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Treating for Two: Reforming Maternal Substance Abuse Policy

Katherine Drabiak

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TREATING FOR TWO: REFORMING MATERNAL SUBSTANCE ABUSE POLICY

Katherine Drabiak

ABSTRACT

In 2018, a nursing mother named Samantha Jones in Pennsylvania made national headlines when her 10-day old infant son Remington died from ingesting drugs through her breastmilk. According to the coroner's report, Remington died from a combination of methadone, methamphetamine, and amphetamine toxicity. The District Attorney charged Jones, who also had a two-year old child, with criminal homicide. Jones was undergoing Medication Assisted Treatment (MAT) and receiving prescribed methadone for Opioid Use Disorder. Many swiftly voiced opposition to the District Attorney, decrying the criminal charges against Jones, arguing people with Opioid Use Disorder should be offered treatment rather than face criminal charges. But Jones *was* receiving treatment: Approximately one year prior to Remington's death, law enforcement found Jones – who was pregnant with Remington at the time and enrolled in MAT – passed out in her vehicle with her other child in the backseat. During that incident, police charged Jones with endangering the welfare of a child and driving under the influence of multiple illicit drugs. In response, the court ordered Jones to continue MAT.

This tragedy – and similar reports – highlight a critical gap in scholarship for treating pregnant and parenting women with Substance Use Disorder: what happens when treatment does not work? How should health professionals, policymakers and the law respond to pregnant and parenting women who continue active substance abuse despite receiving treatment?

Integrating pharmacology, addiction science, and current clinical standards, this article examines research supporting current federal policy that recommends MAT for pregnant and nursing mothers. Treatment options such as MAT carry implications for maternal impairment, recovery, informed

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consent, infant development, and child welfare. Addressing both civil and criminal considerations, this article outlines potential solutions for reforming maternal substance abuse policy. The high stakes of treatment failure require re-envisioning what constitutes compassionate effective treatment while using the law as a lever of accountability to promote maternal recovery and prevent crimes against infants and children.

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INTRODUCTION

In 2018, a nursing mother named Samantha Jones in Bucks County, Pennsylvania made national headlines when her 10-day old infant son, Remington, died from ingesting fatal drugs through her breastmilk.¹ According to the coroner's report, Remington died from a combination of methadone, methamphetamine, and amphetamine toxicity.² The Bucks County District Attorney charged Jones, who also has a two-year old child, with criminal homicide.³ Media sources reported that Jones was undergoing Medication Assisted Treatment (MAT) and receiving prescribed doses of methadone to treat her addiction to opioid painkillers.⁴ Multiple commentators swiftly voiced opposition to the District Attorney, decrying the criminal charges against Jones, arguing that people with Substance Use Disorder (SUD) should be offered treatment rather than face criminal charges⁵ and asserting that Jones' true penalty comes in

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1. Nadia Kounang, *Mom Charged After Drugs In Breast Milk Killed Baby, Prosecutors Say*, CNN (Aug. 29, 2018), <https://www.cnn.com/2018/08/29/health/breastfeeding-drugs-homicide-charge-samantha-jones/index.html> [https://perma.cc/J8K5-YZA9]; see also Katherine Drabiak, *Toxic Breastmilk: When Substance Abuse Relapse Means Death for Baby*, HARV. L. BILL HEALTH (Nov. 15, 2018), <https://blog.petrieflom.law.harvard.edu/2018/11/15/toxic-breastmilk-when-substance-abuse-relapse-means-death-for-baby/> [https://perma.cc/J95N-ZWNY].
 2. Erin Laviola, *Samantha Whitney Jones: 5 Fast Facts You Need to Know*, HEAVY (July 16, 2018), <https://heavy.com/news/2018/07/samantha-whitney-jones/> [https://perma.cc/ZX96-NFRH].
 3. *Id.*
 4. See Kounang, *supra* note 1.
 5. Melissa Jeltsen, *Mother Accused of Killing Baby With Her Own Breastmilk*, HUFFPOST (July 19, 2018), https://www.huffpost.com/entry/woman-charged-baby-death-drugs-breast-milk_n_5b4e4c36e4b0b15aba897538 [https://perma.cc/ZRM2-RGD4].

the form of grief and the loss of a child.⁶ In May 2019, Jones pled guilty to involuntary manslaughter, admitting she transferred a fatal combination of licit and illicit drugs to her son by breastfeeding that caused his death.⁷ Deviating from sentencing guidelines that usually prescribe up to ten years of prison time, the presiding judge sentenced Jones to 36 months of probation and 100 hours of community service.⁸

Although Jones' defense attorney portrayed the death as a tragic accident, Jones's prior conduct, ongoing polysubstance abuse while enrolled in MAT, and pattern of involvement with law enforcement should have raised serious red flags. Approximately one year prior to Remington's death, law enforcement found Jones – who was pregnant with Remington at the time – passed out in her vehicle with her other child in the backseat. During that incident, police charged Jones with endangering the welfare of a child and driving under the influence (DUI).⁹ At that time, Jones was similarly intoxicated under the influence of methadone, methamphetamine, amphetamine, and the antianxiety medication Clonazepam.¹⁰ According to media reports, the court dropped part of the charges and sentenced Jones to a period of house arrest with an order to continue drug treatment.¹¹

This case represents broader questions woven into the current opioid crisis as it pertains to prenatal and parenting substance abuse, illustrating the complexities of disentangling crime, addiction, and treatment: When may, or should, the law intervene to address the conduct of pregnant women who abuse substances during pregnancy and breastfeeding? What

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6. Christian Menno, *Mother Pleads Guilty in Breastfeeding Death of Son*, INTELLIGENCER (May 8, 2019), <https://www.theintell.com/story/news/courts/2019/05/08/mother-pleads-guilty-in-breastfeeding/5217310007/> [<https://perma.cc/J4VY-LS8C>].
 7. *Id.*
 8. *See id.*
 9. James O'Malley, *New Britain Mom Accused of Killing Baby with Drug-Laced Breast Milk*, COURIER TIMES (July 13, 2018), <https://amp.buckscountycouriertimes.com/amp/11528146007> [<https://perma.cc/Q9F2-NLZJ>].
 10. *Id.*
 11. *Id.*

constitutes the safest and most effective treatment for pregnant and nursing mothers with Opioid Use Disorder (OUD)? What is the significance that Jones – and many other people with OUD – continued to engage in polysubstance abuse despite receiving MAT, or refuse treatment altogether? And lastly, who should be held accountable for such tragic outcomes against the most vulnerable members of society – infants and children?

Federal policy states that MAT constitutes a safe and effective treatment for pregnant and nursing mothers with OUD because it improves maternal and infant outcomes, warning that detoxification treatment plans risk a high rate of relapse and poses dangerous risks to the fetus.¹² Although opioids used in MAT cross the placenta and impact the developing infant - often resulting in Neonatal Abstinence Syndrome (NAS) - the American College of Obstetricians and Gynecologists maintains that NAS constitutes an expected and treatable condition, and the Substance Abuse and Mental Health Services Administration (SAM

HSA) asserts there is no evidence that MAT is harmful during pregnancy.¹³

Part I of this article explores the scientific evidence behind promoting MAT for pregnant women, assesses claims of safety and efficacy, and examines the evidence supporting the warning against detoxification during pregnancy. Despite the current

12. *Treating Opioid Use Disorder During Pregnancy*, NAT'L INST. HEALTH: NAT'L INST. DRUG ABUSE (July 2017), <https://nida.nih.gov/publications/treating-opioid-use-disorder-during-pregnancy> [<https://perma.cc/W6TX-9RAF>] [hereinafter NIDA *Treating Opioid Use Disorder During Pregnancy*]; Stephen Patrick & Davida Schiff, *AAP Committee on Substance Use and Prevention, A Public Health Response to Opioid Use in Pregnancy*, 139 PEDIATRICS 1, 3 (2017); U.S. DEP'T HEALTH & HUMAN SERVS.: SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CLINICAL GUIDANCE FOR TREATING PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS (2018) [hereinafter SAMHSA *Treating Pregnant and Parenting Women*]; *Opioid Use and Opioid Use Disorder in Pregnancy*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS [hereinafter ACOG], <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy> [<https://perma.cc/77T4-ZN25>] (last visited Mar. 13, 2022).

13. *Id.*

standard of care promoting benefits of MAT for pregnant mothers, federal policy and medical recommendations downplay or omit risks of medications used in MAT with potentially significant implications for both maternal and neonatal outcomes.

Part II describes these gaps in current substance abuse treatment policy for pregnant women and describes the viability of alternatives including detoxification treatment. Building on previous research examining the metrics assessing treatment success,¹⁴ Part II also explores nuances involved in treating patients struggling with addiction: continued substance abuse; pregnant women who refuse or withdraw from treatment; and specific implications of struggling with impairment as a nursing or parenting mother.

Part III re-assesses risks and benefits to the maternal dyad, describing neurological, psychological and physical effects from opioid agonist medications that the pregnant and parenting patient may experience while receiving MAT. This section also describes the risks of prenatal opioid exposure including impact on developmental, physical and neurological outcomes for infant and child development. Following the maternal dyad during the postpartum period, this section describes current guidelines pertaining to lactation for nursing women enrolled in MAT and how to address continued substance abuse while breastfeeding. Part III provides recommendations for best practices to revise current informed consent as both a clinical and legal standard when physicians discuss treatment options for SUD and the risks and benefits from MAT to pregnant and parenting women.

This article highlights a critical gap in current law and policy: pregnant and parenting women may refuse treatment, may discontinue treatment, may enroll in treatment but still engage in ongoing substance abuse, or may face impairment from medications prescribed in MAT. Both continued substance abuse and impairment directly affects the health of the fetus, the safety of the infant, and the mother's ability to parent. Part IV explores how the law classifies prenatal and parenting substance abuse, explains the civil law system relating to child welfare laws, describes how some states have tried to facilitate treatment through civil commitment, and describes the intersection between substance abuse and crimes against infants and children. This

14. See generally Katherine Drabiak, *Expanding Medication Assisted Treatment is Not the Answer: Flaws in the Substance Abuse Treatment Paradigm*, 21 J. HEALTH CARE L. 1 (2019).

section will also analyze the variation in how jurisdictions approach prenatal and parenting substance abuse when it results in the delivery of controlled substances to an infant or when the mother causes the infant's death.

Finally, Part V concludes by providing policy recommendations designed to facilitate treatment, motivate engagement and recovery, and sets forth guidelines for using the law as an appropriate lever to deter and sanction criminal acts against children.

I. THE STANDARD OF CARE FOR TREATING PREGNANT PATIENTS WITH OUD

This section will explain the pharmacology of the two opioid agonists used in MAT (methadone and buprenorphine), possible side effects and risks listed in FDA labeling, legal classification under the Controlled Substances Act, and FDA labeling information pertaining to use of methadone and buprenorphine during pregnancy and lactation. SAMHSA and current medical literature explicitly warn against detoxification, asserting that supervised withdrawal is not recommended because it poses risks to the fetus. While federal policy acknowledges that prenatal exposure to opioids increases the risk of Neonatal Abstinence Syndrome, SAMHSA and ACOG deny that MAT increases other physical or neurological risks to the developing fetus or infant.

A. *Medication Assisted Treatment Constitutes the Standard of Care for Pregnant Patients*

According to the National Survey on Drug Use and Health, about 4.4% of pregnant women report illicit drug use during pregnancy.¹⁵ From 2004 to 2014, as more pregnant mothers became dependent and addicted to opioids, the rates of NAS increased five-fold, resulting in 32,000 infants born in 2014 who suffered from NAS and opioid withdrawal.¹⁶ Professional

15. Marylou Behnke & Vincent Smith, *Committee on Substance Abuse and Committee on Fetus and Newborn, Prenatal Substance Abuse: Short- and Long-Term Effects on the Exposed Fetus*, 131 PEDIATRICS e1009, e1010 (2013).

16. *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome*, NAT'L INST. HEALTH: NAT'L INST. DRUG ABUSE (Jan. 2019), <https://archives.drugabuse.gov/trends->

guidelines and medical recommendations warn against abrupt discontinuation of opioids during pregnancy, stating that it can cause preterm birth, fetal distress, and fetal demise.¹⁷ The American College of Obstetricians and Gynecologists (ACOG) extends the recommendation further, asserting that withdrawal from opioids is not safe and not medically recommended.¹⁸ Instead of withdrawal or detoxification based treatment, the American Academy of Pediatrics (AAP), the National Institute on Drug Abuse (NIDA), ACOG, and SAMHSA all recommend MAT as the standard of care.¹⁹

Treating substance abuse, or assisting a pregnant patient to discontinue substance abuse, does provide significant health benefits for both the patient and developing infant. Pregnant patients with untreated addiction face higher rates of infectious disease and are at six times the risk for pregnancy complications, and infants born to mothers with untreated addiction have lower birth weights, higher risk of NAS, and a 74-fold increased risk of Sudden Infant Death Syndrome.²⁰ Pregnant patients engaged in MAT are more likely than untreated patients to obtain prenatal care and are less likely to experience fluctuations in opioid exposure levels.²¹ The infants of patients in MAT have a higher

statistics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome [<https://perma.cc/NBM3-PE8L>].

17. Patrick & Schiff, *supra* note 12; ACOG, *supra* note 12; DARLA BISHOP ET AL., JACOB'S INST. WOMEN'S HEALTH AT GEO. WASH. UNIV., PREGNANT WOMEN AND SUBSTANCE ABUSE: OVERVIEW OF RESEARCH & POLICY IN THE UNITED STATES 31 (2017).
18. ACOG, *supra* note 12.
19. Patrick & Schiff, *supra* note 12, at 3, 5; ACOG, *supra* note 12; SAMHSA Treating Pregnant and Parenting Women, *supra* note 12, at 25; NIDA Treating Opioid Use Disorder During Pregnancy, *supra* note 12; U.S. DEP'T OF HEALTH & HUM. SERVS.: SUBSTANCE ABUSE MENTAL HEALTH ADMIN. & ADMIN FOR CHILD. & FAMILIES, A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS: PRACTICE AND POLICY CONSIDERATIONS FOR CHILD WELFARE, COLLABORATING MEDICAL, AND SERVICE PROVIDERS (2016) [hereinafter SAMHSA Collaborative Approach].
20. ACOG, *supra* note 12; Silvia Minozzi et al., *Maintenance Agonist Treatments for Opiate-Dependent Pregnant Women*, 12 COCHRANE DATABASE SYSTEMIC REV. 2013, at 2, 7.
21. U.S. DEP'T HEALTH & HUM. SERVS.: SUBSTANCE ABUSE MENTAL HEALTH ADMIN., MEDICATION-ASSISTED TREATMENT FOR OPIOID

birth weight and longer gestational age as compared to untreated pregnancies.²²

Federal policy asserts there is “consensus”²³ in the medical community that MAT plays a critical role in the treatment of persons with opioid use disorder and that it constitutes the most effective form of treatment.²⁴ General guidelines set forth by NIDA state that medication in conjunction with behavioral therapy constitutes the most effective treatment for opioid use disorder.²⁵ The Office of National Drug Control Policy asserts that medication does not merely assist with psychosocial services, but itself constitutes a central component of evidence-based practice.²⁶

Professional recommendations and guidelines promoting MAT as the standard for care also apply to pregnant patients with OUD. AAP states that medications used in MAT, methadone and buprenorphine, are safe and effective in pregnancy and lead to improved maternal and infant outcomes.²⁷ Similarly, guidelines set forth by the American Society of

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- ADDICTION IN OPIOID TREATMENT PROGRAMS: A TREATMENT IMPROVEMENT PROTOCOL (TIP) 43 (2005) [hereinafter “SAMHSA TIP 43”]; Gabrielle Welle-Strand et al., *Neonatal Outcomes Following In Utero Exposure to Methadone or Buprenorphine: A National Cohort Study of Opioid-Agonist Treatment of Pregnant Women in Norway from 1996-2009*, 127 *DRUG ALCOHOL DEPENDENCE* 200, 201 (2013).
22. SAMHSA TIP 43, *supra* note 21; Welle-Strand et al., *supra* note 21.
 23. COMM. ON ENERGY & COM. DEMOCRATIC STAFF, 113TH CONG., HEARING ON “COMBATING THE OPIOID ABUSE EPIDEMIC: PROFESSIONAL AND ACADEMIC PERSPECTIVES” 4 (2015).
 24. NAT’L INST. HEALTH: NAT’L INST. DRUG ABUSE, MEDICATIONS TO TREAT OPIOID USE DISORDER RESEARCH REPORT (2021) [hereinafter MEDICATIONS TO TREAT OPIOID USE DISORDER]; NAT’L INST. HEALTH: NAT’L INST. DRUG ABUSE, EFFECTIVE TREATMENT FOR OPIOID ADDICTION (2016).
 25. NAT’L INST. HEALTH: NAT’L INST. DRUG ABUSE, DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION (2014).
 26. Memorandum from Michael P. Botticelli, Director of the Office of National Drug Control Policy, to Heads of Executive Departments and Agencies, on Changing Federal Terminology Regarding Substance Use and Substance Use Disorders (Jan. 9, 2017) (on file at whitehouse.gov) [hereinafter ONDCP Memo].
 27. Patrick & Schiff, *supra* note 12.

Addiction Medicine (ASAM) and SAMHSA state that pregnant patients with OUD should be encouraged to start on methadone (a full opioid agonist) or buprenorphine (a partial opioid agonist).²⁸

*B. Pharmacology and Product Labeling Information for
Methadone and Buprenorphine*

1. Methadone

Methadone is a synthetic full opioid agonist, which binds to and activates the same opioid receptors as heroin, morphine, and opioid pain medications.²⁹ It is designed for a slower and more controlled release to prevent cravings and withdrawal symptoms over a longer time duration.³⁰ NIDA maintains the message that methadone does not produce euphoria at therapeutic doses, patients receiving methadone do not appear “high” based on their tolerance to the drug’s effects, and patients are able to function normally enough to attend school or work and engage in activities of daily life.³¹ Under the Controlled Substances Act, methadone is a Class II controlled substance, which means despite an accepted medical use, it has a high potential for abuse and may lead to severe psychological or physical dependence.³² The FDA approved package insert for Methadose, the oral liquid used by Opioid Treatment Providers, states that methadone can be abused in a manner similar to other opioid agonists and are

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28. SAMHSA Collaborative Approach, *supra* note 19, at 10; *see also* Drabiak, *supra* note 14, at 37-41 (describing the regulatory and legal classification of methadone and buprenorphine and pharmacological properties).
29. MEDICATIONS TO TREAT OPIOID USE DISORDER, *supra* note 24; MALLINCKRODT PHARM., METHADOSE ORAL CONCENTRATE 3 (2016) [hereinafter METHADOSE].
30. *See Methadone, Medication Assisted Treatment*, U.S. DEP’T HEALTH & HUM. SERVS.: SUBSTANCE ABUSE MENTAL HEALTH ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone> [https://perma.cc/8L3D-75XR] [hereinafter “SAMHSA Methadone”] (last visited Mar. 12, 2022).
31. MEDICATIONS TO TREAT OPIOID USE DISORDER, *supra* note 24; *see also* SAMHSA Methadone *supra* note 30.
32. Controlled Substances Act, 21 U.S.C. § 812(b)(2) (1971); DRUG ENFORCEMENT ADMIN.: DIVERSION CONTROL DIV., METHADONE (2014).

“sought by drug abusers, people with addiction disorders . . . and [is] subject to diversion.”³³

Use of methadone carries a variety of side effects and risk of adverse events. Side effects may include dizziness, sedation, nausea, vomiting, sweating, confusion, agitation, dysphoria, and insomnia.³⁴ Risks also include life threatening QT prolongation (a heart arrhythmia) and, similar to other opioid analgesics, administration of methadone even in the prescribed amount can cause respiratory depression and death.³⁵

Methadone has unique pharmacological properties that require cautious administration and physician oversight. The analgesic effect of methadone lasts about 4 to 8 hours, but it remains in the body for 8 to 59 hours, binding to tissues including the brain.³⁶ In risk management materials, SAMHSA has warned that the combination of methadone’s long half-life and slow elimination can result in the fatal accumulation of methadone in patients, leading to iatrogenic overdose.³⁷ Methadone also may exert neurotoxic effects, reduce gastrointestinal motility leading to constipation, suppress the immune system, and impact the endocrine system.³⁸ This may manifest as insulin imbalances, impotence, erectile dysfunction, amenorrhea, or infertility.³⁹ The

33. METHADOSE, *supra* note 29, at 10; *see also* Drabiak, *supra* note 14, at 37-41.

34. METHADOSE, *supra* note 29, at 25.

35. *Id.* at 3-4; *see also* AnGee Baldini et al., *A Review of Potential Adverse Effects of Long Term Opioid Therapy: A Practitioner’s Guide*, 14 PRIMARY CARE COMPANION CNS DISORDERS 3 (2010) (discussing the long-term adverse effects of opioids as a class of medications when used in clinical care, with mention of constipation, sleep-disordered breathing, hypothalamic-pituitary-adrenal dysfunction, and overdose, finding a significant decline in patients’ health related quality of life).

36. ROXANE LAB’YS, INC., DOLOPHINE HYDROCHLORIDE CII (METHADONE HYDROCHLORIDE TABLETS, USP) 5MG, 10MG RX ONLY 3, 15 (2006); METHADOSE, *supra* note 29, at 5.

37. *Id.* at 28; U.S. DEP’T HEALTH & HUM. SERVS.: SUBSTANCE ABUSE MENTAL HEALTH SERVS. ADMIN., MINIMIZE LIABILITY, MANAGE RISK, ENSURE PATIENT SAFETY: EFFECTIVE STRATEGIES IN OUTPATIENT METHADONE TREATMENT WEBINAR (2009) [hereinafter “SAMHSA Minimize Liability”].

38. METHADOSE, *supra* note 29, at 4.

39. *Id.*

FDA-approved product information for Methadose also provides a warning statement that methadone may impair the patient's ability to drive or operate heavy machinery.⁴⁰

Despite the profile of risks and adverse events, health professionals maintain “essential questions of safety and efficacy have been definitively answered” and methadone offers a safe and effective treatment for persons with addiction because it normalizes patient function with minimal psychoactive impairment.⁴¹

2. Buprenorphine

Buprenorphine is a partial opioid agonist: it binds to the same receptors as other opioids but activates them less strongly.⁴² It is also designed to reduce cravings and withdrawal at therapeutic doses, and normalize body functions without negative and euphoric effects.⁴³ Some formulations of buprenorphine combine buprenorphine with naloxone, an opioid antagonist, to function as an abuse deterrent.⁴⁴ As a partial agonist, it is designed to block the high from additional opiates; because of this, the National Drug Intelligence Center asserts that buprenorphine carries a lower risk of abuse or diversion based on its “ceiling effect.”⁴⁵ SAMHSA states that buprenorphine assists

40. *Id.* at 13.

41. Vincent Dole, Editorial, *What Have We Learned from Three Decades of Methadone Maintenance Treatment?*, 13 *DRUG & ALCOHOL REV.* 3, 3 (1994); Herbert Kleber, *Methadone Maintenance Four Decades Later: Thousands of Lives Saved, But Still Controversial*, 300 *JAMA* 2302, 2302 (2008).

42. *MEDICATIONS TO TREAT OPIOID USE DISORDER*, *supra* note 24; RECKITT BENKISER PHARM. INC., *SUBUTEX 5* (2010) [hereinafter *SUBUTEX*].

43. *MEDICATIONS TO TREAT OPIOID USE DISORDER*, *supra* note 24, at 5, 12; *Medication-Assisted Treatment (MAT)*, SUBSTANCE ABUSE & MENTAL HEALTH ADMIN., <https://www.samhsa.gov/medication-assisted-treatment> [https://perma.cc/S6NR-RLQT] (last visited Mar. 21, 2022) (hereinafter *SAMHSA MAT*).

44. *Id.*

45. *Intelligence Bulletin: Buprenorphine: Potential for Abuse*, NAT'L DRUG INTEL. CTR. (Sept. 2004), <https://www.justice.gov/archive/ndic/pubs10/10123/index.htm> [https://perma.cc/YQ2V-G9Q6].

persons with opioid abuse disorder to regain normal, healthy lives, and permits patients to function normally.⁴⁶

Under the Controlled Substances Act, buprenorphine is a Class III controlled substance, which means the DEA has determined it has less potential for abuse than a Class II substance, such as methadone.⁴⁷ Buprenorphine has an accepted medical use, and abuse of it “may lead to moderate or low physical dependence or high psychological dependence.”⁴⁸

Side effects from buprenorphine include headache, nausea, vomiting, sweating, constipation, withdrawal symptoms, anxiety, depression, and insomnia.⁴⁹ Additional adverse risks include hepatic events, respiratory depression, and overdose, which is more likely to occur if a patient combines buprenorphine with central nervous system depressants such as alcohol or benzodiazepines.⁵⁰ The FDA-approved product information for one formulation, Subutex, carries specific warnings of its potential for dependence and abuse along with a warning Subutex may impair the patient’s ability to drive or operate machinery.⁵¹

3. Methadone and Buprenorphine During Pregnancy and Lactation

In 2014, the FDA revised its rule governing the content and format of medication labels pertaining to use during pregnancy and lactation.⁵² This rule removed previous risk categories from drug and product information and requires manufacturers to provide specific subsections for product information and potential

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46. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., THE FACTS ABOUT BUPRENORPHINE FOR TREATMENT OF OPIOID ADDICTION 2-3, 9, 11 (2014).
 47. 21 U.S.C. § 812(b)(3); *Buprenorphine*, DRUG ENF’T ADMIN. (July 2013), http://www.deadiversiontest.usdoj.gov/drug_chem_info/buprenorphine.pdf [<https://perma.cc/3W5A-PE8G>].
 48. *Controlled Substance Schedules*, DRUG ENF’T ADMIN.: DIVERSION CONTROL DIV., <https://www.deadiversion.usdoj.gov/schedules/> [<https://perma.cc/Q4PH-HQCS>] (last visited Feb. 12, 2022).
 49. SUBUTEX, *supra* note 42, at 10-11.
 50. *Id.* at 6-8.
 51. *Id.* at 8.
 52. 21 C.F.R. § 201 (2014).

risks during pregnancy and lactation.⁵³ The FDA hoped this would assist providers in making prescribing decisions and more adequately counsel women on the risks of specific medications.⁵⁴

The FDA-approved product information states that methadone should only be used for women in pregnancy when the benefit to the mother *outweighs* the risk to the fetus of untreated drug addiction and a potential relapse to drugs, and warns that there are no controlled studies of methadone use in pregnant women to establish safety.⁵⁵ According to the product information, untreated addiction often results in continued or relapsing illicit opioid use.⁵⁶ Small scale studies comparing infants born to mothers who received methadone found decreased fetal growth with reduced birth weight, length, and head circumference compared to healthy controls.⁵⁷ Animal data referenced in the FDA product information describes an increased risk of neural tube defects, increased neonatal mortality, and differences in neurological development, learning, and behavior.⁵⁸ Maternal use of methadone can cause NAS, which can be fatal if not recognized and treated.⁵⁹ The FDA product information provides a lactation warning that maternal use of methadone will transfer to breastmilk in low levels during lactation, which may cause methadone toxicity in infants; symptoms of methadone toxicity include increased sleepiness, difficulty breastfeeding, breathing difficulties, or limpness.⁶⁰

The FDA-approved product information for buprenorphine states that data on use in pregnancy are limited because clinical trials studying women taking buprenorphine were not designed to assess the risk of major malformations during pregnancy.⁶¹ Although current data does not appear to indicate an increased risk of major malformations, some observational studies have

53. *Id.*

54. *Id.*

55. METHADOSE, *supra* note 29, at 10, 20.

56. *Id.* at 30.

57. *Id.* at 21.

58. *Id.* at 21-22.

59. *Id.* at 10.

60. *Id.* at 16, 23.

61. SUBUTEX, *supra* note 42, at 14.

reported on congenital malformations among buprenorphine exposed pregnancies.⁶² In animal models, reproductive and developmental studies identified adverse events, including an increased risk of fetal demise, dystocia (abnormal fetal growth), and skeletal abnormalities.⁶³ Based on animal data, the buprenorphine labeling instructs providers to advise pregnant women on potential risks to the fetus.⁶⁴ Similar to the FDA product information for methadone, the label for buprenorphine frames the risk assessment as comparing the risk of buprenorphine to the fetus versus the risk of untreated addiction.⁶⁵ Maternal use of buprenorphine can also cause NAS, which can be fatal if not recognized and treated.⁶⁶ Like methadone, maternal use of buprenorphine also transfers low levels of buprenorphine in breastmilk, and lactating mothers should monitor the infant for increased drowsiness and breathing difficulties.⁶⁷

C. Federal Policy Supporting MAT

According to SAMHSA, MAT prevents withdrawal, reduces the patient's cravings for illicit substances, and enables the patient to focus on recovery.⁶⁸ "SAMHSA recommends [that] patients should use medications as long as [they] provide[] [a] benefit."⁶⁹ SAMHSA cautions that "patients who discontinue medication generally return to illicit opioid use" and, because of

62. *Id.* at 14-15.

63. *Id.* at 16.

64. *Id.* at 14.

65. *Id.* at 14-15.

66. *Id.* at 7.

67. *Id.* at 17.

68. See SAMHSA Collaborative Approach, *supra* note 19; see also Kelley Saia et al., *Caring for Pregnant Women With Opioid Use Disorder in the USA: Expanding and Improving Treatment*, 5 CURRENT OBSTETRICS GYNECOLOGY REP. 257, 258 (2016) (stating that MAT provides "an opioid blockade" and prevents euphoria from illicit use, when methadone and buprenorphine are opioid agonists, classified under the Controlled Substances Act and by the FDA as capable of producing euphoria and the DEA states they are abused to produce euphoria.); Drabiak, *supra* note 14, at 37-42 (discussing the regulatory, legal, and pharmacological classifications of methadone and buprenorphine).

69. Drabiak, *supra* note 14, at 44.

that possible lapse, “healthcare policy should prioritize patient access, utilization, and expansion of MAT.”⁷⁰

NIDA, SAMHSA, and the Office of National Drug Control Policy⁷¹ have each issued specific statements asserting that it is a “misconception” that MAT substitutes one substance use disorder for another, lamenting that this perspective has hindered the adoption of evidence-based treatments.⁷² SAMHSA maintains its claim that patients using replacement opioids as part of MAT receive a safe and controlled level of medication.⁷³ NIDA asserts that patients receiving replacement opioid agonists do not experience euphoria because they have developed a tolerance.⁷⁴

In a 2016 report, the Government Accountability Office stated that abstinence-based treatment often fails and is less effective than MAT.⁷⁵ It argued that hesitation or opposition to MAT indicates a “lack of understanding” of addiction and inaccurate beliefs.⁷⁶ According to ACOG, detoxification-based treatment constitutes an inferior option and the current standard of care prescribing MAT for patients with OUD should not be modified based on the patient’s pregnancy status.⁷⁷

D. Standard of Care Warns Against Medically Supervised Withdrawal

Current medical literature explicitly warns against medically supervised detoxification treatment. Both pediatric and addiction medicine articles argue that withdrawal increases the risk of

70. *Id.*

71. MEDICATIONS TO TREAT OPIOID USE DISORDER, *supra* note 24; *Medication Assisted Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH ADMIN. (Jan. 10, 2022), <https://www.samhsa.gov/medication-assisted-treatment> [<https://perma.cc/G5KX-SYCW>] (hereafter SAMHSA Medication Assisted Treatment); ONDCP Memo, *supra* note 26.

72. SAMHSA Medication Assisted Treatment, *supra* note 71.

73. *Id.*

74. MEDICATIONS TO TREAT OPIOID USE DISORDER, *supra* note 24.

75. GOV. ACCOUNTABILITY OFFICE, OPIOID ADDICTION: LAWS, REGULATIONS, AND OTHER FACTORS CAN AFFECT MEDICATION-ASSISTED TREATMENT ACCESS (2016).

76. *Id.*

77. ACOG, *supra* note 12.

relapse and results in the poor engagement in treatment.⁷⁸ Meanwhile, it does not improve newborn health.⁷⁹ Based on high rates of return to substance abuse,⁸⁰ SAMHSA states that health care providers should encourage patients to use a combination of pharmacotherapy and behavioral strategies in treatment and explicitly states providers should discourage opioid withdrawal.⁸¹ In provider education materials, SAMHSA bolds the statement: “Medically supervised withdrawal is NOT recommended.”⁸² SAMHSA also informs providers that abstinence is not the goal of treatment and that discontinuation may not be feasible or safe.⁸³ Instead, SAMHSA aims to educate health care providers on how to use the informed consent process as a means to convey to the patient that pharmacotherapy will help her avoid withdrawal, regain control of her life, and stop substance abuse.⁸⁴

E. Risk of Neonatal Abstinence Syndrome and Risks to Developing Infant

Though federal policy recognizes that MAT provides benefit to pregnant patients, it also acknowledges risk of NAS to the infant. Approximately 55-94% of infants who were prenatally exposed to opioids, whether illicit or prescribed through MAT, will develop withdrawal symptoms from the opioid following birth; this is referred to as Neonatal Abstinence Syndrome, or

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78. Patrick & Schiff, *supra* note 12; BISHOP ET AL., *supra* note 17; Saia et al., *supra* note 68; Stacey Klamman et al., *Treating Women Who Are Pregnant or Parenting for Opioid Use Disorder and the Concurrent Care of their Infants and Children: Literature Review to Support National Guidance*, 11 J. ADDICTION MED. 178, 181-82 (2017); HENDRÉE E. JONES, *TREATING WOMEN FOR OPIOID USE DISORDER DURING PREGNANCY: CLINICAL CHALLENGES* (2019).
79. JONES, *supra* note 78. *See also* Patrick & Schiff, *supra* note 12; BISHOP ET AL., *supra* note 17; Saia et al., *supra* note 69; Klamman et al., *supra* note 78, at 187.
80. Klamman et al., *supra* note 79, at 181; BISHOP ET AL., *supra* note 17.
81. SAMHSA *Treating Pregnant and Parenting Women*, *supra* note 12.
82. *Id.*
83. *Id.*
84. *Id.*

“NAS.”⁸⁵ NAS refers to gastrointestinal, autonomic, and neurological features, presenting as a constellation of symptoms that can include excessive crying, irritability, significant weight loss, seizures, projectile vomiting, and tremors.⁸⁶ Clinical onset of symptoms typically begins in the first few days after birth.⁸⁷ But in some instances, depending on the amount and type of substances used by the pregnant patient, onset could begin post-discharge from the hospital.⁸⁸ Testing the infant can be important to ensure optimal care in cases where there is inadequate information on the amount or severity of prenatal substance exposure.⁸⁹ Infants with NAS are at increased risk for admission to the neonatal intensive care unit and birth complications.⁹⁰ Additionally, they may require pharmacologic treatment and a longer hospital stay.⁹¹

Using medical recommendations, ACOG and ASAM counsel physicians to prescribe medication to the pregnant patient without hesitation about whether the medication will increase the risk or severity of NAS in the future infant.⁹² ACOG informs physicians that NAS is an expected and treatable condition, and the overwhelming scientific consensus shows that NAS does not constitute a long-term condition.⁹³ Although methadone and buprenorphine readily cross the placenta,⁹⁴ SAMHSA asserts that health care providers should reassure pregnant patients that “there is no evidence” that pharmacotherapy for MAT is harmful to the developing infant and there is no research to indicate MAT

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85. Karen McQueen & Jodie Murphy-Oikonen, *Neonatal Abstinence Syndrome*, 375 NEW ENG. J. MED. 2468, 2469 (2016).
86. *Id.* at 2469-70.
87. *Id.*
88. *Id.*
89. Patrick & Schiff, *supra* note 12.
90. McQueen & Murphy-Oikonen, *supra* note 85, at 2470.
91. *Id.*
92. ACOG, *supra* note 12; SAMHSA *Treating Pregnant and Parenting Women*, *supra* note 12.
93. ACOG, *supra* note 12; Saia et al., *supra* note at 68; SAMHSA *Treating Pregnant and Parenting Women*, *supra* note 12.
94. Behnke & Smith, *supra* note 15, at e1012.

increases risk of birth defects.⁹⁵ ACOG warns that any concerns that pharmacotherapy could result in adverse developmental outcomes on the future infant are non-scientific and stigmatizing.⁹⁶

II. CRITICAL ANALYSIS OF THE EVIDENCE SUPPORTING MAT FOR PREGNANT PATIENTS

Despite federal policy and current clinical recommendations against detoxification, research shows that supervised detoxification is not only safe for the fetus, but can promote high rates of successful recovery.⁹⁷ Federal policy and medical literature touting the efficacy of MAT downplay critical metrics, such as high rates of continued opioid abuse, ongoing polysubstance abuse, and dependence or addiction to the prescribed medication.⁹⁸ While MAT may assist some patients with recovery and constitute a helpful tool as part of a greater treatment plan, some patients enrolled in MAT may struggle with impairment and conducting activities of daily life.⁹⁹

A. *Scientific Evidence Does Not Support the Proposition that Medically Supervised Detoxification Poses Risks to the Pregnancy*

Despite ACOG's warning that withdrawal from opioids during pregnancy is extremely dangerous for the fetus, ACOG acknowledges this standard is based on limited information.¹⁰⁰ One report noted a correlation between increased epinephrine and norepinephrine levels in the amniotic fluid as the patient tapered

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95. SAMHSA *Treating Pregnant and Parenting Women*, *supra* note 12.
96. ACOG, *supra* note 12.
97. Steve Caritis & Ashok Panigrahy, *Opioids Affect the Fetal Brain: Reframing the Detoxification Debate*, 221 AM. J. OBSTETRICS & GYNECOLOGY 602, 602-03 (2019).
98. Tracey L. Kelley, *Pitfalls of Medication-Assisted Treatment*, WILLINGWAY (Nov. 20, 2019), <https://willingway.com/pitfalls-medication-assisted-treatment/#:~:text=While%20some%20people%20experience%20effective,or%20die%20on%20MAT%20programs> [<https://perma.cc/K4FL-X8ZQ>].
99. Drabiak, *supra* note 14, at 51-52.
100. ACOG, *supra* note 12.

from medication.¹⁰¹ This finding suggested that withdrawal produced fetal stress.¹⁰² A second article described a pregnant patient with heroin addiction who was enrolled in MAT and receiving methadone, but who continued to abuse heroin.¹⁰³ The night prior to delivery, the pregnant patient injected heroin and, the following day, the infant was stillborn.¹⁰⁴

Several articles in the *American Journal of Obstetrics and Gynecology*, *Obstetrics and Gynecology*, and *The Journal of Substance Abuse Treatment* have questioned whether these two sources of narrowly limited patient reports should constitute sufficient evidence to support a standard of care warning of severe dangers associated with detoxification.¹⁰⁵ Multiple other studies conducted since the case reports in the 1970s, totaling hundreds of patients surveyed, demonstrate the opposite: there is no clear evidence to support that medically assisted detoxification during pregnancy increases adverse outcomes, such as miscarriage, premature labor, or fetal demise.¹⁰⁶

Addiction specialist Jason Luty and colleagues conducted a retrospective analysis of 101 pregnant patients who underwent inpatient methadone detoxification and found no evidence that detoxification was associated with risk of miscarriage in the

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101. Winston Campbell, *Opioid Detoxification During Pregnancy: The Door Continues to Open*, 215 AM. J. OBSTETRICS & GYNECOLOGY 258, 258 (2016).
 102. Jennifer Bell et al., *Detoxification from Opiate Drugs During Pregnancy*, 215 AM. J. OBSTETRICS & GYNECOLOGY 374.e1, 374.e1 (2016); Frederick Zuspan et al., *Fetal Stress from Methadone Withdrawal*, 122(1) AM J. OF OBSTETRICS AND GYNECOLOGY 43 (1975); Jose Luis Rementeria & Nemesio Nuang, *Narcotic Withdrawal in Pregnancy: Stillbirth Incidence with a Case Report*, 116(8) AM J. OF OBSTETRICS AND GYNECOLOGY 1152 (1973).
 103. Campbell, *supra* note 101.
 104. *Id.*
 105. See Bell et al., *supra* note 102; Campbell, *supra* note 101; see also Jodi S. Dashe et al., *Opioid Detoxification in Pregnancy*, 92 OBSTETRICS & GYNECOLOGY 854, 854 (1998).
 106. Bell et al., *supra* note 102; Dashe et al., *supra* note 105; Robert D. Stewart et al., *The Obstetrical and Neonatal Impact of Maternal Opioid Detoxification in Pregnancy*, 209 AM. J. OBSTETRICS AND GYNECOLOGY 267.e1, 267.e3-.e4 (2013); Jason Luty et al., *Is Opiate Detoxification Unsafe in Pregnancy?*, 24 J. SUBSTANCE ABUSE TREATMENT 363, 365 (2003).

second trimester or risk of premature labor in the third trimester.¹⁰⁷ Physician Robert Stewart and colleagues designed a retrospective cohort study of 95 pregnant patients who elected to undergo inpatient detoxification and found no cases of stillbirth or fetal demise among the inpatient population.¹⁰⁸ In one of the largest studies examining pregnancy outcomes related to detoxification, physician Jennifer Bell and colleagues assessed 301 pregnant patients with opiate addiction who elected to participate in four methods of medically-assisted detoxification treatment. Bell and colleagues found no increased risk of premature labor or fetal demise associated with detoxification.¹⁰⁹ Finally, in a systematic review examining fifteen separate studies assessing potential risks of detoxification that included hundreds of patients, physician Mishka Terplan and colleagues concluded that detoxification does *not* appear to contribute to rates of fetal demise.¹¹⁰

This research suggests that not only does detoxification constitute a safe option for both the pregnant patient and fetus, but that successful detoxification *is* possible. Current research shows detoxification without relapse at promising rates of success ranging from 56%-82.6%.¹¹¹ A comparison study conducted by Bell and colleagues demonstrated that short-term inpatient detoxification followed by intense behavioral health support produced the most successful rates of recovery.¹¹² The impact of

107. Luty et al., *supra* note 106.

108. Stewart et al., *supra* note 106, at e3. One case of fetal demise did occur in a pregnant patient who was not undergoing detoxification, refused MAT, and did not return for prenatal care. *Id.*

109. See Bell et al., *supra* note 102, at e3.

110. Mishka Terplan et al., *Opioid Detoxification During Pregnancy: A Systematic Review*, 131 *OBSTETRICS & GYNECOLOGY* 803, 812 (2018).

111. Stewart et al., *supra* note 106, at e4-5 (finding 56% of pregnant patients successfully detoxified without relapse); Dashe et al., *supra* note 105, at 854 (finding 59% of pregnant patients successfully detoxified without relapse); Bell et al., *supra* note 102 (finding Group 2, pregnant patients who underwent inpatient detoxification with intense behavioral therapy only relapsed at a rate of 17.4%, or 82.6% remained successful).

112. Bell et al., *supra* note 102, at e3, tbl.1.

behavioral therapy is significant.¹¹³ Bell and colleagues demonstrated the stark difference in outcomes: whereas only 17.4% of pregnant patients who underwent inpatient detoxification *with* intense behavioral therapy relapsed, 74% of pregnant patients undergoing inpatient detoxification *without* receiving behavioral therapy relapsed.¹¹⁴

In addition to the impact of behavioral therapy, Stewart and colleagues considered what additional factors appeared to contribute to successful detoxification without relapse and found that a longer length of time the pregnant patient spent enrolled in the inpatient facility corresponded to rates of success.¹¹⁵ Notably, Stewart and colleagues did not find a correlation between maternal demographic characteristics, type of drug abuse (intravenous versus ingestion), or years of prior drug abuse and successful detoxification.¹¹⁶ These studies concluded that detoxification with supportive measures requires substantial commitment, but should be offered to all patients who do not want to continue opioid use or want to reduce the risk of opioids affecting the fetus.¹¹⁷

B. Federal Policy Supporting MAT's Efficacy Downplays Significant Metrics

MAT may indeed work for some patients, particularly if the patient tolerates the medication without adverse effects and the provider offers comprehensive behavioral treatment. But promoting MAT as the standard of care for all women with OUD, especially while warning of dangers of detoxification, requires critical analysis. Research analyzing the evidence behind MAT's efficacy among the general population and specific to pregnant patients suggests several issues.¹¹⁸ Sources describing MAT's efficacy rely on partial metrics and omit discussion of problematic

113. See ACOG, *supra* note 12. It should be noted that the current standard of care warning against poor outcomes and high rates of relapse after detoxification generally refers to detoxification without additional treatment. *See id.*

114. Bell et al., *supra* note 102.

115. Stewart et al., *supra* note 106, at e2-e3.

116. *Id.*

117. *Id.* at e5.

118. Drabiak, *supra* note 14, at 45-57.

outcomes, including: high rates of continued opioid and polysubstance abuse, potential for dependence or addiction to the replacement medication, risk of serious physical and neurological outcomes to the pregnant patient, and potential risks to the fetus and infant above the risk of NAS.¹¹⁹

1. Many Patients in MAT Continue Opioid Abuse and Polysubstance Abuse

Statements asserting that MAT constitutes the most effective treatment contain a number of potentially misleading caveats: some studies support this proposition by comparing MAT to detoxification without additional treatment¹²⁰ and do not address the significance of continued substance abuse.¹²¹ One commonly cited study by physician Karen Sees and colleagues did compare MAT against treatment (where the detoxification group was required to attend therapy sessions), and reported that MAT increased retention and reduced opioid use.¹²² Yet this claim requires further scrutiny: despite a slight decrease in opioid use among the MAT group, opioid use in both groups remained “consistently high;” additionally, both groups continued polysubstance abuse of both opioids and cocaine, which Sees and colleagues noted “remains a concern.”¹²³ Though rates of

119. See discussion *supra* Part II (B)(3).

120. Valerie Gruber et al., *A Randomized Trial of 6-Month Methadone Maintenance With Standard or Minimal Counseling Versus 21-Day Methadone Detoxification*, 94 DRUG & ALCOHOL DEPENDENCE 199, 203-04 (2008); Richard Mattick et al., *Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence (Review)*, COCHRANE DATABASE SYSTEMATIC REVIEWS, 2009, at 1, 11.

121. *But see* Karen Sees et al., *Methadone Maintenance vs 180-Day Psychosocially Enriched Detoxification for Treatment of Opioid Dependence: A Randomized Controlled Trial*, 283 JAMA 1303, 1308 (2000). Each group had disparate therapy requirements: the methadone maintenance group required 2 hours of psychosocial therapy per week, while the detoxification group was required to attend 3 hours of psychosocial therapy per week, 14 educational sessions, and 1 hour of cocaine group therapy where appropriate and therapy related to aftercare. *Id.*

122. *Id.*

123. *Id.* at 1303 (reporting the presence of other drugs from monthly urinalysis); *Id.* at 1307-08 (a consistently high use of heroin among

substance abuse vary over time and by study, rates of continued opioid abuse among general population patients enrolled in MAT range from over 50% to 89.5%, even after being enrolled in MAT for several months.¹²⁴ Indeed, addiction scientist Suzanne Nielsen and colleagues concluded that there appears to be no significant difference in days of unsanctioned opioid use among study groups who receive MAT versus those who do not.¹²⁵

Studies examining pregnant and parenting patients who abuse heroin demonstrated similarly high rates of ongoing opioid abuse. 49% -81% of patients did not merely relapse but engaged in an ongoing pattern of injecting heroin several times per week.¹²⁶ Importantly, high rates of continued substance abuse did not appear to be related to maintenance dosing.¹²⁷ This has led some researchers to question whether MAT should still constitute the standard of care for pregnant patients when they continue ongoing substance abuse.¹²⁸

Research cited to support the efficacy of MAT also demonstrates consistently high rates of other types of

both groups); *Id.* at 1309 (noting that the rates of continued heroin use among both groups remain a concern).

124. Gruber et al., *supra* note 120, at 203, tbl. 1 (citing 89.5% abuse of opiates at 8.5 months); Sees et al., *supra* note 121 (citing over 50% continued abuse of opiates at 12 months).
125. Suzanne Nielsen et al., *Opioid Agonist Treatment for Pharmaceutical Opioid Dependent People (Review)*, COCHRANE DATABASE SYSTEMATIC REVIEWS, 2016, at 1, 16.
126. Gary Hulse et al., *The Relationship Between Maternal Use of Heroin and Methadone and Infant Birth Weight*, 92 ADDICTION 1571, 1573 (1997) (finding 49% of patients enrolled in MAT continued to abuse heroin); Carolien Konijnenberg & Annika Melinder, *Prenatal Exposure to Buprenorphine: A Review of Potential Effects on Cognitive Development*, 17 CHILD NEUROPSYCHOLOGY 495, 509 (2011) (citing 81% of parenting women enrolled in MAT for heroin addiction self-reported abusing heroin several times per week or on a more frequent basis since their first child was born); Anne Kolar et al., *Children of Substance Abusers: The Life Experiences of Children of Opiate Addicts in Methadone Maintenance*, 20 AM. J. DRUG ALCOHOL ABUSE 159, 165 (1994).
127. Sees et al., *supra* note 121, at 1307-1308.
128. Hulse et al., *supra* note 126, at 1571.

polysubstance abuse across study groups.¹²⁹ Research shows both the general patient population and pregnant patients enrolled in MAT abuse multiple other licit and illicit substances in addition to opioids, including alcohol, cocaine, and marijuana.¹³⁰ Addiction scientist Hendrée Jones and colleagues found varying rates of polysubstance abuse based on treatment group, finding that up to 57% of pregnant patients receiving methadone maintenance continued to abuse cocaine, and up to 48% continued to abuse marijuana.¹³¹ Additional research specifically studying pregnant and parenting patients demonstrates similarly high rates of polysubstance abuse, ranging from 56% up to 81% of patients who supplemented their opioid replacement with illicit substances.¹³²

Discounting high rates of continuing opioid or polysubstance abuse among persons enrolled in MAT should trigger a re-assessment of blanket declarations of efficacy. Evidence of high rates of polysubstance abuse also allows healthcare providers to foresee that many pregnant and parenting women enrolled in MAT will continue polysubstance abuse.

2. The Problem of Refusing Treatment: Not All Pregnant Patients with SUD Want Treatment

In addition to patients who continue substance abuse while enrolled in MAT, a sizable portion of patients refuse treatment, leave MAT, or disappear and do not return for any medical

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129. See Gruber et al., *supra* note 120, at 202-204; see also Miriam Mintzer & Maxine Stitzer, *Cognitive Impairment in Methadone Maintenance Patients*, 67 DRUG & ALCOHOL DEPENDENCE 41, 43 (2002).
130. Mintzer & Stitzer, *supra* note 129 (citing subjects enrolled in MAT self-reported the following polysubstance abuse: 50% continued to abuse heroin, 44% abused cocaine, and 28% abused cannabis).
131. Hendrée Jones et al., *Methadone Maintenance v. Methadone Taper During Pregnancy: Maternal and Neonatal Outcomes*, 17 AM. J. ON ADDICTIONS 372, 379 (2008).
132. Lauren Jansson et al., *Maternal Buprenorphine Treatment and Infant Outcome*, 180 DRUG & ALCOHOL DEPENDENCE 56, 60 (2017) (citing 56% of pregnant women had positive toxicology tests to indicate polysubstance abuse during enrollment in MAT); Stewart et al., *supra* note 106, at e1, e3 (citing 71% of pregnant patients enrolled in MAT continued to engage in polysubstance abuse); Konijnenberg & Melinder, *supra* note 126 (citing 81% of parenting patients continued abusing heroin).

care.¹³³ In a Cochrane Review, epidemiologist Silvia Minozzi and colleagues conducted a systematic review of studies specifically looking at pregnant patients with SUD enrolled in MAT prescribed methadone or buprenorphine.¹³⁴ Minozzi and colleagues found high rates of attrition across multiple studies: 30-40% of women enrolled in MAT left treatment.¹³⁵

While some patients leave treatment, other women with SUD do not enter treatment at all. Some stakeholders frame the issue as a matter of access, asserting that access to quality treatment would ameliorate the number of pregnant patients with SUD who continue substance abuse or who do not seek treatment.¹³⁶ While this may apply in some instances, one study by social science researchers Afton Jackson and Lisa Shannon found that only 25.9% of women listed availability of treatment as a barrier preventing them from seeking treatment.¹³⁷ Jackson and Shannon also found that about 15% of women with SUD did not want treatment at all.¹³⁸ These findings should raise multiple questions, such as whether women should be provided assistance to stop substance abuse by other supportive resources, or whether treatment includes sufficient resources for pregnant and parenting patients (such as providing childcare, education, parenting classes, job training, and family counseling).¹³⁹

133. Stewart et al., *supra* note 106, at e3; Minozzi et al., *supra* note 20, at 2-7.

134. Minozzi et al., *supra* note 20, at 2-7.

135. *Id.*

136. Afton Jackson & Lisa Shannon, *Barriers to Receiving Substance Abuse Treatment Among Rural Pregnant Women in Kentucky*, 16 MATERNAL CHILD HEALTH J. 1762, 1763 (2012).

137. *Id.* at 1767; *see also* Marilyn Daley et al., *Substance Abuse Treatment for Pregnant Women: A Window of Opportunity?* 23 ADDICTIVE BEHAVIORS 239-49 (1998) (finding that for some pregnant women, an increased access to care does not necessarily translate to better treatment outcomes).

138. Jackson & Shannon, *supra* note 136, at 1767.

139. *Id.*; *see also* Katherine Davis & Kimberly Yonkers, *Making Lemonade Out of Lemons: A Case Report and Literature Review of External Pressure as an Intervention with Pregnant and Parenting Substance Using Women*, 73 J. CLINICAL PSYCHIATRY 51-55 (2012) (describing family centered treatment care, the possibility of residential facilities where pregnant and parenting patients can live with their children, and therapeutic communities).

Women with SUD who engage in ongoing substance abuse, with no desire to stop, should prompt researchers, clinicians, and policymakers to consider whether coercion and incentives that motivate women to stop substance abuse and engage in treatment should be considered. Some research indicates that pregnant patients can and do respond to incentives and pressure, such as warnings or mandates to enter treatment.¹⁴⁰ For women in treatment whose children had been removed by Child Protective Services (CPS), linking successful engagement in treatment and stopping substance abuse with regaining custody of their child served as a powerful motivating factor.¹⁴¹ Finally, women in treatment reporting external pressure not only remained in treatment for a longer duration, but reported fewer days of substance abuse.¹⁴² These women were also twice as likely to have negative toxicology screens.¹⁴³

3. MAT *Does* Serve as Medically Sanctioned Substitute Opioid with Serious Risks for Dependency

Despite rhetoric in federal policy asserting that MAT does not constitute replacement or substitution of one addiction for another,¹⁴⁴ these claims are not supported by pharmacology, legal classification by the DEA, or warnings on FDA-approved package information. As opioid agonists, both methadone and buprenorphine occupy the same receptors as other opioids such as heroin or oxycodone.¹⁴⁵ Though NIDA denies that patients receiving methadone and buprenorphine experience euphoria,

140. Davis & Yonkers, *supra* note 139.

141. *Id.* (finding that mothers who entered treatment were more likely (60.6%) to be reunified with their children than mothers who did not enter treatment (35.5%)).

142. Steven Ondersma et al., *External Pressure, Motivation, and Treatment Outcomes Among Pregnant Substance Abusing Women*, 107 DRUG & ALCOHOL DEPENDENCE 149, 151 (2010).

143. *Id.*

144. *See* discussion *supra* Part B. Federal Policy Supporting MAT.

145. METHADOSE, *supra* note 29; SAMHSA Methadone, *supra* note 30; SUBUTEX *supra* note 42; Buprenorphine, SUBSTANCE ABUSE & MENTAL HEALTH ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphinebuprenorphine> [<https://perma.cc/HWS5-3FYK>] (last visited Feb. 9, 2022) (hereinafter SAMHSA Buprenorphine).

both FDA and DEA product labeling caution that both controlled substances *are* capable of producing significant euphoria even in persons with tolerance.¹⁴⁶ In a graph illustrating sustained activation of opioid receptors (euphoria), NIDA compares the relative euphoria of heroin to methadone, buprenorphine, and naltrexone.¹⁴⁷ The graph shows that buprenorphine, as a partial opioid agonist, produces less euphoria than heroin, but also shows that methadone produces the *same level of euphoria as heroin* and sustains this activation for a longer duration than heroin.¹⁴⁸

Research also indicates that MAT may not reduce cravings. Many persons enrolled in MAT abuse the prescribed agonist itself (e.g. injecting methadone or buprenorphine) in addition to continuing concurrent polysubstance abuse.¹⁴⁹ This suggests a deficiency in the premise of MAT – patients are still experiencing a compulsion and drive to abuse drugs, including the prescribed opioid agonist, for pharmacological effect.

4. Patients Still May Struggle with Impairment and Activities of Daily Life

Pregnant and parenting women enrolled in MAT who continue ongoing substance abuse may also face barriers to psychosocial functioning, employment, and parenting ability. Many studies use retention in treatment as a metric of success, but presuming treatment retention equates to success reveals conflicting and troubling evidence.¹⁵⁰ While addiction scientist Richard Mattick and colleagues assert that MAT constitutes an effective intervention, their comprehensive review found no

146. *Id.*

147. MEDICATIONS TO TREAT OPIOID USE DISORDER, *supra* note 24.

148. *Id.*

149. See Hanna Uosukainen et al., *Twelve-Year Trend in Treatment Seeking for Buprenorphine Abuse in Finland*, 127 DRUG & ALCOHOL DEPENDENCE 207, 211 (2013) (over 80% of subjects enrolled in MAT injected buprenorphine and describes rates of concurrent polysubstance abuse); see also Michelle Lofwall & Sharon Walsh, *A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World*, J. ADDICTION MEDICINE, 2014, at 1, 6 (citing varied research that 18-28% of persons enrolled in methadone or buprenorphine maintenance programs have shared, sold, or given away their prescribed medication).

150. See Mattick et al., *supra* note 120.

statistically significant differences in criminal involvement or mortality.¹⁵¹ Several studies conflict with the Surgeon General's claims that MAT helps persons return to a productive life, finding continued psychosocial dysfunction and rates of marginal employment or unemployment.¹⁵² One key barrier to employment and psychosocial functioning rests upon patients' ability to conduct activities of daily living, such as driving, working, going to school, and engaging in family life, without significant impairment such as experiencing euphoria, craving, intoxication, and symptoms of withdrawal.¹⁵³

Multiple media reports question pregnant and parenting patients' abilities to conduct activities of daily life while enrolled in MAT based on accounts of ongoing polysubstance abuse, intoxication, and impairment.¹⁵⁴ Samantha Jones exemplified the grim impact of continued polysubstance abuse in multiple contexts.¹⁵⁵ Despite Jones' enrollment in MAT, while abusing a variety of prescribed and illicit drugs, she lost consciousness in her vehicle with her other child in the back seat.¹⁵⁶ She abused multiple prescribed and illicit substances throughout her pregnancy with Remington; and transferred a toxic amount of drugs to Remington while breastfeeding—ultimately causing his death.¹⁵⁷

151. *Id.*

152. Sees et al., *supra* note 121, at 1309; Julie Harris & Karen McElrath, *Methadone as Social Control: Institutionalized Stigma and the Prospect of Recovery*, 22 QUALITATIVE HEALTH RSCH. 810, 818 (2012) (discussing barriers to societal reintegration and how many MAT patients are still unemployed or marginally employed).

153. Lisa Torres, *Risk Management: Patient Safety; Public Safety and OTP Liability*, SUBSTANCE ABUSE & MENTAL HEALTH ADMIN. [hereinafter "SAMHSA Risk Management"] (on file with author).

154. Kounang, *supra* note 1; Laviola, *supra* note 2.

155. Kounang, *supra* note 1; Laviola, *supra* note 2.

156. Simon Veazey, *Pennsylvania Mother Whose Drugs-Laced Breast Milk Killed Her Baby Will Not Be Jailed*, Epoch Times (May 9, 2019), https://www.theepochtimes.com/pennsylvania-mother-whose-drugs-laced-breast-milk-killer-her-baby-will-not-be-jailed_2913419.html [https://perma.cc/R62J-7MTU].

157. Kounang, *supra* note 1; Laviola, *supra* note 2.

Other cases with similar facts - mothers who continue to engage in polysubstance abuse, suffer from extremesomnolence,¹⁵⁸ lose consciousness, and accidentally cause their child's death - have also garnered media attention.¹⁵⁹ Amanda McKenzie described her prescription for methadone as "10 times stronger than any pill."¹⁶⁰ Its impact was more powerful than she expected and she fell asleep in the bathtub with her infant son, who died as a result of accidental drowning.¹⁶¹ Intoxication, impairment, accidents, and infant deaths not only raise serious concerns for the pregnant and parenting women's ability to go about daily life and care for their children. These issues implicate criminal liability considerations when these mothers' actions cause their child's death.

III. RE-ASSESSING RISKS AND BENEFITS OF MAT TO THE MATERNAL-INFANT DYAD

This section explores the less discussed, yet centrally important, side effects and risks of MAT, specifically to the maternal-infant dyad for prenatal and parenting patients. First, this section will describe the effects of opioid agonist medications on patients' physical well-being, neurological function, and

158. Lauren Jansson & Martha Velez, *Lactation and the Substance-Exposed Mother-Infant Dyad*, 29 J. PERINATAL & NEONATAL NURSING 277, 278 (2015) (describing the impact of maternal somnolence on the mother's ability to breastfeed and care for her infant).

159. Duff Wilson, *A Hospital Fails to Test for Drugs; A Day Later, A Newborn is Dead*, REUTERS (Dec. 7, 2015), <https://www.reuters.com/article/us-baby-opioids-pederson/hospital-fails-to-test-for-drugs-days-later-a-newborn-is-dead-idUSKBN0TQ2RH20151208> [<https://perma.cc/R7MZ-GER6>]; Duff Wilson & John Shiffman, *Newborns Die After Being Sent Home With Mothers Struggling To Kick Drug Addictions*, REUTERS (Dec. 7, 2015), <https://www.reuters.com/investigates/special-report/baby-opioids/#article-1-unprotected> [<https://perma.cc/L6NN-R2AM>]; Duff Wilson, *As Social Services Stand Back, A Mother and Her Baby Fall 'Through the Canyon Into Hell'*, REUTERS (Dec. 7, 2015), <https://www.reuters.com/investigates/special-report/baby-opioids/#article-2-failures-to-act> [<https://perma.cc/E8TL-Y72X>].

160. Wilson, *As Social Services Stand Back, A Mother and Her Baby Fall 'Through the Canyon into Hell'*, *supra* note 159.

161. *Id.*

psychological function, articulating how these risks take on particular significance in the context of parenting patients with infants and children. Second, this section will explore research describing the variety of developmental, physical, and neurological risks to the infant from prenatal opioid exposure. Next, this section explores the postpartum period when the infant is born, providing specific points for clinicians to consider.

A. *Risks for the Patient: MAT Can Produce Physical, Neurological, and or Psychological Harm that Hinders Recovery*

Research suggests that the extensive side effects and adverse effects of methadone and buprenorphine used in MAT should not be dismissed as infrequent. Prescribed medications used in MAT – even if patients do not engage in polysubstance abuse – may still exert significant influence on patients’ quality of life. In one study, over half of patients enrolled in methadone maintenance programs experienced depression, fatigue, and headaches, which negatively impacted patients’ subjective assessments of quality of life.¹⁶² Even in cases where patients appear to be functioning socially and engaged in activities of daily life, addiction scientist Benedikt Fischer asserts that metrics of success should include the patients’ own subjective assessments of how they feel.¹⁶³ Fischer points to the “critical, yet often ignored” dysphoric impact of methadone, wherein some patients describe the influence of methadone as “discomforting, disabling, numbing and tiring.”¹⁶⁴

In addition to patients’ subjective assessments of how they feel when taking medications in MAT as prescribed, opioid agonists also pose risks to neurological and or psychological functioning. Physician Wei-Che Lin and colleagues demonstrated that patients enrolled in MAT who received an opioid agonist experienced prominent adverse effects on multiple cognitive functions, increased rates of depression and suicide, and a lower

162. Janie Sheridan et al., *Health Problems and Help-Seeking Activities of Methadone Maintenance Clients and Auckland Methadone Services: A Potential for Community Pharmacy Expansion*, 2 HARM REDUCTION J. 1, 4 (2005).

163. Benedikt Fischer et al., *Eyes Wide Shut? A Conceptual and Empirical Critique of Methadone Maintenance Treatment*, 11 EUROPEAN J. ADDICTION RES. 1, 2 (2005).

164. *Id.* at 4.

quality of life.¹⁶⁵ Opioid agonists negatively impact memory processing, impair short term memory, impair visuo-spatial attention, and reduce cognitive speed.¹⁶⁶ Research shows that opioid agonists produce changes in both white matter and gray matter in the brain, resulting in structural and functional abnormalities.¹⁶⁷ Chronic exposure to opioid agonists may lead to apoptosis (death) of neuronal cells and demyelination (impaired connectivity within the brain's synapses), which has been connected to behaviors including impulsivity, lack of self-control, and intolerance for cognitive complexity.¹⁶⁸ Notably, research correlates this neurological damage to duration and dose of MAT, not pre-existing differences or damage from illicit opioid abuse.¹⁶⁹ Wei Li and colleagues summarize these findings as evidence that MAT induces a type of brain disease that may substantially impair enrolled patients.¹⁷⁰ This research suggests that MAT does not promote neurological recovery, but rather extends neurological dysfunction and may hinder behavioral therapy options that rely on new neurological growth, cognitive judgment, and discernment.

165. Wei-Che Lin et al., *White Matter Abnormalities Correlating With Memory and Depression in Heroin Users Under Methadone Maintenance Treatment*, PLOS ONE, Apr. 2012, at e33809, e33809; see also Mintzer & Stitzer, *supra* note 129, at 46-47 (finding patients enrolled in MAT had significantly worse performance than controls on tests for memory and cognitive speed); Shane Darke et al., *Comparative Patterns of Cognitive Performance Amongst Opioid Maintenance Patients, Abstinent Opioid Users and Opioid Nonusers*, 126 DRUG & ALCOHOL DEPENDENCE 309, 312-13 (2012) (finding no substantive differences between patients using methadone or buprenorphine where both groups had similar poor performance and finding that patients enrolled in MAT had worse cognitive performance than both controls and former opioid users who were not abstinent).
166. Darke et al., *supra* note 165.
167. Wei Li et al., *Methadone Induced Damage to White Matter Integrity in Methadone Maintenance Patients: A Longitudinal Self-Control DTI Study*, NATURE SCIENTIFIC REPORTS, 2016, at 1, 5.
168. *Id.* at 2, 5; Darke et al., *supra* note 165, at 309; Mintzer & Stitzer, *supra* note 129, at 46-47; Lin et al., *supra* note 165, at 1, 7.
169. Li et al. *supra* note 167, at 3-4; Darke et al., *supra* note 165, at 312; Lin et al., *supra* note 165, at 1, 7.
170. Li et al., *supra* note 167, at 5.

These neurochemical changes in the maternal brain relating to impulsivity, attention, emotional regulation, and risk taking are particularly salient during the postpartum period.¹⁷¹

Facing physical recovery from childbirth, sleep deprivation, and the stress of parenting a new infant, executive regulation constitutes a core component of maternal behavior.¹⁷² In animal models, opioids markedly impact maternal behavior by disrupting maternal bonding, attention, and responsiveness to cues, both based on maternal drug seeking behaviors and the pharmacological impact of the drug on the mother's ability to care for her young.¹⁷³ Indeed, physicians Jansson and Velez caution that physicians prescribing MAT to parenting mothers must consider the effects of both MAT and the possibility of ongoing substance abuse on the mother's ability to parent.¹⁷⁴

Even when taken as prescribed, opioid agonist medications can result in maternal somnolence, or extreme sedation and tiredness.¹⁷⁵ This is compounded by normal postpartum sleep deprivation.¹⁷⁶ Falling asleep or becoming unconscious has apparent risk when in a vehicle,¹⁷⁷ but somnolence also impacts the mother's ability to breastfeed and whether she can: position the infant safely; respond to infant cues of tiredness, hunger and comfort; make effective judgments; and accurately assess risks.¹⁷⁸

171. See Anna Fodor et al., *Behavioral Effects of Perinatal Opioid Exposure*, 104 LIFE SCIENCES 1, 5 (2014) (discussing opioids effect on animal maternal behavior); Jansson & Velez, *supra* note 158, at 279-79.

172. Jansson & Velez, *supra* note 158, at 278-79.

173. Fodor et al., *supra* note 171.

174. Jansson & Velez, *supra* note 158, at 284.

175. ACOG, *supra* note 12.

176. *Id.*

177. See, e.g., Petr Svab, *Opioid Epidemic: Mother, Father, Found in Car Unconscious, Their Baby in Back Seat*, EPOCH TIMES (Oct. 25, 2017), https://www.theepochtimes.com/opioid-epidemic-mother-father-found-in-car-unconscious-their-baby-in-back-seat_2341941.html [<https://perma.cc/59KX-PRXA>]; Wilson & Shiffman, *Newborns Die After Being Sent Home With Mothers Struggling To Kick Drug Addictions*, *supra* note 159; Veazey, *supra* note 156.

178. See, e.g., Wilson & Shiffman, *Newborns Die After Being Sent Home With Mothers Struggling To Kick Drug Addictions*, *supra* note 159.

Adverse effects listed on FDA package information, neurological research, and patient accounts suggest that even patients who attempt to engage in treatment and take the medication as prescribed may encounter significant barriers potentially hindering their recovery and ability to effectively parent their infant.

B. Risks to the Developing Fetus and Infant

Although federal policy and current guidelines recognize the risks of NAS, this constitutes a profoundly narrow view of the potential risks to the fetus and infant. SAMHSA and ACOG assert that MAT does not increase risk of birth defects, minimally affects neurodevelopment, and the benefits of MAT outweigh the risks of untreated addiction.¹⁷⁹ However, several scholarly articles suggest evidence of the negative effects of MAT on the developing fetus.¹⁸⁰ Though many scientists and scholars concede developmental harms of prenatal drug abuse, multiple stakeholders still deny inherent risk of prenatal substance abuse on the developing infant.¹⁸¹ Such a position stands in stark contrast to current research that shows prenatal substance use – even taking prescribed opioids – poses serious risks to the

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179. U.S. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CLINICAL GUIDANCE FOR TREATING PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS (2018); ACOG, *supra* note 12.
180. *See generally* Fodor et al., *supra* note 171; Adriana Forray & Dawn Foster, *Substance Use in the Perinatal Period*, CURRENT PSYCH. REP., 2015, at 1; Egil Nygaard et al., *Longitudinal Cognitive Development of Children Born to Mothers with Opioid and Polysubstance Abuse*, 78 PEDIATRIC RES. 330 (2015); Elizabeth Byrnes & Fair Vassoler, *Modeling Prenatal Opioid Exposure in Animals: Current Findings and Future Directions*, FRONT NEUROENDOCRINAL, 2018, at 1; Behnke & Smith, *supra* note 15; Kristine Walhovd et al., *Child Neuroanatomical, Neurocognitive, and Visual Acuity Outcomes with Maternal Opioid and Polysubstance Detoxification*, 52 PEDIATRIC NEUROLOGY 326 (2015).
181. *See, e.g.* Lynn Paltrow, *Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs*, 8 DEPAUL J. HEALTH CARE L. 461, 462 (2005); Cortney Lollar, *Criminalizing Pregnancy*, 92 INDIANA L.J. 947, 967 (2017); BISHOP ET AL., *supra* note 17, at 12-13.

developing infant.¹⁸² Substance use can impact growth, neurological development, and cognitive development, as well as increase the risk of infant morbidity and mortality.¹⁸³

1. Dangers of Denying Harm from Maternal Substance Abuse

During the crack cocaine epidemic of the 1990s, legal scholars and health professionals were divided on how best to respond to the problem of prenatal substance abuse.¹⁸⁴ Many legal scholars acknowledged the potential risks of prenatal substance abuse on fetal health and agreed it should be minimized.¹⁸⁵ However, some legal scholars, health professionals, and media reports adopted the narrative that the war on drugs was another extension of the war on women,¹⁸⁶ asserting that reports of infant harm from the crack cocaine epidemic were hyperbolic and misleading.¹⁸⁷ Legal scholar, Cortney Lollar, characterizes the concerns about prenatal substance abuse as the “fetal harm fallacy,” arguing that such fears were unfounded and that any potential effects were relatively small and limited to short term duration.¹⁸⁸ According to some scholars, researchers “debunked” this “myth” in the vast majority of cases, showing that exposure to illicit drugs does not

182. See sources cited *supra* note 180.

183. See sources cited *supra* note 180.

184. See Barry Lester et al., *Substance Use During Pregnancy: Time for Policy to Catch Up with Research*, HARM REDUCTION J., 2004., at 1, 2-3.

185. *Id.* at 11-13.

186. Nina Martin, *This Law is Supposed to Protect Babies, But It's Putting Their Moms Behind Bars*, MOTHER JONES (Sept. 23, 2015), <https://www.motherjones.com/politics/2015/09/alabama-chemical-endangerment-drug-war/> [https://perma.cc/G9AT-7A6X].

187. BISHOP ET AL., *supra* note 17, at 13; Mina Dixon Davis, “Bad Moms” and Powerful Prosecutors: Why a Public Health Approach to Maternal Drug Use is Necessary to Lessen the Hardship Borne by Women in the South, 25 GEO. J. ON POVERTY L. & POL’Y 305, 310-11 (2018); Lollar, *supra* note 181, at 954; Jennifer Egan, *Children of the Opioid Epidemic*, N.Y. TIMES MAG. (May 9, 2018), <https://www.nytimes.com/2018/05/09/magazine/children-of-the-opioid-epidemic.html> [https://perma.cc/6Y2L-7ZNA].

188. Lollar, *supra* note 181, at 953-54.

cause long term harm.¹⁸⁹ Legal activist Lynn Paltrow declared that poverty exerts more of a detrimental impact on fetal health than illicit drugs.¹⁹⁰ Extending this premise further, some stakeholders argued that the focus on maternal substance abuse is not based on scientific evidence, but instead merely a demonization of women of low socioeconomic standing, motivated by racial animus.¹⁹¹ Finally, legal scholars and even the ACOG attempt to undermine causality for infant harm by asserting that other factors, such as prenatal diet, parenting, and licit substances such as prescribed drugs, alcohol, and tobacco exert far greater harm.¹⁹²

2. Scientific Evidence Demonstrates Risk of Significant Harm from Opioid Use During Pregnancy

Asserting that concerns about maternal substance abuse are merely alarmist myths is unsupported by scientific evidence.¹⁹³ Further suggesting they are motivated by race or class bias is not only misleading, but factually incorrect.¹⁹⁴ Current evidence demonstrates maternal opioid use during pregnancy – both illicit

189. *Id.* at 951-54; BISHOP ET AL., *supra* note 17, at 6-7; Davis, *supra* note 187.

190. Paltrow, *supra* note 181; Davis, *supra* note 187.

191. Lollar, *supra* note 181, at 954; BISHOP ET AL., *supra* note 17, at 6-7; Egan, *supra* note 187.

192. Paltrow, *supra* note 181 (stating poverty has more of an impact on the developing infant and infants that are born to low socioeconomic status are exposed to the same neurological risks as infants exposed prenatally to cocaine); Lollar, *supra* note 181, at 952 (stating smoking, alcohol, and prescription drugs are more harmful to the developing infant than prenatal substance abuse); Catherine Monk et al., *Maternal Prenatal Distress and Poor Nutrition – Mutually Influencing Risk Factors Affecting Infant Neurocognitive Development*, 54 J. CHILD PSYCH. & PSYCHIATRY 115, 115 (2013) (stating that the environment, including the maternal diet and psychological state, affect a child's neurodevelopment); Lisa A. Serbin, *The Influence of Parenting on Early Childhood Health and Health Care Utilization*, 39 J. PEDIATRIC PSYCH. 1161, 1169-70 (2014) (finding that greater parental support was linked to better health).

193. *See supra* note 181.

194. *Id.*

abuse and use as prescribed pursuant to MAT – exerts a variety of effects on the fetus.¹⁹⁵

Opioids readily cross the placenta and enter the fetal bloodstream, impacting fetal growth, cell development, and neurological and neurotransmitter development.¹⁹⁶ Maternal opioid use and abuse also impacts blood flow to the fetus and alters the delivery of nutrients during fetal development.¹⁹⁷ Opioids are modulatory, which means that they influence cellular growth, maturation, and neurological development both prenatally as well as throughout the infant’s life.¹⁹⁸ Only a few studies have examined long term outcomes for people prenatally-exposed to opioids, and many long term consequences are unknown.¹⁹⁹ Some researchers suggest that opioids may exert an epigenetic influence (turning on or off certain genes that increase risk of disease) during fetal development, which would influence the physiology and behavior of future descendants.²⁰⁰

a. *Physical Risks to Infants Arising from Prenatal Opioid Exposure*

Despite federal policy stating without treatment, pregnant women with OUD face increased risks of preterm delivery or low

195. *Id.*

196. Federica Gilardi et al., *Will Widespread Synthetic Opioid Consumption Induce Epigenetic Consequences in Future Generations*, FRONTIERS IN PHARMACOLOGY, 2018, at 1, 4 (stating opioids readily cross the placenta); Emily Ross et al., *Developmental Consequences of Fetal Exposure to Drugs: What We Know and What We Must Still Learn*, 40 NEUROPSYCHOPHARMACOLOGY 61, 61-62 (2015) (stating how opioids readily cross the placenta and affect fetal brain development); Behnke & Smith, *supra* note 15, at e1012 (describing how opioid cross the placenta and exert influence on fetal growth and development).

197. Ross et al., *supra* note 196, at 62; Behnke & Smith, *supra* note 15, at e1012.

198. Kurt Hauser & Pamela Knapp, *Opiate Drugs with Abuse Liability Hijack the Endogenous Opioid System to Disrupt Neuronal and Glial Maturation in the Central Nervous System*, FRONTIERS PEDIATRICS, 2018, at 1, 2.

199. Gilardi et al., *supra* note 196, at 4.

200. *Id.* at 2.

infant birth weight,²⁰¹ but this comparison measures infants exposed to MAT versus infants born to mothers with untreated addiction, not healthy controls or infants born to mothers who underwent detoxification.

Although some assert infants exposed to MAT follow normal developmental trajectories,²⁰² robust research demonstrates that prenatal opioid exposure results in a lower infant birth weight,²⁰³ decreased head circumferences,²⁰⁴ decreased body length,²⁰⁵ and decreased brain volume.²⁰⁶ Research suggests these differences in growth persist throughout childhood, affecting the child's growth and size.²⁰⁷

Even controlling for polysubstance abuse, one study by Jansson and colleagues examined the impact of prenatal buprenorphine exposure.²⁰⁸ It found that higher maternal doses of

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201. Hulse et al., *supra* note 126, at 1577; *Federal Guidelines for Opioid Treatment Programs*, *infra* note 264.
202. Karol Kaltenbach et al., *Prenatal Exposure to Methadone or Buprenorphine: Early Childhood Developmental Outcomes*, 185 *DRUG & ALCOHOL DEPENDENCE* 40, 47 (2018). Kaltenbach and colleagues assert infants exposed to opioids in MAT follow a path of normal development with the average range and normal limits. The authors cite that mothers report increasing behavioral difficulties with their children and developmental problems but the authors attribute these reports to deficiencies in parent-child relationship rather than the impact of prenatal opioid exposure. *Id.* The study authors received funding from Reckitt Benckiser (now Invidior) manufacturer of buprenorphine formulations used in MAT. *Id.* at 48.
203. Nygaard et al., *supra* note 180, at 330; Forray & Foster, *supra* note 180; Ross et al., *supra* note 196, at 66; Konijnenberg & Melinder, *supra* note 126, at 497; Mette Norgaard et al., *Birth and Neonatal Outcomes Following Opioid Use in Pregnancy: A Danish Population-Based Study*, 9 *SUBSTANCE ABUSE: RSCH. & TREATMENT* 5, 5 (2015); Megan Thomas et al., *Medication Assisted Treatment in Pregnancy and Neonatal Anthropometrics*, 131 *OBSTETRICS & GYNECOLOGY* 136S, 136S (2018).
204. Konijnenberg & Melinder, *supra* note 126, at 497; Ross et al., *supra* note 196, at 66; Thomas et al., *supra* note 203.
205. Konijnenberg & Melinder, *supra* note 126, at 497.
206. *Id.* at 498.
207. *Id.* at 497.
208. Jansson et al., *supra* note 132, at 56.

buprenorphine corresponded with lower infant birth weights.²⁰⁹ In another study, neuropsychologist Kristine Walhovd and colleagues examined whether decreased brain volume in infants resulting from prenatal exposure to opioids and polysubstance abuse would decrease over time if children were raised by supportive adoptive parents.²¹⁰ Walhovd and colleagues still found persistent lower brain volumes of children living in supportive homes who were prenatally exposed to opioids.²¹¹

Prenatal opioid exposure affects a variety of physical attributes, such as increasing the risk of cardiac malformation,²¹² infant respiratory insufficiency,²¹³ decreased visual acuity,²¹⁴ strabismus (crossed eyes),²¹⁵ and risk of preterm birth two- to three-fold.²¹⁶ Fodor and colleagues assert that MAT is not without substantial risks, as it also increases the risk of Sudden Infant Death Syndrome, risk of stillbirth, and rate of infant mortality.²¹⁷

b. Neurological Risks to Infants Associated with Prenatal Opioid Exposure

In addition to physical growth differences, increased risk of morbidities, and increased risk of infant mortality, prenatal opioid

209. *Id.*

210. Kristine B. Walhovd et al., *Volumetric Cerebral Characteristics of Children Exposed to Opiates and Other Substances in Utero*, 36 NEUROIMAGE 1331, 1332 (2007).

211. *Id.* at 1342-43.

212. Norgaard et al., *supra* note 203, at 9; Gilardi et al., *supra* note 196, at 5.

213. Austin D. Hocker et al., *Maternal Methadone Destabilizes Neonatal Breathing and Desensitizes Neonates to Opioid-Induced Respiratory Frequency Depression*, 12 FRONTIERS IN PHYSIOLOGY 1, 1 (2021).

214. Walhovd et al., *supra* note 180, at 326.

215. Sylvia H. Yoo, Lauren M. Jansson, & Hee-Jung Park, *Sensorimotor Outcomes in Children with Prenatal Exposure to Methadone*, 21 J. AM. ASS'N PEDIATRIC OPHTHALMOLOGY & STRABISMUS 316, 316 (2017).

216. Norgaard et al., *supra* note 203, at 10; Ross et al., *supra* note 196, at 64.

217. Fodor et al., *supra* note 171, at 2; Forray & Foster, *supra* note 180, at 8.

exposure hinders normal neurological development and maturation.²¹⁸ Addiction psychologists Carolien Konijnenberg and Annika Melinder note that prenatal opioid exposure occurs during rapid growth, a critical window of neurological development in which the developing fetus is particularly vulnerable.²¹⁹ Research shows that prenatal opioid exposure detrimentally affects learning,²²⁰ cognition,²²¹ memory,²²² and executive function (goal-directed behaviors, planning, decision-making) in both young children and schoolaged children.²²³ In addition, prenatal exogenous opioid exposure alters endocrine function, modifying the infant's hormonal development in sexually dimorphic brain regions, and in adults, impacts social and reproductive behavior.²²⁴

While some scientists and stakeholders theorize that the observed differences in neurological development and cognition are only attributable to social and environmental factors rather than prenatal opioid exposure,²²⁵ research does not support this stance. Even when prenatally-opioid-exposed children are adopted into what researchers characterize as supportive homes—they still demonstrate lower brain maturation and cognitive function compared to healthy controls.²²⁶ Importantly, prenatal

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218. Eivind Sirnes et al., *Brain Morphology in School-Aged Children with Prenatal Opioid Exposure: A Structural MRI Study*, 106-107 *EARLY HUM. Dev.*, 33, 33 (2017).
219. Konijnenberg & Melinder, *supra* note 126, at 500.
220. Sirnes et al., *supra* note 218 (describing impaired learning ability); Byrnes & Vassoler, *supra* note 180, at 7 (describing impaired spatial learning ability).
221. *See* Walhovd et al., *supra* note 180, at 330 (describing lower cognitive scores); Nygaard et al., *supra* note 180, at 333 (measuring lower cognitive scores); Sirnes et al., *supra* note, 218, at 33 (measuring lower cognitive scores).
222. Behnke & Smith, *supra* note 15, at e1015 (impaired short term memory); Fodor et al., *supra* note 171, at 3 (in animal models, prenatally opioid exposed animals experiences demonstrated impairment in short term memory).
223. Byrnes & Vassoler, *supra* note 180, at 7; Nygaard et al., *supra* note 180, at 331.
224. Ross et al., *supra* note 196, at 65.
225. Sirnes et al., *supra* note 218, at 33.
226. Walhovd et al., *supra* note 180, at 326.

opioid exposure exerts a lasting impact on children's cognitive abilities: differences in cognition persist over time, and one study by psychologist Egil Nygaard and colleagues demonstrated that decreases in cognition actually increased over time.²²⁷

Research suggests that prenatal opioid exposure not only decreases neuroanatomical volume and cognitive function, but may alter the neurochemical and morphological maturation of the brain.²²⁸ Prenatal exposure to opioids leads to both reduced brain volume and structural deficits in certain areas of the brain, such as the basal ganglia (responsible for learning, cognition, and emotional processing).²²⁹ These differences persist even when controlling for lower birth weight, which researchers theorize results from opioids' influence on apoptosis (cell death) in the brain.²³⁰ Multiple studies also demonstrate prenatal opioid exposure influences neurotransmitter development, myelination (neurotransmitters' ease and ability to communicate),²³¹ and synaptic organization (optimal neurotransmitter communication).²³²

c. Implications of Risks to Infants Associated with Prenatal Opioid Exposure

Some research suggests these perturbations in neurotransmitter development may increase risk of depression, or alternatively, increase risk of inattention, hyperactivity, impulsivity, and aggression.²³³ Exposure to exogenous opioids combined with variations in neurotransmitter development and organization may also impact the brain's ability to produce endogenous opioids, which may correlate to drug-seeking behavior

227. Nygaard et al., *supra* note 180, at 330.

228. Hauser & Knapp, *supra* note 198, at 8; Sirnes et al., *supra* note 218, at 34.

229. Hauser & Knapp, *supra* note 198, at 8; Sirnes, *supra* note 218, at 35.

230. Walhovd et al., *supra* note 180, at 330; Ross et al., *supra* note 196, at 65.

231. Fodor et al., *supra* note 171, at 3; Byrnes & Vassoler, *supra* note 180, at 4; Konijnenberg & Melinder, *supra* note 126, at 503.

232. Konijnenberg & Melinder, *supra* note 126, at 505.

233. Fodor et al., *supra* note 171, at 3; Behnke & Smith, *supra* note 15, at e1015.

later in life.²³⁴ Importantly, variations in endogenous opioids combined with impulsivity and impairment of executive function such as self-control and goal-directed behaviors lead researchers to hypothesize that prenatally-exposed infants may be at an increased risk for addiction during adolescence and adulthood.²³⁵

Walhovd and colleagues demonstrated the impact of residential detoxification and reduced prenatal exposure.²³⁶ Walhovd's team studied women who underwent opioid agonist taper and supportive care in a residential facility, finding that infants born to mothers who detoxified did not show significant differences in general cognitive function and neuroanatomical volume as compared to the control group.²³⁷ Moreover, none of the infants born to the mothers who underwent detoxification experienced NAS.²³⁸ Walhovd's team concluded that "detoxification in a residential setting is a promising way of facilitating positive neurodevelopmental outcome of these children."²³⁹ This particular study, combined with the research demonstrating successful detoxification with intensive behavioral therapy, raises substantial policy questions because it demonstrates a viable treatment alternative that poses less risk to both the mother and infant.²⁴⁰

234. Fodor et al., *supra* note 171, at 3; *but see* Behnke & Smith, *supra* note 15, at e1016.

235. Gilardi et al., *supra* note 196, at 4; Fodor et al. *supra* note 171, at 3; Nygaard et al., *supra* note 180, at 333; Byrnes & Vassoler, *supra* note 180, at 4-5.

236. Walhovd et al., *supra* note 180, at 330.

237. *Id.* at 329.

238. *Id.* at 330.

239. *Id.*

240. *See id.* at 327 (referencing a study that study occurred in Norway, a country that permits detention of pregnant substance abusing women in residential treatment as a means to protect the fetus. To compare in the U.S., only a small minority of states permit civil commitment for treatment specifically for persons who are engaging in substance abuse while pregnant.).

C. *Addressing Gaps in Breastfeeding Guidance*

1. Federal Policy and Clinical Care Recommendations for Breastfeeding While Enrolled in MAT

According to the World Health Organization (WHO) and SAMHSA, during the postpartum period women who are stable and enrolled in MAT should be encouraged to breastfeed their infant.²⁴¹ Globally recognized as the ideal method of infant feeding,²⁴² breastfeeding provides multiple benefits to the infant. These include optimal nutrition, increased skin to skin contact, promoting stress reduction in the dyad, and enhanced mother-infant bonding.²⁴³ Some research also suggests that breastfeeding improves symptoms of NAS, such as a reducing the infant's need for pharmacological intervention and decreasing the infant's length of hospital stay.²⁴⁴

Exposure to opioid agonists during breastfeeding is not without risks: the AAP found that infants exposed to methadone or buprenorphine prenatally and through breastmilk exhibited poor weight gain, lethargy, and respiratory difficulty as compared to healthy controls.²⁴⁵ Infants exposed to methadone prenatally and through breastmilk also exhibit more neurocognitive and motor delays as compared to healthy controls.²⁴⁶ To be sure, these

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241. *Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy*, WHO (Nov. 19, 2014) [hereinafter WHO], <https://www.who.int/publications/i/item/9789241548731> [<https://perma.cc/B7C3-9DC2>]; SAMHSA *Treating Pregnant and Parenting Women*, *supra* note 12.
242. American Academy of Pediatrics, *Policy Statement: Breastfeeding and the Use of Human Milk*, 129 PEDIATRICS e827, e837 (2012) [hereinafter AAP Statement on Breastfeeding]; Jill Demirci et al., *Breastfeeding and Methadone Therapy: The Maternal Experience*, SUBSTANCE ABUSE, 2015, at 1, 8.
243. Demirci et al., *supra* note 242.
244. Elisha Wachman et al., *Revision of Breastfeeding Guidelines in the Setting of Maternal Opioid Use Disorder: One Institution's Experience*, 32 J. HUM. LACTATION 382, 382 (2015).
245. Hari C. Sachs et al., *Clinical Report: The Transfer of Drugs and Therapeutics into Human Breastmilk: An Update on Selected Topics*, 132 AM. ACAD. OF PEDIATRICS e796, e800 (2013).
246. Sarah Stretman et al., *ABM Clinical Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder*, 10 BREASTFEEDING MED. 135, 136 (2015).

findings are constrained by the limitation of discerning the attribution of prenatal versus postpartum impact of methadone exposure.²⁴⁷ Infants exposed to opioids – whether prescribed or illicit – demonstrate physical side effects such as hypertonicity (rigid muscles), excessive movement of their extremities, irritability, and a disorganized sucking reflex, each of which can also render breastfeeding difficult.²⁴⁸ The AAP cautions that there is less information available about buprenorphine during breastfeeding, stating that animal lactation studies demonstrate both decreased maternal milk production and decreased viability of offspring.²⁴⁹ The long-term effects of exposure to opioid agonists during lactation are unknown.²⁵⁰

Despite potential risks, both federal policy and clinical care recommendations assure physicians and new mothers that only a minimal amount of opioids are transferred into breastmilk, and that maternal use of opioid agonists alone should not alter the recommendation to breastfeed.²⁵¹ Nursing professor Jill Demirci and colleagues lament that stigma, fears, misconception, along with physician suspicion of the patient’s polysubstance abuse may lead the physician to discourage breastfeeding.²⁵²

SAMHSA provides general recommendations, stating that breastfeeding is “generally safe” for patients enrolled in MAT but that a return to substance abuse should trigger several steps.²⁵³ First, the provider should assess whether the dose of maintenance medication is sufficient based on patient report and may need to increase behavioral counseling.²⁵⁴ If a return to substance abuse stands as an isolated incident, the provider should not necessarily counsel the patient to terminate breastfeeding.²⁵⁵ Next, SAMHSA advises that if substance abuse while enrolled in MAT and

247. *Id.*

248. Jansson & Velez, *supra* note 158, at 280.

249. Sachs et al., *supra* note 245.

250. *Id.*

251. SAMHSA Tip 43, *supra* note 21; Demirci et al., *supra* note 242, at 7; Stretman et al., *supra* note 246.

252. Demirci et al., *supra* note 242, at 7.

253. SAMHSA Treating Pregnant and Parenting Women, *supra* note 12.

254. *Id.*

255. *Id.*

breastfeeding becomes a “common occurrence,” the patient “should be counseled on her lactation options” and the provider may consider whether the patient should continue breastfeeding based on individualized knowledge of the patient.²⁵⁶

The AAP and ACOG suggest that breastfeeding may continue during substance abuse, provided that certain benchmarks are met. Both institutions state that maternal substance abuse is not a categorical contraindication to breastfeeding, and recommend that mothers can be encouraged to breastfeed if they are HIV negative, negative for illicit drugs, and enrolled in a supervised methadone maintenance program.²⁵⁷ The AAP does caution, however, that use of street drugs does pose risks to an infant’s long term neurobehavioral development and is contraindicated.²⁵⁸ ACOG also advises that physicians should have accurate information about the transfer of illicit substances through breastmilk to adequately counsel nursing mothers with SUD on the risks and benefits of breastfeeding.²⁵⁹

The Academy of Breastfeeding Medicine (ABM) provides greater detail within its recommendations. Women with SUD who are enrolled in MAT and who wish to breastfeed, according to ABM, should be compliant with substance abuse treatment, demonstrate abstinence from drug abuse for 90 days prior to delivery, and should have a negative toxicology screen at delivery.²⁶⁰ If the patient is not engaged in treatment or has no plans to obtain treatment, has positive toxicology screens at birth, or relapses to illegal substance abuse, ABM states that patients should be counseled not to breastfeed.²⁶¹ This is specifically because there is an absence of pharmacokinetic data to establish the presence or concentration of the illicit substance or its metabolites in human milk and its effect on the infant.²⁶² Finally, ABM warns: “[W]omen using illicit substances in the postnatal period may exhibit impaired judgment and secondary behavioral changes that may interfere with the ability of the

256. *Id.*

257. AAP Statement on Breastfeeding, *supra* note 242, at e833.

258. *Id.*; ACOG, *supra* note 12.

259. *Id.*

260. Stretman et al., *supra* note 246, at 138.

261. *Id.* at 139.

262. *Id.*

mother to care for her infant or to breastfeed adequately.”²⁶³ Such a detailed recommendation, recognition that continued breastfeeding may not be a safe option for the infant, and acknowledgement that substance abuse impacts maternal behavior should be recognized as the standard of care in both clinical interactions and public health discussions.

2. Clinical Considerations for Providers Counseling Women with SUD on Breastfeeding

Integrating statistics relating to patients who either relapse or continue substance abuse raises the question of how physicians should counsel breastfeeding women who may be enrolled in MAT. Federal policy, set forth by SAMHSA, provides that generalized recommendations may be insufficient to communicate to physicians the significant impact of ongoing substance abuse: the high rates at which pregnant patients enrolled in MAT continue abusing illicit opioids (49-81%), abuse the prescribed opioid, and/or engage in ongoing polysubstance abuse with other substances such as cocaine or marijuana (48-81%).²⁶⁴ These statistics must be interpreted in conjunction with the severity of consequences that may follow infant ingestion of breastmilk containing multiple intoxicating substances. All providers on the care team, including physicians, nurses, and lactation consultants should communicate not only the benefits of breastfeeding, but also the challenges and serious risks of breastfeeding while abusing prescribed medications or illicit drugs.

Despite Demirci and colleagues’ perception that unwarranted stigma and misconceptions underlie providers’ subtle discouragement against breastfeeding,²⁶⁵ these statistics provide a more nuanced view.

First, despite the lack of well-controlled data on side effects to the infant from breastmilk exposure to illicit substances, observational data *does* exist and shows adverse effects from

263. *Id.*

264. SAMHSA Treating Pregnant and Parenting Women, *supra* note 12; *see also Federal Guidelines for Opioid Treatment Programs*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Jan. 2015), <https://store.samhsa.gov/sites/default/files/d7/priv/pep15-fedguideotp.pdf> [<https://perma.cc/VN4P-E3DM>].

265. Demirci et al., *supra* note 242.

certain drug categories.²⁶⁶ These categories range from infant agitation, lethargy, apnea, central nervous system depression, infant intoxication, and infant death.²⁶⁷ Based on the above statistics, adverse effects to the infant are not merely a remote possibility, but probable. Accordingly, ABM's statement cautioning that patients who relapse should be counseled not to breastfeed must be explicitly made clear by physicians to other providers in the care team and to the patient.

Second, physicians Jansson and Velez assert that maternal self-reporting of substance abuse is "markedly inaccurate" due to underreporting.²⁶⁸ The high rates of maternal substance abuse combined with underreporting suggest a high probability that nursing mothers enrolled in MAT continue to engage in substance abuse. Alternatively, nursing mothers struggling with SUD with no intention of stopping may act strategically to avoid detection by their providers.²⁶⁹

To illustrate: in 2014, Stephanie Greene, a nursing mother of four, was numerous prescribed opioids, including morphine and opioid patches.²⁷⁰ Greene was prescribed opioids for her fibromyalgia and pain following a motor vehicle accident. Allegedly struggling with addiction, she lost her nursing license for trying to illegally obtain drugs and refusing drug testing.²⁷¹

266. Jansson & Velez, *supra* note 158, at 278.

267. *Id.*

268. *Id.* at 280.

269. *South Carolina Mom Gets 20 Years in Breastfeeding Overdose*, FOX NEWS (Apr. 5, 2014), <https://www.foxnews.com/us/south-carolina-mom-gets-20-years-in-breast-feeding-overdose> [<https://perma.cc/2RB6-XY75>] (stating that Stephanie Greene, a former nurse with four children, lost her nursing license for trying to illegally obtain drugs and refusing drug testing. Greene acted strategically throughout her pregnancy; concealing her pregnancy from her primary care provider so that she could continue obtaining prescribed opioids—morphine and opioid patches—while concealing information about her drug use to her obstetrician).

270. *Id.*; *Mother Gets 20 Years for Infant's Death Due to Negligent Breastfeeding*, REUTERS (Apr. 10, 2014), <https://www.rt.com/usa/mother-20-prison-negligent-breastfeeding-524/> [<https://perma.cc/J3B6-6KP3>].

271. *Mother Gets 20 Years for Infant's Death Due to Negligent Breastfeeding*, *supra* note 270; *South Carolina Mom Gets 20 Years in Breastfeeding Overdose*, *supra* note 269.

Greene intentionally hid her pregnancy from her primary care provider so she could continue obtaining prescribed opioids (morphine and opioid patches) while concealing information about her drug abuse to her obstetrician.²⁷² Greene's daughter, Alexis, died from acute morphine intoxication transferred by Greene's breastmilk.²⁷³ According to the coroner's report, there was almost 50 times greater morphine in Alexis's system than would be expected from prescribed pain medication, along with three additional drugs.²⁷⁴ Greene's circumstances demonstrate that patients taking a prescribed medication may struggle with addiction to that medication, take measures to avoid discovery of the addiction, and may abuse the medication. Moreover, abusing the medication can result in the transfer of lethal amounts of that medication in breastmilk.²⁷⁵

Similarly, Amoret Powell, a mother to three children, employed a similar strategy in efforts to continue abusing drugs while breastfeeding.²⁷⁶ Struggling with SUD, Powell had been prescribed methadone but had relapsed back to injecting heroin following the birth of her third child, Eve.²⁷⁷ Powell told investigators that she would wait two hours after injecting heroin to pump breastmilk, then breastfeed Eve.²⁷⁸ Eve also died from acute drug toxicity transferred by breastmilk from her mother.²⁷⁹

Despite impairment from the influence of substances, Greene's and Powell's cases illustrate that pregnant and

272. *Id.*

273. *Woman Given 20 Years for Killing Daughter With Morphine in Breastmilk*, GUARDIAN (Apr. 4, 2014), <https://www.theguardian.com/world/2014/apr/04/woman-20-years-killing-daughter-morphine-breast-milk> [<https://perma.cc/4FWH-ERFB>].

274. *Mother Gets 20 Years for Infant's Death Due to Negligent Breastfeeding*, *supra* note 270.

275. *Id.* Kounang, *supra* note 1 (noting that there is no clear proof that the small amount of drugs that exist in breast milk are actually enough to kill a baby).

276. Associated Press, *Drug-Tainted Breast Milk Leads to Charge of Murder*, N.Y. TIMES (Aug. 3, 1997), <https://www.nytimes.com/1997/08/03/us/drug-tainted-breast-milk-leads-to-charge-of-murder.html> [<https://perma.cc/W2DA-B5QP>].

277. *Id.*

278. *Id.*

279. *Id.*

parenting women with SUD still exhibit planning and reason, seemingly focused on how to conceal their drug abuse from providers.²⁸⁰ Patients taking prescribed opioids while breastfeeding may act intentionally to conceal their addiction, with no intention of stopping substance abuse. Further, they may continue substance abuse despite receiving MAT. At a minimum, this triggers a duty for providers to counsel their patients about the serious risks of breastfeeding following relapse or during ongoing substance abuse and explicitly warn the patient of risks not only to herself, but also the risk of infant intoxication and death that triggers criminal liability.²⁸¹

Third, Demirci and colleagues' semi-structured interviews and focus groups with women enrolled in MAT revealed that multiple women expressed apprehension related to nursing, while in MAT, including concerns about the transfer of prescribed medication and that the infant could become "high" or overdose.²⁸² This suggests that nursing mothers acknowledge that substances they consume are transferred through their breastmilk to their infant. Physicians should respond to these reasonable anxieties by explaining the risk-benefit calculation behind MAT while nursing – acknowledging that, while opioid agonists used in MAT may present risk to the infant, this is weighed against the benefit of the mother's recovery.²⁸³ Notably, this calculation presumes that pregnant, parenting, and nursing mothers enrolled in MAT are actively engaged in recovery and have discontinued

280. Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUST. 1, 6-7 (2015).

281. See, e.g., *Pregnancy and Substance Abuse: A Harm Reduction Toolkit*, NAT'L HARM REDUCTION COALITION (Sept. 2020), <https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/> [<https://perma.cc/VJ9X-XWZN>].

282. Demirci et al., *supra* note 242, at 3-4; see also Doyle Murphy, *California Baby Dies After Drinking Mother's Drug-Laced Milk*, N.Y. DAILY NEWS (Sept. 13, 2013), <https://www.nydailynews.com/news/national/cops-baby-killed-mom-drug-laced-milk-article-1.1443412> [<https://perma.cc/4WCF-KUR4>] (describing the case of Sarah Stevens, who abused Xanax, illicit (prescribed) methadone, and Opana while breastfeeding, which transferred a fatal cocktail of drug into the system of her son, Ryder Salmen, resulting in his death).

283. See discussion *supra* notes 50-63 and accompanying text.

substance abuse. It must change when women continue substance abuse in addition to receiving opioid agonists through MAT. In that circumstance, the physician should not only counsel the patient to stop breastfeeding, but must re-evaluate the patient's treatment for SUD and consider whether it is a sufficient intervention.

D. Best Practices for Informed Consent

1. Ethical and Legal Considerations for Informed Consent to SUD Treatment

After evaluating current research, it is apparent that the standard of care for the informed consent process must be modified. Both the legal doctrine of informed consent and ethicist Tom Beauchamp's framework of medical ethics principles illustrate that informed consent constitutes more than acquiescence – cursory agreement to a physician's recommendation for a particular course of treatment – and instead requires disclosure, comprehension, voluntariness, competence, and consent.²⁸⁴ Providing accurate and balanced information relating to risks, benefits, and alternatives promotes the values of patient autonomy, dignity, and trust in the medical profession. Acting as fiduciaries, physicians should interpret the complexities of research-supported benefits and risks of different treatment options. Within this specific context, informed consent promotes optimal maternal decision-making by allowing the mother to assess risks and benefits for herself and her infant.²⁸⁵

If physicians omit relevant information or do not provide sufficient information to satisfy the element of disclosure, this not only exposes the patient to risks of treatment for which she did not actually consent, but also raises issues of potential liability for the physician.²⁸⁶ Some courts, recognizing a physician's duty to guard the patient's interest, have held that physicians treating persons with addiction are held to a heightened standard because patients struggling with addiction may have diminished decision-

284. Tom L. Beauchamp, *Informed Consent: Its History, Meaning, and Present Challenges*, 20 CAMBRIDGE Q. HEALTHCARE ETHICS 515, 518-19 (2011).

285. WHO, *supra* note 241, at 7.

286. *See e.g.*, Jennifer Grauberger et al., *Allegations of Failure to Obtain Informed Consent in Spinal Surgery Medical Malpractice Claims*, JAMA SURGERY, 2017, at 1, 5-6.

making capacity when they act contrary to their own interests to obtain and ingest more drugs.²⁸⁷ The duty of informed consent, as both a legal and ethical matter, then becomes a consideration of how to provide treatment that enables the patient to recover and restores her to a state of autonomy.²⁸⁸

Patient autonomy and choice are imperative to recovery, and patients should be provided with factually-correct information.²⁸⁹ SAMHSA recommends that patient education and treatment decisions should reflect shared decision-making, a respect for the patient's goals and preferences, and should address balancing the treatment needs of the pregnant or parenting patient with the impact of treatment to the fetus or infant.²⁹⁰

2. Specific Recommendations for Providers Discussing Treatment Options with Pregnant and Parenting Women with SUD

As a preliminary matter, conversations relating to treatment options should acknowledge that most research conducted on prenatal and parenting opioid addiction pertains to women abusing heroin, which is a clinically distinct patient population.²⁹¹

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287. *See Procaccini v. Lawrence and Memorial Hospital Inc.*, 175 Conn. App. 682 (Conn. App. Ct. 2017) (involving a deceased patient who previously received treatment from an Opioid Treatment Provider wherein she received methadone. The Opioid Treatment Provider discharged the patient, and one week after the patient's last dose of prescribed methadone, the patient obtained illicit methadone and overdosed, dying of respiratory distress—despite administration of naloxone and admission for emergency care); *see also Piscitelli v. Hospital Authority of Valdosta*, 691 S.E.2d 616 (11th Cir. 2010) (involving a deceased patient who was enrolled in a drug and alcohol abuse treatment facility and died during the induction period four days into the treatment—a medical examiner testified that methadone toxicity was the cause of death in the patient).
288. *See JONATHAN PUGH, AUTONOMY, RATIONALITY, AND CONTEMPORARY BIOETHICS* 155-57 (2020).
289. Lauren M. Wancata & Daniel B. Hinshaw, *Rethinking Autonomy: Decision Making Between Patient and Surgeon in Advanced Illnesses*, 4 *ANNALS TRANSLATIONAL MED.* 77, 77 (2016).
290. SAMHSA *Treating Pregnant and Parenting Women*, *supra* note 12; SAMHSA *Collaborative Approach*, *supra* note 19.
291. ACOG, *supra* note 12; *see also Andrew Kolodny et al., The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addition*, 36 *ANN. REV. PUB. HEALTH* 559, 560

As addiction physician Andrew Kolodny points out—not all pregnant or parenting women with opioid dependence have an addiction, but instead may seek assistance managing the physical and psychological symptoms of withdrawal from dependence on a prescribed opioid.²⁹²

The current evidence for either population – women with opioid dependence, or women with OUD struggling with addiction – does not suggest that withdrawal during pregnancy is extremely dangerous to the fetus or leads to pregnancy loss or preterm labor.²⁹³ Physician conversations with patients should not further promote this warning as a risk when it stands contrary to current evidence. Instead, the most recent evidence demonstrates that medically supervised detoxification is not only a safe clinical option, but that a majority of women, independent of length of addiction, can successfully undergo detoxification with supportive therapy without relapse.²⁹⁴ Multiple studies suggest that women should be offered the option to detoxify, and it is reasonable that adequate disclosure would include the probability of success and the key role of supportive behavioral treatment as a variable that promotes successful detoxification.²⁹⁵ Although some physicians maintain that detoxification causes fetal distress, there is limited evidence to support this claim;²⁹⁶ as compared to MAT, supervised detoxification does not pose a distinct set of risks to fetal physical and neurological development.²⁹⁷

Compounding the recommendation against detoxification, federal policy and clinical recommendations currently demonstrate a marked bias toward directing pregnant patients to accept MAT. Indeed, a sample informed consent form published

(2015) (describing the link between the increase in prescriptions for opioids and rising rates of overdose); Drabiak, *supra* note 14, at 32.

292. Drabiak, *supra* note 14, at 31.

293. *See supra* notes 106-7 and accompanying text; *but see* Mishka Terplan, et al., *Opioid Detoxification During Pregnancy: A Systematic Review*, 131 *OBSTETRICS & GYNECOLOGY* 803, 804 (2018).

294. *See supra* Part II(A).

295. Stone *supra* note 281, at 13.

296. *See supra* Part II(A).

297. Editorial Staff, *Detoxing While Pregnant*, AM. ADDICTION CTRS., <https://americanaddictioncenters.org/drug-detox/pregnant> [<https://perma.cc/B6MJ-F7JB>] (last updated Feb. 25, 2022).

by SAMSHA instructs providers to use the informed consent process to counsel their patients to understand that pharmacotherapy will help them.²⁹⁸ SAMHSA depicts the patient education process as a time to discuss the risks of untreated addiction, comparing these risks against the risks of benefit of MAT.²⁹⁹ But this discussion should acknowledge that the presented options are not a binary of MAT versus no treatment. Instead, physicians should counsel patients that treatment may include MAT or other options, such as supervised tapering for opioid dependence or supervised detoxification with behavioral treatment for addiction. Sample patient brochures downplay adverse effects and risks indicated in FDA product information and current literature.³⁰⁰ These brochures inform pregnant and parenting patients that MAT is safe and normalizes patient function, but this simplification omits significant aspects of clinically relevant information.³⁰¹ Conversations between provider and patient should not only include potential benefits of MAT, but also a discussion of the complexities of risks involved. These risks may include physical side effects such as: headaches, depression, and endocrine dysfunction; neurological effects on cognition, memory, and executive function; and risks associated with somnolence and impairment.³⁰² Each of these possible side effects not only affects the woman's quality of life and recovery, but directly impacts the woman's ability to conduct daily life activities, including her ability to safely parent.

Providers should further communicate the limitations of MAT, and state that while it may work for some patients who tolerate its side effects, it may not necessarily block the craving for illicit substances and patients may still feel a compulsion to

298. SAMHSA *Treating Pregnant and Parenting Women*, *supra* note 12.

299. *Id.*

300. *Id.*

301. *Id.*

302. Theresa Parisi, *Medication-Assisted Treatment for Opioid Use Disorders*, ADDICTION CTR. (Mar. 20, 2019) <https://www.addictioncenter.com/community/medication-assisted-treatment-for-opioid-use-disorders/> [<https://perma.cc/PWN5-DK59>]; *see also* Sheridan et al., *supra* note 162.

engage in substance abuse.³⁰³ Importantly, providers should communicate to patients that they may experience impairment on prescribed doses of opioid agonists.³⁰⁴ Based on high rates of continued substance abuse among general patient populations and pregnant and parenting women who are enrolled in MAT, providers should counsel women on the risks to the fetus or infant associated with continued substance abuse.³⁰⁵

Acting as decision-makers on behalf of their fetus and infant, pregnant and parenting patients require accurate information on the benefits and risks of MAT on fetal and infant development. Although clinical literature acknowledges the risk of NAS to infants prenatally-exposed to opioid agonists, federal policy, clinical guidelines, and physician conversations pertaining to potential risks to the fetus and infant require modification to comport with accurate disclosure based on available evidence. SAMHSA and ACOG's statements asserting that there is "no evidence" that MAT is harmful to the developing infant and concerns that MAT increases risk of adverse developmental outcomes are "unscientific" stand contrary to numerous studies.³⁰⁶ Multiple studies demonstrate physical risks of prenatal opioid exposure to the infant, including: an increased risk of low birth weight, decreased brain volume, decreased body length; and risk of morbidities including: cardiac malformation, respiratory insufficiency, visual anomalies, preterm birth, and SIDS.³⁰⁷

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303. New Choices Treatment Centers Admin, *Medication-Assisted Treatment: Pros and Cons of MAT for Recovery*, NEW CHOICES TREATMENT CTRS. (July 10, 2020), <https://newchoicestc.com/blog/medication-assisted-treatment-pros-and-cons-of-mat-for-recovery-nc/> [<https://perma.cc/G8ED-BVB8>]; see also *The Role (and Limitations) of Medication Assisted Treatment (MAT)*, LIGHTHOUSE RECOVERY TEX. (Dec. 26, 2020), <https://lighthousecoverytx.com/the-role-and-limitations-of-medication-assisted-treatment-mat/> [<https://perma.cc/RA56-V5EE>].
304. *Opioid Agonist Therapy*, CTR. FOR ADDICTION & MENTAL HEALTH (2016), <https://www.camh.ca/-/media/files/oat-info-for-clients.pdf> [<https://perma.cc/3UCR-S59G>].
305. See SAMHSA *Treating Pregnant and Parenting Women*, *supra* note 12; see also Jean Ko, *What Can We Do About Opioid Use Disorder in Pregnancy*, MEDSCAPE (Jan. 28, 2019), https://www.medscape.com/viewarticle/907407?src=par_cdc_stm_mscpedt&faf=1 [<https://perma.cc/U4Z9-ZPFR>].
306. See *supra* notes 95-98 and accompanying text.
307. See *supra* notes 202-218 and accompanying text.

Additionally, federal policy, clinical guidelines, and physicians should disclose the neurological risks of MAT, including: an adverse effect on neuroanatomical volume, neurological development, cognition, memory and executive function.³⁰⁸

Finally, all postpartum providers - including physicians, nurses, and lactation consultants - should become familiar with the specific guidance set forth by ABM for how to address women with SUD. This recommendation remains relevant even when the patient is taking an opioid agonist as prescribed or pursuant to MAT or when breastfeeding is recommended or contraindicated. While providers should encourage safe breastfeeding practices, they should also counsel their patients about the serious risks of breastfeeding following relapse or during ongoing substance abuse. Providers should explicitly warn the patient of the risks of intoxication and death, both to herself and her infant, and explain how that could expose her to criminal liability.

IV. HOW THE LAW CLASSIFIES MATERNAL SUBSTANCE ABUSE

This section explores how the law addresses the problem of prenatal and parenting substance abuse, explaining why presenting a binary solution as either offering treatment or punishment is misleading and misses key nuances. Next, this section will address the impact of prenatal and parenting substance abuse on parental conduct and the intersection in the civil law context. It will also provide an overview of state laws that define prenatal and parenting substance abuse as civil child neglect or abuse and discuss corresponding state interventions through CPS. To address the problem of pregnant and parenting women who leave treatment or refuse treatment despite ongoing substance abuse, this section will describe how a minority of states have laws that permit civil commitment to facilitate treatment for persons with habitual and uncontrollable substance abuse. Finally, this section will describe the intersection of the criminal justice system with pregnant and parenting substance abuse and provide an analysis of key cases that involve death or injury to infants resulting from maternal substance abuse.

308. Margaret A. Maglione et al., *Effects of Medication Assisted Treatment (MAT) for Opioid Use Disorder on Functional Outcomes: A Systematic Review*, 89 J. SUBSTANCE ABUSE TREATMENT 28, 34 (2018).

A. *False Binary: Treatment v. Punitive Measures*

Clinicians, public health professionals, policymakers, and legislators hold a range of opinions on how the law should address maternal substance abuse. Current debates present responses to maternal substance abuse as a binary—either offer treatment or favor punitive enforcement measures. The latter frames prenatal substance abuse simplistically as a problem of insufficient treatment facilities or a scarcity of programs designed for pregnant and parenting women.³⁰⁹ ACOG asserts punitive enforcement policies are ineffective, and the AAP calls for a public health response rather than a punitive response, stating that prosecuting pregnant women for drug abuse has no proven benefit to maternal or infant health, may lead the patient to avoid prenatal care, and may decrease the patient’s likelihood of engaging in treatment.³¹⁰ Similarly, the American Public Health Association (APHA) recommends that no punitive measures be taken against a pregnant woman for prenatal substance abuse “when no other illegal acts, including drug-related offenses have been committed.”³¹¹ ACOG asserts that civil reporting statutes designed to alert CPS of maternal drug abuse are undesirable policy interventions and calls for the retraction of “punitive legislation.”³¹² ACOG and AAP both disfavor civil mandatory-reporting statutes that would trigger a CPS investigation for prenatal substance abuse, asserting that this will cause patients with SUD to avoid prenatal care.³¹³

Multiple stakeholders including Amnesty International and National Advocates for Pregnant Women frame both criminal

309. See Wendy K. Mariner et al., *Pregnancy, Drugs, and the Perils of Prosecution*, 9 CRIM. JUST. ETHICS 30, 36-37 (1990); see also BISHOP ET AL., *supra* note 17, at 4-5; ACOG, *supra* note 12; Patrick & Schiff, *supra* note 12.

310. ACOG, *supra* note 12; Patrick & Schiff, *supra* note 12, at 1-3.

311. *Medical and Public Health Statements Addressing Prosecution and Punishment of Pregnant Women*, NAT’L ADVOCS. PREGNANT WOMEN, <https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2019/02/Health20Statements20re.20Punitive20Policies20NAPW202015.pdf> [https://perma.cc/T2DQ-4MBK] (last visited Mar. 7, 2021).

312. ACOG, *supra* note 12.

313. *Id.*; Patrick & Schiff, *supra* note 12, at 3; Paltrow, *supra* note 181, at 464.

and civil state law interventions aimed at addressing prenatal substance abuse as actions that “criminalize pregnancy”³¹⁴ and discriminate against pregnant women.³¹⁵ These stakeholders assert that both criminal and civil interventions place blame upon women for conduct they do not freely choose;³¹⁶ that substance abuse during pregnancy is rarely voluntary; and that women may not be able to stop drug abuse.³¹⁷ As described *supra* in Section III B, some stakeholders further argue that there is insufficient evidence to even establish that prenatal or parenting substance abuse causes harm to the fetus or infant.³¹⁸ Extending this premise, Lollar maintains that laws aimed at intervening against pregnant and parenting women’s abuse of substances are merely tied to a subjective negative connotation associated with drugs in our society and moral judgments against mothers who use those drugs.³¹⁹

However, as former State’s Attorney Paul Logli has pointed out, there is almost a universal misconception that criminal prosecution for substance abuse related-offenses leads to punitive measures such as incarceration.³²⁰ Prosecuting women who engage in habitual substance abuse during pregnancy does not equate to “stripping a woman of her rights, denying her legal representation, locking her up, and calling her a criminal.”³²¹ Instead, it may lead to a period of court supervision to ensure that the woman stops drug abuse if she can; alternatively, the supervision may facilitate her entering treatment and may involve CPS oversight to assess the safety of her home environment,

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314. AMNESTY INT’L, CRIMINALIZING PREGNANCY: POLICING PREGNANT WOMEN WHO USE DRUGS IN THE USA 47 (2017).
315. *Id.* at 10; Patrick & Schiff, *supra* note 12, at 3.
316. AMNESTY INT’L, *supra* note 314, at 25.
317. Paltrow, *supra* note 181, at 475-78.
318. *See supra* Part III (B).
319. Lollar, *supra* note 181, at 980-81.
320. Paul Logli, *The Prosecutor’s Role in Solving the Problems of Prenatal Drug Use and Substance Abused Children*, 43 HASTINGS L.J. 559, 561-62 (1992).
321. Jessica Boudreaux & John Thompson, *Maternal-Fetal Rights and Substance Abuse: Gestation Without Representation*, 43 J. AM. ACAD. PSYCHIATRY & L. 137, 140 (2015).

particularly if there are other children in the home.³²² Some legal experts such as Logli frame prosecution as a lever of accountability to foster rehabilitation by providing treatment referrals, periodic drug testing to ensure compliance, and assistance such as parenting classes.³²³ In many courts, the system functions as a diversion program or offers deferred prosecution (no prosecution and no sentence as long as the defendant follows the court orders relating to treatment).³²⁴

These positions raise the question of how the law should approach pregnant and parenting women who engage in substance abuse while enrolled in, leave, or refuse treatment. Despite ACOG and AAP's stance against civil reporting statutes, many states do consider maternal substance abuse *civil child abuse*.³²⁵ However, even if CPS intervenes to facilitate treatment, this may be insufficient to prevent harm if the mother continues substance abuse in treatment or does not comply with CPS's order to attend treatment. Should the law instead permit civil commitment for pregnant women who habitually abuse substances and refuse treatment?

Finally, how should the law address egregious acts by pregnant and parenting women that are connected to their substance abuse and result in harm or death to infants and children?

B. Maternal Substance Abuse: Civil Child Abuse and Neglect Laws

1. The Impact of Maternal Substance Abuse on Parenting

Some legal activists and scholars deny that maternal substance abuse adversely impacts the infant or even exerts an effect upon mothers' parenting, asserting that CPS interventions function to penalize parents.³²⁶ Paltrow maintains there is "no

322. See Logli, *supra* note 320, at 562-66.

323. *Id.*

324. *Id.*

325. *Substance Use During Pregnancy*, GUTTMACHER INST., (Jan. 1, 2022) [hereinafter GUTTMACHER], <https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy#:~:text=24%20states%20and%20the%20District,it%20grounds%20for%20civil%20commitment> [<https://perma.cc/E9R6-VES9>].

326. Paltrow, *supra* note 181, at 474; Martin, *supra* note 186.

significant difference” between addicted and non-addicted mothers, arguing that it is a “misconception” that prenatal substance abuse indicates neglect or abuse after birth.³²⁷ Child welfare reporting statistics, crime reports, and disturbing media cases do not support such assertions.³²⁸ While some CPS investigations undoubtedly sweep in parents without merit or involve mothers who recovered from substance abuse,³²⁹ this is neither the intention nor purpose of CPS.³³⁰

Current research instead suggests a significant correlation between habitual parental substance abuse and child neglect, with one study finding a correlation as high as eighty-three percent.³³¹ Notably, discussion of parental substance abuse here involves habitual, chronic, or excessive substance abuse that implicates impairment and ability to function. Parental substance abuse can impact parenting in a variety of ways—increasing parental forgetfulness, increasing somnolence or erratic behavior, forgoing purchasing food and instead using household finances to buy drugs.³³² Or further, leaving children unattended,³³³ exposing children to crimes related to substance abuse such as theft, prostitution, and drug dealing, and living in a home environment in which controlled substances are within

327. Paltrow, *supra* note 181, at 480-81.

328. See, e.g., Mohsen Hosseinbor, *Family Functioning of Addicted and Non-Addicted Individuals: A Comparative Study*, 1 INTER’L J. HIGH RISK BEHAVIORS & ADDICTION 109, 109 (2012).

329. Bruce Vielmetti, *Pregnant Woman Fights Wisconsin’s Fetal Protection Law*, MILWAUKEE J. SENTINEL (Oct. 24, 2013), <http://archive.jsonline.com/news/crime/pregnant-woman-fights-wisconsins-fetal-protection-law-b99127289z1-229077121.html> [<https://perma.cc/B72Z-ZW67>] (describing the case of Alicia Beltran who asserted she had recovered from addiction and did not want to need treatment including an order to begin MAT).

330. See *How to Report Child Abuse and Neglect*, *Child Welfare Information Gateway*, <https://www.childwelfare.gov/topics/responding/reporting/how/> [<https://perma.cc/4B97-A7X4>] (last visited Feb. 8, 2022).

331. Logli, *supra* note 320, at 561.

332. See Arlene Levinson, *Crack Mom Does Time as Her Children Grow*, SOUTH COAST TODAY (Apr. 26, 1998), <https://www.southcoasttoday.com/article/19980426/News/304269949> [<https://perma.cc/C5D7-A7DL>].

333. *Id.*

children's reach.³³⁴ One report examining substance-exposed infants at birth found that 61.2% involved subsequent investigations opened by CPS to assess claims of child abuse or neglect, 45.4% of which claims were substantiated by CPS before the child's first birthday.³³⁵

In fact, a variety of media reports have raised the question of whether CPS sufficiently intervenes, asserting that, in the cases reported upon, CPS should have been more aggressive investigating the safety of the home environment.³³⁶ In one investigation, Reuters identified 110 cases of infants and toddlers whose mothers abused opioids during pregnancy and died preventable deaths, including forty children who suffocated and thirteen who swallowed toxic doses of controlled substances.³³⁷ In approximately seventy-five percent of those cases, the mother was implicated in causing the death of her child, but most women were sent home from the hospital after giving birth to a substance-exposed infant without the hospital ever notifying CPS.³³⁸

In one case, Sarah Stephens abused multiple drugs, including methadone, while breastfeeding her son Ryder.³³⁹ When Ryder

334. *Id.*

335. John J. Prindle et al., *Prenatal Substance Exposure Diagnosed at Birth and Infant Involvement with Child Protective Services*, 76 CHILD ABUSE & NEGLECT 75, 79 (2018).

336. Jenifer McKim, *Explosion of Drug-Dependent Infants Reveals Weakness of Mass. Child Protection*, GBH NEWS (Mar. 30, 2014), <https://www.necir.org/2014/03/30/explosion-of-drug-dependent-infants-reveals-weakness-in-mass-child-protection/> [https://perma.cc/K4VX-KPUC]; Wilson & Shiffman, *Newborns Die After Being Sent Home With Mothers Struggling To Kick Drug Addictions*, *supra* note 159.

337. Wilson & Shiffman, *Newborns Die After Being Sent Home With Mothers Struggling To Kick Drug Addictions*, *supra* note 159.

338. *Id.*

339. Doyle Murphy, *California Baby Dies After Drinking Mother's Drug Laced Milk*, N.Y. DAILY NEWS (Sept. 2, 2013), <https://www.nydailynews.com/news/national/cops-baby-killed-mom-drug-laced-milk-article-1.1443412> [https://perma.cc/YF6C-64VK]; Anthony Bond, *Pictured: The Eight-Month-Old Baby Who Died From a Cocktail of Methadone and Xanax in Mother's Breast Milk and Now She Faces Murder Charges*, DAILY MAIL (Sept. 2, 2013), <https://www.dailymail.co.uk/news/article-2408718/Ryder->

was four months old, he was admitted to the emergency department for an accidental overdose from drugs transferred by Stephens via breastmilk.³⁴⁰ At that time, the hospital notified CPS to initiate an investigation; however CPS neglected to act for three months, releasing Ryder into Stephens' custody only with the warning to discontinue breastfeeding, and then determined there was "low risk of future mistreatment."³⁴¹ Months later, police called CPS again when Stephens ran her vehicle off road with Ryder in the backseat; CPS did not complete any other risk assessment or conduct further investigation.³⁴² Less than a month later, Ryder died from acute drug intoxication by ingesting Xanax, Opana, and methadone-laced breastmilk from Stephens.³⁴³ This raises questions about the timeliness and responsiveness of CPS in assessing and remediating serious safety concerns.

As described in the cases of Stephanie Greene and Amoret Powell, pregnant and parenting women who engage in substance abuse may alternate between periods of impairment and carelessness and periods of demonstrated planning designed to avoid detection and fuel their addiction.³⁴⁴ Media reports have uncovered the corresponding impact on safety and related accidents, such as when maternal somnolence results in a mother falling asleep and smothering her infant,³⁴⁵ when Amanda McKenzie fell asleep while bathing her infant, Liam, causing him to drown,³⁴⁶ or cases like Samantha Jones' and others, when parents become unconscious in a vehicle with a child in the backseat.³⁴⁷ Impairment may also contribute to parents leaving

Salmen-months-died-cocktail-drugs-mothers-breast-milk.html
[<https://perma.cc/YF6C-64VK>].

340. Bond, *supra* note 339.

341. *Id.*

342. *Id.*

343. *Id.*

344. *See* Part III(b).

345. Wilson, *A Hospital Fails to Test for Drugs; A Day Later, A Newborn is Dead*, *supra* note 159; Wilson & Shiffman, *Newborns Die After Being Sent Home with Mothers Struggling To Kick Drug Addictions*, *supra* note 159.

346. Wilson, *As Social Services Stand Back, A Mother and Her Baby Fall 'Through the Canyon into Hell'*, *supra* note 159.

347. Veazey, *supra* note 156; Svab, *supra* note 177.

controlled substances in areas that children can access. In one case, Penny Cormani's parents actively abused heroin in their home, leaving heroin and drug paraphernalia such as burnt foil and straws in multiple places around the home.³⁴⁸ Thirteen-month-old Penny accidentally ingested her parents' heroin and died from acute heroin intoxication.³⁴⁹

Notably, several cases raise the possibility that the mothers themselves would have liked to discontinue taking prescribed opioid agonists but struggled with dependence on the prescribed medication,³⁵⁰ or alternatively, were unaware that taking opioid agonist medications along with postpartum pain relief medications as prescribed could result in infant intoxication and death.³⁵¹ Several mothers expressly stated that they wished CPS would have intervened, or that they would have welcomed help.³⁵² Critically, the population of women experiencing problems that involve substance abuse, impairment, and accidents that result in the infant's death includes women who are enrolled in MAT.³⁵³ One investigation examined a Bradenton, Florida methadone clinic where, in the span of six months, four infants born dependent on substances whose mothers were enrolled in MAT died accidental deaths.³⁵⁴ Cases such as these highlight the importance of solutions to address pregnant and parenting substance abuse, even when the mother is already enrolled in MAT.

348. McKenzie Romero, *Lehi Mother Sent to Prison for Baby's Heroin Overdose*, DESERET NEWS (Mar. 2, 2017), <https://www.deseretnews.com/article/865674722/Lehi-mother-sent-to-prison-for-babys-heroin-overdose.html> [<https://perma.cc/8YVF-CFFH>]; Julie Turkewitz, *'The Pills Are Everywhere': How the Opioid Crisis Claims Its Youngest Victims*, N.Y. TIMES (Sept. 20, 2017), <https://www.nytimes.com/2017/09/20/us/opioid-deaths-children.html> [<https://perma.cc/5FSE-3AXQ>].

349. *Romero*, supra note 348; *Turkewitz*, supra note 348.

350. Wilson & Shiffman, *Newborns Die After Being Sent Home with Mothers Struggling To Kick Drug Addictions*, supra note 160.

351. *Id.*

352. *Id.*

353. Duff Wilson, *Infant Deaths Prompt Changes at Methadone Clinic*, REUTERS (Dec. 7, 2015), <http://news.trust.org/item/20151207221247-lr4c5> [<https://perma.cc/M4JY-DMNJ>].

354. *Id.*

Finally, the most egregious cases demonstrate unspeakable cruelty toward children. These cases raise questions about society's role in protecting children from a small subset of parents who fail to act in their children's best interest, deviating far away from a minimum standard of care. Cases range from reckless indifference, such as Mya Barry's parents who tainted her baby bottles with heroin, causing her overdose,³⁵⁵ to utter disregard, such as a mother who gave her infant Tylenol and methadone to keep her infant quiet.³⁵⁶ In one of the most gruesome cases, Lyndsey Fiddler engaged in ongoing substance abuse, became intoxicated, started a load of laundry and dumped her infant Maggie May into the washing machine where she violently drowned and died.³⁵⁷ Alarming, CPS had received *five* reports alleging that Fiddler neglected or abused her three children, including a report when Maggie May was born.³⁵⁸ CPS, however, determined that Fiddler's children were safe and that Fiddler could work on parenting services.³⁵⁹

To be sure, in practice, CPS interventions may include examples of overbroad investigations or unwarranted intrusions.³⁶⁰ Yet, where maternal substance abuse and substance-dependent infants are involved, these cases demonstrate the breadth of impact and severity of consequences when CPS does not intervene in a timely and responsive manner, or fails to intervene at all.

2. Maternal Substance Abuse May Constitute Civil Child Abuse or Neglect

Twenty-three states and the District of Columbia classify prenatal substance abuse as civil child abuse, and twenty-four states require healthcare providers to report prenatal substance

355. McKim, *supra* note 336.

356. Wilson & Shiffman, *Newborns Die After Being Sent Home with Mothers Struggling to Kick Drug Addictions*, *supra* note 160.

357. *Id.*

358. *Id.*

359. *Id.*

360. See Michelle Goldberg, *Has Child Protective Services Gone Too Far?*, NATION (Sept. 30, 2015), <https://www.thenation.com/article/archive/has-child-protective-services-gone-too-far/> [<https://perma.cc/ADW4-P95Z>].

abuse to CPS.³⁶¹ Some legal activists and media assert that healthcare providers' notifications to CPS are punitive, will deter women from seeking prenatal care, and cause unnecessary harm.³⁶² Despite such criticism, the goal of CPS is neither punitive nor designed to disconnect family structures.³⁶³ Rather, CPS serves as an intermediary for state intervention that provides investigation that assesses the safety of the home environment.³⁶⁴ CPS also provides referrals for services such as substance abuse treatment and parenting classes, a supervised case plan, and—only where necessary—removes the child from the home.³⁶⁵ In fact, multiple state laws explicitly clarify that the goal of CPS intervention is to preserve the family structure or enable family reunification.³⁶⁶

States that define prenatal substance abuse as child abuse vary in a number of ways.³⁶⁷ There are differences as to the amount of evidence required, whether the statute indicates testing for the mother and/or infant upon birth when the provider suspects maternal substance abuse, what level of evidence is sufficient to initiate a report to CPS, and whether reporting to CPS is required or discretionary.³⁶⁸ For example, California states that a positive toxicology screen of the infant at birth alone is insufficient to report suspected child abuse absent additional factors, such as history of maternal substance abuse or other evidence of suspected child abuse or neglect.³⁶⁹ Other states specify that maternal substance abuse of controlled substances or

361. CHILD WELFARE INFORMATION GATEWAY, PARENTAL SUBSTANCE USE AS CHILD ABUSE (2016) [hereinafter PARENTAL SUBSTANCE USE AS CHILD ABUSE].

362. Paltrow, *supra* note 181, at 481; *see also* Martin, *supra* note 186.

363. PARENTAL SUBSTANCE USE AS CHILD ABUSE, *supra* note 361.

364. *What is Child Protective Services?*, STOP IT NOW, <https://www.stopitnow.org/ohc-content/what-is-child-protective-services> [https://perma.cc/KAU9-Z5D7] (last visited Jan. 30, 2022).

365. *Id.*; Logli, *supra* note 320, at 564-65.

366. CHILD WELFARE INFORMATION GATEWAY, REASONABLE EFFORTS TO PRESERVE OR REUNIFY FAMILIES AND ACHIEVE PERMANENCY FOR CHILDREN (2019) [hereinafter PRESERVE OR REUNIFY FAMILIES].

367. *See id.*

368. *Id.*

369. CAL. PENAL CODE § 11165.13 (West 2001).

alcohol constitutes child abuse when it becomes “habitual or excessive”³⁷⁰ or reflects “chronic or severe use,”³⁷¹ suggesting that these states aim to separate minor or isolated incidents from pregnant women who engage in a pattern of ongoing substance abuse. To compare, other states specify that infant withdrawal symptoms or the presence of any controlled substance and/or alcohol at birth by toxicology screen constitutes a sufficient basis to begin an investigation.³⁷²

Importantly, several states clarify that the basis for intervention does not apply to maternal use of legitimately prescribed substances, which would apply to mothers enrolled in MAT.³⁷³ However, based on rates of both relapse and ongoing substance abuse for pregnant and parenting women enrolled in MAT, their status of being in treatment should not preclude either the mother or infant from undergoing toxicology screening. Failing to screen mothers and infants based on treatment status could exclude mothers who are struggling with treatment and infants who are at risk from ongoing substance abuse. Finally, multiple states specifically limit the scope of culpability to civil child welfare interventions and further specify that positive toxicology results of the infant at birth shall not be used for criminal prosecution purposes.³⁷⁴

State laws also specify the point at which parental substance abuse constitutes child abuse or neglect within the home environment.³⁷⁵ These laws also implicate instances when the mother takes the infant home from the hospital and also pertains

370. MINN. STAT. § 260E.31 (2020).

371. LA. CHILD. CODE ANN. art 603(22) (2017).

372. Ch. 325 ILL. COMP. STAT. ANN. 5/3 (LexisNexis 2019); Ch. 325 ILL. COMP. STAT. ANN. 5/7.3b (LexisNexis 2019); Ch. 705 ILL. COMP. STAT. ANN. 5 (LexisNexis 2019); IND. CODE ANN. § 31-34-1-10 (West 2019); IND. CODE ANN. § 31-34-1-11 (West 2019); IOWA CODE § 232.2(6) (2022).

373. COLO. REV. STAT. § 19-1-103(1)(a) (2016); FLA. STAT. ANN. § 39.01(34)(a)(2) (West 2021); FLA. STAT. ANN. § 39.01(34)(g) (West 2021).

374. IOWA CODE § 232.77(2) (2022); LA. CHILD. CODE ANN. art. 610(G) (2009); KY. REV. STAT. ANN. § 214.160 (West 2011); MO. REV. STAT. § 191.737 (2019).

375. See Hollie Hendrikson & Kate Blackman, *State Policies Addressing Child Abuse and Neglect*, NAT’L CONF. ST. LEGISLATURES (2015).

to other children present in the home. According to the Administration for Children and Families, these actions include exposing children to illegal drug activity, such as: exposing a child or allowing a child to be present where controlled substances are stored, giving drugs or alcohol to a child, using a controlled substance that impairs the parent's ability to care for the child, or exposing the child to the sale or distribution of drugs.³⁷⁶ In some states, exposing or providing drugs to a child constitutes a criminal felony defined as “chemical endangerment” or “endangering the welfare of the child,” where state law specifies more serious felony violations depending on whether the child suffers harm or dies as a result.³⁷⁷

C. Civil Commitment Laws Pertaining to Substance Abuse

Some states have adopted an approach to address habitual, chronic, or excessive substance abuse by enacting specific laws that permit civil commitment in certain circumstances.³⁷⁸ Many states have civil commitment laws designed to facilitate a process for involuntary commitment for the purpose of substance abuse treatment, applicable to the general class of all persons with SUD.³⁷⁹ These laws apply in narrow circumstances in which the person with SUD exhibits chronic, habitual, or excessive use of drugs and or alcohol and is incapacitated by substance abuse to an extent they can no longer provide for their basic needs, or there is reason to believe they will likely harm another by their conduct if they are not detained in treatment.³⁸⁰ A very small minority of states have additional laws addressing pregnant

376. PARENTAL SUBSTANCE USE AS CHILD ABUSE, *supra* note 361.

377. ALA. CODE § 26-15-3.2 (2012); DEL. CODE ANN. tit. 11 § 1102 (West 2022); N.D. CENT. CODE ANN. § 19-03.1-22.2 (West 2021).

378. Megan Hull, *Involuntary Commitment Laws*, RECOVERY VILL. (Nov. 9, 2021), <https://www.therecoveryvillage.com/mental-health/related/involuntary-commitment-laws/> [https://perma.cc/D7H2-37ZS].

379. *See Involuntary Commitment for Individuals with Substance Use Disorder or Alcoholism*, NAT'L ALLIANCE MODEL ST. DRUG L., Aug. 2016, at 1, 3; *Commitment and Guardianship Laws for Persons with a Substance Use Disorder*, NAT'L CTR. ST. CTS. (Oct. 2018), [https://www.ncsc.org/~media/4EC4A03001EB4E5BB5F649FE2D4F7802.ashx](https://www.ncsc.org/~/media/4EC4A03001EB4E5BB5F649FE2D4F7802.ashx) [https://perma.cc/R7LB-PU4U].

380. *Commitment and Guardianship Laws for Persons with a Substance Use Disorder*, *supra* note 379.

women as a class who engage in habitual, chronic, excessive, or uncontrollable substance abuse, and provide a similar procedure for civil commitment to facilitate treatment.³⁸¹ As with other laws for civil commitment, state procedures must comport with due process: providing notice, an opportunity to object, a chance to assess evidence supporting the reason for commitment, and using the least restrictive method of treatment.³⁸²

Some states, such as Oklahoma, specifically indicate that it would like to address the problem of prenatal substance abuse by offering treatment.³⁸³ The legislature also recognizes that not all pregnant women with habitual SUD will seek treatment and, in some cases, the state should have the authority to intervene.³⁸⁴ Oklahoma law notes the state's interest in preventing harm to children from excessive substance abuse during pregnancy and mitigating the cost of providing medical care.³⁸⁵

Some stakeholders argue that these laws target pregnant women, amount to unlawful and arbitrary physical restraint, constitute forced medical treatment, and violate fundamental human rights.³⁸⁶ Indeed, any laws that curtail individual liberties, particularly in the context of civil commitment for treatment, must be fastidiously applied to guard against overreach, misuse, or abuse. But these laws do not aim to restrict pregnant women's rights. Rather, they are meant to address a behavior of severe habitual substance abuse, and should be viewed as an extension of similar laws that apply to all adults exhibiting such behavior.

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381. Cynthia Soohoo & Risa Kaufman, *The Detention and Forced Medical Treatment of Pregnant Women: A Human Rights Perspective*, AM. CONST. SOC. L. & POL'Y (Mar. 2018), https://www.acslaw.org/issue_brief/briefs-landing/the-detention-and-forced-medical-treatment-of-pregnant-women-a-human-rights-perspective/ [https://perma.cc/LB4G-GD7]; see also OKLA. STAT. ANN. tit. 3 § 1-546. (West 2021); MINN. STAT. § 253B.02 (2021); S.D. CODIFIED LAWS § 34-20A-63, 34-20A-70 (2022); WIS. STAT. ANN. § 48.133 (West 1997).
382. *City of Newark v. JS*, 652 A.2d 265, 274-75 (N.J. Super. Ct. Nov. 8, 1993).
383. OKLA. INTERAGENCY CHILD ABUSE PREVENTION TASK FORCE, OKLAHOMA STATE PLAN FOR THE PREVENTION OF CHILD ABUSE AND NEGLECT 11, 47-48 (2014).
384. OKLA. STAT. ANN. tit. 3 § 1-546. (West 2021).
385. *Id.*
386. Soohoo & Kaufman, *supra* note 381.

Moreover, the laws do not serve a punitive function by detaining and jailing women for no reason, as commonly described in media reports.³⁸⁷

In one controversial case, *Loertscher v. Anderson*, Tamara Loertscher sought medical treatment for hypothyroidism and prenatal care.³⁸⁸ Loertscher tested positive for methamphetamine, amphetamine, and tetrahydrocannabinol, and asserted that she was “self-medicating” with illicit substances and alcohol.³⁸⁹ Loertscher reported that, when she learned that she was pregnant, she “cut back” from daily drug abuse to less frequent drug and alcohol abuse at a rate of two to three times per week.³⁹⁰ Her medical record at the time indicated she was aware she was pregnant, was diagnosed with polysubstance abuse, and abused alcohol to the point of losing consciousness during her pregnancy.³⁹¹

Under the state’s civil commitment law, the court considered not only evidence of Loertscher’s substance abuse, but also her obstetrician’s testimony that Loertscher had refused prior offers for treatment while simultaneously continuing polysubstance abuse.³⁹² The court initially ordered Loertscher to report to a substance abuse treatment facility for assessment and possible treatment.³⁹³ Loertscher ignored the court order, failed to comply, and as a result, the court found Loertscher in contempt, after which she was briefly detained in jail.³⁹⁴ In response, media reports decried the Wisconsin law as a draconian tool for imprisoning women because they are pregnant.³⁹⁵ To clarify, the

387. See, e.g., Sara Finger, *Women Are Treated Shamefully Under Wisconsin’s “Cocaine Mom” Law*, HUFF POST (Apr. 18, 2017), https://www.huffpost.com/entry/wisconsins-dirty-secret-about-the-treatment-of-pregnant_b_58efdd88e4b0156697224d94 [https://perma.cc/7J6W-UBEG].

388. *Loertscher v. Anderson*, 893 F.3d 386, 390 (7th Cir. 2017).

389. *Id.*

390. *Id.*

391. *Id.*; *Loertscher v. Anderson*, 259 F. Supp. 3d 902, 909-10 (W.D. Wis. 2017).

392. *Loertscher*, 893 F.3d at 390-91.

393. *Id.* at 391.

394. *Id.*

395. Finger, *supra* note 387.

court did not order Loertscher to a brief jail sentence for no reason, nor based on her substance abuse; rather, *anyone* who violates a court order may be placed in contempt.³⁹⁶ Courts must have a measure of accountability to ensure compliance with orders for any person under its jurisdiction.

Under the Wisconsin state law at the time, if the CPS investigation and medical reports suggested that a pregnant mother engaged in habitual and excessive substance abuse, the care team offered treatment, and the mother refused, then CPS could petition the court for an order of civil commitment to facilitate treatment.³⁹⁷ Loertscher insisted that she did not need substance abuse treatment despite continued substance abuse.³⁹⁸ Incidentally, Loertscher's treatment plan only required her to attend regularly scheduled prenatal appointments and submitting urine toxicology screens.³⁹⁹

Loertscher challenged the constitutionality of the Wisconsin law, asserting that it amounted to forced medical treatment, arbitrary detention, and a violation of liberty, privacy, and bodily integrity.⁴⁰⁰ Though the 7th Circuit Court of Appeals found the suit moot on technical grounds,⁴⁰¹ the case raises the question of whether civil commitment may be an appropriate mechanism to facilitate treatment in narrow circumstances for pregnant mothers with severe and habitual SUD. Loertscher's case highlighted the importance of cautiously adhering to due process safeguards. This includes reviewing evidence from multiple sources including the pregnant woman herself, avoiding any orders that require the patient to use medication based on serious risks from opioid agonists, and opting for the least restrictive alternative. If the pregnant patient insists that she does not want or need treatment, the least restrictive alternative could reflect this by merely ordering toxicology screens to monitor whether the patient's stated lack of need for treatment is accurate.

396. *Loertscher*, 893 F.3d at 391.

397. *Loertscher v. Anderson*, 259 F. Supp. 3d 902, 907 (W.D. Wis. 2017).

398. *Loertscher*, 893 F.3d at 390.

399. *Id.* at 391.

400. *See Soohoo & Kauffman*, *supra* note 381.

401. *Loertscher*, 893 F.3d at 396.

D. Defining Maternal Substance Abuse in Criminal Law

1. Prenatal Substance Abuse is NOT a Crime in Most States

In the vast majority of states, maternal substance abuse is not classified as a crime.⁴⁰² At the time of this writing, only Alabama and South Carolina define substance abuse during pregnancy as a distinct crime.⁴⁰³ In states where maternal substance abuse is not a crime, prosecutors have been largely unsuccessful when bringing criminal charges related to prenatal substance abuse. They have been brought under the umbrella of criminal child abuse, reckless endangerment or injury to a child, or homicide when maternal drug abuse results in the transfer of drugs to a born alive infant and causes death.⁴⁰⁴ Contrary to the position that abusing drugs during pregnancy merely constitutes a neutral social choice, many defendants in such cases engaged in an ongoing pattern of habitual substance abuse that caused severe damage. This harm includes brain death of the infant;⁴⁰⁵ morbidities such as respiratory arrest, extreme prematurity and low birth weight; or infant death.⁴⁰⁶ Prosecutors have (unsuccessfully) attempted to bring charges against mothers who engaged in habitual prenatal substance abuse where an infant was born alive, but subsequently died days or weeks after birth as a result of acute intoxication.⁴⁰⁷ Even in cases that involved death of an infant – not a fetus – the majority of courts have dismissed such charges or overturned convictions.⁴⁰⁸ Though this class of

402. GUTTMACHER, *supra* note 325.

403. *Id.*; see *Ex Parte Ankrom*, 152 So. 3d 397, 401 (Ala. 2013) (holding the state's chemical endangerment statute did apply to prenatal substance affecting unborn children); *Whitner v. State*, 492 S.E. 2d 777, 786 (S.C. 1997) (holding the child abuse and endangerment statute did apply to prenatal substance abuse affecting unborn children).

404. See Cara Angelotta & Paul Appelbaum, *Criminal Charges for Child Harm from Substance Use During Pregnancy*, 45 J. AM. ACAD. PSYCHIATRY & L. 193, 193 (2017).

405. *State v. Louk*, 786 S.E.2d 219, 222 (W. Va. 2016).

406. Ross et al., *supra* note 196, at 64, 68-69.

407. *Kilmon v. State*, 905 A.2d 306, 308, 315 (Md. Ct. App. 2006); see also *Louk*, 786 S.E.2d at 222; *Johnson v. State*, 602 So.2d 1288, 1291 (Fla. 1992); *State v. Aiwohi*, 123 P.3d 1210, 1210 (Haw. 2005).

408. Angelotta & Appelbaum, *supra* note 404; *Johnson*, 602 So.2d at 1296 (dismissing drug delivery charges, holding the legislature did

cases involves defendants with multiple types of substance abuse, the central questions of criminal responsibility similarly apply.

To underscore, these cases exemplify instances where harm to the infant did not result from one isolated incident of substance abuse, but rather reflected a pattern of long-term habitual substance abuse. In *Johnson v. State*, Jennifer Johnson admitted to smoking marijuana and crack cocaine three to four times every other day throughout the duration of her pregnancy, including the night prior to delivery.⁴⁰⁹ In that case, the prosecutor adopted the theory that prenatal substance abuse constituted a crime because it delivered drugs through the umbilical cord following delivery to her infant, an existing child at the time of commission.⁴¹⁰ In *State v. Aiwohi*, Tayshea Aiwohi admitted that she smoked crystal meth every day leading up to delivery and continued daily drug abuse while breastfeeding her infant, who subsequently died of acute drug intoxication after she took him home from the hospital.⁴¹¹ Notably, Aiwohi was enrolled in substance abuse treatment during this time, yet still continued habitual substance abuse.⁴¹²

In Johnson's case, she admitted to ongoing polysubstance abuse during both of her two pregnancies, and both of her children were born with illicit substances in their system.⁴¹³ CPS had been

not intend to authorize prosecution of mothers for umbilical cord delivery); *see also Kilmon*, 905 A.2d at 307 (holding reckless endangerment statute does not apply to conduct of pregnant women); *Louk*, 786 S.E.2d at 219 (holding that child endangerment statute does not encompass prenatal acts that result in physical harm to the subsequently born child); *Aiwohi*, 123 P.3d at 1210 (holding the homicide statute did not apply to prenatal conduct that subsequently caused the infant's death).

409. *Johnson*, 602 So. 2d at 1291; *see also Ex Parte Ankrom*, 152 So. 3d 397, 397 (Ala. 2013) (where Hope Ankrom tested positive for cocaine and marijuana multiple times throughout her pregnancy).

410. *Johnson*, 602 So. 2d at 1290.

411. *Aiwohi*, 123 P.3d at 1211.

412. *Id.*

413. *Johnson*, 602 So. 2d at 1291 (Johnson admitted to substance abuse during both of her two pregnancies); *see also Kounang*, *supra* note 1 (discussing Samantha Jones, where Jones admitted to substance abuse during her pregnancy that resulted in losing consciousness while in a motor vehicle and her other child was also in that vehicle).

involved, prior to the death of her infant, to investigate allegations of substance abuse and reports of child abuse against another child in the home; yet her children remained in her care.⁴¹⁴

Aiwohi's and Johnson's cases exemplify the potential insufficiency of relying on CPS. The unfortunate consequence of ongoing substance abuse, even while in treatment, and delayed intervention is that the child may become injured or die.

Prosecution for prenatal transfer of illicit substances has been unsuccessful in most jurisdictions because courts have held that the victim of the crime must be in the class of offenders at the time of commission.⁴¹⁵ Accordingly, even if prenatal substance abuse results in the transfer of illicit substances to a born-alive infant or causes that infant's death, this does not constitute a crime in these jurisdictions.⁴¹⁶ *State v. Aiwohi* references a long list of precedent across multiple jurisdictions which held that even if the mother's conduct demonstrated "reckless indifference" and "created a substantial risk of death or great bodily harm to the subsequently born child," such conduct would only constitute a crime when it was directed against another person or human being at the time of commission.⁴¹⁷ These courts also clarify that the fetus does not constitute a person or another human being.⁴¹⁸

For some courts, this distinction exists based on separation of powers and policy considerations.⁴¹⁹ Courts must discern legislative intent to determine what acts constitute a crime, and some courts have adopted a narrow view: if the legislature does not specify that prenatal substance abuse constitutes a separate

414. *Id.*

415. *Aiwohi*, 123 P.3d at 1212; *State v. Louk*, 786 S.E.2d 219, 223-24 (W. Va. 2016); *Kilmon v. State*, 905 A.2d 306, 312 (Md. Ct. App. 2006).

416. *Kilmon*, 905 A.2d at 312.

417. *Aiwohi*, 123 P.3d at 1216.

418. *Id.* at 1223. *But see* *Whitner v. State*, 492 S.E.2d 777, 780-81 (S.C. 1997); *Ex Parte Ankrom*, 152 So. 3d 397, 412 (Ala. 2013); ALA. CODE § 13A-6-1 (2006) (defining "person," for the purpose of criminal homicide or assaults, to include an unborn child in utero at any stage of development, regardless of viability); S.C. CODE ANN. § 16-3-1083 (2006) (defining "unborn child" as a child in utero, and "child in utero" or "child who is in utero" as a member of the species *Homo sapiens*, at any state of development, who is carried in the womb).

419. *Whitner*, 492 S.E. 2d at 780.

crime or that acts against a fetus constitute a crime, then the court will *not* permit prosecution.⁴²⁰ While integrating policy considerations, some courts have questioned whether permitting prosecution constitutes the most effective solution.⁴²¹ These courts cite position statements from the American Medical Association and APHA that disfavor prosecution for prenatal substance abuse as reasons for foreclosing such acts from being considered crimes.⁴²² Moreover, state courts in Florida and West Virginia have expressed concerns that permitting prosecution of pregnant women would create a slippery slope and “proscribed conduct would be impermissibly broad and ill-defined.”⁴²³ The court in *Kilmon v. State* opined that permitting prosecution for prenatal substance abuse within the scope of reckless endangerment would open the door to an untenably broad list of other conduct.⁴²⁴ Courts could punish women for maintaining an improper diet, not wearing a seatbelt, exercising too much or too little, or bearing a child with a genetic disability.⁴²⁵

Despite *Kilmon’s* fear of a slippery slope, ongoing polysubstance abuse is not a neutral, ordinary activity or exercise in value judgment as compared to choices about food and exercise, because possession of illicit substances already constitutes a crime.⁴²⁶ The dissent in *State v. Louk* convincingly addressed this issue, stating, “It is common knowledge that use of illegal substance by pregnant mothers subject their unborn children to high risk of injury. The petitioner readily admitted she knew injecting methamphetamine into her vein would put [the fetus] at risk. She simply chose to disregard Olivia’s welfare. She should be held accountable for her actions.”⁴²⁷ Indeed, even activities such as race car driving, sky diving, or disarming explosive devices while pregnant may be risky, but still do not meet the clear demarcation of an activity that constitutes both

420. *Louk*, 786 S.E.2d at 228; *Johnson v. State*, 602 So.2d 1288, 1291 (Fla. 1992); *Kilmon*, 905 A.2d at 312; *Aiwohi*, 123 P.3d at 1223.

421. *Johnson*, 602 So. 2d at 1296.

422. *Id.*

423. *Louk*, 786 S.E.2d at 225.

424. *Kilmon*, 905 A.2d at 311.

425. *Id.*

426. *Id.* at 314.

427. *Louk*, 786 S.E. 2d at 237 (Loughry, J., dissenting).

existing illegal conduct and certain harm to the fetus—rendering the fear of a slippery slope unconvincing.

Finally, though most jurisdictions do not permit prosecution for maternal substance abuse even when it leads to injury and death of the infant, the majority of jurisdictions (thirty eight states) do permit prosecution for acts against the fetus committed by a third party through specific fetal homicide laws.⁴²⁸ Jurisdictions that contain fetal homicide laws vary as to whether they recognize any rights of the fetus or whether the law classifies the harm as depriving the mother of her pregnancy without her consent (as to distinguish fetal homicide from legal abortion).⁴²⁹ The comparison of maternal conduct versus third-party conduct creates a dilemma, because some fetal homicide laws apply even if there is no born-alive infant, where the third party's conduct causes the death of the fetus.⁴³⁰ Moreover, twenty-nine states recognize fetal homicide as a crime even in early stages of pregnancy.⁴³¹ This raises the difficult question of why states recognize the criminal nature of conduct perpetrated against fetuses that cause injury or death by third parties, but do not criminalize egregious illegal acts by the mother. As the court in *State v. Aiwohi* observed, “[T]he two propositions cannot logically co-exist,” leading the court to only recognize claims for offenses perpetrated against an existing child, — that is, crimes against a child that occur after the child has been born.⁴³²

2. Consequences of Exempting Prenatal Acts from Prosecution

Courts' unwillingness to permit prosecution for conduct that impacts an existing infant constitutes a troublesome gap in the law and poses the question of why the courts choose not to hold

428. *State Laws on Fetal Homicide and Penalty-Enhancement for Crimes Against Pregnant Women*, NAT'L CONF. ST. LEGISLATURES (May 1, 2018) [hereinafter *State Laws on Fetal Homicide*], <http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx> [https://perma.cc/YQK8-8SGW]; see also *Louk*, 786 S.E.2d at 226; *Kilmon*, 905 A.2d at 310; *State v. Aiwohi*, 123 P.3d 1210, 1218 (Haw. 2005).

429. *State Laws on Fetal Homicide*, *supra* note 428.

430. *Aiwohi*, 123 P.3d at 1218.

431. *State Laws on Fetal Homicide*, *supra* note 428.

432. *Aiwohi*, 123 P.3d at 1221.

the mother accountable for an infant's preventable death.⁴³³ First, this stance appears to be fueled by distorting privacy and reproductive liberty arguments ordinarily used during the prenatal period and advocating for those arguments' application to already-born infants. Second, this narrative relies on the perspective that persons acting as a result of their addiction have lost control over their actions and should not be criminally punished. Though addiction is not a crime, prosecution targets specific crimes that directly impact the welfare of society, which may be motivated or influenced by the individual's drug abuse.⁴³⁴ The key issue becomes disentangling private substance abuse from substance abuse connected to actions that affect other persons, the public safety, or that are linked to other crimes.⁴³⁵

Johnson v. State viewed the delivery of controlled substances as an incidental outcome of the mother's substance abuse, but not as a distinct crime.⁴³⁶ Adopting materials from the AMA Board of Trustees Report, the court in *Johnson* reasoned that courts should not punish people for substance abuse because they have impaired capacity for decision-making and do not intend to harm the fetus.⁴³⁷

Courts addressing the issue of addiction and free will have held that even if addiction constrains choice, it does not negate free will: persons still make choices, and may still be held accountable by the judicial system when they commit a crime.⁴³⁸ They may also face liability for violating a court order to comply with substance abuse treatment even if the action was linked with the defendant's underlying substance abuse.⁴³⁹ Indeed, one of the

433. See Logli, *supra* note 320, at 566 (stating that ignoring a newborn's death is "simply unconscionable.").

434. Drabiak, *supra* note 14.

435. See *id.* at 19.

436. *Johnson v. State*, 602 So.2d 1288, 1292 (Fla. 1992).

437. *Id.* at 1295 n.5.

438. *Powell v. Texas*, 392 U.S. 514, 526 (1968).

439. See *id.* at 519 (Powell, an alcoholic who had been arrested 100 times for public intoxication made a conscious decision to have only one drink the morning before his court appearance because he did not want to "pass out or be picked up" and miss the court appearance). See also *Commonwealth v. Eldred*, 101 N.E.3d 911, 924 (2018) (holding the court may exercise its authority to prohibit illicit substance abuse, particularly when substance abuse is directly

seminal cases distinguishing addiction from crimes that affect public safety and welfare was *Robinson v. California*.⁴⁴⁰ In *Robinson*, the Supreme Court held: “There can be no question of the authority of the State . . . to regulate the . . . use of . . . drugs [through, inter alia] a program of compulsory treatment for those addicted to narcotics[. . .] [even requiring] involuntary confinement [and] penal sanctions for failure to comply with established compulsory treatment procedures.”⁴⁴¹ The Court distinguished a defendant’s status as a person with addiction from the action of abusing substances, recognizing that the latter poses risk to society and may constitute a criminal violation.⁴⁴²

Problematically, the push to use substance abuse as an exculpatory factor has extended into excusing maternal conduct toward infants during the postpartum period, as illustrated in the Samantha Jones case.⁴⁴³ All states – even states that adopt of policy of non-intervention for prenatal substance abuse – must demarcate that the delivery of controlled substances to an infant after birth undoubtedly constitutes a criminal action. To be sure, *no one* has the right to abuse children by delivering drugs into their system, not even their parents.

3. Only a Very Small Minority of States Consider Prenatal Substance Abuse a Crime

Grappling with the problem of ongoing substance abuse during pregnancy, only two states, Alabama and South Carolina, recognize substance abuse during pregnancy as a crime.⁴⁴⁴ Notably, from 2014-2016, Tennessee briefly had a law that classified prenatal substance abuse within its criminal assault framework.⁴⁴⁵ It classified assault as the illegal use of narcotics while pregnant that resulted in infant dependence or death of the

related to associated crimes, such as Eldred’s theft as a method to purchase more drugs).

440. *Robinson v. California*, 370 U.S. 660, 664 (1962).

441. *Id.*

442. *Id.* at 666.

443. *See Menno supra* note 6.

444. *Whitner v. State*, 492 S.E.2d 777, 786 (S.C. 1997); *Ex Parte Ankrom*, 152 So. 3d 397, 429 (Ala. 2013).

445. TENN. CODE ANN. § 39-13-107 (2015).

infant once born.⁴⁴⁶ The Tennessee law further recognized enrollment and sustained engagement in treatment as an affirmative defense.⁴⁴⁷ That law contained a sunset provision which caused it to expire in 2016.⁴⁴⁸ Legislators have unsuccessfully tried to re-introduce a similar bill in Tennessee.⁴⁴⁹ The Tennessee law was highly controversial: some critics referred to the law as criminalizing women and pregnancy,⁴⁵⁰ while Tennessee State Representative, Terri Weaver, insisted the law was intended as a measure of accountability that would motivate recalcitrant women with severe addiction to enter treatment.⁴⁵¹

Two notable courts in *Whitner v. State*⁴⁵² and *Ex Parte Ankrom*⁴⁵³ deviate from most jurisdictions in their treatment of prenatal substance abuse.

a. *Whitner v. State*

In *Whitner v. State*, Cornelia Whitner was charged with criminal child neglect pursuant to South Carolina's child abuse and endangerment statute when she admitted to smoking crack cocaine during her pregnancy.⁴⁵⁴ Her actions caused her third child, Tevin, to be born with cocaine metabolites in his system.⁴⁵⁵ The case did not reflect an isolated incident, but rather a pattern of conduct by a mother who routinely placed her children at risk. From the time she was a teenager, Whitner struggled with addiction, abusing marijuana, alcohol, cocaine, and crack

446. *Id.* §§ 39-13-107, 39-13-214.

447. *Id.* § 39-13-107.

448. *Id.*

449. AMNESTY INT'L, *supra* note 314, at 7-8.

450. *Id.*

451. Mallory Yu, *In Tennessee, Giving Birth to a Drug Dependent Baby Can Be a Crime*, HOUS. PUB. MEDIA (Feb. 10, 2017), <https://www.houstonpublicmedia.org/npr/2017/02/10/455924258/in-tennessee-giving-birth-to-a-drug-dependent-baby-can-be-a-crime/> [https://perma.cc/4GVE-FAT4].

452. *Whitner v. State*, 492 S.E.2d 777, 782 (S.C. 1997).

453. *Ex Parte Ankrom*, 152 So. 3d 397, 404 (Ala. 2013).

454. *Whitner*, 492 S.E.2d at 778-79.

455. *Id.* at 779; *see also* Levinson, *supra* note 332.

cocaine.⁴⁵⁶ To fund her addiction, Whitner relied on theft and prostitution, allegedly leaving her children unattended without food for days and disappearing after leaving them with relatives.⁴⁵⁷ While pregnant with Tevin, Whitner was charged with child neglect of her existing two children; the presiding judge sentenced her to probation on the condition she avoid drugs and alcohol and avoid further legal trouble.⁴⁵⁸ Two months later, Whitner appeared before the same presiding judge, charged with criminal child abuse and endangerment for delivering cocaine metabolites into Tevin’s system.⁴⁵⁹

Whitner addressed the question of whether the legislature intended for the state’s child endangerment statute to apply to “unborn children.” The court reasoned that it is the policy of the state to protect children from harm, accepting through judicial notice that recurrent prenatal substance abuse can cause serious harm to children.⁴⁶⁰ Examining fetal homicide laws as a comparison, *Whitner* opined it would be “unsound, illogical, and unjust” to recognize harm to the fetus from a third party, but to insulate the mother from culpability for acts that would also harm or injure the fetus.⁴⁶¹ The *Whitner* court held that the fetus has an independent right to protection from the state.⁴⁶² Remarkably, *Whitner* cited oft-forgotten precedent from *Roe v. Wade* and *Planned Parenthood v. Casey* that recognized – and balanced – competing interests of pregnant women and fetuses.⁴⁶³ The *Roe* court held that the state’s protection of the life and health of a viable fetus is not merely legitimate, but the state’s interest becomes compelling at the point of viability.⁴⁶⁴ The court in *Casey* went further, holding that the state professes a “substantial

456. Levinson, *supra* note 332.

457. *Id.*

458. *Id.*

459. *Id.*

460. *Whitner*, 492 S.E.2d at 782.

461. *Id.* at 780.

462. *Id.* at 783.

463. *Id.* at 785-86. *See also* *Roe v. Wade*, 410 U.S. 113, 193 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833, 867 (1992).

464. *Whitner*, 492 S.E.2d at 785-86; *Roe*, 410 U.S. at 193.

interest” in protecting potential life of the fetus not only after viability but throughout the entire pregnancy.⁴⁶⁵

Whitner argued that applying the statute constituted an invasion of her privacy.⁴⁶⁶ The court in *Whitner* dismissed her argument that applying the child endangerment statute to conduct during pregnancy infringes upon women’s right to privacy, and said that it “strains belief” to argue that abusing crack cocaine during pregnancy should be encompassed within a right to privacy because such conduct is already illegal.⁴⁶⁷ According to *Whitner*, including “unborn children” within the scope of the child endangerment law neither criminalizes pregnancy nor applies to seeking an abortion, but rather recognizes that certain actions during pregnancy already constitute a crime.⁴⁶⁸

b. Ex Parte Ankrom

Similar to *Whitner*, the court in *Ex Parte Ankrom* addressed whether the state’s criminal chemical child endangerment statute included unborn children.⁴⁶⁹ *Ex Parte Ankrom* involved two separate defendants, Hope Ankrom and Amanda Kimbrough.⁴⁷⁰

On several occasions throughout her pregnancy, Ankrom tested positive for cocaine and marijuana, and prior to the birth of B.W. she again tested positive for cocaine.⁴⁷¹ When Ankrom’s son B.W. was born and tested positive for cocaine metabolites, Ankrom was charged and pled guilty to violating the state’s child endangerment statute that criminalized causing a child to be exposed to, to ingest or inhale, or to have contact with a controlled substance.⁴⁷²

During her pregnancy with her third child Timmy, Amanda Kimbrough’s physician and Timmy’s biological father both

465. *Casey*, 505 U.S. at 867.

466. *Whitner*, 492 S.E.2d at 777.

467. *Id.* at 768. To be sure, crimes connected to controlled substances pertain to possession, distribution, or public intoxication, rather than ingestion.

468. *Id.*

469. *Ex Parte Ankrom*, 152 So. 3d 397, 397-98 (Ala. 2013).

470. *Id.* at 397.

471. *Id.* at 402.

472. *Id.* at 430.

confronted her about her methamphetamine abuse, which she denied.⁴⁷³ At 25 weeks into the pregnancy, Kimbrough went into preterm labor, delivering Timmy via Caesarian section.⁴⁷⁴ Born alive but not breathing, Timmy was intubated and placed on a ventilator. Timmy died nineteen minutes after birth.⁴⁷⁵ The medical examiner who performed an autopsy on Timmy determined that the cause of death was acute methamphetamine toxicity transferred by Kimbrough.⁴⁷⁶ In a subsequent interview with CPS, Kimbrough admitted to methamphetamine abuse during pregnancy, prior to Timmy's preterm birth.⁴⁷⁷

The court in *Ex Parte Ankrom* held that Alabama state public policy protects the life of unborn children, particularly when the unborn life is capable of living outside the womb, in recognition that every child is entitled to live in safety, in a reasonably healthy environment, and survive into adulthood.⁴⁷⁸ Citing *Whitner*, the *Ex Parte Ankrom* court also held that fetal homicide laws provided comparable precedent to permit prosecution for acts that injure or cause the death of a viable fetus.⁴⁷⁹ Indeed, the *Ex Parte Ankrom* court reasoned that "it would be absurd to recognize the fetus as a person for homicide and wrongful death statutes, but not for statutes proscribing child abuse."⁴⁸⁰ Stating that the court was unconvinced by the majority of jurisdictions that do not recognize the application of criminal child endangerment statutes as applied to fetuses, the court reasoned that it could not abandon common sense.⁴⁸¹ To support its reasoning, the court looked to dictionary definitions of "child;" Merriam-Webster's Dictionary defined child to include an "unborn or recently born person" and Black's Law Dictionary included "a baby or fetus" within the definition of "child."⁴⁸²

473. *Id.* at 403.

474. *Id.*

475. *Id.*

476. *Id.*

477. *Id.* at 404.

478. *Id.* at 404, 416.

479. *Id.* at 423.

480. *Id.* at 406.

481. *Id.* at 409.

482. *Id.* at 411.

Accordingly, in Alabama, delivery of a controlled substance to the fetus constitutes a crime at the time of infliction, and includes all “unborn children” without distinction to viability.⁴⁸³

Whitner and *Ex Parte Ankrom* stand in the minority of most decisions; most jurisdictions dismiss charges and overturn convictions of pregnant mothers’ conduct of habitual substance abuse during pregnancy that cause harm to, or the death of, their born infant.⁴⁸⁴ Many courts appear to be locked into inaction: the concurrence in *State v. Louk* acknowledged that “however addiction may explain irresponsible behavior, it does not excuse it,” but lamented that the state’s law was “inadequate to address this tragedy.”⁴⁸⁵ Writing for the dissent in *State v. Louk*, Justice Loughry convincingly argued that the court should not have looked at the status of the victim when the crime occurred.⁴⁸⁶ Rather, infants born alive who died from prenatal drug toxicity or related complication following their birth died by reason of a chain of circumstances: the pregnant mother’s drug abuse was the causal factor of a child’s injury or death, an action or series of actions for which the law should hold her criminally responsible.⁴⁸⁷

V. POLICY SOLUTIONS TO ADDRESS PRENATAL SUBSTANCE ABUSE

Integrating varied state law responses, this section will discuss the concept of a prenatal duty and offer policy strategies to initiate both healthcare and legal intervention during the prenatal period to most effectively address prenatal substance abuse.

A. *Defining Prenatal Duty*

Some legal scholars and courts adopt the position that the state not only has a duty to protect children, but also holds a duty to protect the health of the unborn.⁴⁸⁸ This places a corresponding

483. *Id.* at 416.

484. See generally Krista Stone-Manista, *Protecting Pregnant Women: A Guide to Successfully Challenging Criminal Child Abuse Prosecutions of Pregnant Drug Addicts*, 99 J. CRIM. L. & CRIMINOLOGY 823 (2009).

485. *State v. Louk*, 786 S.E.2d 219, 229 (W. Va. 2016).

486. *Id.* at 234-35.

487. *Id.* at 237.

488. Logli, *supra* note 320.

duty on pregnant mothers to maintain a minimum standard of care.⁴⁸⁹ Legal scholars Andrew Weisberg and Frank Vandervort note that substance abuse during pregnancy increases the risk of inflicting serious and lasting harm on the future child, underscore that each incident imposes an entirely avoidable, unnecessary, and unacceptable risk, and remark that the resulting harm can be severe or permanent.⁴⁹⁰ Attorney Patricia Congdon (adopting arguments from *Roe* and *Casey*) asserts that there is a legally binding obligation to refrain from endangering or neglecting the fetus through substance abuse, particularly once the pregnant mother has accepted the pregnancy.⁴⁹¹

This applies not only to substance abuse, but also to conduct that far deviates from a minimal standard of care such that it causes demonstrable harm to the infant. In *People v. Pointer*, the court addressed a mother whose diet was so excessively restrictive she suffered from such severe malnutrition and starvation throughout her pregnancy that caused her infant to be born with “severe growth retardation and permanent neurological damage.”⁴⁹² This mother also had other children in her care who were malnourished and suffered discrete physical harm as a result of her care.⁴⁹³ The *Pointer* court held that protecting the health of unborn children was a legitimate government objective and that the government had a duty to intervene, particularly where the mother had no intention of modifying the actions that had already caused harm to several of her children.⁴⁹⁴ Legal scholar Phillip Johnson reasons that if the mother has a legal and moral duty to refrain from starving her children or administering controlled substances and alcohol to them after birth, there is no

489. *Id.*; Philip Johnson, *The ACLU Philosophy and the Right to Abuse the Unborn*, 9 CRIM. JUST. ETHICS 48, 50 (1990); Andrew J. Weisberg & Frank E. Vandervort, *A Liberal Dilemma: Respecting Autonomy While Also Protecting Inchoate Children From Prenatal Substance Abuse*, 24 WM. & MARY BILL RTS. J. 659, 660 (2016).

490. Weisberg & Vandervort, *supra* note 489, at 670, 702.

491. Patricia R. Congdon, Note, *Prenatal Prosecution: Taking a Stand for the State and the Well-Being of its Soon-to-Be Citizens*, 5 CHARLESTON L. REV. 621, 643 (2011).

492. *People v. Pointer*, 151 Cal. App. 3d 1128, 1133 (Ct. App. 1984).

493. *Id.* at 1132.

494. *Id.*

reason to exempt her from the same duty of care during pregnancy.⁴⁹⁵

Parents have the primary responsibility to ensure the health, safety, and well-being of their children, and as such they should not be permitted to engage in objectively harmful behavior toward their offspring.⁴⁹⁶ Accordingly, the state has a duty to intervene in cases where a mother with substance abuse cannot, or will not, take steps to protect her future infant or children.⁴⁹⁷

B. Stepped Strategies to Address Prenatal Substance Abuse

Legal scholars Jeremiah Ho and Alexander Rovzar suggest a facilitative approach, whereby the state shares the interest in promoting both maternal and fetal health during pregnancy with the pregnant patient.⁴⁹⁸ Ho and Rovzar suggest early identification of substance abuse via universal screening and toxicology testing as a method to identify pregnant women in need of assistance or treatment, and suggest offering stepped care based on each patient's own treatment needs.⁴⁹⁹ Importantly, Ho and Rovzar note the insufficiency of relying on substance abuse screening after the infant is born because this model does not address or remediate preventable prenatal substance abuse and harm to the infant that occurred during the pregnancy.⁵⁰⁰ Health care providers could offer treatment during the pregnancy, but they may have insufficient resources to effectively assist with referrals and follow-up and, acting alone, they would have no means to produce accountability.

To facilitate the referral of treatment services and oversight, states could notify CPS during the pregnancy rather than following the infant's birth.⁵⁰¹ Ideally, CPS would assist with

495. Johnson, *supra* note 489, at 49.

496. Congdon, *supra* note 491, at 643.

497. Weisberg & Vandervort, *supra* note 489, at 706.

498. Jeremiah Ho & Alexander Rovzar, *Preventing Neonatal Abstinence Syndrome Within the Opioid Epidemic: A Uniform Facilitative Approach*, 54 HARV. J. LEGIS. 301, 332 (2017).

499. *Id.* at 392.

500. *Id.* at 305.

501. Weisberg & Vandervort, *supra* note 489, at 687; Ho & Rovzar, *supra* note 498, at 318.

providing the pregnant patient with information on effective treatment programs for pregnant and parenting mothers.

Health professionals and policymakers should clarify that state intervention through CPS functions as a method to facilitate treatment and does not constitute an unwarranted or punitive intervention. Even in states that classify prenatal substance abuse as civil child abuse, media reports and recent cases exemplify how this strategy still permits multiple cases to slip through the cracks.⁵⁰² In such cases, a carefully applied civil commitment model could serve the dual roles of facilitating treatment for the pregnant mother and preventing harm to the future infant.⁵⁰³

As an alternative for cases in which pregnant and parenting women refuse or leave treatment, states may consider the role of prosecution as a last resort for extreme circumstances. Criminal prosecutor Paul Logli asserts that prosecutors have a duty to protect all children and are thus bound to investigate reports of infants exposed or dependent on controlled substances or alcohol.⁵⁰⁴ No prosecutor, according to Logli, can stand by while a child is allowed go home with a parent who is actively engaging in substance abuse because there is a high probability that the child will re-enter the system as a victim of abuse or neglect.⁵⁰⁵ Logli and Johnson agree that prosecution should serve as a force for accountability and assistance, by first offering treatment and utilizing strategies such as deferred prosecution to foster rehabilitation.⁵⁰⁶ If the pregnant woman who is engaging in substance abuse successfully adheres to the drug treatment program and refrains from substance abuse, then the court should dismiss any criminal charges.⁵⁰⁷ If, however, the pregnant woman refuses treatment or continues substance abuse, Logli and Johnson suggest that the courts may then use punitive measures.⁵⁰⁸ Criminal prosecution in those cases signals to the community that society will enforce social norms, but will

502. *See supra* Part III (B).

503. Weisberg & Vandervort, *supra* note 489, at 662; Congdon, *supra* note 491, at 644 (providing an example of a model statute).

504. Logli, *supra* note 320, at 561.

505. *Id.* at 562.

506. *Id.* at 563; Johnson, *supra* note 489, at 49.

507. Johnson, *supra* note 489, at 49.

508. *Id.*

sanction egregious and harmful conduct by setting limits on what actions are not morally tolerable.⁵⁰⁹

Finally, states should address the question of how to hold pregnant and parenting women accountable for actions that result in harm or death to infants and children. They should adopt the reasoning proffered by Justice Loughry in the *State v. Louk* dissent.⁵¹⁰ If a pregnant mother's drug abuse was a causal factor in the child's death or injury, then the law should hold her criminally accountable. As Logli correctly asserts, ignoring an infant's death or evading responsibility by reason of lack of legal recourse is simply unconscionable.⁵¹¹

CONCLUSION

Prenatal substance abuse moves beyond impacting the pregnant patient. It influences developmental outcomes for infants and radiates into the social well-being of families. It also corresponds to civil interventions and criminal violations for actions related to substance abuse, such as child neglect, abuse, and homicide. Women struggling with dependence or addiction should be offered treatment, assistance, and effective resources to discontinue substance abuse.

However, health professionals and policymakers must re-examine the unanswered questions of how to address situations where the treatment itself poses serious risks and consider whether current clinical recommendations accurately disclose those risks. This includes situations where the treatment does not work and pregnant and parenting women continue to abuse substances while enrolled in treatment or refuse treatment. Further, policymakers must consider at what point the law can – and must – intervene to protect infants and children. It is time to re-assess federal policy and current clinical care standards: acting as fiduciaries, physicians have an ethical and legal duty to explain a range of treatment options. During that explanation, physicians should explain the likelihood of success in detoxification treatment and the significant physical,

509. *Id.*

510. *State v. Louk*, 786 S.E.2d 219, 234-35 (W. Va. 2016).

511. Logli, *supra* note 320, at 566.

neurological, and psychological risks of MAT for both the patient and her future infant.

Currently, pregnant and parenting patients committed to stopping substance abuse may be advised to adopt MAT without full disclosure, and as a result, may experience side effects such as adverse neurological effects, cognitive dysfunction, somnolence, and impairment. These undisclosed effects render the already-exhausting and stressful postpartum period exceedingly difficult to manage. They may even lead to devastating accidents. Federal policy, clinical conversations, and state legislation must account for the high incidence and impact of ongoing substance abuse even when pregnant and parenting patients are enrolled in treatment. This requires modifying clinical risk-benefit calculations and raising the question of what constitutes the best method of facilitating treatment for pregnant and parenting women.

Finally, we must not equivocate substance abuse during pregnancy with a neutral social choice. It exerts a detrimental impact on infants and children. In the civil context, the law should provide a mechanism to facilitate treatment for women with SUD, serve as a lever of accountability, and should motivate engagement in treatment. Importantly, the law must also recognize that, in some cases, pregnant and parenting women's actions deviate so far from a minimum standard of care that the state has an *affirmative duty* to intercede. In doing so, the state will work to protect the rights of the child, while criminally sanctioning substance abuse that results in harm or death to infants and children.