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A No-Win Situation: Pregnant Mothers in Medication Assisted Therapy Programs Face Discrimination for Following Doctors Orders

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A No-Win Situation: Pregnant Mothers in
Medication Assisted Therapy Programs Face
Discrimination for Following Doctors Orders

*Axl Campos Kaminski**

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I. INTRODUCTION

The Centers for Disease Control has proclaimed opioid addiction a national epidemic.¹ According to new research, one in five pregnant women in the United States take some form of opioid during pregnancy, and one in twenty are addicted to opioid medications.² In response, the government has increased their attempts to regulate pregnant women's conduct in order to protect the health of unborn children.³ Opioid dependent mothers often find themselves subject to being reported to Child Protective Services ("CPS") by doctors and hospital staff for ingesting drugs while pregnant.⁴

Individuals in substance abuse treatment, including pregnant mothers receiving opioid replacement therapy, are protected from discrimination under the Americans with Disabilities Act ("ADA").⁵ However, mothers who are prescribed opioid replacement medication as part of a substance abuse treatment program are often reported in the same way, and to the same authorities as mothers who are taking illicit opioids.⁶ I argue that not only is there a strong constitutional argument against the practice of reporting mothers receiving Medication Assisted Therapy ("MAT") to social services, but also the way the federal statute is currently written and applied constitutes illegal discrimination against a group of people classified as disabled under various federal statutes.

Moreover, inconsistent reporting practices, which vary not only from state to state, but also from county to county, and hospital to hospital—create a confusing situation for pregnant mothers receiving opioid

1. CTR. FOR DISEASE CONTROL & PREVENTION, *Understanding the Epidemic*, <https://www.cdc.gov/drugoverdose/epidemic/index.html> (last visited May 1, 2018) [<http://perma.cc/9CU5-E92Z>]; see also NBC NEWS, *Pregnant on Opiates: When Following Doctors' Orders Breaks the Law*, (May 9, 2014, 1:42 AM), <https://www.nbcnews.com/news/us-news/pregnant-opiates-when-following-doctors-orders-breaks-law-n100781> [<https://perma.cc/5F6P-YNTU>].

2. Rishi J. Desai et al., *Increase in Prescription Opioid Use During Pregnancy Among Medicaid-Enrolled Women*, 123 OBSTETRICS & GYNECOLOGY 997, 1002 (2014); see also Rachel Blustain, *Medical Consensus or Child Abuse? Moms on Methadone Caught in the Middle*, THE DAILY BEAST (Sept. 2012 4:45 AM), <https://www.thedailybeast.com/medical-consensus-or-child-abuse-moms-on-methadone-caught-in-the-middle> [<https://perma.cc/PPM5-ZEGE>].

3. Brian Bornstein, *Pregnancy, Drug Testing, and the Fourth Amendment: Legal and Behavioral Implications*, 188 FAC. PUB., DEP'T PSYCHOL. 220, 220 (2003), <http://digitalcommons.unl.edu/psychfacpub/188> [<http://perma.cc/Q27U-YYJC>].

4. Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH JUST. (Dec. 2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5151516/> [<http://perma.cc/ER3D-KLKM>].

5. 42 U.S.C. § 12210 (2008); see also U.S. DEPT. HEALTH AND HUM. SERVICES, *Know Your Rights: Rights for Individuals on Medication-Assisted Treatment*, (2009), http://atforum.com/documents/Know_Your_Rights_Brochure_0110.pdf [<https://perma.cc/SH5N-K2PL>].

6. See Blustain, *supra* note 2.

replacement therapy.⁷ Federal law,⁸ including the newly passed SUPPORT for Patients and Communities Act (“SUPPORT Act”), which was signed into law on October 24, 2018, provides little guidance to the states and continues to make funding contingent on regressive reporting practices.⁹ This issue is further compounded by the fact that the basis for reporting, the presence of neonatal abstinence syndrome (“NAS”) in the newborn, fails to distinguish between mothers who are legally prescribed opioids as part of a treatment program and those who are taking illicit drugs.¹⁰

This note makes a plea to lawmakers to address the issue statutorily—by explicitly defining and creating clear categories of NAS that are screened using readily available, inexpensive, and reliable methods.

A. THE HISTORY OF MEDICATION ASSISTED THERAPY

Opioid dependence is the fastest growing substance use problem in the United States, and one of the most common reasons for seeking addiction treatment worldwide.¹¹ MAT providers utilize opioid analogs in combination with counseling and behavioral therapies in order to stabilize and improve patients’ lives.¹² The only two drugs federally approved for use as replacement therapies for opioid dependence in the United States are methadone and buprenorphine, both of which have been studied extensively and deemed to be safe.¹³ In the United States, methadone has been used for more than five decades, and is dispensed only through federally approved opioid treatment programs.¹⁴ In 2002, the Food and

7. Leticia Miranda et al., *How States Handle Drug Use During Pregnancy*, PROPUBLICA (Sept. 30, 2015), <https://projects.propublica.org/graphics/maternity-drug-policies-by-state> [<http://perma.cc/PZ23-UE9W>].

8. *See* Keeping Children and Families Safe Act of 2003, Pub. L. No. 108-36; *see also* The Comprehensive Addiction and Recovery Act S. 524 114th Cong. (2015-2016); *see also* SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2017-2018).

9. SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2017-2018) Pub. L. No. 115-271 (enacted Oct. 24, 2018).

10. *See* Lauren Jansson et al., *The Opioid Exposed Newborn: Assessment and Pharmacologic Management*, 5 J. OPIOID MGMT. 47-55 (2009) (discussing the various differential scoring tools commonly used by medical staff to diagnosis NAS. These scoring tools require medical professionals to observe and rank the infant on different categories according to the severity of their symptoms. This form of diagnosis does not distinguish between the substances causing the NAS symptoms); *see also* NBC NEWS, *supra* note 1.

11. Gavin Bart, *Maintenance Medication for Opiate Addiction: The Foundation of Recovery*, 31 J. ADDICTION DIS. 207, 225 (2012); *see also* CTR. FOR DISEASE CONTROL & PREVENTION, *Understanding the Epidemic*, <https://www.cdc.gov/drugoverdose/epidemic/index.html> (last visited May 1, 2018) [<http://perma.cc/9CU5-E92Z>].

12. SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., *Medication and Counseling Treatment*, <https://www.samhsa.gov/medication-assisted-treatment/treatment> (last visited May 6, 2018) [<https://perma.cc/D8MC-MXRE>].

13. PROVIDERS CLINICAL SUPPORT SYS., *Pregnancy: Methadone and Buprenorphine* http://pcssnow.org/wp-content/uploads/2015/10/WAGBrochure-Opioid-Pregnancy_Final.pdf (last visited May 13, 2018) [<https://perma.cc/NDX4-9CYP>].

14. SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., *Report to Congress on the*

Drug Administration (“FDA”) approved buprenorphine for the treatment of opioid dependence, however, physicians must obtain specialized training to prescribe it.¹⁵ Some of these trained physicians are in private office-based practices, while others are affiliated with substance abuse treatment facilities.¹⁶

MAT has a proven track record as the most effective treatment for opioid dependent individuals.¹⁷ Patients have substantially lower rates of dropout than other forms of addiction treatment, and methadone maintenance (“MM”) treatment is associated with large decreases in criminal activity, and a reduction in HIV and Hepatitis C transmission.¹⁸ Unfortunately, many communities and social service agencies view MAT providers and their patients with antipathy or disdain.¹⁹ Often, they misunderstand opiate agonist therapy and consider MAT providers to be little more than legalized drug dealers. Consequently, many communities and social service agencies want nothing to do with the providers or their patients.²⁰

B. MOTHERS ON MEDICATION ASSISTED THERAPY

The misuse of opioids during pregnancy significantly increases rates of preterm birth, spontaneous abortion, and infant mortality.²¹ Opioid dependence during pregnancy results in a six-fold increase in obstetric complications and a seventy-four-fold increase in sudden infant death syndrome.²² In pregnancy, MAT serves to stabilize the uterine environment, protecting the fetus from the stress of repeated withdrawal.²³

MAT has been considered the gold standard of care for mothers diagnosed with opioid use disorder for decades.²⁴ Infant mortality rates

Nation's Substance Abuse and Mental Health Workforce Issues, (Jan. 24, 2013), <https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf> [<http://perma.cc/4MLZ-XC4L>].

15. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training> (last visited Dec. 15, 2019) [<https://perma.cc/BN4J-QZR4>].

16. *Id.*

17. Bart, *supra* note 11.

18. *Id.*

19. Jeff Deeney, *A Methadone Clinic? Not in My Neighborhood!*, SUBSTANCE.COM <https://www.substance.com/a-methadone-clinic-not-in-my-neighborhood/> (last visited Apr. 18 2015) [<https://perma.cc/8GGH-2LHE>].

20. *Id.*

21. Eliza M. Park et al., *Evaluation and Management of Opioid Dependence in Pregnancy*, 53 PSYCHOSOMATICS 424 (2012).

22. O. Fajemirokun-Odudeyi et al., *Pregnancy Outcome in Women who use Opiates*, 126 EUR. J. OBSTETRICS, GYNECOLOGY, & REPROD. BIOLOGY 170 (2006).

23. Margaret A. Jarvis & Sidney H. Schnoll, *Methadone Treatment During Pregnancy*, 26 J. PSYCHOACTIVE DRUGS 155 (1994).

24. Stone, *supra* note 4.

among mothers receiving MAT are higher than rates among women who have not used any substances during pregnancy.²⁵ However, when compared with outcomes of substance-using women who are not in treatment, it is clear that MAT lowers infant mortality rates and promotes fetal stability.²⁶ Despite the controversy associated with MAT, it has been proven to be the most effective treatment for opioid dependent mothers who have been unreceptive or unsuccessful with abstinence-based treatment approaches.²⁷ Studies have shown that abstinence without opioid assisted therapy during pregnancy has only about a 1-4% success or compliance rate.²⁸ One study of abstinence based treatment showed that out of 101 pregnant mothers who were opioid dependent, only 42 completed withdrawal, and out of those, only 1 tested free from opioids at delivery.²⁹

Infants prenatally exposed to opioids in utero often become passively addicted.³⁰ NAS manifests 24-72 hours after birth because the infant is abruptly cut off from narcotics used by the mother during pregnancy.³¹ Between 55% and 94% of infants born to opioid dependent women show signs of NAS.³² The symptoms include: irritability, hyper-reflexia, hyperactivity, abnormal cry, diarrhea, fever, vomiting, respiratory distress, tachypnea, convulsions or seizures, and coma.³³ Although the symptoms of NAS are jarring and upsetting to observe, studies have found that NAS responds well to both pharmacological and non-pharmacological treatment.³⁴

After adjustment for social disadvantage, the weight of evidence suggests that methadone treatment throughout pregnancy does not generally have significant adverse effects on postnatal development.³⁵ When compared to the developmental outcomes of children exposed to

25. Scott A. Shinker, *Opioid Addiction in Pregnancy*, 67 OBSTETRICAL & GYNECOLOGICAL SURV. 817 (2012).

26. Ursula A. Pritham et al., *Methadone and buprenorphine treatment during pregnancy: What are the effects on infants?*, 11 NURSING FOR WOMEN'S HEALTH 558 (2007).

27. Pritham et al., *supra* note 26.

28. Jason Luty et al., *Is Opiate Detoxification Unsafe in Pregnancy?*, 24 J. SUBSTANCE ABUSE 363 (2003).

29. *Id.*

30. Karol Kaltenbach & Loretta Finnegan, *Neonatal Abstinence Syndrome, Pharmacotherapy and Developmental Outcome*, 8 NEUROBEHAVIORAL TOXICOLOGY & TERATOLOGY 353, 353 (1986).

31. Prabhakar Kocherlakota, *Neonatal Abstinence Syndrome*, 134 PEDIATRICS 547 (Aug. 2014).

32. Walter Kraft, *Pharmacologic Management of the Opioid Neonatal Abstinence Syndrome*, 59 PEDIATRIC CLINIC N. AM. 1147 (2012); *see also* AM. ACAD. OF PEDIATRICS COMM. ON DRUGS, *Neonatal drug withdrawal*, 101 PEDIATRICS 1079 (1998).

33. *Id.*

34. Walter Kraft, *Buprenorphine in Neonatal Abstinence Syndrome*, 103 CLINICAL PHARMACOLOGY & THERAPEUTICS, 112, 117 (2018).

35. Kaltenbach & Finnegan, *supra* note 30.

illicit opioids during pregnancy, the children of mothers maintained on MAT have better developmental outcomes.³⁶ Generally the long-term developmental impact for children prenatally exposed to methadone is minimal and environmental factors in the home are more predictive of later social and developmental outcomes.³⁷

A review of the scientific evidence reveals that pregnant mothers on MAT have better treatment outcomes, receive better prenatal care than mothers using illicit opioids, and have less risk of pre and post-natal complications.³⁸ Unfortunately, a lack of education and awareness among healthcare providers and the general population has created a situation that punishes opioid dependent mothers for doing what science has proven is best for them and their children.³⁹

One of the principal hurdles when it comes to pregnant mothers on MAT is stigma. Patients receiving MAT therapies are viewed with disdain and this prejudice is magnified when the opioid dependent individual is a pregnant woman.⁴⁰ Patients are often reluctant to seek or continue treatment fearing the disapproval of friends, family, and service providers, or due to fear of unknown medical and developmental consequences for the fetus.⁴¹ Even the healthcare providers in the medical unit where infants diagnosed with NAS are treated tend to “punish” the mothers.⁴² “[S]ometimes the medical staff doesn’t want the mother to be with the baby and will work to make sure they are separated.”⁴³ This form of punitive removal only serves to harm the infant by depriving intimate contact between infant and mother during a critical stage of bonding, new evidence suggest that in order to improve developmental outcomes for the infant and to curb NAS severity, every effort should be made to keep mother and child together.⁴⁴ For the sake of the mother-infant dyad, pregnant mothers

36. Kaltenbach & Finnegan, *supra* note 30.

37. Diana Kronstadt, *Complex Developmental Issues of Prenatal Drug Exposure*, 1 FUTURE CHILD. 36 (1991).

38. *Id.* (these outcomes are only expected when the mother is earnestly following a MAT program and is not engaging in polysubstance abuse. The use of other harmful substances is common among mothers on MAT, however, this note only concerns mothers on MAT who are not using other substances).

39. Mishak Terplan et al., *Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness*, LIBERTAS ACADEMIA (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4578572/> [<https://perma.cc/L95M-3TNH>].

40. Perilou Goddard, *Changing attitudes towards harm reduction among treatment professionals: A report from the American Midwest*, 14 INT’L J. DRUG POL’Y 257 (2003).

41. William Alto & Alane O’Connor, *Management of Women Treated with Buprenorphine During Pregnancy*, 205 AM. J. OBSTETRICS & GYNECOLOGY 302 (2011).

42. Blustain, *supra* note 2.

43. *Id.*

44. See generally BEHAV. HEALTH COORDINATING COUNCIL SUBCOMM. ON PRESCRIPTION DRUG ABUSE, PROTECTING OUR INFANTS ACT: FINAL STRATEGY (2017); see also STEVE CHRISTIAN, SUBSTANCE-EXPOSED NEWBORNS: NEW FEDERAL LAW RAISES SOME OLD ISSUES,

on MAT should be met with kindness and understanding—not hostility and judgment.⁴⁵

II. THE LEGAL ISSUES

A. MOTHERS ON MEDICATION ASSISTED THERAPY ARE PROTECTED UNDER THE AMERICANS WITH DISABILITIES ACT.

Currently, the federal law creates a requirement that states have policies and procedures requiring health care providers to notify CPS of “infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure.”⁴⁶ This federal law lumps mothers who are receiving physician recommended MAT therapies into the same group as mothers using illicit drugs.⁴⁷ Instead of modifying this federal requirement, the newly approved SUPPORT Act, continues to require that states report all incidences of NAS.⁴⁸ The practice of blindly placing all women who give birth to children diagnosed with NAS in the same category is untenable and discriminatory.

Federal civil rights laws protect qualified individuals with disabilities from discrimination in many areas of life.⁴⁹ People in recovery from drug addiction, including those in MAT, are protected from discrimination by the following statutes: Americans with Disabilities Act, Rehabilitation Act of 1973, and the Fair Housing Act.⁵⁰

Section 12102 of the ADA defines a “disability” as “a physical or mental impairment that substantially limits one or more of the major life activities...”⁵¹ of a “qualified individual.”⁵² The legislative history of the

NATIONAL CONFERENCE OF STATE LEGISLATURES: CHILDREN’S POLICY INITIATIVE (Sept. 2004).

45. Terplan et al., *supra* note 39.

46. Keeping Children and Families Safe Act of 2003, Pub. L. No. 108-36; as amended by P.L. 111-320 & P.L. 115-271.

47. For the purposes of this Note mothers using illicit opioids and mothers testing positive for opioid use due to their participation in a MAT program are treated as two separate groups—wherein mothers in MAT programs are assumed not to be engaging in illicit drug use. The issue of polysubstance abuse by mothers in MAT is serious and often pervasive. However, for the purposes of this note it can be assumed that when referring to mothers on MAT, I am specifically referring to mothers who are successfully abstaining from all illicit and harmful drugs.

48. SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2017-2018) Pub. L. No. 115-271 (enacted Oct. 24, 2018).

49. U.S. DEPT. HEALTH AND HUM. SERVICES, *Know Your Rights: Rights for Individuals on Medication-Assisted Treatment*, (2009), http://atforum.com/documents/Know_Your_Rights_Brochure_0110.pdf [<https://perma.cc/SH5N-K2PL>].

50. 42 U.S.C § 12101; 29 U.S.C § 701; 42 U.S.C § 3601.

51. 42 U.S.C. § 12102(1)(A)-(C).

52. 42 U.S.C. § 12102(1); see Haley Johnston, *Exploring an Old Act for New Protection: How Title II of the ADA Protects Pregnant Women Undergoing Methadone Treatment from State Agency Child Removal* 4 INDIANA J. OF L. & SOCIAL EQUALITY 99, 114 (2016)

ADA supports the inclusion of “drug addiction” as one of the forms of physical or mental impairment protected under the ADA.⁵³

Additionally, Section 12210(b) of the ADA provides that persons “participating in a supervised rehabilitation program and no longer engaging in [illegal drug] use” cannot be excluded as a protected class.⁵⁴ Illegal use of drugs is defined in section 12210(d) as “. . . the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act.”⁵⁵ This definition distinctly does not include the use of a drug taken under the supervision of a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provisions of federal law.⁵⁶

The ADA protects disabled individuals from both private⁵⁷ and public entities.⁵⁸ Public entities are defined broadly as “any state or local government; any department, agency, special purpose district, or other instrumentality of a State or States or local government . . .”⁵⁹ States, counties, cities, CPS, private and public hospitals are all entities subject to the provisions of the ADA, meaning they cannot discriminate against protected groups.⁶⁰ Congress intended the ADA’s provisions to apply broadly and provide strong protections for individuals with disabilities in an effort to eliminate discrimination.⁶¹ Based on this broad understanding mothers on MAT should be protected under the ADA.

Several courts have confirmed that MAT patients are indeed included under the ADA’s provision. In *Ocasio v. Klassen*, the court ruled that the United States Postal Service’s policy of refusing to hire people on MAT was discriminatory.⁶² This decision led the USPS to change its hiring practices to conform to the Federal Rehabilitation Act.⁶³ In *Perez v. New York State Division of Human Rights*, the court held that a person in MAT treatment has a protected disability under the New York State Human

(discussing what a “qualified individual” is).

53. S. Rep. No 101-116, at 22 (1989) (discussing the meaning and definition of “physical or mental impairment.” In their non-exhaustive list of examples what would qualify as an impairment, the Senate included “drug addiction” and “alcoholism”); see Johnston, *supra* note 52.

54. 42 U.S.C. § 12210 (2008).

55. *Id.*; see also 21 U.S.C. § 801 (2012).

56. See 21 U.S.C. § 801 (2012) (declarations concerning controlled substances).

57. 42 U.S.C. § 12184(a).

58. See 42 U.S.C § 12101(b) (2012).

59. 42 U.S.C. §§ 12131(1) (A)-(B).

60. See Haley Johnston, *supra* note 51 at 112-115 (discussing the application of the ADA to mothers on methadone).

61. Johnston, *supra* note 52 at 113.

62. *Ocasio v. Klassen*, 73 Civ. 2496 (S.D.N.Y. Nov. 25, 1974).

63. *Id.*

Rights Law.⁶⁴ A number of other courts have recognized MAT patients as being protected based on their disability.⁶⁵

It is illegal to discriminate against MAT patients based on their disability because of their status as a protected group.⁶⁶ CPS and hospitals have no more of a right to single out MAT patients and require them to stop taking their medication than they do to tell a diabetic to stop taking their insulin.⁶⁷ Therefore, when hospitals and healthcare workers report mothers who are participating in MAT programs to CPS they are illegally discriminating against this protected class of women. Additionally, federal, state and local governments should be forbidden from instituting discriminatory policies against mothers on MAT. This institutionalized discrimination forces mothers into a situation where they must discontinue MAT, obtain an abortion, or risk losing their child to CPS. This impermissible practice also perpetuates the notion that women possess the sole responsibility for the care of their children and if they do not live up to the standard of what a “good mother” should be they are not only reprimanded, but they deserve this treatment.⁶⁸

B. A BRIEF DISCUSSION OF POTENTIAL CONSTITUTIONAL ARGUMENTS

The United States Supreme Court held in *Robertson v. California* that criminalizing the status of being a drug addict was unconstitutional and constituted cruel and unusual punishment.⁶⁹ Furthermore, in *Ferguson v. City of Charleston*, the Supreme Court struck down a South Carolina hospital’s policy of testing pregnant women for cocaine and turning positive results over to law enforcement for prosecution.⁷⁰ However, they did not conclude that all such policies were unconstitutional.⁷¹ Although it is not necessarily unconstitutional to test pregnant mothers for drugs, it does require their consent.

Testing pregnant mothers for drugs without consent violates their right to privacy. Mothers on MAT are often tested without their knowledge or consent. In some instances, the testing practices of hospitals can implicate Fourth Amendment search and seizure rights when mothers are not informed that these tests are being performed.⁷² In *Griswold v. Connecticut*, the Supreme Court located a women’s right to privacy in making

64. *Perez v. N.Y. St. Div. of Hum. Rts.*, 70 A.D. 2d 558 (N.Y.S 2d. May 24, 1979).

65. *See e.g.*, *New Directors Treatment Servs. v. City of Redding*, 490 F. 3d 293 (3d Cir. 2007); *see also* *MX Grp., Inc. v. City of Covington*, 293 F. 3d 326 (6th Cir. 2002).

66. *See* 42 U.S.C. § 12210 (2008).

67. *Jansson et al.*, *supra* note 10.

68. *See* *Terplan et al.*, *supra* note 39.

69. *Robertson v. Cal.*, 370 U.S. 660, 667 (1962).

70. *Ferguson v. City of Charleston*, 532 U.S. 67, 85 (2001).

71. *Id.*

72. *Wendy Chavkin et al., Drug-Using Families and Child Protection: Results of a Study and Implications for Change* 54 U. PITT. L. REV. 295 (1992).

reproductive decisions within the Fourth Amendment right to be secure from unreasonable searches and seizures.⁷³ Oftentimes women are not informed of the testing that is taking place while their children are being assessed for a variety of conditions. For example, in Alabama, a state with a chemical endangerment law, many hospital consent forms were found to be lacking any information regarding possible testing procedures or the consequences of positive tests.⁷⁴ Situations like this violate the mother's rights to be free from unreasonable search and seizure.⁷⁵ Tolerating this type of invasion creates a situation where it is routine for hospitals to violate a mother's right to be informed about, and to consent to such testing.⁷⁶

The federal laws mandating the reporting of children suspected of suffering from NAS are vague and do not provide adequate notice to mothers on MAT. The federal law's failure to exempt, distinguish, or specifically address the reporting of NAS caused by a mother's participation in a MAT program deprives these mothers of sufficient notice that they may be subject to the same reporting as mothers taking illegal drugs.⁷⁷ The federal law does not clearly address mothers on MAT and whether or not they will be reported as if they were taking illicit drugs. The Keeping our Children and Families Safe Act only required reporting of NAS caused by exposure to illegal drugs but did not require testing or procedures for distinguishing between NAS caused by legally prescribed drugs.⁷⁸ The language was slightly changed in 2016 by the Comprehensive Addiction and Recovery Act ("CARA"), which requires that a report be made for "infants born and identified as being affected by substance abuse."⁷⁹ It remains unforeseen if the terminological shift has had any actual effect on mothers in MAT because they were already being reported, however, it did explicitly broaden the group of individuals that hospitals are required to report. This updated language has been carried over into the SUPPORT Act.⁸⁰

73. Bornstein, *supra* note 3; *citing* Griswold v. Connecticut, 381 U.S. 479 (1965).

74. Nina Martin, *How Some Alabama Hospitals Quietly Drug Test New Mothers—Without Their Consent*, PROPUBLICA (Sept. 15, 2015) <https://www.propublica.org/article/how-some-alabama-hospitals-drug-test-new-mothers-without-their-consent> [<https://perma.cc/6FRZ-UPCU>].

75. *Id.*

76. *Id.*

77. *See* Keeping Children and Families Safe Act of 2003, Pub. L. No. 108-36; *see also* The Comprehensive Addiction and Recovery Act S. 524 114th Cong. (2015-2016); *see also* SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2017-2018) Pub. L. No. 115-271 (enacted Oct. 24, 2018).

78. Comprehensive Addiction and Recovery Act of 2016, Pub. L. 114-198.

79. *See* the Comprehensive Addiction and Recovery Act of 2016, Pub. L. 114-198, § 503(b) *amending* § 106(b)(2)(B) of the Child Abuse Prevention and Treatment Act 42 U.S.C. 5106a(b)(2)(B).

80. SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2017-2018) Pub. L. No. 115-271 (enacted Oct. 24, 2018).

Despite the broader language, the choice not to explicitly exempt or require specific screening procedures to identify mothers on MAT was a missed opportunity which will continue to disadvantage mothers on MAT. Mothers on MAT are not abusing a substance but rather are partaking in a treatment program. Therefore, although, this language expands the category of women to be reported, it still falls short of notifying mothers on MAT that they are included in this group. I argue that the application of this reporting requirement is unconstitutionally vague because it does not provide clear notice to mothers on MAT that they could be sanctioned under this reporting requirement.

Additionally, there is precedent to raise an equal protection argument. Studies have shown that although urine tests of both black and white women revealed both groups are just as likely to have used illicit substances, black women were ten times more likely to be reported to the local authorities.⁸¹ This type of testing and reporting disproportionately and discriminatorily impacts the lives of poor women of color.⁸² The demographics of opioid users are rapidly changing as the growing class of opioid abusers tends to be predominantly middle class white suburban residents. However, the women who are reported and prosecuted still tend to be poor women of color.⁸³ Additionally, because of the protections MAT patients are granted under various federal statutes, it is discriminatory to single these mothers out and force them into a situation where their only options are to obtain an abortion, discontinue their medical treatment, or risk losing their child to CPS.

There are several other valid constitutional concerns that could be raised in this context; however, to raise them all here would be beyond the scope of this note.

C. CASE STUDY

A brief search of news articles reveals that there are countless instances of mothers on MAT being separated from their children for following their doctor's orders. Rebecca's story is just one of many that demonstrates the complicated and difficult situation that mothers on MAT are placed in.⁸⁴

"Rebecca's obstetrician was off duty on the day she went into labor in 2010."⁸⁵ This posed an insurmountable problem for Rebecca because she was taking methadone on doctor's orders—something her regular

81. Sherry Deren et al., *Children of Substance Abusers in New York State*, 90 N.Y. ST. J. MED. 179 (1990); U.S. GEN. ACCT. OFF., *Drug-exposed infants: A Generation at Risk, Report to the Chairman, Committee of Finance, U.S. Senate*, (1990); see also Ira J. Chasnoff et al., *The Prevalence of Illicit-drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 N. ENG. J. MED. 1202 (1990).

82. See Chasnoff et al., *supra* note 81.

83. *Id.*

84. Blustain, *supra* note 2 (mothers name has been changed to protect her identity).

85. *Id.*

obstetrician was well aware of.⁸⁶ Rebecca was legally prescribed methadone eight months earlier in an effort to help break her addiction to the prescription painkiller Vicodin.⁸⁷ Doctors told her it was the best thing she could do for the fetus growing inside her.⁸⁸ Despite the fact that every major health organization in North America supports the use of methadone during pregnancy for similarly situated mothers, the hospital staff treated Rebecca with disdain and immediately assumed that Rebecca was abusing methadone.⁸⁹

“Between contractions, Rebecca tried frantically to convince the staff that she was only doing what her doctor had ordered.”⁹⁰ Doctors and hospital staff ignored her pleas.⁹¹ The surgeon asked, “Do you want an epidural or do you want painkillers?”⁹² Rebecca remembers him replying rhetorically: “You probably want painkillers, because you’re a drug addict.”⁹³ Despite ridicule from hospital staff, Rebecca’s son “Sam, was delivered via Caesarean section in good health: [weighing in at] 8 pounds, 1 ounce.”⁹⁴ Rather than waking up to Sam’s face Rebecca was greeted with a barrage of question from hospital staff and social workers.⁹⁵ Rebecca had no chance, the doctors and hospital staff made up their minds before even talking to her or doing any research into her situation.⁹⁶ Investigators from CPS told Rebecca she would not be allowed to go home with her boyfriend because he was also on MM.⁹⁷ “They said she could only keep her baby if a family member supervised her around the clock.”⁹⁸ She would not even be allowed to sit in the same room with Sam alone.⁹⁹

The case dragged on throughout the first year of Sam’s life, which is common for mothers in Rebecca’s situation.¹⁰⁰ Once family service agencies are involved, they tend to stay involved.¹⁰¹ Rebecca’s doctors cautioned her that if she weaned herself from methadone too rapidly, she could relapse.¹⁰² Shortly before Sam’s first birthday, Rebecca’s relatives

86. Blustain, *supra* note 2.

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

decided they could no longer manage the burden of supervising her, and a social worker came and placed her son in a foster home.¹⁰³

In total disregard of what Rebecca's doctors advised, the judge assigned to Rebecca's case said he wouldn't close her case until she got off methadone.¹⁰⁴ When she introduced letters from experts testifying that the federal government recommends MM for opioid-addicted women, she said the judge told her, "I can make a paper airplane out of these papers and glide it across the courtroom."¹⁰⁵

After the ordeal was resolved and her child returned to her, Rebecca said a caseworker who visited her home told her: "Y'all did good. Y'all are reformed. We actually changed you."¹⁰⁶ Rebecca has a different view of what happened: "What they did was terrify us, traumatize my son, ruin my relationship with my family, and leave us in so much debt that we lost our house. I felt like they'd destroyed my life, even though everything I'd done since I'd found out I was pregnant was absolutely legal."¹⁰⁷

Cases like this are becoming increasingly more common.¹⁰⁸ Maternal-health and drug treatment advocates report that more patients are being charged with child abuse for undergoing MAT despite the strong scientific evidence that MAT is the most effective treatment for pregnant mothers with opioid addiction.¹⁰⁹ In some areas of the country the number of infants admitted to the NICU for NAS has increased tenfold.¹¹⁰ This statistic is not surprising considering that between 2000 and 2009 there has been a five-fold increase in reports of pregnant women using opioids and the numbers have only gotten worse in recent years.¹¹¹

Compounding the issue is the fact that in the majority of states the diagnostic tool used to determine NAS fails to distinguish between mothers in MAT treatment and those taking illicit opioids.¹¹² The enforcement of the federal rule requiring reporting of NAS is completely arbitrary with hospitals in the same county having differing policies.¹¹³ Moreover,

103. Blustain, *supra* note 2.

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.*

108. Bart, *supra* note 11.

109. *Id.*

110. Kocherlakota, *supra* note 31.

111. M. J. Hayes & M. S. Brown, *Epidemic of Prescription Opiate Abuse and Neonatal Abstinence*, 307 JAMA 1974,1975 (2012); see also R. J. Desai et al., *Increase in Prescription Opioid Use During Pregnancy Among Medicaid-Enrolled Women*, 123 OBSTETRIC GYNECOLOGY 997 (2014).

112. Maia Szalavitz, *How Drug Laws Aimed at Pregnant Women Penalize Their Children*, THE VERGE (Mar. 25 2016) <https://www.theverge.com/2016/3/25/11301898/prenatal-drug-testing-custody-laws-child-welfare> [<https://perma.cc/FFP3-7RZ5>].

113. NBC NEWS, *supra* note 1.

caseworkers and judges appear to overrule doctors' orders and even official child-welfare policies.¹¹⁴ Mothers get caught in the middle because “[j]udges and caseworkers are practicing medicine without a license, even against medical advice.”¹¹⁵ This frightening and confusing landscape helps explain why parents struggling with addiction often choose to hide their drug problems rather than ask for help.¹¹⁶

D. STATE AND LOCAL POLICY DICTATES TESTING POLICIES

There is currently no national standard of care or protocol for screening or treating NAS.¹¹⁷ Federal law simply requires the reporting of “infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure.”¹¹⁸ There are multiple scoring tools used to screen infants to determine the appropriate course of treatment, however, none of them distinguish the medications used in MAT from illicit opioids.¹¹⁹

Because of the lack of clear federal regulation, screening procedures, legal standards, and policies vary widely from state to state.¹²⁰ Fifteen states have laws that require healthcare professionals to report pregnant mothers if drug use is suspected.¹²¹ However, only four states have laws that require hospitals to test infants and mothers for controlled substances.¹²² Even among the states that require drug testing the hospitals are left with the discretion to decide when, how, and who to test.¹²³

Of forty-six states that responded to the Government Accountability Office's questionnaire,¹²⁴ seventeen reported that all notifications of substance-affected infants are accepted for investigation, regardless of the circumstances.¹²⁵ The remaining twenty-nine states reported that they apply specific criteria to determine if children who present as substance-affected

114. Blustain, *supra* note 2.

115. *Id.*

116. *Id.*

117. See CHRISTIAN, *supra* note 44.

118. See Keeping Children and Families Safe Act of 2003, Pub. L. No. 108-36; see also The Comprehensive Addiction and Recovery Act S. 524 114th Cong. (2015-2016); see also SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2017-2018) Pub. L. No. 115-271 (enacted Oct. 24, 2018).

119. See Jansson et al., *supra* note 10.

120. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 18-196, SUBSTANCE-AFFECTED INFANTS—ADDITIONAL GUIDANCE WOULD HELP STATES BETTER IMPLEMENT PROTECTIONS FOR CHILDREN (Jan. 2018) [hereinafter GAO 18-196].

121. *Id.*

122. *Id.*

123. CHRISTIAN, *supra* note 44.

124. GAO 18-196, *supra* note 120.

125. *Id.*

are accepted for investigation by CPS.¹²⁶ “Examples of the differences include the following: South Carolina relies on a single positive drug test result, Florida mandates reporting newborns that are ‘demonstrably adversely affected’ by prenatal drug exposure, and in Texas, an infant must be “addicted” to an illegal substance at birth.”¹²⁷ The federal law allows for too much inconsistency and places pregnant mothers on MAT in the precarious situation of not knowing who to trust or what standard they will be held to.¹²⁸ This creates poor outcomes for both the mother and the developing fetus.

States also vary widely in the severity and type of enforcement mechanisms they choose to implement. For example, in 2014, Tennessee adopted a statute that specifically made it a crime to use drugs while pregnant—fortunately the state has since let the statute expire.¹²⁹ Additionally, high courts in Alabama and South Carolina have interpreted existing child endangerment statutes to allow for prosecution of drug dependent pregnant mothers.¹³⁰ Eighteen states have chosen to impose civil liability for child abuse due to substance abuse during pregnancy and three states allow involuntary commitment of mothers found to be using drugs.¹³¹ Wisconsin civil commitment laws are especially regressive and actually allows for a pregnant mother to be detained against her will for the duration of the pregnancy and provides the fetus with a court-appointed attorney.¹³² The wide array of sanctions only serves to further alienate pregnant mothers from the medical and social welfare systems.

The ‘Protecting Our Infants Act: Final Strategy’ issued by the Department of Health and Human Services (“HHS”) found that it is necessary to distinguish NAS caused by non-opioid drugs and NAS caused by opioid drugs to better evaluate postnatal care protocol.¹³³ The report recommended a terminological shift that would classify NAS caused by opioids as Neonatal Opioid Withdraw Syndrome (“NOWS”).¹³⁴ Some states have attempted to take steps to create a more equitable situation for mothers on MAT while still working within federal reporting guidelines.

States like Massachusetts and Oregon have followed GAO and HHS recommendations by directing their efforts towards developing new screening processes, procedures and policies to identify NAS and

126. GAO 18-196, *supra* note 120.

127. CHRISTIAN, *supra* note 44.

128. *Id.*

129. Miranda, *supra* note 7.

130. *Id.*

131. *Id.*

132. *Id.*

133. BEHAV. HEALTH COORDINATING COUNCIL SUBCOMM. ON PRESCRIPTION DRUG ABUSE, PROTECTING OUR INFANTS ACT: FINAL STRATEGY (2017).

134. *Id.*

NOWS.¹³⁵ Massachusetts has developed policies that recognize the importance of distinguishing NAS caused from exposure to drugs such as: benzodiazepines, alcohol, cigarettes, hypnotics, cocaine, and stimulants and NAS that is directly caused by prenatal-exposure to opioids.¹³⁶ This is a step in the right direction because it allows for better treatment protocols to be developed that specifically cater to infants experiencing NAS because of their mother's opioids use during pregnancy.¹³⁷ Although this is a useful distinction, it can be taken further. The technology is readily available to distinguish methadone and buprenorphine, the two commonly prescribed opioid replacement therapy drugs, from other opioids of abuse.¹³⁸

One very common and troubling occurrence that makes this screening process and distinction difficult is polysubstance abuse.¹³⁹ Even mothers properly maintained on MAT may still struggle with other substances, including, cigarettes and alcohol. Two substance that are well known to cause severe birth defects and developmental issues in the fetus. In instances of polysubstance abuse standard reporting protocols should be instituted regardless of the mother's participation in a MAT program.

"[I]n Massachusetts, CPS can "screen out" referrals of mothers if the only substance affecting the infants was used by the mothers as prescribed by their physician."¹⁴⁰ When CPS in Massachusetts is notified by the hospital about an infant, the screener gathers information from the caller and consults with a supervisor to determine whether the referral should be accepted for investigation or screened out.¹⁴¹ If the mother is on methadone and in a treatment program, CPS can verify with medical or other qualified providers that the mother used the drug legally and as prescribed.¹⁴² The screener can then determine whether the investigation should be ended or if more information is necessary.¹⁴³

Oregon has also taken action to develop protocols and procedures that identify mothers with opioid use disorder ("OUD").¹⁴⁴ Oregon officials

135. See generally OR. HEALTH AUTHORITY, OR. PREGNANCY AND OPIOIDS WORKGROUP RECOMMENDATIONS, OHA 8280 (2017-2018) see also COMMONWEALTH OF MASS., INTERAGENCY TASK FORCE ON NEWBORNS WITH NEONATAL ABSTINENCE SYNDROME, STATE PLAN FOR THE COORDINATION OF CARE AND SERVICES FOR NEWBORNS WITH NEONATAL ABSTINENCE SYNDROME AND SUBSTANCE-EXPOSED NEWBORNS (Mar. 17, 2017).

136. See generally COMMONWEALTH OF MASS., *supra* note 135.

137. BEHAVIORAL HEALTH COORDINATING COUNCIL SUBCOMM. ON PRESCRIPTION DRUG ABUSE, PROTECTING OUR INFANTS ACT: FINAL STRATEGY (2017).

138. HEALTH QUALITY ONTARIO, OPTIMUM METHADONE COMPLIANCE TESTING: AN EVIDENCE BASED ANALYSIS, 6 ONTARIO HEALTH TECH. ASSESSMENT SERIES 1 (2006).

139. GAO 18-196, *supra* note 120, at 16.

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.*

144. See generally OR. HEALTH AUTHORITY, OREGON PREGNANCY AND OPIOIDS WORKGROUP RECOMMENDATIONS, OHA 8280 (2017-2018).

developed the Oregon Pregnancy and Opioids Workgroup (“OPOW”) in recognition of the need for a comprehensive approach to optimizing health outcomes for mothers with OUD and their infants.¹⁴⁵ The OPOW has focused much of their effort on developing strategies to identify pregnant mothers with OUD.¹⁴⁶ This includes attempts at fact finding before delivery.¹⁴⁷ Oregon uses various questionnaires and databases to determine if mothers are enrolled in a MAT program in addition to other institutional safeguards that help coordinate the flow of information between healthcare providers.¹⁴⁸

Both the Oregon and Massachusetts programs specifically attempt to identify mothers who are using opioids and whose children are likely to be born suffering from NAS. However, they are doing so within a federal framework that stifles them and essentially compels them to report all incidences of NAS. The lack of federal guidance and the variation between state policies is damaging to pregnant mothers with OUD because it leaves them in fear of persecution which often causes them to avoid contact with healthcare providers.

The situation is further compounded by the variation at the county level. Not only do the policies and laws regarding testing and reporting of prenatally drug-exposed children vary by state, but there is also inconsistency at the local level.¹⁴⁹ “You can have counties right next to each other where one would not bat an eye at a baby diagnosed with NAS [and experiencing withdrawal from MAT] and would allow parents and doctors to proceed as they wish. In the next county, the baby may be kept from going home from the hospital with the mother.”¹⁵⁰ Many counties around the country consider NAS grounds for reporting cases to child welfare services regardless of whether the NAS symptoms are the result of MAT drugs or heroin.¹⁵¹ Depending on where the mother resides, she might be subject to reporting, mandatory drug treatment, or even prison.¹⁵² This is considered a perfectly acceptable practice because the federal law does not require further blood testing or for hospitals to distinguish between legally prescribed medications and illicit drugs.

The laws currently implemented that dictate the testing and reporting of prenatal drug exposure using NAS scoring criteria discriminate against and punish pregnant mothers undergoing MAT. There are no cases directly on point but the courts have addressed similar questions in dicta. For example,

145. OR. HEALTH AUTHORITY, *supra* note 144.

146. *Id.*

147. *Id.*

148. *Id.*

149. NBC NEWS, *supra* note 1.

150. *Id.*

151. *Id.*

152. *Id.*

in *N.J. Division of Child Protection and Permanency v. Y.N.*, a New Jersey judge stated, “[w]here there is evidence of actual impairment, it is immaterial whether the drugs were from a legal or illicit source.”¹⁵³ I argue that this reasoning is wrong and unjustly discriminates against a protected class of people.¹⁵⁴ Conversely, in *Doe v. Roe*, a New York plaintiff successfully challenged denial of employment because of a drug test that could not distinguish between an opioid and a poppy seed bagel.¹⁵⁵ The court ruled that the employer violated New York State’s Human Rights Law.¹⁵⁶ I would argue that, in the context of pregnant mothers on MAT, the protected interest is even greater. Testing procedures for NAS should differentiate between illicit drugs and legally prescribed MAT. Additionally, after a drug test indicates the presence of medications used in MAT, a follow-up should be done with the mother and her prenatal health care providers to verify participation in a MAT program. Policies and screening procedure like those developed by special taskforces in Massachusetts and Oregon are a step in the right direction, however, they can be taken further. The current testing and reporting procedures punish mothers for taking the advice of their doctors and of every major medical organization in this country.¹⁵⁷ I argue that it is unlawful discrimination and a violation of patient’s rights to punish them for following the recommended course of care.

III. CHANGING THE LEGAL LANDSCAPE

A. IS THERE POSSIBLE HOPE FOR A SOLUTION IN THE SUPPORT FOR PATIENTS AND COMMUNITIES ACT?

According to the SUPPORT for Patients and Communities Act (“SUPPORT Act”) which was recently signed into law October 24th, 2018, reporting of mothers giving birth to children displaying symptoms of NAS is still required and encouraged.¹⁵⁸ The bill garnered overwhelming support from both Republicans and Democrats alike. After passing in the House with a 396-14 margin, the bill moved to the Senate where it received an

153. *N.J. Div. of Child Prot. & Permanency v. Y.N.*, 220 N.J. 165 (2014).

154. 42 U.S.C. § 12102 (2008). 42 U.S.C. § 12102; *see also supra* sections II (A)&(B) (discussing the legality of discriminating against individuals in substance abuse treatment—specifically pregnant mothers on MAT).

155. *Doe v. Roe*, 539 N.Y.S. 2d 876 (N.Y. Sup. Ct. 1989) *affirmed in Doe v. Roe*, 160 A.D. 2d 255 (App. Div. 1st Dept. 1990).

156. *Id.*

157. AM. CONG. OF OBSTETRICIANS & GYNECOLOGIST, *Tool Kit on State Legislation: Pregnant Women & Prescription Drug Abuse, Dependence and Addiction*, <https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf> (last visited May 20, 2018). [<https://perma.cc/BYA5-JM63>].

158. SUPPORT Act, H.R. 6 115th Cong. Subtitle G § 7065 (d)(ii)(I).

almost unanimous vote of 98-1.¹⁵⁹ The SUPPORT Act is actually a conglomeration of smaller pieces of legislation that concern the current opioid crisis. Critics of the legislation say that the SUPPORT Act does not go far enough to ensure funding for resources and treatment in the future.¹⁶⁰

The SUPORT ACT is the largest piece of legislation to be enacted specifically addressing opioids and contains a multitude of provisions that concern mothers and children affected by the opioid crisis.¹⁶¹ Specifically relevant to the discussion at hand are a variety of provisions in Title VII, Subtitle G-Protecting Pregnant Woman and Infants.¹⁶²

At this point the bill itself does nothing to explicitly establish a more equitable standard for determining NAS in newborns. According to section 7065 (a)(7)(C)(iii), in order to receive certain funding and block grants, the state must ensure the federal government that they will comply with the reporting requirements instituted by the Child Abuse Prevention and Treatment Act (“CAPTA”), which fails to specify a standard to differentiate between NAS caused by opioids prescribed as part of a MAT program, and NAS resulting from exposure to other substances.¹⁶³ This essentially leaves pregnant women on MAT in the same situation as they were.

However, there is some light at the end of the tunnel: Title VII-Subtitle G-Section-1005 of the bill requires the Secretary of Health and Human Services to issue guidance to improve the care of infants with NAS and their families.¹⁶⁴ The same Title also authorizes a GAO study of neonatal abstinence syndrome, something that was approved and completed by the Obama administration in 2017.¹⁶⁵ However, the focus of the 2017 study was on gaps in Medicaid funding and postnatal care protocols.¹⁶⁶ The study authorized by the SUPPORT Act specifically requires “a report regarding the implementation of the recommendations in the strategy relating to prenatal opioid use, including neonatal abstinence syndrome, developed pursuant to Section 2 of the Protecting Our Infants Act of 2015 . . .”¹⁶⁷ Hopefully this study will identify the need for progressive guidance and

159. Bill History Congressional Record, (last visited Nov. 18, 2018) <https://www.congress.gov/bill/115th-congress/house-bill/6/all-actions?overview=closed&q=%7B%22roll-call-vote%22%3A%22all%22%7D> [<https://perma.cc/9GWD-7YXS>].

160. Abby Vesolulis, *Opioid Bill Shows Congress Can Still Work Together*, TIME MAGAZINE (Oct. 6, 2018) <http://time.com/5416380/opioid-bill-congress/> [<https://perma.cc/XE8V-F6ZL>].

161. *See generally* SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2017-2018) Pub. L. No. 115-271 (enacted Oct. 24, 2018).

162. SUPPORT Act, H.R. 6 115th Cong. Title VII, Subtitle G.

163. SUPPORT Act, H.R. 6, 115th Cong. Title VII, Subtitle G § 7065 (a)(7)(C)(i)(ii).

164. SUPPORT Act, H.R. 6, 115th Cong. Title I § 1005 (a).

165. SUPPORT Act, H.R. 6, 115th Cong. Title I § 1005 (b).

166. U.S. GOV'T ACCOUNTABILITY OFF., GAO 18-32 NEWBORN HEALTH: FEDERAL ACTION NEEDED TO ADDRESS NEONATAL ABSTINENCE SYNDROME (Oct. 2017) [HEREINAFTER GAO 18-32].

167. Public Law 114-91(Nov 25, 2015).

regulations at the federal level that recognize the illegality of removing children from their mothers based on their participation in medically approved and scientifically proven MAT programs.

One of the more interesting sections of the legislation regarding mothers on opioid replacement therapy and NAS is section 7065 (a)(C)(i)(IV), which requires that the states monitor the implementation of plans of safe care with regards to differences between substance use disorder and medically supervised substance use, including for the treatment of substance abuse.¹⁶⁸ This creates a situation where states must have a plan that monitors and distinguishes between NAS caused by medically approved prescription medication, including medication administered as part of a MAT program, in order to receive funding. Although, this is a far cry from an explicit requirement that pregnant mothers in MAT programs be held out as a separate group, it is a positive indication that states will be required to distinguish between mothers on MAT, and those taking illicit drugs. This could help lead to a policy change in the way infants are assessed for NAS.

The SUPPORT Act also explicitly encourages states to “. . . develop policies, procedures or protocols for the development of evidence-based and validated screening tools for infants who may be affected by substance use withdrawal symptoms . . .”¹⁶⁹ This provides an opportunity for states to come into compliance with the ADA by developing a screening process that distinguishes between withdrawal symptoms precipitated from the use of illegal drugs and those resulting from the mother's participation in a medically approved MAT program. As a protected class of people, mothers on MAT should not have their children forcibly removed from them simply for following evidence-based best practices. It is only a slight burden on the states to require hospitals to switch from using a diagnostic scoring tool alone, to the use of a diagnostic scoring tool plus a drug screen that distinguishes between MAT drugs and other substances. It is reassuring that the SUPPORT Act is encouraging states to develop evidence-based validated screening tools, and hopefully, this will encourage a departure from relying solely on diagnostic scoring tools.

Additionally, the SUPPORT Act requires that the recommendations developed in the report “Protecting Our Infants Act: Final Strategy”, issued by HHS in 2017 be implemented.¹⁷⁰ The Protecting Our Infants Act: Report to Congress report found that it is necessary to distinguish NAS caused by non-opioid drugs and NAS caused by opioid drugs to better evaluate

168. SUPPORT Act, H.R. 6, 115th Cong. Title VII, Subtitle G 7065 (a)(C)(i)(IV).

169. SUPPORT Act, H.R. 6, 115th Cong. Title VII, Subtitle G § 7065 (a)(D)(i)(II)(aa).

170. SUPPORT Act, H.R. 6, 115th Cong. Title VII, Subtitle G § 7063 (b)(3).

postnatal care protocol.¹⁷¹ The report recommended a terminological shift that would classify NAS caused by opioids as Neonatal Opioid Withdraw Syndrome (“NOWS”).¹⁷²

The report suggests that this would lead to better treatment outcomes for infants. Although this is a step in the right direction, I would argue that there should also be a delineation between NOWS cause by illicit opioids use, and NOWS that result because the mother was participating in a MAT program during pregnancy. The testing technology to distinguish Methadone and Buprenorphine from other opioids is readily available and relatively inexpensive.¹⁷³ Additionally, protocols for reporting mothers in MAT programs should be tailored to acknowledge their efforts instead of punishing them for following doctor’s orders. On the whole, the recommendations in the “Protecting Our Infants Act: Final Strategy” are mostly positive. However, more could be done to protect mothers on MAT from having their rights and privileges stripped.

The SUPPORT Act contains other provisions that although not aimed directly at protecting mothers on MAT, signal a shift in thinking that it is better to keep mother and child together if at all possible—such as provisions that make Medicaid funding available for Residential Pediatric Recovery Centers (“RPRC’s”).¹⁷⁴ RPRC’s are essentially recovery centers that provide comprehensive treatment and counseling and are aimed at keeping mother and child together after birth.¹⁷⁵ However, there are also provisions that uphold mandatory reporting of mothers whose children have been identified as experiencing NAS symptoms without requiring a definitive and distinguishing testing methodology.¹⁷⁶ This dichotomy creates a situation where mothers on MAT are still left without clear or absolute answers. However, a potential glimmer of hope comes from the SUPPORT Act’s many research directives, which could have significant effects for mothers on MAT in the near future. Time will tell if mothers on MAT will continue to have to live in fear that their child will be taken from them for following doctor’s orders.

171. THE BEHAVIORAL HEALTH COORDINATING COUNCIL SUBCOMMITTEE ON PRESCRIPTION DRUG ABUSE, PROTECTING OUR INFANTS ACT: REPORT TO CONGRESS, https://www.samhsa.gov/sites/default/files/topics/specific_populations/protecting-our-infants-act-report-congress-2017.pdf [<https://perma.cc/W7FG-6KZK>].

172. *Id.*

173. HEALTH QUALITY ONTARIO, *supra* note 138.

174. SUPPORT Act, H.R. 6, 115th Cong. Title 1, § 1007 (b)(pp).

175. SUPPORT Act, H.R. 6, 115th Cong. Title 1, § 1007 (b)(pp).

176. SUPPORT Act, H.R. 6, 115th Cong. Title VII, Subtitle G § 7065 (a)(D)(ii)(I); *see also* SUPPORT Act, H.R. 6, 115th Cong. Title VII, Subtitle G § 7065 (a)(D)(iii)(I).

B. RECOMMENDATION FOR A PROPOSED FEDERAL LAW

The federal law currently discriminates against mothers maintained on MAT therapies.¹⁷⁷ The Keeping Children and Families Safe Act makes funding for state child welfare services through CAPTA,¹⁷⁸ contingent upon reporting instances of NAS.¹⁷⁹ This is a practice that the SUPPORT Act will continue to mandate. The problem is that the federal law is crafted in a way that lumps all cases of NAS into one group. This has resulted in a situation where mothers acting on the best medical advice available are subject to being reported to child protective services and possibly losing custody of their children.¹⁸⁰

In order to begin to remedy the situation, the federal law should be amended to include language that distinguishes instances of NAS caused by prenatal exposure to opioids prescribed to treat OUD, and NAS resulting from illicit drug use. Alternatively, the statute could be amended to include an exception for NAS that is the result of a mother's participation in a MAT program. That way if a mother presents evidence that she is enrolled in a MAT program, hospital staff will not be compelled to report her to authorities, assuming there are no other drugs in her system.

Currently, the instruments used to diagnose NAS do not identify the substance that is causing the syndrome.¹⁸¹ This is because the federal law is silent on the methods states are required to use to determine NAS. Complicating the issue is the fact that the vast majority of states do not use a urine, blood, or other form of drug test to diagnosis NAS.¹⁸² Instead, they rely on a Diagnostic Scoring Tool.¹⁸³ This issue could be remedied by using a drug test to determine the presence or absence of drugs, the type of drugs, and then requiring a follow-up with the mother about the results. Or, conversely, if the initial diagnostic scoring tools indicate the infant is suffering from NAS, then a drug test can be administered to determine the drugs involved. The technology has been available for decades to distinguish between the types of medications administered as part of a MAT program and illicit opioids.¹⁸⁴ The tests are inexpensive and could save mothers and their children tremendous damage and heartache.¹⁸⁵

In most cases, mothers maintained on MAT are doing so out of concern for their child's welfare. Mothers who come in with documentation or have

177. Jansson et al., *supra* note 10.

178. 42 U.S.C § 5106(b)(2)(B); *see also* the Child Abuse Prevention and Treatment Act § 106(b)(2)(B).

179. CHRISTIAN, *supra* note 44.

180. NBC NEWS, *supra* note 1.

181. Szalavitz, *supra* note 112.

182. *Id.*

183. *Id.*

184. HEALTH QUALITY ONTARIO, *supra* note 138.

185. *Id.*

given notice to hospital staff and their OBGYN's should not be subject to reporting for child abuse, or criminal child endangerment sanctions. Studies have repeatedly shown that it is in the best interest of the mothers, the infants, and society to allow mother and child to remain together, except in the most extreme situations.¹⁸⁶ In order to effectively institute a policy that helps realize that goal the federal law must be amended or replaced.

C. DE-STIGMATIZING THROUGH EDUCATION

Social stigma is a significant part of the problem and must be addressed in a systematic fashion. A national study completed in 2017 by the Government Accountability Office (“GAO”) stated that addressing and educating healthcare professionals about the stigma associated with pregnant mothers and NAS is extremely important.¹⁸⁷ The SUPPORT Act has made some strides concerning resources and funding for opioid dependent mothers, however, more has to be done to educate the public and combat stigma.

Many health professionals and social service providers view MAT patients with antipathy or disdain.¹⁸⁸ They view MAT therapy as little more than legalized drug dealing and consequently want nothing to do with the treatment provider or its patients.¹⁸⁹ This concern is magnified when the opioid-dependent individual is a pregnant woman.¹⁹⁰ This stigma creates a situation where mothers avoid contact with healthcare professionals out of fear of being judged and in some cases even jailed or sanctioned.¹⁹¹ Pregnant mothers on MAT are often reluctant to seek or continue their MAT program, fearing judgment and ridicule, or due to apprehension about unknown medical and developmental consequences for the fetus.¹⁹² Both of these situations leave the fetus in a precarious and often dangerous situation.

Because healthcare providers tend to judge mothers on MAT they are quick to utilize what punitive mechanism they have available. Richard Wexler, the Director for the National Collation for Child Protection Reform said, “[w]e don’t have a child welfare system, we have a parent punishment system.”¹⁹³ Prejudices about illegal drug users tend to trump rational consideration about what is best for the children of opioid dependent mothers.¹⁹⁴ Wexler also stated, “[i]f we really believe all the rhetoric about

186. GAO 18-32, *supra* note 165.

187. *Id.*

188. NBC NEWS, *supra* note 1; *see also* Terplan et al., *supra* note 39.

189. Deeney, *supra* note 19.

190. Goddard, *supra* note 40.

191. Terplan et al., *supra* note 39.

192. Alto & O’Connor, *supra* note 41.

193. Szalavitz, *supra* note 112.

194. *Id.*

putting children's needs first, we have to put them ahead of everything, including how we may feel about their mothers."¹⁹⁵ The science has proven that MAT is the safest and most effective treatment for mothers addicted to opioids and their fetuses.¹⁹⁶ In order to bring policy in line with the science there must be an effort to educate healthcare professionals and social service agencies.¹⁹⁷

Outside of changing the law, education may be the most powerful and productive tool available. Studies have shown that educating healthcare professionals about MAT and other harm reduction treatments can have a significant effect on the way they view these treatment modalities and the patients that receive them.¹⁹⁸ It would be immensely beneficial for healthcare professionals to understand that although the symptoms are the same for NAS caused by illegal and legal opioid use, the mental state, preparedness, and health of the mother is not.

Opioid dependence is a notoriously difficult addiction to beat. By refraining from illicit opioids and working a successful MAT program a pregnant mother has surmounted immeasurable odds and deserves help and kindness from medical staff in the maternity ward, not disdain, contempt, and judgment. Additionally, mothers who are using illicit drugs should also be met with kindness and offered help, not threatened with civil and criminal sanctions. Although, revising the federal law is an important step towards correcting the problem, challenging the stigma associated with the issue is a goal that is achievable now.

IV. CONCLUSION

The current legal landscape concerning mothers on MAT is dangerous. In order to better protect the rights of mothers receiving MAT therapies and their children, federal law should be altered to distinguish NAS caused by illicit drug use, and NAS resulting from prenatal exposure to MAT. The SUPPORT Act falls short of making this distinction and instead continues to allow the states to develop their own best practice. This was a missed opportunity to resolve a serious injustice that violates the statutory protections mothers on MAT are entitled to. States need a federal statute that provides guidance on how to best deal with these vulnerable patients. The use of opioids in the United States is at an all-time high and there is an epidemic of children being born suffering from NAS. It is imperative that these children are given the best opportunity for success. Social stigma paired with discriminatory laws are already putting them at a disadvantage. In order to mitigate and reverse this situation, the law and the healthcare system must catch up to the science—the harm is too grave to ignore.

195. Szalavitz, *supra* note 112.

196. *Id.*

197. GAO, *supra* note 165 at 26.

198. Goddard, *supra* note 40.