**HOUSE OF PENNSYLVANIA**
**CHILDREN AND YOUTH COMMITTEE**

**March 27, 2019**

# SUBSTANCE-EXPOSED INFANTS

**Testimony of**
**Frank P. Cervone, Esq., Executive Director**
**Support Center for Child Advocates**

The Support Center for Child Advocates is Philadelphia's lawyer pro bono program for abused and neglected children. We offer the skills and dedication of lawyer-social worker teams, and we represent more than 1,100 children each year. *Child Advocates'* legal and social services are offered to child victims through Direct Representation Services and Child Advocacy Leadership and Training. For more than 42 years, we have served as a resource to this Legislature and its staff, and I thank you for the invitation to serve in this role once again. When asked, we attempt to offer to you a balanced, candid and constructive assessment of what our children need and how we are all doing for our kids.

Today we consider the impact of the opioid epidemic on children and families while acknowledging that a focus on opioids alone will be detrimental to Pennsylvania's children because daily the headlines and law enforcement reports remind us that meth and cocaine and yes alcohol are also having an impact. Others will chronicle the demographics of this crisis. Governor Wolf has declared a state of emergency that includes having made neonatal abstinence syndrome (NAS) a reportable health condition - a request many of us asked for initially in March 2016. These large-scale dimensions are easy to learn about, but they are exceedingly difficult to solve, for one well-known reason: addiction is a difficult nut to crack. Anyone who has a person who has an opioid use/substance use disorder (OUD/SUD) in their family or work life knows that recovery and sobriety take tremendous investments of public and private dollars – for counseling, treatment, housing, child care, employment supports and more. We know too, that recovery and sobriety need the even more precious investments of patience, courage and love. I will briefly explore what the law provides pertaining to the care and protection of children; and what those who practice in child welfare and

related fields can teach us about the way forward. I will suggest some points of study for the Opioid Abuse Child Impact Task Force (House Bill 316 introduced by your colleague on this committee, Representative Owlett) that is being considered. If we really want to help, we will need to get a lot more serious about our investment, not just our laws.

I note the contributions here by the neonatologist Dr. Hallam Hurt, M.D., and by Dr. Frederick M. Henretig, M.D., specialist in pediatric emergency medicine and medical toxicology, both of whom are Professors of Pediatrics in Philadelphia.

I would like to recognize the leadership and study of our colleague Cathleen Palm, founder of the Center for Children's Justice. Cathy's commitment to the needs of children and families is both legendary and profound. Dating back years to her collaborative work with Representative Jim Greenwood, Cathy has kept her focus on the well-being of children, and kept our focus on real and effective plans for their safe care.

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We know from the decision of the Pennsylvania Supreme Court in December 2018 that prenatal substance exposure is not child abuse as defined by Pennsylvania's Child Protective Services Law (CPSL). *In The Interest Of: L.J.B., A Minor* found that a person cannot have committed child abuse unless he or she was a perpetrator, and a person cannot be a perpetrator unless there is a "child" at the time of the act. Thus a woman's use of opioids while pregnant, which results in a child born suffering from neonatal abstinence syndrome ("NAS"), does not constitute "child abuse" under law.

Was this a good decision? I think it was the right one, both on the law and as a practical matter for both the mothers and for their young children. Also, that decision falls into line with the unanimous vote of the General Assembly when it approved Act 54 of 2018 altering the language of Pennsylvania's Child Protective Services Law (CPSL), including to say that any notification by a health care provider about an affected infant was not to equate with a child abuse report. I urge the General Assembly to protect the Court's decision and its own efforts with Act 54, by not reversing either with new legislation. [1] Some of my remarks today come with that court decision in mind, with

[1] The Center for Children's Justice notes that the CPSL has been amended 4 times since 2006 related to these infants:

sensitivity that some in the legislature and in the community may be interested in a different, more punitive, course. Criminalizing pregnancy cannot be a good idea.

What should we know about substance-exposed infants and their mothers?

First, on the question of child protection, recognizing that the safety of the child is paramount for all parties involved in the child welfare system, **Pennsylvania's existing mechanisms can sufficiently protect the safety of substance-exposed infants and children.** Pennsylvania has sufficient, existing law and procedures to protect children from inadequate parents. Pennsylvania's CPSL, Juvenile Act, 42 Pa. Cons. Stat. § 6301, *et seq.*, and Rules of Juvenile Court Procedure all include provisions for taking children into protective custody when necessary. [2] The legal standard governing the removal of a

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- **Act 146 of 2006** amended the CPSL to create "§ 6386. Mandatory reporting of infants born and identified as being affected by illegal substance abuse." It was a simple paragraph ending with "The county agency shall provide or arrange for appropriate services for the infant." - https://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2006&sessInd=0&smthLwInd=0&act=146
- **Act 4 of 2014** amended the CPSL § 6386 adding fuller language and requirements related to "county agency duties" including physically seeing the child, etc - https://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=4
- **Act 15 of 2015** amended § 6386 to stipulate that health care providers didn't need to call a children and youth agency for certain infants (e.g., those who were born affected by drugs the infant's mother took as prescribed/while under the care of a health care provider) - https://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2015&sessInd=0&smthLwInd=0&act=15
- **Act 54 of 2018** – removed the language specific to "Mandatory reporting of" altering it to "Notification to department and development of plan of safe care for children under one year of age." This law also said health care providers are to notify PA DHS (via ChildLine or the web-based reporting portal) instead of calling the local children and youth agency so that ChildLine is deciding what to do with any calls from health care providers. It also had the directive that DHS/DDAP/DOH develop "interagency protocols" which were to address the notification provisions including identifying that "Ongoing involvement of the county agency after taking into consideration the individual needs of the child and the child's parents and immediate caregivers may not be required." This 2018 law eliminated all of the earlier § 6386 (b) related to safety and risk assessment and (c) specific to "county agency duties." For a cross reference to confirm these changes, see page 327 of Title 23 - https://www.legis.state.pa.us/WU01/LI/LI/CT/PDF/23/23.PDF.

[2] The Commonwealth considers a child to be dependent if the child "is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his [or her] physical, mental, or emotional health, or morals." 42 Pa. Cons. Stat. § 6302. An adjudicatory hearing is held to determine whether there is clear and convincing evidence for the court to make a finding of dependency. 42 Pa. Cons. Stat. § 6341(c). For a child adjudicated dependent, the court holds a disposition hearing through which the court may permit the child to *inter alia* remain with his

child from his or her parent's care is "clear necessity" -- having your awareness and responsiveness compromised by opiates is one such necessity. [3]

I feel certain in asserting that there is not a county in the Commonwealth that, once made aware of the situation allows a person actively under the influence of drugs to continue to care for a child. Being stoned gets your kids removed.

**Second, and consistent with federal law, Pennsylvania law requires a report and assessment for all substance-exposed births.** The CPSL requires healthcare providers "involved in the delivery or care of children under one year of age" (hereinafter "infants") who are born with or affected by "substance abuse by the child's mother[,] . . . [w]ithdrawal symptoms resulting from prenatal drug exposure . . . [or a] Fetal Alcohol Spectrum Disorder" **to immediately "give notice or cause notice to be given to the department**" 23 Pa. Cons. Stat. § 6386(a). Importantly, this notification is explicitly not a report of suspected child abuse. Pennsylvania's CPSL builds upon the federal Child Abuse Prevention and Treatment Act (CAPTA) that also stipulates that a health

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or her parents, guardian, or other custodian; transfer temporary legal custody to an individual or public or private agency; or transfer permanent legal custody to an individual found to be qualified to receive and care for the child. 42 Pa. Cons. Stat. § 6351(a).

[3] 42 Pa. Cons. Stat. § 6351(b). Prior to any order or disposition removing a child from his or her home, a court must find "that continuation of the child in his [or her] home would be contrary to the welfare, safety or health of the child; and...whether reasonable efforts were made prior to the placement of the child to prevent or eliminate the need for removal of the child from his [or her] home, if the child has remained in his [or her] home pending such disposition[.]" 42 Pa. Cons.Stat. § 6351(b)(1)-(2). Pennsylvania's existing legal mechanisms effectively remove children from the care of inadequate parents, including active drug users when applicable; a further finding of civil child abuse for prenatal substance exposure is unnecessary.

Under Pennsylvania's CPSL, a child may be taken into protective custody by a physician examining or treating the child, the director of a hospital or medical institution where the child is being treated, or a person designated by the director "if protective custody is immediately necessary to protect the child" 23 Pa. Cons. Stat. § 6315(a)(2). The physician, director, or designee of a hospital also may take a child into protective custody if the child is a newborn pursuant to the Newborn Protection Act (Chapter 65), 23 Pa. Cons. Stat. § 6501, *et seq*. 23 Pa. Cons. Stat.§ 6315(a)(3). The child may be held in protective custody up to 24 hours, after which time the appropriate county Children and Youth ("C&Y") Agency must obtain a court order permitting the child to be held in custody for a longer period. *Id.* at § 315(b).

Further, a police officer or juvenile probation officer, pursuant to the Juvenile Act and the Rules of Juvenile Court Procedure, also has authority to take a child into protective custody for 24 hours without a court order "if there are reasonable grounds to believe that the child is suffering from illness or injury or is in imminent danger from his [or her] surroundings, and that his [or her] removal is necessary." 42 Pa. Cons. Stat. § 6324(3); Pa. R. Juv. Ct. P. § 1202. A police officer, juvenile probation officer, or county C&Y agency also may obtain a protective custody order to remove a child from his or her home if the court determines that "remaining in the home is contrary to the welfare and the best interests of the child." Pa. R. Juv. Ct. P. § 1202(A)(2)(a). Following a court order, the county agency may take the child into protective custody in order to protect the child from abuse. Pa. R. Juv. Ct. P. § 1202(A)(2)(b).

care professional notifying a child welfare agency about an infant born affected is done in order to develop a plan of safe care for the infant, upon discharge from the hospital, it was not Congress creating a federal definition of child abuse and/or providing justification to criminally prosecute a woman who uses drugs while pregnant. Congress recently updated CAPTA and did something unusual for Congress - it sent a little extra money to the states (still modest in nature) to aid states in efforts to have multidisciplinary teams come together to create, implement and monitor a plan of safe care for the affected infant and the infant's family.

***Whether all substance-exposed births are getting reported, and whether there are any biases or other irregularities in the patterns of these reports and assessments, and whether the individualized Plans of Safe Care are effective in defining and delivering on needed services, are among the questions that might be studied by the Task Force.***

Third, the stories you will hear today about infants experiencing withdrawal can be quite upsetting. **Any study of prenatal substance exposure must acknowledge that an infant may experience pain and other symptoms of withdrawal that should be avoided at all costs.** [4] However, evidence does not indicate opioid exposure itself as life threatening or causing permanent harm. At a minimum we can agree that there has been insufficient research on the question of harm. However one respected source observes that "there have been no reported long term effects of maternal opioid use on the developing child. Longitudinal studies over 5 to 10 years have shown that children who experienced NAS as infants do not exhibit signs of physical or cognitive impairment as they mature." [5]

Acknowledging that opioid use during pregnancy may put children at risk for neonatal

[4] Infants exposed to opioids in utero may experience withdrawal symptoms, commonly referred to as NAS, including *inter alia* irritability, sleep disturbances, feeding issues, gastrointestinal disturbances, seizures, low birth weight, and respiratory complications. *See* Lauren M. Jansson, M.D., *Neonatal Abstinence Syndrome* Cara Angelotta, UpToDate, Wolters Kluwer (Jan. 2018), *available at* https://www.uptodate.com/contents/neonatal-abstinence-syndrome?search=neonatal%20abstinence%20syndrome&source=search_result&selectedTitle=1 .

[5] ACOG Toolkit, at 2. *See also* AI Report, at 31.

abstinence syndrome ("NAS") or withdrawal, "evidence has shown that it does not lead to long-term complications." [6] Infants exposed to opioids in utero may experience withdrawal symptoms, commonly referred to as NAS, including *inter alia* irritability, sleep disturbances, feeding issues, gastrointestinal disturbances, seizures, low birth weight, and respiratory complications. [7]

Though relatively limited research to-date has focused on the effects of prenatal opioid exposure on a subsequent child, there is a wide body of clinical and research evidence that "findings once thought to be specific effects of gestational cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana and/or alcohol and the quality of the child's environment." [8]The ground-breaking work of Eileen Tyrala, M.D., then at Einstein Hospital in Philadelphia and Hallam Hurt, M.D. of The Children's Hospital of Philadelphia – during the height of the "crack" epidemic investigated the effects of in utero cocaine exposure on infant, child, and young adult outcomes. In particular, Dr. Hurt's research showed that cocaine-exposed and non-exposed subjects, all from low socio-economic backgrounds, did not differ in developmental or cognitive outcome. [9] However, both groups performed poorly and below average on standardized testing. Dr. Hurt's conclusion: poverty is more injurious

[6] *ACOG Statement on Opioid Use During Pregnancy* (May 26, 2016), at 1, *available at* https://www.acog.org/About-ACOG/News-Room/Statements/2016/ACOG-Statement-on-Opioid-Use-During-Pregnancy.

[7] *See* Lauren M. Jansson, M.D., *Neonatal Abstinence Syndrome* Cara Angelotta, UpToDate, Wolters Kluwer (Jan. 2018), *available at https://www.uptodate.com/contents/neonatal-abstinence-syndrome?search=neonatal%20abstinence%20syndrome&source=search_result&selectedTitle=1*

[8] Hallam Hurt et al., *Children With and Without Gestational Cocaine Exposure: A Neurocognitive Systems Analysis*, Neurotoxicology and Teratology, Nov.-Dec. 2009, at 335.

[9] Hallam Hurt, M.D., et al., *Cocaine-exposed Children: Follow-up Through 30 Months*, 16 Dev. Behav. Pediatr. 29, 29-35 (1995); Hallam Hurt, et al., *Natal Status of Infants of Cocaine Users and Control Subjects: A Prospective Comparison*, 15 J. Perinatology 297, 297-304 (1995; Hallam Hurt, et al., *School Performance of Children with Gestational Cocaine Exposure*, 27 Neurotoxicology and Teratology 203, 203-11 (2005); Hallam Hurt, et al., *Children With In Utero Cocaine Exposure Do Not Differ From Control Subjects on Intelligence Testing*, 151 Arch. of Pediatr. and Adolescent Med., 1237, 1237-41 (1997); Hallam Hurt, M.D., et al., *A Prospective Evaluation of Early Language Development in Children With In Utero Cocaine Exposure and in Control Subjects*, 130 J. Pediatr. 310, 310-12 (1997); Hallam Hurt, et al., *Inner-City Children Perform Poorly on Intelligence Testing Regardless of In Utero Cocaine Exposure*, 39 Pediatr.Res. (1996); Hallam Hurt, et al., *Children With and Without Gestational Cocaine Exposure: A Neurocognitive Systems Analysis*, 31 Neurotoxicology and Teratology 334, 334-41 (2009); Hallam Hurt, M.D. and Laura M. Betancourt, Ph.D., *Turning 1 Year of Age in a Low Socioeconomic Environment: A Portrait of Disadvantage*, 38 J. Dev. Behav. Pediatr. 493, 493- 500; Hallam Hurt and Laura M. Betancourt, *Effect of Socioeconomic Status Disparity on Child Language and Neural Outcome: How Early is Early?*, 79 Pediatr. Res. 1-28 (2016); Katherine T. Wild, et al., *The Effect of Socioeconomic Status on the Language Outcome of Preterm Infants at Toddler Age*, 89 Early Hum. Dev. 743, 743-46 (2013).

to children's outcomes than prenatal exposure to cocaine. [10] *Id.* Indeed, medical professionals liken the current furor surrounding prenatal opioid exposure to the misplaced fear surrounding the "crack baby" epidemic and caution against prematurely jumping to similar conclusions, which resulted in long-term harms.

Fourth, **public health disfavors construction of prenatal substance exposure as child abuse**. Such a punitive approach (i) discourages necessary maternal and prenatal care; (ii) ignores the effects of prenatal opioid exposure on infants and opens the door to over legislating the various decisions women make during pregnancies; and (iii) disproportionately harms women of color, poor women and rural women. Rather than promoting healthier children and pregnancies, construing prenatal substance exposure as child abuse will harm children and women. The prevailing standard of care recognized by every leading medical and public health organization is that prenatal substance exposure is a health concern "best addressed through education, prevention and community-based treatment, not through punitive drugs laws or criminal prosecution."[11]

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[10] Within the first two years of life, infants of lower socio-economic status show poorer cognitive and language performance than their counterparts. MRIs of infants have even shown the effects of poverty on brain scans within one month of age. *See generally supra* note 10. *See also* ACOG Toolkit, at 2; AI Report, at 22 (subsequent long-term studies of cocaine exposed infants found "cocaine exposure does not result in measurable differences in intelligence and other outcomes[;]" developmental outcomes are tied to complex social environments in which people develop and poverty is a more powerful influence than exposure to cocaine).

[11] The American College of Obstetricians and Gynecologists ("ACOG"), *Toolkit on State Legislation, Pregnant Women & Prescription Drug Abuse, Dependence and Addiction* ("ACOG Toolkit"), at 1. **All leading medical and public health organizations in the United States oppose punitive responses to prenatal substance use**, including American Academy of Pediatrics, *A Public Health Response to Opioid Use in Pregnancy* (2017)("punitive measures taken toward pregnant women are not in the best interest of the health of the mother-infant dyad[;]" they "are ineffective and may have detrimental effects on both maternal and child health."); American Medical Association, *Perinatal Addiction - Issues in Care and Prevention H-420.962* (2017)("[p]regnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation Transplacental drug transfer should not be subject to criminal sanctions or civil liability"); American Society of Addiction Medicine, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (2017)("[s]tate and local governments should avoid any measures defining alcohol or other drug use during pregnancy as 'child abuse or maltreatment,' and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care services for these women"); National Perinatal Association, *Position Statement 2017: Perinatal Substance Use* (2017)("[t]reating [perinatal substance use] as a deficiency in parenting that warrants child welfare intervention -- results in pregnant and parenting people avoiding prenatal and obstetric care and putting the health of themselves and their infants at increased risk"); ACOG, Committee on Health Care for Underserved Women, *Committee Opinion No. 473, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician- Gynecologist* (January 2011, reaffirmed 2014)("[s]eeking obstetric–gynecologic care should not expose a woman to criminal *or civil penalties*, such as [*inter alia*] loss of custody of her children. . . . Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes.")(emphasis

"[T]he medical model of addiction views substance use disorders as chronic, relapsing diseases, with substance abuse during pregnancy an unfortunate, but common occurrence. **In the medical model, treatment not punishment, is the remedy to reduce consumption of substances during pregnancy.**" [12]

Punitive laws do not work. Instead of promoting healthier pregnancies, such policies discourage women from seeking prenatal care and erode women's trust in healthcare providers, putting women and fetuses at risk. [13]Moreover, removing a subsequently born child from a woman's care likely will not encourage treatment during future pregnancies; instead, lack of prenatal treatment likely will result. [14]

**Fifth, whether in screening/assessment protocols or in considering a punitive approach, there is the possibility of confusing the motivations behind drug use, or**

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added); March of Dimes, *Fact Sheet: Policies and Programs to Address Drug-Exposed Newborns* (2014)("[MoD] opposes policies and programs that impose punitive measures on pregnant women who use or abuse drugs Pregnant women who are addicted to opioids often do not seek prenatal care until late in pregnancy because they are worried that they will be stigmatized or that their newborn will be taken away. [MoD] supports policy interventions that enable women to access services in order to promote a healthy pregnancy and build a healthy family"); American College of Nurse Midwives, *Position Statement: Addiction in Pregnancy* (2013)("ACNM supports a health care system in which women with substance addictions in pregnancy are treated with compassion, not punishment. Women should not be deterred from seeking care during pregnancy due to fear of prosecution"); and American Public Health Association, *Policy Statement No. 9020: Illicit Drug Use by Pregnant Women* (1990)("use of illicit drugs by pregnant women as a public health problem, and recommends that no punitive measures be taken against pregnant women who are users of illicit drugs when no other illegal acts, including drug-related offenses, have been committed").

[12] Cara Angelotta, M.D. & Paul S. Appelbaum, M.D., *Criminal Charges for Child Harm from Substance Use in Pregnancy*, 45 J. Am. Acad. Psychiatry Law 193, 193 (2017).

[13] ACOG Toolkit, at 3; Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in America* (2017) ("AI Report"), at 9.

[14] **Several other states have considered this issue and found against civil, punitive measures.** *See e.g.*, *New Jersey Div. of Child Protection and Permanency v. Y.N.*, 104 A.3d 244, 246 (N.J.2014) ("absent exceptional circumstances, a finding of abuse or neglect cannot be sustained based solely on a newborn's enduring methadone withdrawal following a mother's timely participation in a bona fide treatment program prescribed by a licensed healthcare professional to whom she has made full disclosure."); *New Jersey Dept. of Children and Families, Div. of Youth and Family Services v. A.L.*, 59 A.3d 576 (N.J. 2013) (drug use during pregnancy by itself does not establish child abuse or neglect); *In re Valerie D.*, 613 A.2d 748 (Conn. 1992) (prenatal cocaine use did not permit the state to terminate mother's parental rights); *Johnson v. State*, 602 So. 2d 1288, 1296 ( Fla. 1992) ("by imposing criminal sanctions, women may turn away from seeking Prenatal care for fear of being discovered"). *See also* California's Child Abuse and Neglect Reporting Act, providing that an "indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child." Cal. Penal Code § 11165.13. But, "a positive toxicology screen at the time of delivery of an infant is not in and of itself a sufficient basis for reporting child abuse and neglect." *Id.*

**perhaps of confusing the identification of the drugs themselves.** Opioid-based medications are common, if potentially problematic, pain medications used both illicitly and by prescription for moderate to severe pain during pregnancy and/or childbirth. Short term use of opioids during pregnancy for episodic pain has not resulted in symptoms of neonatal abstinence syndrome. [15] When women receive opioids for pain management during labor, the drug often will cross the placental barrier in varying degrees to the baby. [16]

ACOG, SAMHSA and other medical organizations explain that while opioid withdrawal during pregnancy may be "associated with poor neonatal outcomes, including early preterm birth or fetal demise, and with higher relapse rates among women; robust evidence has demonstrated that maintenance therapy during pregnancy can improve outcomes." *Id.* Accordingly, medical professionals actually recommend pharmacotherapy treatment of opioid dependency – referred to varyingly as opioid substitution maintenance, opioid agonist therapy (OAT), or medication-assisted treatment (MAT) – for pregnant women using opioids to improve maternal and fetal outcomes. [17] MAT and similar therapies involve physician-prescribed and -supervised use of opioid-based medications to treat a woman's disease, and they have beneficial effects on infants, including lower use of assisted ventilation and reduced incidence of low birthweight and premature delivery. [18]In a 2017 report on the policing of pregnant women using drugs in the United States, Amnesty International found that such treatments play "an important role in attracting and retaining pregnant women in treatment and ensuring good contact with obstetric and community-based services

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[15] Malaika Babb et al., *Treating Pain During Pregnancy*, Canadian Family Physician, Vol. 56, (Jan. 2010), at 25–27; and U.S. Department of Health of Human Services, Factsheet, *Pregnancy and Opioid Pain Medications*, *available at https://www.cdc.gov/drugoverdose/pdf/pregnancy_opioid_pain_factsheet-a.pdf*. *See also* ACOG Toolkit, at 2.

[16] Jay E. Mattingly et al., *Effects of Obstetric Analgesics and Anesthetics on the Neonate: A Review*, Pediatric Drugs, 2003, 5 (9), at 616.

[17] ACOG Toolkit, at 1. *See also* AI Report, at 31, 33. *See also* U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration: Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (Treatment Improvement Protocol (TIP) Series, No. 43.), Chapter 13: Medication-Assisted Treatment for Opioid Addiction During Pregnancy (2005), at 2, *available at* www.ncbi.nlm.nih.gov/books/NBK64148/ (since 1998, the National Institutes of Health consensus panel has "recommended methadone maintenance as the standard of care for pregnant women with opioid addiction").

[18] ACOG Toolkit, at 1; Mary Anne Armstrong et al., *Perinatal Substance Abuse Intervention in Obstetric Clinics Decreases Adverse Neonatal Outcomes*, Journal of Perinatology, 2003, Vol. 23, at 3, 7.

including primary care." AI Report, at 33. [19] Women battling their illnesses by engaging in physician-supported opioid therapies could be liable for civil child abuse as opioids would still be found in the women's or infants' systems.

While most anesthetic and analgesic agents in current use "are well tolerated by the fetus if judiciously administered[,]" they still will appear in a woman or infant's system and further confound the issue of testing inaccuracies. *Id.* [20] **"[W]hether or not a pregnant woman can stop her drug use, obtaining prenatal care, staying connected to the health care system, and being able to speak openly with a physician about drugs problems helps to improve birth outcomes."** [21]

**Sixth, it would problematic, and Pennsylvania lawmakers have to date declined, to legislate lawful substances that a woman may choose to use during pregnancy, such as alcohol and tobacco, which are known to cause more pain and long-term harm to an infant.** ACOG observes that "[d]ecades of evidence have shown that alcohol and cigarettes – unlike opioids – cause long-term serious health consequences for mothers and infants, including prematurity. Smoking is the number one risk factor for delivering a baby prematurely.") An infant also can experience withdrawal from the broad class of anti-anxiety medications including barbituates, benzodiazames, and psychotropics. Use of these medications both on- and off-prescription occurs widely across the nation during pregnancy. Significantly, despite a higher likelihood of detrimental impact, there is little, if any, movement in the Commonwealth – nor anywhere else in the United States that *amici* could determine – to characterize in utero exposure to these substances and drugs as child abuse. Prenatal substance exposure and NAS have consequences that are not fully understood, but certainly not yet seen at the magnitude that smoking and alcohol may impart upon the child, and the Commonwealth's legislature and courts have not recognized ingestion of these substances as civil child abuse.

[19] 23 Pa. Cons. Stat. § 6386(a)(2) exempts health care providers from mandatory reporting when an infants in utero exposure was "under the care of a prescribing medical professional" and "in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional." *Id.* Thus, a health care provider is not mandated to report a woman for prenatal exposure who engaged in MAT or other therapies.

[20] "For labor analgesia, many options are available. Systemic administration of opioids and sedatives is one such option. Repeated maternal administration of opioids such as pethidine (meperidine) results in significant fetal exposure and neonatal respiratory depression. Patient- controlled analgesia with synthetic opioids such as fentanyl, alfentanil, and the new ultra-short- acting remifentanil may be used for labor analgesia in selected patients." *Id.*

[21] ACOG Toolkit, at 1.

Construction of prenatal substance exposure as child abuse opens the door to statutory interpretations of other, lawful actions that also could "cause[ ], or create[ ] a reasonable likelihood of, bodily injury to a child after birth." *Interest of L.B.*, at 309. Public policy – as well as constitutional law – warn against the slippery slope of intruding upon the myriad decisions a pregnant woman makes that could be reasonably likely to result in bodily injury to her child after birth, which may vary depending on the advice of the particular practitioner she sees and cultural norms in the country where she resides. Should a woman engage in physical activity or restrict her activities? Should she eat a turkey sandwich, soft cheese, or sushi?

Should she drink an occasional glass of wine? What about a daily cup of coffee? Should she continue to take prescribed medication even though there is a potential risk to the child? Should she travel to countries where the Zika virus is present? Should she obtain cancer treatment even though it could put her child at risk? Should she travel across the country to say goodbye to a dying family member late in her pregnancy? Is she a child abuser if her partner kicks or punches her in her abdomen during her pregnancy and she does not leave the relationship because she fears for her own life? . . . reasonable people may differ as to the proper standard of conduct. *Id.* at 314.

Thus suggests the conundrum of the question posed by the *L.J.B.* case – **what makes opioids different from smoking or other potentially harmful actions?** Researchers and clinicians have identified many other environmental factors and conditions with potentially harmful effects on a developing fetus and/or infant, including polysubstance use, maternal stress, household environment such as chaos or violence, maternal IQ, maternal obesity and lead poisoning. No studies are large enough to control for every influence or condition that may have a lasting effect on the child, which leads to a question of causation – how to determine what factor caused a particular effect on a child – and a problem with disparate treatment of these several conditions.

**Should some or all pregnant women be tested?** Drug testing policies generally dictate testing based upon discretionary risk factors that largely are applied selectively and subjectively, disproportionately harming women of color, poor women, and rural women. AI Report at 23-24. A 2007 study of over 8,000 women found "black women were 1.5 times more likely to be tested for illicit drugs than non-black women, despite similar rates of testing positive." *Id.* at 25. Similarly, a National Association of Pregnant Women study from 1973 to 2005 identified 413 arrests, detentions, or forced

interventions on pregnant women concerning prenatal substance exposure. *Id.* at 23. Of these women, 71 percent qualified for indigent defense and 59 percent were women of color; fifty-nine percent statistic was based on cases within the study where racial data was available. . *Id.* Comprising only 52 percent of cases within the study, African-Americans were overrepresented. *Id.* These results are not new. The American Civil Liberties Union (ACLU) Reproductive Freedom Project documented prosecutions of women for prenatal substance exposure from 1990 to 1992; about 75 percent of the prosecutions were brought against women of color, even though approximately 75 percent of the United States' population was white. *Id.* at 22.

Poor and rural women also will be disproportionately impacted, especially those receiving care via Medicaid programs. *Id.* Drug treatment centers and programs, particularly those accepting – much less specializing in – treatment of pregnant women, generally are inaccessible to poor and rural women. *Id.* at 11, 30-31. Many treatment centers do not accept Medicaid and most private medical insurers does not include drug treatment, forcing women to pay out-of-pocket for care and unjustifiably harming poor women who may be willing, but unable to access treatment for drug addictions. *See id.* at 30 n.140 (*e.g.*, the annual cost for methadone treatment in the United States is $4,700; "[m]any women are simply are unable to pay and left without treatment as a result"). [22]

The inherent inaccuracy of drug detection methods additionally will complicate investigative practices and compromise the results of drug testing of infants and mothers. Typical hospital routine drug screening tests can detect the naturally derived opiates codeine and morphine, and the morphine derivative, heroin. These routine drug screens today also can detect, with variable accuracy depending on dose, the common prescription opioids oxycodone (*e.g.*, in Percocet, OxyContin) and hydrocodone (in Vicodin). Of note, a positive drug screen result typically indicates only that an opioid is present; it does not distinguish amongst these agents. The screening test may miss

[22] Another 1990 study similarly found that black women testing positive were 10 times more likely to be reported to child protective services than their counterparts. *Id.* at 25. Racial disparities in testing – even if based upon the unintentional implicit biases of well-intentioned healthcare professionals seeking to help – likely will lead women of color to more frequently be identified as using opioids or other substances while pregnant and be subjected to liability for civil child abuse. A similar differential pattern occurred in the disparate criminal prosecution and sentencing practices applied a decade ago to "crack" users (*i.e.*, by poor, predominantly minority populations) and powder cocaine users (*i.e.*, by wealthy white populations). Danielle Kurtzleben, *Data Show Racial Disparity in Crack Sentencing*, U.S. News & World Report, Aug. 3, 2010.

oxycodone or hydrocodone in low concentrations, and it will not detect many commonly used (therapeutically and illicitly) opioids such as fentanyl and its derivatives, meperidine, oxymorphone and tramadol. [23]

Specific testing for these opioid drugs is complicated and requires more sophisticated levels of laboratory testing that is expensive, often requires send-out of specimens to reference laboratories, and may be unavailable in many community hospitals and other settings. *Id.* Lastly, while uncommon, a routine opioid screen may be positive if significant recent ingestion of poppy seeds has occurred, such as in muffins or bagels. While such false positive test results (that is, tests that incorrectly indicate drug use) may be uncommon in opioid testing, the failure of screening tests to detect some drugs may have a discriminatory effect. For example, if one class of users (*i.e.*, poor women) predominately use the easily- detectable street drug heroin, while another class of users (*i.e.*, women of higher socioeconomic status and ready access to physician prescribers) predominately use less-detectable prescription opioids such as oxycodone, hydrocodone, or suboxone, the former class will experience a higher rate of positive screens and a higher rate of indicated child abuse reports.

Thus, even in routine practice or in cases of mandatory drug testing for all women and infants, positive screening is a reliable confirmation of detectable opioids. But, distinguishing between heroin and commonly abused prescription opioids may require a much more sophisticated level of toxicology testing. With cost-prohibitive second-level testing needed – combined with a necessary assessment of a woman's motivation for taking a drug – it is hard to imagine a drug testing rubric being administered routinely and well in all settings.

> ***The Task Force should study subjective selection biases and drug testing inaccuracies that may result in unlawful discriminatory practices that disproportionately harm women of color, as well as poor and rural women.***

Finally, interpreting prenatal substance exposure as child abuse imposes restrictions that

[23] Fred M. Henretig, et al., *Child Abuse by Poisoning, in* Child Abuse: Medical Diagnosis and Management 549-599 (F.M. Henretig, et al. eds., Amer. Acad. of Pediatr. 3rd ed. 2009). *See also* Lewis S. Nelson, Opioids, *in* Goldfrank's Toxicologic Emergencies 492-509 (Robert S. Hoffman, et al. eds., 10th ed. 2015).

may last a lifetime and long exceed the addiction itself. Having a rule that prenatal substance exposure constitutes child abuse to the subsequently born child likely will have the dual effect of (i) causing child abuse investigators to "indicate" most, if not all, substance-exposed newborns, and (ii) occasion many additional findings of child abuse by Dependency Courts. We would be asking a Child Protective Services ("CPS") investigator to determine the intentionality of the mother – the intentional, knowing or reckless inquiry – at the moment of drug use. Beyond being an inappropriate decision for an investigator to make, such results would impose employment restrictions on a mother that may detrimentally impact her and a child, and may long exceed the period of addiction itself.

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For more information:
Frank P. Cervone, Executive Director
Support Center for Child Advocates
1617 John F. Kennedy Boulevard, Suite 1200
Philadelphia, PA 19103
t: (267) 546-9202 f: (267) 546-9201
e: fcervone@ SCCALaw.org www.SCCALaw.org

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