3, 5, OFFICE OF POPULATION RESEARCH & PRINCETON UNIVERSITY (Nov. 3, 2017), http://ec.princeton.edu/questions/ec-review.pdf; I. Rodrigues et al., *Effectiveness of Emergency Contraceptive Pills Between 72 and 120 Hours After Unprotected Sexual Intercourse*, 184 AM. J. OBSTETRICS & GYNECOLOGY 531 (2001).

with the mandate—it effectively outlaws medication abortions, which are often preferred because they are less invasive and more under the woman's own control.[32] Second, it gives "parents" the right to make decisions about disposing of all embryonic or fetal tissue.[33] Where one parent is "absent," the other parent has to make "reasonable efforts" to locate the absent parent to provide notice.[34] This requirement is untenable for rape victims, who would be required to notify their rapists about tissue disposal before obtaining abortions. Although many victims do not know their attackers, the law would nonetheless require victims to try to locate them to give notice—a futile effort—and thus delay the abortion. Finally, in all cases, contacting the rapist is likely to heighten the trauma itself and may be too terrifying for the rape victim to proceed. This requirement constitutes an unconstitutional obstacle, as held in *Casey*.[35]

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[32] M. Creinin et al., *Medical Abortion in Early Pregnancy*, *in* MANAGEMENT OF UNINTENDED AND ABNORMAL PREGNANCIES: COMPREHENSIVE ABORTION CARE (M. Paul et al. eds., 2009).

[33] *Id.* §20-17-102(d)(1)(E).

[34] *Id.* §20-17-102(d)(1)(E)(ii).

[35] 505 U. S. at 893-94.

The D&E Ban would eliminate the safest second trimester procedure, even though it is the *only* procedure used in Arkansas after the first trimester.[36] Because rape victims may not realize they are pregnant or may still be recovering from the rape itself during the first trimester, the D&E Ban would likely prevent them from accessing abortion at all. The Medical Records Mandate's medically unjustified and time-consuming requirements may likewise cause rape victims to miss the window for first-trimester procedures because their circumstances result in a later start of the process of obtaining an abortion.

Delays cost money. Rape victims already face thousands of dollars of expenses following rape—regardless of pregnancy—including expenses such as medical and mental health bills, property losses, and reduced productivity.[37] Any delays in accessing abortion caused by the challenged laws will exacerbate many rape victims' already tenuous financial position, because abortion costs

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[36] CENTER FOR HEALTH STATISTICS, ARKANSAS DEPARTMENT OF HEALTH, *Induced Abortions by Probable Post-Fertilization (PPF) and Type of Procedure: Arkansas Occurrences – 2016* (2016), http://www.healthy.arkansas.gov/images/uploads/pdf/2016_ITOP_Report.pdf.

[37] Greco, *supra* note 19, at 81.

rise the longer a pregnancy progresses. In 2006, for example, the median cost for a first-trimester abortion was $430, whereas a second-trimester abortion cost roughly three times that amount.[38]

The inherent risks in all pregnancies may pose more dangers for victims of rape. Abortion, while in general a very safe procedure, has a higher medical risk when undergone later in pregnancy; compared to an abortion at 8 weeks' gestation or earlier, the relative risk increases exponentially at higher gestations.[39] A woman who has been raped and intends to have an abortion may not seek prenatal care. Consequently, abnormally developing pregnancies with serious risks of complications may not be identified before they become serious and even life-threatening.[40]

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[38] R. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 6, 14 (2008), https://www.guttmacher.org/pubs/journals/4000608.pdf.

[39] L. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States,* 74 CONTRACEPTION 334, 334 (2006) (citing L. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 729–37 (2004) (finding that during 1988-1997, compared to an abortion at or before eight weeks, the relative risk increases exponentially as pregnancy advances)).

[40] J. Kulp et al., *Ectopic Pregnancy*, *in* MANAGEMENT OF UNINTENDED AND ABNORMAL PREGNANCIES: COMPREHENSIVE ABORTION CARE 280 (M. Paul et al. eds., 2009) ; *see generally* D. Grimes, *Estimation of Pregnancy-*

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Finally, rape survivors who carry their pregnancies to term may suffer long-term negative health effects. Whether women must raise or adopt out children conceived through rape, they face challenges.[41] If they raise the child, they may be legally bound to their rapists due to the rapists' parental claims.[42] If the child is adopted out, the woman may still face long-term effects. Both choices are life-altering experiences that can result in long-term trauma.[43]

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Related Mortality Risk by Pregnancy Outcome, United States, 1991 to 1999, 194 AM. J. OBSTETRICS & GYNECOLOGY 92, 92-94 (2006).

[41] *See* Holmes, *supra* note 26, at 322 (just under six percent of women in this study gave up for adoption their children conceived through rape).

[42] *See* S. Prewitt, *Giving Birth to a "Rapist's Child": A Discussion and Analysis of the Limited Legal Protections Afforded to Women Who Become Mothers Through Rape*, 98 GEO. L.J. 827, 831-36 (2010).

[43] H. Haskren & K. Bloom, *Postadoptive Reactions in the Relinquishing Mother: A Review*, 28 J. OBSTETRICAL & GYNECOLOGICAL NURSING 395, 396-399 (1999) (noting that "a woman who . . . relinquishes her child is at risk for the additional emotional stress of long-term grief").

II. The Challenged Laws Pose Severe Risks to the Life and Health of Pregnant Victims of Domestic Violence

A. Recent Studies Document the Extent and Dynamics of Domestic Violence

Domestic abuse is all too prevalent for women across all racial, ethnic, and economic groups, but women of color are particularly vulnerable. Nationally, an estimated 51.7% of American Indian/Alaska Native women, 51.3% of multiracial women, 41.2% of non-Hispanic black women, 30.5% of non-Hispanic white women, 29.7% of Hispanic women, and 15.3% of Asian or Pacific Islander women experienced physical violence by an intimate partner during their lifetimes.[44]

Approximately half of all battered women are also sexually assaulted by their intimate partner.[45] The CDC estimates that,

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[44] M. Breiding et al., *Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization—National Intimate Partner and Sexual Violence Survey, United States, 2011* 11, CENTERS FOR DISEASE CONTROL AND PREVENTION (Sept. 5, 2014), http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6308a1.htm.

[45] J. McFarlane et al., *Intimate Partner Sexual Assault Against Women: Frequency, Health Consequences, and Treatment Outcomes*, 105 OBSTETRICS & GYNECOLOGY 99, 99 (2005); *The National Intimate Partner and Sexual Violence Survey*, *supra* note 3, at 45-47 (in Arkansas, 51. 5% of victims of sexual assault were attacked by intimate partners; rapes not reported separately); *see also* M. Anderson, *Marital Immunity, Intimate Relationships, and*

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over their lifetime, women have an approximately 9% chance of being subjected to a rape by an intimate partner.[46] Relationships in which marital rape has occurred tend to be more severely physically violent.[47] Approximately one in four survivors of intimate partner violence who are raped by their intimate partners become pregnant, a rate five times the national average for rape-related pregnancy.[48]

B. Many Domestic Violence Victims Face Problems Accessing Abortion Due to Abuser Coercion

Reproductive coercion is very common among women who face domestic violence.[49] Abusive partners often attempt to dominate a

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Improper Inferences: A New Law on Sexual Offenses by Intimates, 54 HASTINGS L. J. 1463, 1500 (2003); R. Bergen & E. Barnhill, *Marital Rape: New Research and Directions*, VAW NET, 2-3 (Feb. 2006), http://www.vawnet.org/Assoc_Files_VAWnet/AR_MaritalRapeRevised.pdf.

[46] Breiding, *supra* note 44, at 10.

[47] J. Bennice and P. Resick, *Marital Rape: History, Research, and Practice,* 4 TRAUMA, VIOLENCE, & ABUSE 228, 239 (2003) (citing J. Bennice et al., *The Relative Effects of Intimate Partner Physical and Sexual Violence on PTSD Symptomology*, 18 VIOLENCE & VICTIMS 87 (2003)).

[48] J. McFarlane, *Pregnancy Following Partner Rape: What We Know and What We Need to Know*, 8 TRAUMA, VIOLENCE, & ABUSE 127, 128 (2007).

[49] THE NAT'L DOMESTIC VIOLENCE HOTLINE, *1 in 4 Callers Surveyed at the Hotline Report Birth Control Sabotage and Pregnancy Coercion* (Feb. 18, 2011), http://www.thehotline.org/2011/02/18/1-in-4-callers-surveyed-at-the-

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woman's reproductive choices, denying them access to contraception and using sexual violence as a means of control.[50] In some instances, the pregnancy puts the victim at greater risk of violence, and having a baby from an unwanted pregnancy may result in sustained physical violence over time.[51]

Victims of domestic violence often seek abortions.[52] Multiple studies have found that victims cite intimate-partner violence as a key reason for seeking to terminate a pregnancy.[53] Women in abusive relationships often find it difficult to leave their part-

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hotline-report-birth-control-sabotage-and-pregnancy-coercion/.

[50] E. Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 CONTRACEPTION 316 (2010), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896047/; M. Hall et al., *Associations between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis*, 11 PLOS MED. 1 (2014), (https://doi.org/10.1371/journal.pmed.1001581); Bergen, *supra* note 45, at 5; Bennice and Resick, *supra* note 47, at 235-37; K. Eby et al., *Health Effects of Experiences of Sexual Violence for Women with Abusive Partners*, 16 HEALTH CARE FOR WOMEN INT'L 563 (1995).

[51] S. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC MED. 144 (2014), (http://www.biomedcentral.com/1741-7015/12/144.

[52] R. Jones et al., *More Than Poverty: Disruptive Events Among Women Having Abortions in the USA*, 39 J. FAM. PLAN. & REPROD. HEALTH CARE 36 (2012), http://srh.bmj.com/content/39/1/36.

[53] Hall, *supra* note 49, at 15.

ners.[54] Studies show that women who have an abortion under these circumstances "were more able to escape abusive relationships."[55] Conversely, women who give birth to their abuser's child typically find it more difficult to leave abusive relationships and seek safety.

Coercion by abusers often interferes with women's access to reproductive medical care in general, and abortion in particular. Abusers often control women by limiting access to money and transportation, keeping close watch on their activities and time,[56]

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[54] *See* K. Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 S.M.U. L. REV. 2117, 2132-39 (1993) (describing how hard it is for abused women to leave their intimate partners); E. Stark, *Re-Presenting Woman Battering: From Battered Woman Syndrome to Coercive Control*, 58 ALB. L. REV. 973, 985 (1995).

[55] R. Sherman, *For Survivors of Abuse, Access to Abortion Can Be a Lifesaver*, REWIRE (Oct. 8, 2014), https://rewire.news/article/2014/10/08/survivors-abuse-access-abortion-can-lifesaver/; *See, e.g.*, N. Cahn, *Civil Images of Battered Women: The Impact of Domestic Violence on Child Custody Decisions*, 44 VAND. L. REV. 1041, 1051 (1991) (describing the practical and legal difficulties faced by abused women trying to leave their spouses and take their children with them); *see also* S. Buel, *Fifty Obstacles to Leaving, A.K.A., Why Abuse Victims Stay*, 28 COLO. LAW. 19 (1999).

[56] Fischer, *supra* note 54, at 2121-22, 2131-32; *see also* L. Goodmark, A TROUBLED MARRIAGE: DOMESTIC VIOLENCE AND THE LEGAL SYSTEM 42 (2011) (describing how these behaviors contribute to an abused woman's economic insecurity, making it even more difficult to leave the relationship).

and threatening to harm or kidnap their children.[57] These tactics are particularly effective at controlling women who are immigrants or whose first language is not English.[58] Batterers may monitor credit card charges and bank accounts, and demand that their victims turn over their entire paychecks.[59] Abusive partners may focus on blocking access to healthcare, withholding funds to cover co-pays or to purchase prescriptions or policing use of health insurance.[60] Women experiencing reproductive coercion often report that their partners interfered with their abortion appointments or used other strategies to postpone their partner's abortions.[61]

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[57] Fischer, *supra* note 54, at 2122.

[58] *See, e.g.*, M. Dutton et al., *Characteristics of Help-Seeking Behaviors, Resources and Service Needs of Battered Immigrant Latinas: Legal and Policy Implications*, 7 GEO. J. ON POVERTY L. & POL'Y 245, 251-56 (2000).

[59] *See* J. Postmus et al., *Understanding Economic Abuse in the Lives of Survivors,* 27(3) J. INTERPERSONAL VIOLENCE 411 (2012).

[60] *See* K. Oehme et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 GEO. J. GENDER & L. 613, 633-34 (2014).

[61] A. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 SOC. SCIENCE & MED. 1737 (2010).

Women who become pregnant following rape by their intimate partners or family members and who wish to abort may face serious additional health risks due to delay: the high likelihood of continued severe domestic violence, potentially resulting in serious injuries to the woman and her pregnancy.[62] Women who are abused during pregnancy are more likely to experience poor birth outcomes, miscarriage, and stillbirth.[63] Pregnant women in abusive relationships risk being killed by their abusers;[64] in the United States, homicide is a leading cause of the death of pregnant women.[65]

C. The Challenged Laws Will Harm Women in Abusive Relationships

The Tissue Disposal Mandate will significantly harm pregnant victims of domestic violence. In cases of partner or family member abuse, the woman would have to confront her abuser,

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[62] *See, e.g.*, D. Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 670-73 (2006).

[63] *Id.*

[64] *Id.*; *see also* A. Camp, *Coercing Pregnancy*, 21 WM. & MARY J. WOMEN & L. 275, 296-98 (2015).

[65] P. Janssen et al., *Intimate Partner Violence and Adverse Pregnancy Outcomes: A Population-Based Study*, 188 AM. J. OBSTETRIC & GYNECOLOGY 1341, 1346-47 (2003); *see also* Tuerkheimer, *supra* note 61, at 672.

placing herself in his power to resolve the disposition issue and possibly putting her at risk of further violence. *Casey* unequivocally barred such notice requirements.[66] In addition, by precluding medication abortion, the Tissue Disposal Mandate a method of abortion that would allow her to mask it as a miscarriage if she needed to, further undermining confidentiality and potentially exposing the woman to further abuse.

The Medical Records Mandate is also likely to put victims of domestic violence at risk. Such victims have heightened concerns about confidentiality to avoid triggering additional violence by their abusers. The Mandate's requirement of collecting medical records would involve disclosure of the abortion to other medical providers, numerous record requests may involve telephone, mail, or email contact with the patient. Such contacts increase the risk that the abuser will learn that the victim is seeking an abortion and either take steps to block the woman from proceeding or engage in further abuse.

[66] 505 U.S. 833, 893-95.

Delays encountered by domestic violence victims in accessing medical care—stemming from the coercive dynamics involved in abusive relationships—may prevent them from obtaining an abortion during their first trimester. The D&E Ban would effectively block their access to the safest remaining method of abortion.

III. The Disclosure and Tissue Disposal Mandates Especially Burden Pregnant Minors' Access to Abortions

A. Pregnant Minors Seek Abortions at Higher Rates than Older Women

In 2013, the most recent year for which data are available, Arkansas had the second-highest pregnancy rate among women between 15 and 19 (59 per 1000 women, or 5.9%).[67] The rate is even higher for Arkansas teenagers of color—8.5% for black teenagers and 6.4% for Hispanic teenagers.[68] A much higher percentage of pregnancies among minors are terminated by abortion than for older women. Nationally, 31% of all pregnancies for women 15 to 17 years old ended in abortions; for girls 14 years old or young-

[67] New Mexico had the highest pregnancy rates amount women between 15 and 19 at 6.2%. Kost, *supra* note 9, at 7.
[68] *Id.*, Table 2.7 at 47.

er, the rate was 52%.[69] In contrast, in 2011 the rate was 18% for all pregnancies.[70] Access to safe, legal abortions is critical for pregnant minors and especially for minors who are rape victims or who face unstable home situations, as they are among the most vulnerable victims.

B. Pregnant Minors Already Face Delays and Barriers to Accessing Abortions

Minors typically consult their parents when they seek abortion, but many may have good reasons not to do so. They may fear a violent reaction, being kicked out of their home, or damaging fragile family relationships.[71]

Minors who lack parental support face particular difficulties in traveling to and paying for abortions, as they often lack driver's licenses or other access to transportation and lack financial resources. Minors may also be slow to realize they are pregnant

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[69] *Id*. at 5.

[70] Guttmacher Institute, *supra* note 29.

[71] *See* J. Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision Without Involving Their Parents*, 18 BERKELEY WOMEN'S L.J. 61, 94-96 (2003); L. Hasselbacher et al., *Factors Influencing Parental Involvement Among Minors Seeking an Abortion: A Qualitative Study*, 104 Am. J. Pub. Health 2207 (Nov. 2014), https://www.ncbi.nlm.nih.gov/pubmed/25211726.

and, through unwitting delay, may lose the window of opportunity for a first-trimester abortion.[72]

C. The Challenged Laws Will Impose Undue Burdens on Minors' Access to Abortion

Because of their family and financial circumstances, minors will be significantly burdened by the challenged laws. By eliminating the safest method of second trimester abortions, the D&E Ban burdens minors who face delay, whether because they may not realize they are pregnant or because they must deal with complicated home situations. The Local Disclosure, Tissue Disposal, and Medical Records Mandates also create distinct and difficult barriers for minors.

The Local Disclosure Mandate targets pregnant minors seeking abortion—and *only* minors—by requiring reports to local police of all abortions involving patients who are 14 to 16 years old and preservation of any tissue. Because under Arkansas criminal law the age of consent is 14, pregnancy is not *prima facie* evidence of a crime where the pregnant minor was 14 or older. Nonethe-

[72] Finer, *supra* note 38, at 338, 343.

less, the Local Disclosure Mandate requires physicians to provide local police highly personal medical and sexual information, both about the teenager's abortion and her sexual activity. Where there is any indication that the minor is a victim of rape or abuse, physicians already have reporting requirements under existing law.[73] The Local Disclosure Mandate thus serves no purpose while" interfer[ing] with a constitutional right of privacy between a pregnant woman and her physician" and burdening her "right to physical autonomy."[74] Indeed, by diverting resources away from victims of rape and sexual abuse, the Local Disclosure Mandate could harm actual victims.

The Medical Records Mandate may result in breaching the confidentiality of minors with respect to their abortions, as their parents may be contacted by other doctors about the records requests, with the same attendant risks as the notification requirement invalidated by *Casey*.

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[73] *See*, *e.g.*, Ark. Code Ann. § 12-18-101 *et seq*.
[74] *Casey,* 505 U.S. at 883, 884.

The Tissue Disposal Mandate also especially burdens minors. Because the law prohibits minors from making disposal decisions, a pregnant minor's parents must be notified. If the sexual partner also is a minor, *his* parents must be notified as well.

Adolescents are particularly loath to disclose their reproductive medical history, even to their parents, much less the police. Confidentiality concerns significantly deter adolescents from seeking reproductive health care.[75] Indeed, 36% of adolescent girls revealed that they did not visit a doctor on at least one occasion when they needed reproductive medical care because they were worried that their parents might learn about the visit.[76] More than 50% of adolescent girls said they would stop using all sexual health care services based on confidentiality concerns.[77]

Such concerns are particularly acute in Arkansas' rural areas, as "smaller communities have higher density of acquaintance-

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[75] C. Schoen et al., THE COMMONWEALTH FUND SURVEY OF THE HEALTH OF ADOLESCENT GIRLS 5 (Nov. 1997).

[76] *Id.* at 5.

[77] D.M. Reddy, *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 JAMA 710, https://jamanetwork.com/journals/jama/fullarticle/195185.

ships"[78] and maintain a "high level of familiarity between [their] citizens and police officers."[79] This familiarity jeopardizes confidentiality in communities where such breaches can have serious consequences.[80]

CONCLUSION

Pregnant rape survivors, victims of domestic violence, and minors are constitutionally entitled to access to safe, legal abortions. The challenged laws impose substantial harms, unduly burdening their ability to access abortions in light of their circumstances. The D&E Ban eliminates the only method of second-trimester abortion used in Arkansas, placing extreme time pressure upon women in these three groups who face particularly difficult circumstances. The Tissue Disposal Mandate effectively

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[78] NAT'L INST. OF JUSTICE, *Crime and Policing in Rural and Small-Town America: An Overview of the Issues* 26 (1995), https://www.ncjrs.gov/pdffiles1/Digitization/154354NCJRS.pdf.

[79] J. Liederbach & J. Frank, *Policing Mayberry: The Work Routines of Small-Town and Rural Officers*, 28 AM. J. OF CRIM. JUSTICE 23 (2003), https://www.uc.edu/content/dam/uc/ccjr/docs/articles/frank_articles/mayberry.pdf.

[80] *See*, *e.g.*, *Sterling v. Burough of Minersville,* 232 F.3d 190 (3d Cir. 2000) (police officer's threat to disclose a teenage arrestee's homosexuality, which led to the teenager's suicide, violated the teenager's constitutional right to privacy).

eliminates medication abortion, the least invasive method, and unconstitutionally imposes partner and parental notification requirements that put women in these three groups at great risk. The Disclosure and Medical Records Mandates violate their heightened needs for confidentiality. In combination, the challenged laws may force these women to carry unwanted pregnancies to term because of the combined invasion of privacy, delay, and unavailability of safe, legal abortion in the state of Arkansas. In short, the challenged laws unduly burden their right to choose whether to terminate unintended pregnancies.

For the foregoing reasons, the injunction entered by the District Court should be affirmed.

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CERTIFICATE OF COMPLIANCE

I certify that the foregoing brief complies with the type-volume limitation of Fed. R. App. P. 35(b)(2)(A) because it contains approximately 6,462words, excluding the parts exempted by Fed. R. App. P. 32(f).

I also certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(a)(5)-(6) and 8th Cir. R. 28A(c) because it has been prepared in a proportionally-spaced typeface using Microsoft Word in 14-Point New Century Schoolbook.

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/S/ Kent A. Yalowitz
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I hereby certify that on February 28, 2018, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that counsel for *amici curiae* are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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