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Haley Johnston

INTRODUCTION

A woman who is addicted to heroin discovers that she is pregnant. She quickly realizes her limited options: continue to use heroin, quit “cold turkey,”¹ or seek medical rehabilitation. She learns that if she chooses to quit cold turkey, she is likely to miscarry. On the other hand, should she continue to use heroin, the state will take away her child, once born. In review of these possibilities, she believes seeking medical rehabilitation, such as a methadone-treatment program, will be the most responsible decision. However, she soon learns that because her child could suffer withdrawal symptoms at birth, state child services will strip her of custody and accuse her with civil child abuse and neglect before she even leaves the delivery room.

Many pregnant women across the country who are addicted to heroin and other opiates face this reality.² In *N.J. Division of Youth & Family Services v. Y.N.*, the New Jersey Superior Court Appellate Division addressed this catch-22 situation.³ The court held that under a New Jersey civil statute dealing with child abuse,⁴ a pregnant woman obtaining doctor-recommended methadone treatment that

¹ “Cold turkey” is the “abrupt withdrawal of narcotics from an addict without the use of medications to reduce the discomfort and minimize the symptoms resulting therefrom.” Andrew G. Bucaro & Mary Williams Cazalas, *Methadone: Treatment and Control of Narcotic Addiction*, 44 TUL. L. REV. 14, 19 (1969).

² Heroin is just one type of opiate, but for the purposes of this Note, I will be using “heroin” and “opiate” interchangeably.

³ 66 A.3d 237 (N.J. Super. Ct. App. Div. 2013).

⁴ N.J. STAT. ANN. § 9:6–8.21(c)(4)(b) (West 2012).

harmed the fetus had committed child abuse.⁵ After the New Jersey Division of Youth and Family Services took the woman's newborn son into custody, she filed suit to regain custody of her child.⁶

Child protective services' removal of an infant because of the mother's participation in methadone maintenance treatment (MMT) during pregnancy alarmingly violates those women's rights.⁷ These rights include, but are not limited to, those provided in Title II of the Americans with Disabilities Act (ADA), which precludes public entities from discriminating against individuals on the basis of a disability.⁸ In cases such as *Y.N.*, a state agency's removal of a child because of his or her mother's participation in a drug rehabilitation program counteracts the exact purpose of Title II of the ADA: to protect individuals with disabilities from discrimination.⁹

This Note will explain how Title II of the Americans with Disabilities Act of 1990 is violated when a state department takes custody of an infant solely because his or her mother participated in a methadone maintenance program during pregnancy. Part I of this Note examines the case of *Y.N.*—a case that demonstrates why the ADA is necessary to protect both women and their children. Part II of this Note provides a background on methadone maintenance treatment, with a focus on how it is the recommended and preferred treatment for pregnant women with opiate addictions. Part II also briefly discusses how the New Jersey state legislature's policies, as interpreted by the appellate court, are misguided and run counter to state interests in maternal and fetal health. Part III reviews the flawed legal analysis used by the appellate court in the case of *N.J. Division of Youth & Family Services v. Y.N.*,¹⁰ and how the standard set by the appellate court in this case leads to an overbroad application of the New Jersey child abuse and neglect statute by depriving pregnant women of choices regarding daily activities. Part IV describes the Americans with Disabilities Act of 1990 and explores interpretations of Title II. This

5 See *Y.N.*, 66 A.3d at 242 (“The fact that defendant obtained the methadone from a legal source does not preclude our consideration of the harm it caused to the newborn. An inquiry under N.J.S.A. 9:6–8.21 must focus on the harm to the child, rather than on the intent of the caregiver. *G.S. v. Dep’t of Human Servs.*, 157 N.J. 161, 180–81, 723 A.2d 612 (1999). Harm to the child need not be intentional in order to substantiate a finding of abuse or neglect. *N.J. Div. of Youth & Family Servs. v. M.C.* III, 990 A.2d 1097, 1106 (2010).”).

6 See *Y.N.*, 66 A.3d at 239.

7 Pregnancy and state intervention has created numerous constitutional arguments amongst legal scholars. For discussions that a woman's constitutional liberties and autonomy are violated when medical choices are restricted by the state, see, for example, Julie B. Ehrlich, *Breaking the Law by Giving Birth: The War on Drugs, the War on Reproductive Rights, and the War on Women*, 32 N.Y.U. REV. L. & SOC. CHANGE 381 (2008); see also Molly McNulty, *Pregnancy Police: The Health Policy & Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 N.Y.U. REV. L. & SOC. CHANGE 277 (1989).

8 *A Guide to Disability Rights Laws*, U.S. DEP'T JUST. C.R. DIV. (July 2009), <http://www.ada.gov/cguide.htm>.

9 See *Y.N.*, 66 A.3d 237; see also 42 U.S.C. § 12101(b) (2012).

10 66 A.3d 237 (N.J. Super. Ct. App. Div. 2013).

exploration reveals the purpose of Title II of the ADA and provides guidance for how courts should interpret it in the future. Finally, Part V ties the analysis together to explain how Title II of the ADA protects the parental rights of pregnant women participating in MMT.

I. THE HARM OF OVERBROAD STATUTORY INTERPRETATION IN THE CASE OF Y.N.

Y.N. had been using prescription Percocet¹¹ prior to her pregnancy.¹² Upon learning of her pregnancy, she continued to use Percocet for four months before entering a methadone treatment program.¹³ Y.N. began taking methadone prescribed by her doctor on January 5, 2011¹⁴ and continued the methadone treatment through February 18, 2011,¹⁵ when she gave birth to her son, Paul.¹⁶ Upon birth, Paul tested positive for methadone and was diagnosed with neonatal abstinence syndrome (NAS).¹⁷ Due to Paul's withdrawal symptoms, he was placed in the neonatal intensive care unit and given morphine doses to manage the effects of his withdrawal.¹⁸

The New Jersey Division of Youth and Family Services ("Division") quickly began an investigation of Y.N.¹⁹ When Paul was due to be released from the hospital, on April 1, 2011, the Division placed a hold preventing his discharge.²⁰ "The Division then filed a complaint and order to show cause seeking custody, care, and supervision of Paul."²¹ Upon review of the case, the judge decided the Division had not established that Y.N. presented a risk of harm to her child, and the child was released to Y.N.'s custody, pending Y.N.'s negative drug screening.²² Because Y.N. failed this screening, the Division retained supervision and care of the child.²³

A fact-finding hearing was held on June 29, 2011.²⁴ At this hearing, Y.N. testified and the infant's medical records were examined.²⁵ Y.N. testified that she was taking prescribed Percocet when she became pregnant and was told that if she

11 Percocet contains oxycodone; oxycodone is an opioid pain medication. *Percocet*, DRUGS.COM, <http://www.drugs.com/percocet.html> (last visited Jan. 6, 2015).

12 Oral Argument at 02:10, N.J. Div. of Youth & Family Servs. v. Y.N., 104 A.3d 244 (N. J. 2014) (No. 072804), <http://165.230.71.5/query.php?var=A-24-13>.

13 *Y.N.*, 66 A.3d at 241.

14 *Id.* at 239.

15 *See id.*

16 *Id.*

17 *Id.* at 239-40.

18 *Id.* at 240; *see also id.* at 242 ("Paul's discharge summary indicates that it took thirty-nine days until the morphine could be discontinued.").

19 *Id.* at 240.

20 *Id.*

21 *Id.*

22 *Id.*

23 *Id.*

24 *Id.*

25 *Id.*

stopped taking Percocet, she could lose the baby due to withdrawal.²⁶ The trial court found by a preponderance of the evidence that Y.N. abused or neglected Paul.²⁷

When the case reached the appellate court, the court relied on the “harm” element of New Jersey’s civil child abuse and neglect statute.²⁸ The statute provides a definition for an “abused or neglected child”:

[A] child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian, as herein defined, to exercise a minimum degree of care . . . in providing the child with proper supervision or guardianship, by *unreasonably inflicting* or allowing to be inflicted harm, or substantial risk thereof.²⁹

The appellate court’s broad interpretation of the harm element was the sole basis for the court’s finding.³⁰ Contrary to traditional child custody proceedings, the court ignored the requisite statutory elements for child abuse and broadly applied the statute to *any* harm inflicted on an infant.³¹ The child abuse or neglect statute clearly dictates that harm inflicted on a child by a parent must be unreasonable.³² Instead of applying the statutory element of unreasonable harm to the case at hand, the court simply recounted the harm suffered by the infant. This misapplication of New Jersey’s child abuse or neglect statute constitutes a “sweeping, confounding generalization that completely ignores [the] statutory elements.”³³

Infant Paul undeniably suffered harm from withdrawal symptoms due to his mother’s methadone use during pregnancy. However, the statutory provision at issue requires unreasonable harm to prevent unnecessary removal of a child and judicial overreach. In turning a blind eye to the reasonableness element of the statute, the court essentially held that any harm caused by the mother to a newborn during pregnancy constitutes child abuse. Y.N. appealed this decision, and the Supreme Court of New Jersey granted certification to review the issue of statutory interpretation regarding “whether a finding of abuse or neglect under N.J.S.A. 9:6–8.21(c)(4)(b) can be based solely on the harm caused to Paul by methadone

26 *Id.*

27 *Id.*

28 N.J. STAT. ANN. § 9:6–8.21(c)(4)(b) (West 2012); *Y.N.*, 66 A.3d at 242.

29 N.J. STAT. ANN. § 9:6–8.21(c)(4)(b) (emphasis added).

30 *See Y.N.*, 66 A.3d at 242.

31 *Id.*

32 N.J. STAT. ANN. § 9:6–8.21(c)(4)(b).

33 Oral Argument at 04:00, N.J. Div. of Youth & Family Servs. v. *Y.N.*, 104 A.3d 244 (N. J. 2014) (No. 072804), <http://165.230.71.5/query.php?var=A-24-13>.

withdrawal—without regard to whether [Y.N.] acted unreasonably or with a minimum degree of care.”³⁴

On December 22, 2014, the Supreme Court of New Jersey reversed the holding of the New Jersey Superior Court Appellate Division, holding that “absent exceptional circumstances, a finding of abuse or neglect cannot be sustained based solely on a newborn’s enduring methadone withdrawal following a mother’s timely participation in a bona fide treatment program prescribed by a licensed healthcare professional to whom she has made full disclosure.”³⁵ The Supreme Court of New Jersey remanded the case to the appellate division to decide whether the record contained sufficient evidence to support the finding of child abuse or neglect on an alternate theory.³⁶

II. PROMISES FOR A HEALTHIER FUTURE: METHADONE MAINTENANCE TREATMENT

Methadone maintenance treatment was first studied at The Rockefeller University in 1964 as a research project.³⁷ After decades of research and use of MMT to treat heroin addiction, experts discovered the proper dosage of methadone to overcome many symptoms of opiate addiction.³⁸ MMT has proved to be a successful form of rehabilitation for opiate addicts.³⁹ MMT reduces cravings for opiate drugs, prevents opiate withdrawal symptoms, and blocks the physical effects of other

34 N.J. Div. of Child Prot. and Permanency v. Y.N., 104 A.3d 244, 251–52 (N.J. 2014) (emphasis omitted). Y.N.’s continued drug use for four months after finding out she was pregnant could be classified as acting unreasonably or without a minimum degree of care. However, the public interest of maternal and fetal health should dissuade policymakers from punishing pregnant drug addicts for seeking medical rehabilitation.

35 *Id.* at 246.

36 *Id.* at 256.

37 Herman Joseph, Sharon Stancliff & John Langrod, *Methadone Maintenance Treatment (MMT): A Review of Historical and Clinical Issues*, 67 MOUNT SINAI J. MED. 347, 348 (2000).

38 *See id.* at 348–49 (explaining the proper dose of methadone will be sufficient to relieve narcotic cravings, suppress opioid abstinence syndrome for twenty-four to thirty-six hours, block the effects of heroin, develop tolerance to the narcotic effects of methadone so the individual’s emotional responses, functions, and perception are not impaired, and develop tolerance to analgesic properties of methadone).

39 *See Frequently Asked Questions (FAQ) about Methadone and Pregnancy*, NAT’L ADVOCES. FOR PREGNANT WOMEN, <http://advocatesforpregnantwomen.org/MethadoneFAQ.pdf> (last visited Jan. 6, 2015) [hereinafter *FAQ about Methadone and Pregnancy*]; *see also Methadone Treatment for Pregnant Women*, U.S. DEP’T HEALTH & HUM. SERVS. (2006), <http://advocatesforpregnantwomen.org/SAMHSA%20Brochure%20%2522Methadone%20Treatment%20for%20Pregnant%20Women%2522.pdf>; Comm. on Health Care for Underserved Women & Am. Soc’y Addiction Med., *Opioid Abuse, Dependence, and Addiction in Pregnancy*, AM. C. OBSTETRICIANS & GYNECOLOGISTS (May 2012), <http://acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy>.

opiates.⁴⁰ The use of MMT has consistently demonstrated a reduction in illicit drug use and a significant drop in the likelihood of overdose and death.⁴¹

Since the 1970s, MMT has been the optimal treatment for heroin addiction for pregnant women.⁴² MMT “remains the gold standard” for treating opiate addiction in pregnant women.⁴³ There is a clear medical consensus that MMT during pregnancy provides benefits for both the woman and the fetus.⁴⁴ The Centers for Disease Control and Prevention declared methadone maintenance treatment “the most effective treatment for opiate addiction” and included “improved pregnancy outcomes” as one of the important benefits of MMT.⁴⁵ The United States Department of Health and Human Services (HHS) reported that MMT can save a newborn’s life by blocking withdrawal symptoms.⁴⁶ The World Health Organization (WHO) published a “strong”—as opposed to standard—recommendation that methadone maintenance treatment should be used to treat opiate dependency in pregnancy.⁴⁷ The WHO reserves “strong” recommendations for treatments or interventions that “most individuals should receive . . . [and] most individuals would want . . . and only a small proportion would not[;]” and further stating that “the recommendation could unequivocally be used for policy making.”⁴⁸ The WHO went as far as to recommend MMT over all other opiate agonist maintenance treatments.⁴⁹

The evidence supporting MMT over other forms of treatment for opiate addicts is “clear and unambiguous.”⁵⁰ Because of the clear and unambiguous evidence supporting MMT, the National Institutes of Health considers “the safety

⁴⁰ *FAQ about Methadone and Pregnancy*, *supra* note 39.

⁴¹ *Id.*

⁴² See Brief of Proposed *Amici Curiae* Experts in Maternal and Fetal Health, Public Health, and Drug Treatment in Support of Defendant-Petitioner’s Petition for Certification at 6, N.J. Div. of Youth & Family Servs. v. Y.N., 66 A.3d 237 (N.J. Super. Ct. App. Div. 2013) (No. A-5880-11T2) [hereinafter Brief of Proposed *Amici Curiae*]; see also Comm. on Health Care for Underserved Women & Am. Soc’y Addiction Med., *supra* note 39.

⁴³ Stacy Seikel, *Methadone Treatment in Pregnancy...That Can’t Be Right, Can It?*, 63 N.E. FLA. MED. 28, 29 (2012).

⁴⁴ See, e.g., Brief of Proposed *Amici Curiae*, *supra* note 42, at 8–9.

⁴⁵ *Methadone Maintenance Treatment*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 2002), [http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20\(20\).pdf](http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20(20).pdf).

⁴⁶ See *Methadone Treatment for Pregnant Women*, *supra* note 39.

⁴⁷ See *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, WORLD HEALTH ORG. xviii (2009), http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf.

⁴⁸ *Id.* at xiii (explaining that standard recommendations are given when “most individuals would want the suggested course of action, but an appreciable proportion would not,” and “values and preferences vary widely”).

⁴⁹ See *id.* at xi.

⁵⁰ Brief of Proposed *Amici Curiae*, *supra* note 42, at 7 (citing L. Amato, M. Davoli, C.A. Perucci, M. Ferri, F. Faggiano & R.P. Mattick, *An Overview of Systematic Reviews of the Effectiveness of Opiate Maintenance Therapies: Available Evidence to Inform Clinical Practice and Research*, 28 J. SUBSTANCE ABUSE TREATMENT 321, 326 (2005)).

and efficacy of methadone treatment ‘unequivocally established’ and supports MMT “as the most effective treatment for this condition.”⁵¹

Not only does use of MMT for opiate-addicted pregnant women reduce maternal illness and mortality rates, but it also promotes fetal growth and stability, as compared to mothers who use heroin during pregnancy.⁵² MMT during pregnancy is associated with “better compliance with obstetric care and better preparation for parenting responsibilities.”⁵³

Maternal recovery from illicit drug addiction is important for the long-term health and safety of a mother and her child.⁵⁴ Methadone treatment during pregnancy increases the likelihood of the mother achieving recovery from her addiction early in treatment and becoming a sustainable provider.⁵⁵

A. *Neonatal Abstinence Syndrome*

Although MMT remains the best treatment to combat opiate addiction during pregnancy, it is likely to cause neonatal abstinence syndrome in infants.⁵⁶ NAS manifests as “the constellation of symptoms and signs exhibited by infants, who had intrauterine exposure to addictive drugs like opiates . . . [,] which can cause physical and psychological dependence.”⁵⁷

NAS in infants is an expected and medically controllable consequence of methadone use during pregnancy.⁵⁸ The intensity of NAS symptoms and the medical care required is case specific.⁵⁹ Infants who experience mild symptoms resulting from NAS may not need any medical treatment,⁶⁰ while infants who experience moderate to severe symptoms of NAS are treated with medication-assisted withdrawal methods, which can require anywhere from three to five weeks of hospital monitoring.⁶¹

51 *Id.* at 7–8.

52 See John J. McCarthy, Martin H. Leamon, Michael S. Parr & Barbara Anania, *High-Dose Methadone Maintenance in Pregnancy: Maternal and Neonatal Outcomes*, 193 AM. J. OBSTETRICS & GYNECOLOGY 606 (2005).

53 *Id.*

54 *Id.*

55 *Id.* at 609.

56 See Joseph et al., *supra* note 37, at 355; see also C. Dryden, D. Young, M. Hepburn & H. Mactier, *Maternal Methadone Use in Pregnancy: Factors Associated with the Development of Neonatal Abstinence Syndrome and Implications for Healthcare Resources*, 116 BJOG 665 (2009).

57 V. Tiroumourougane Serane & Ommen Kurian, *Neonatal Abstinence Syndrome*, 75 INDIAN J. PEDIATRICS 911 (2008).

58 *Id.*

59 See, e.g., *id.*; Seikel, *supra* note 43, at 29.

60 McCarthy et al., *supra* note 52.

61 *Id.*

Regardless of the intensity of the symptoms experienced, infants who suffer from NAS do not face long-term physical or mental disabilities or abnormalities.⁶² Infants born to mothers who received both methadone treatment during pregnancy and prenatal care showed normal development.⁶³ HHS reported that babies born to mothers on methadone do as well as other babies, and better than babies born to mothers on heroin.⁶⁴ While use of a methadone treatment regimen by a pregnant woman can cause some complications in the first few weeks of the infant's life, these complications are medically manageable.⁶⁵ Medical studies show that possible complications are outweighed by the benefits of methadone treatment: stable opiate levels for the pregnant woman and fetus (drastically decreasing the likelihood of fetal death) and disassociation from the heroine lifestyle and its negative consequences.⁶⁶

B. Policy Implications of Pregnant Women, MMT & State Intervention

Punishing women for seeking treatment for their opiate addictions negatively impacts the health of the women and their unborn children. Pregnant women who quit opiate use cold turkey risk fetal death due to fetal withdrawal symptoms.⁶⁷ Pregnant women who continue to use heroin subject the fetus to daily fluctuations of opiate abstinence syndrome, which can result in “stillbirth, premature delivery, low birth weight, and sudden infant death syndrome.”⁶⁸ In addition to fetal harm or death, the lifestyle associated with heroin addiction can cause various harms to pregnant women: transmission of diseases such as HIV and hepatitis, poor nutrition, and other complications from the use of contaminated needles.⁶⁹

Medical experts have considered the delicate balance between protecting fetuses from unnecessary harm and incentivizing pregnant women to seek medical care for the wellbeing of the women and the fetuses. While MMT alone is insufficient to combat all of the issues a heroin addict must confront, when MMT is combined with prenatal care, medical care, nutritional counseling, and attention to

62 See Joseph et al., *supra* note 37, at 356 (“[N]o chronic conditions or abnormalities attributable to methadone have been identified in those children exposed to methadone in utero when their mothers also received prenatal care.”).

63 *Id.* (“A follow-up study of 25 four-year-olds whose mothers were maintained on methadone during their pregnancies and who had received prenatal care showed normal development . . . The results of all neurological examinations were within normal parameters, and there was no relationship between IQ scores and the severity of the abstinence syndrome at time of birth. There were no statistical differences between the infants exposed to methadone in utero and non-exposed controls.”).

64 *Methadone Treatment for Pregnant Women*, *supra* note 46.

65 Joseph et al., *supra* note 37, at 356.

66 See, e.g., *id.* at 355.

67 See *FAQ about Methadone and Pregnancy*, *supra* note 39.

68 Joseph et al., *supra* note 37, at 355.

69 *Id.*

all the medical, personal, and social concerns the patient may face, a pregnant woman can overcome her heroin addiction in a manner that is healthy for both herself and the fetus.⁷⁰

Without the option to receive MMT, many pregnant women will completely forgo necessary medical and prenatal care out of fear that the government will take their children away.⁷¹ This is not the first time in history that pregnant drug addicts have faced discrimination. During the “crack baby” scare of the 1980’s,⁷² Congress passed laws to extend the length of criminal sentences for crack cocaine offenses.⁷³ Pregnant women were targeted and routinely prosecuted for use of crack cocaine.⁷⁴ Today, women who take proactive steps to curb drug addiction are punished with removal of their children from their custody and faced with potential criminal charges for the use of MMT during pregnancy.

Legislative policies related to pregnant women undergoing MMT should reflect the research of medical and scientific experts and should be focused on improving maternal and infant health. Enacting policies in such a way has been termed by Professor Dawn Johnsen, a legal scholar in the area of civil liberties, as the “facilitative model.”⁷⁵ The facilitative model operates under the assumption that each pregnant woman is in the best situation to decide for herself how to balance reducing risks for unhealthy fetal development with competing demands and desires.⁷⁶ Such competing interests include whether “to continue working in their jobs” while dealing with “illness, addiction, poor information, lack of health insurance, and poverty.”⁷⁷ A facilitative model is the most effective model in cases of women using drugs during pregnancy;⁷⁸ policies that are enacted according to the facilitative model can save government dollars while providing benefits to the pregnant woman and her fetus.⁷⁹

70 *See id.*

71 Brief of Proposed *Amici Curiae*, *supra* note 42, at 3; *see also* Ehrlich, *supra* note 7, at 392. This disincentive to seek prenatal care is reminiscent of the “crack baby” scare in the 1980’s. In the 1980’s, the fear of losing custody of their babies or being arrested caused pregnant crack cocaine addicts to avoid seeking prenatal care. Craig Reinerman & Harry G. Levine, *Crack in the Rearview Mirror: Deconstructing Drug War Mythology*, 31 SOC. JUST. 182, 194 (2004).

72 *E.g.*, Clay Dillow, *How Science Got the ‘Crack Baby’ Epidemic So Wrong*, POPULAR SCI. (May 20, 2013), <http://www.popsci.com/science/article/2013-05/crack-baby-epidemic-never-happened>.

73 Reinerman & Levine, *supra* note 71, at 182.

74 *See* Ehrlich, *supra* note 7, at 386.

75 *See* Dawn E. Johnsen, *Shared Interests: Promoting Healthy Births Without Sacrificing Women’s Liberty*, 43 HASTINGS L.J. 569, 573 (1992).

76 *Id.* at 573 (explaining the core assumption of facilitative policies is that maternal and infant health can best be improved by “building on the shared interests of women and the government”).

77 *Id.* at 574. It could be argued that a woman who abused drugs is not the best person to make decisions regarding her competing desires and demands. However, in this Note, I discuss women who have sought medical rehabilitation to overcome drug addiction. These women are receiving treatment to become healthy and aid fetal development.

78 *Id.* at 571–72.

79 *Id.* at 574.

For pregnant women, the government has a strong interest in implementing policies that will positively impact the likelihood that the woman's baby will be healthy.⁸⁰ While a woman is pregnant, "the government can affect fetal development, and thus the health of the infant at birth, only through the woman's body and actions."⁸¹ However, if formulated improperly, government policies aimed at healthy births and healthy children can result in the opposite effect.⁸²

Negative social stigmas that exist regarding drug addicts, especially regarding pregnant drug addicts, often lead to irrational policymaking. These stigmas have caused the legislature and courts to view drug addicts as second-class citizens. Since the beginning of MMT programs, people undergoing the treatment have been stigmatized as merely "substitut[ing] one drug for another."⁸³ This belief blurs the crucial line between "an active heroin addiction and the use of methadone in a maintenance program."⁸⁴ As a result, the legislature has enacted policies based on the adversarial model,⁸⁵ in which the pregnant woman and fetus are viewed as two distinct entities with competing interests.⁸⁶

The appellate court's interpretation of the New Jersey model, in which a pregnant woman can be charged with civil child abuse for participating in MMT, is an example of a policy enacted under the adversarial approach that punishes women for seeking necessary medical treatment while pregnant.⁸⁷ The policy deters women from seeking necessary prenatal care, medical services, and other rehabilitation treatment by instilling fear of government intervention, civil child abuse and neglect charges, loss of custody, and criminal prosecution.

When a drug addict seeks medical help to overcome the addiction (whether pregnant or not), the state has a public health interest in encouraging the individual's rehabilitation. This interest increases in the case of pregnant drug addicts, for the state then has an interest in the health of the woman and the fetus.

80 *Id.* at 570.

81 *Id.*

82 *See id.* at 570–71 ("[T]he most effective policies for improving the health of newborns are those that facilitate women's choices, not those that infringe on their liberty.").

83 Joseph et al., *supra* note 37, at 358.

84 *Id.*

85 *See* Johnsen, *supra* note 75, at 576.

86 *Id.* In November 2014, Colorado voters rejected a "personhood" measure (for the third time), which proposed inclusion of unborn fetuses as "children" under the state's criminal code. Zach Schonfeld, *Fetal 'Personhood' Laws Defeated in Colorado and North Dakota*, NEWSWEEK (Nov. 5, 2014, 3:27 PM), <http://www.newsweek.com/fetal-personhood-laws-defeated-colorado-and-north-dakota-282545>. North Dakota voters rejected a ballot measure, which would have added to the state constitution: "[t]he inalienable right to life of every human being at any stage of development must be recognized and protected." Tierney Sneed, *A Tale of Two 'Personhood' Amendments*, U.S. NEWS & WORLD REP. (Oct. 29, 2014, 6:00 AM), <http://www.usnews.com/news/articles/2014/10/29/personhood-amendments-shake-up-elections-in-north-dakota-colorado>. State "personhood" proposals in the 2014 election reflected the idea of treating the pregnant woman and fetus as two separate entities with conflicting interests. *Id.*

87 *See infra* Part III.

The overwhelming amount of medical and scientific research supporting MMT for pregnant women should lead policymakers to enact policies that support this medical consensus. If the public interests are the health of the fetus and the mother, these ends are not achieved by penalizing women for seeking help to overcome their addiction.

III. EXPLORING THE APPELLATE COURT'S REASONING IN Y.N.

Returning to the case of Y.N., the New Jersey Superior Court Appellate Division applied the New Jersey child abuse and neglect statute in a manner so broad that it did not even consider the statutory language or purpose. The statute requires unreasonable harm or risk of harm for a finding of child abuse or neglect.⁸⁸ Therefore, the proper inquiry should have examined whether the harm Y.N. caused to her infant was reasonable.

While conducting a reasonableness analysis, it is important to note that the newborn tested positive for methadone, but not Percocet.⁸⁹ The State never alleged that Y.N. was using *illegal* drugs during her pregnancy. Furthermore, methadone maintenance treatment is easily distinguished from illicit drugs used by a mother during pregnancy.⁹⁰ As discussed earlier, MMT is well regarded as the appropriate treatment for opiate addiction.⁹¹ Besides Y.N.'s use of prescribed methadone treatment, there were no other findings of child abuse or neglect by Y.N.⁹² Therefore, the State's basis for removing the child relied solely on the fact that Y.N. used her prescribed methadone treatment.

Determining whether a pregnant woman's actions were "reasonable" during pregnancy is purely a subjective test; the legislature does not provide a clear line for how "unreasonable" a pregnant woman's actions would need to be in order to satisfy the child abuse or neglect statute. Almost all daily activities of a pregnant woman have the ability to affect the fetus and potentially cause harm. For example, a woman could be charged with child abuse for exercising too much during pregnancy if it had a negative impact on the fetus that the state classified as "unreasonable harm." In another scenario, a woman's refusal to take expensive prenatal vitamins that would benefit the fetus could be deemed unreasonable. These scenarios are just a few of many that show the line between reasonable and unreasonable harm to a fetus is blurred in instances of a pregnant woman's legal activity.⁹³

88 See N.J. STAT. ANN. § 9:6-8.21(c)(4)(b) (West 2013).

89 Oral Argument at 02:33, N.J. Div. of Youth & Family Servs. v. Y.N., 104 A.3d 244 (N. J. 2014) (No. 072804), <http://165.230.71.5/query.php?var=A-24-13>.

90 See, e.g., Ilene B. Anderson & Thomas E. Kearney, *Use of Methadone*, 172 WEST J. MED. 43 (2000).

91 See *supra* Part II.

92 See N.J. Div. of Youth & Family Servs. v. Y.N., 66 A.3d 237 (N.J. Super. Ct. App. Div. 2013).

93 The Alabama Supreme Court held that a "child" under the chemical-endangerment statutes includes *all* unborn children. Therefore, a woman can be held criminally liable for exposing a fetus to, "a controlled substance, chemical substance, or drug paraphernalia." *Ex parte Hicks v. Ala.*, 153 So.3d 53, 54-55 (Ala. 2014) (citing Ala. Code § 26-15-3.2 (2014)).

Even if one was to accept the legitimacy of the reasonableness provision of the New Jersey child abuse and neglect statute, Y.N.'s conduct during her pregnancy was reasonable in light of her particular circumstances. As a pregnant woman addicted to opiates, Y.N. had three choices: (1) continue using opiates, which would ultimately lead to child abuse charges and her child's removal at birth; (2) abruptly cease any drug use and face the possibility of miscarriage or stillbirth; or (3) seek medical treatment for her drug addiction. Faced with three difficult choices, all of which would likely result in some degree of harm to the fetus, Y.N. chose the most reasonable—and medically recommended—option.

Instead of commending Y.N.'s proactive steps during her pregnancy, the appellate court relied on *In re Guardianship of K.H.O.*⁹⁴ to classify her infant's withdrawal symptoms as harm.⁹⁵ The *K.H.O.* case differs drastically from the case of Y.N. because the mother in *K.H.O.* was using heroin and the newborn suffered from heroin withdrawal.⁹⁶ Comparing the cases of *K.H.O.* and Y.N. illuminates the problem with the broad application of civil child abuse statutes. Heroin is an illegal drug that was not prescribed by a doctor to *K.H.O.*'s mother, and served no medical purpose.⁹⁷ An absence of all of these factors from the case of Y.N. demonstrates that the application of *K.H.O.* was inapposite.

Most notably, the appellate court held that for child abuse and neglect claims, it does not matter whether the pregnant woman was prescribed the methadone, or whether she obtained it from an illegal source.⁹⁸ This lies at the heart of the catch-22 problem for pregnant women who need medical treatment during their pregnancies. If a woman can be charged with child abuse or neglect from the side effects suffered by the newborn for any drug she takes while pregnant,⁹⁹ she is less likely to seek proper and necessary medical treatment. In fact, she is likely to forgo not only the treatment for her drug addiction, but also prenatal care as a whole.¹⁰⁰ And, as medical experts have noted in cases of drug addiction, if a pregnant woman does not seek medical treatment, there is a possibility that the drug use—or withdrawals from unsuccessful attempts to quit—will result in a miscarriage or stillbirth.

94 736 A.2d 1246 (N.J. 1999).

95 *Y.N.*, 66 A.3d at 243 (citing *In re Guardianship of K.H.O.*, 736 A.2d 1246).

96 *Id.* at 1249.

97 *See id.*

98 *Y.N.*, 66 A.3d at 242.

99 *Id.* at 241. The trial court based its finding of child abuse or neglect without distinguishing methadone treatment from illicit drugs. The judge reasoned, "[w]hen a child is born drug exposed to illicit drugs, we routinely say that's abuse and neglect." *Id.*

100 *See* Brief of Proposed *Amici Curiae*, *supra* note 42, at 3; *see also Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, AM. CONGRESS OBSTETRICIANS & GYNECOLOGISTS (Jan. 2011), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist>.

Since methadone treatment improves the health and well-being of both the pregnant woman and fetus, methadone is indistinguishable from other drugs prescribed to pregnant women to improve or maintain fetal health. Many pregnant women require prescription drug therapy due to a variety of conditions developed during pregnancy.¹⁰¹ According to medical professionals, to promote the interest of fetal safety, “effective drugs that have been in use for long periods are preferable to newer alternatives.”¹⁰² Methadone has been tested and used to successfully treat opiate addiction for decades.¹⁰³

Many drugs used during pregnancy, whether prescribed by doctors or available over the counter, result in increased the likelihood of fetal harm. For example, a study of pregnant women who were prescribed antidepressants (tricyclic antidepressants or selective serotonin reuptake inhibitors) displayed a positive correlation between the use of antidepressants in utero and a significantly increased risk of preterm delivery.¹⁰⁴ In utero fetal exposure to decongestants, one of the most commonly used over-the-counter medications during pregnancy, has been shown to result in birth defects to newborns.¹⁰⁵ Therefore, under the appellate court’s holding, even a pregnant woman who uses Sudafed for a common cold as per her doctor’s advice can find herself facing child abuse and neglect charges.

The potential for fetal harm and birth defects resulting from use of these drugs displays the difficult problem that results from trying to protect the health of both the pregnant woman and the fetus separately. Fetal development, well-being, and behavior are implicated by depression in pregnant women.¹⁰⁶ However, if the pregnant woman takes antidepressants, there is an increased chance of preterm delivery.¹⁰⁷ This exemplifies the reasons why medical professionals, in consultation with their patients, should prescribe treatment regimens—not the courts.

101 Gideon Koren, Anne Pastuszak & Shinya Ito, *Drugs in Pregnancy*, 338 NEW ENG. J. MED. 1128, 1135 (1998).

102 *Id.*

103 See Joseph et al., *supra* note 37, at 348.

104 See Hanan El Marroun, Vincent W. V. Jaddoe, James J. Hudziak, Sabine J. Roza, Eric A. P. Steegers, Albert Hofman, Frank C. Verhulst, Tonya J. H. White, Bruno H. C. Stricker & Henning Tiemeier, *Maternal Use of Selective Serotonin Reuptake Inhibitors, Fetal Growth, and Risk of Adverse Birth Outcomes*, 69 ARCHIVES GEN. PSYCHIATRY 706, 710 (2012); see also Robert L. Davis, David Rubanowice, Heather McPhillips, Marsha A. Raebel, Susan E. Andrade, David Smith, Marianne Ulcickas Yood & Richard Platt, *Risks of Congenital Malformations and Perinatal Events Among Infants Exposed to Antidepressant Medications During Pregnancy*, 16 PHARMACOEPIDEMIOLOGY & DRUG SAFETY 1086, 1093 (2007).

105 Wai-Ping Yau, Allen A. Mitchell, Kueiyu Joshua Lin, Martha M. Werler & Sonia Hernández-Díaz, *Use of Decongestants During Pregnancy and the Risk of Birth Defects*, 178 AM. J. EPIDEMIOLOGY 198, 198 (2013) (“Epidemiologic studies of specific decongestants have identified elevated risks of specific birth defects, including defects of the heart, eyes and ears, gut, abdominal wall, and feet.”).

106 See generally Judith Alder, Nadine Fink, Johannes Bitzer, Irene Hösli & Wolfgang Holzgreve, *Depression and Anxiety During Pregnancy: A Risk Factor for Obstetric, Fetal, and Neonatal Outcome? A Critical Review of the Literature*, 20 J. MATERNAL-FETAL & NEONATAL MED. 189 (2007).

107 See Hanan El Marroun, et al., *supra* note 104.

A fetus should not be considered a separate “person” from the woman carrying the fetus. Considering a fetus a separate “person” from the moment of fertilization implicates a woman’s rights, including a woman’s ability to obtain MMT during pregnancy.¹⁰⁸ Recognizing a fertilized egg as a “person” will deprive a woman of the choice to have an abortion.¹⁰⁹ If a woman and her fetus are considered separate people, a woman with a life-threatening pregnancy would not be able to abort the fetus to save her own life.¹¹⁰

IV. THE AMERICANS WITH DISABILITIES ACT OF 1990

The Americans with Disabilities Act of 1990 was passed by an overwhelming majority¹¹¹ with the congressional intent of providing full and equal opportunity for Americans with disabilities.¹¹² The ADA provides protection for individuals who are discriminated against based on their disability in various critical areas: “housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services.”¹¹³

Title I of the ADA requires employers to provide qualified individuals with a disability the equal opportunity to benefit from employment-related opportunities.¹¹⁴ Title I prohibits employers from discriminating in “recruitment, hiring, promotions, training, pay, social activities, and other privileges of employment.”¹¹⁵ Title II of the ADA covers all state and local government activities, regardless of the entity’s size or receipt of federal funding.¹¹⁶ Title II requires state and local governments to give people with disabilities the equal opportunity to benefit from government programs, services, and activities.¹¹⁷ For instance, a transportation provision is included in Title II, prohibiting public transportation authorities from discriminating against people with disabilities in providing

¹⁰⁸ See *ACOG Statement on “Personhood” Measures*, AM. CONGRESS OBSTETRICIANS & GYNECOLOGISTS (Feb. 10, 2012), http://www.acog.org/About_ACOG/News_Room/News_Releases/2012/Personhood_Measures.

¹⁰⁹ See *id.*

¹¹⁰ Erik Eckholm, *Push for ‘Personhood’ Amendment Represents New Tack in Abortion Fight*, N.Y. TIMES (Oct. 25, 2011), http://www.nytimes.com/2011/10/26/us/politics/personhood-amendments-would-ban-nearly-all-abortions.html?_r=0.

¹¹¹ NAT’L COUNCIL ON DISABILITY, EQUALITY OF OPPORTUNITY: THE MAKING OF THE AMERICANS WITH DISABILITIES ACT 101 (1997).

¹¹² See 42 U.S.C. § 12101(b) (2012).

¹¹³ *Id.* § 12101(a)(3).

¹¹⁴ 42 U.S.C. §§ 12101–213 (2012); *A Guide to Disability Rights Laws*, *supra* note 8.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

services.¹¹⁸ Title III of the ADA extends nondiscrimination requirements to private entities, businesses, nonprofit service providers, and commercial facilities.¹¹⁹

In particular, Title II of the ADA mandates: “[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or subjected to discrimination by any such entity.”¹²⁰ “Public entity” is defined broadly in the statute: “any state or local government; any department, agency, special purpose district, or other instrumentality of a State or States or local government.”¹²¹ Title II applies to all state and federal activities, programs, and branches of state and federal government, regardless of whether the program or activity receives federal funding.¹²²

While the scope of public entities covered by Title II of the ADA is not enumerated, Congress and the United States Supreme Court have applied the “public entity” standard broadly.¹²³ The purpose statement of the ADA indicates that Congress intended to “invoke the sweep of congressional authority” and eliminate all forms of state discrimination.¹²⁴ Title II specifically targets discrimination in public services, which further indicates congressional intent to eliminate such discrimination in the public sector.¹²⁵

The Supreme Court has held that public services not enumerated by Title II are still protected, as “the fact that the ADA can be ‘applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth.’”¹²⁶ Federal courts have broadly interpreted “service” under Title II to apply to a wide array of public services: social services,¹²⁷ arrests,¹²⁸ education,¹²⁹ housing,¹³⁰

118 See, e.g., *Tandy v. City of Wichita*, 380 F.3d 1277, 1287 (10th Cir. 2004); *Walter v. Se. Pa. Transp. Auth.*, 434 F. Supp. 2d 346, 350–51 (E.D. Pa. 2006); *Liberty Res., Inc. v. Se. Pa. Transp. Auth.*, 155 F. Supp. 2d 242, 253 (E.D. Pa. 2001) (“Improving transportation services for disabled persons is a key component of the ADA.”).

119 42 U.S.C. § 12184(a).

120 *Id.* § 12132.

121 *Id.* §§ 12131(1)(A)–(B).

122 *A Guide to Disability Rights Laws*, *supra* note 8.

123 See, e.g., *Pa. Dep’t of Corrections v. Yeskey*, 524 U.S. 206, 212 (1998) (stating that even though the language in 42 U.S.C. § 12101(b) did not mention prisons, prisons fell squarely within the statutory definition of “public entity” and the statute demonstrated “breadth,” not ambiguity).

124 42 U.S.C. § 12101(b)(4).

125 *Id.* § 12132.

126 *Pa. Dep’t of Corrections*, 524 U.S. at 212 (holding the “public entity” requirement of Title II of the ADA applies to state prisons (quoting *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 499 (1985))).

127 See *Henrietta D. v. Bloomberg*, 331 F.3d 261, 261–62 (2d Cir. 2003).

128 See *Delano-Pyle v. Victoria Cnty.*, 302 F.3d 567, 567 (5th Cir. 2002).

129 See *Smith v. Univ. of N.Y.*, No. 95-CV-0477E(H), 1997 WL 800882, at *6 (W.D.N.Y. Dec. 31, 1997); *Garret v. Chicago Reform Bd. of Trs.*, No. 95-C-7341, 1996 WL 411319, at *1, *3 (N.D. Ill. July 19, 1996); *Essen v. Bd. of Educ. of Ithaca City Sch. Dist.*, No. 92-CV-1164(FJS)(GJD), 1996 WL 191948, at *9 (N.D.N.Y. Apr. 15, 1996).

130 See *Burgess v. Alameda Hous. Auth.*, 98 F. App’x 603, 605–06 (9th Cir. 2004).

loans,¹³¹ transportation,¹³² and even parole proceedings.¹³³ The Second Circuit Court of Appeals held that “programs, services, or activities,” in Title II is a “catch-all phrase that prohibits all discrimination by a public entity, regardless of the context.”¹³⁴ Therefore, it follows that the Title II “public entity” provision may apply to state child welfare services.

For purposes of Title II, a “qualified individual” is defined as:

an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.¹³⁵

“Disability” under Title II of the ADA is defined as: “a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such impairment; or being regarded as having such an impairment.”¹³⁶

The ADA does not expound upon what qualifies as an “impairment.” In 1989, while discussing the Americans with Disabilities Act of 1990,¹³⁷ the Senate enumerated “drug addiction” as one form of physical or mental impairment.¹³⁸ Title II of the ADA expressly excludes individuals who are “currently engaging in the illegal use of drugs.”¹³⁹ The statutory language of the ADA explains that the exclusion of individuals currently engaged in the illegal use of drugs exception does not apply to an individual who:

has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use; is participating in a supervised rehabilitation program and is no longer engaging in such use; or is erroneously regarded as engaging in such use, but is not engaging in such use.¹⁴⁰

131 See *Gaona v. Town & Country Credit*, 324 F.3d 1050, 1050 (8th Cir. 2003).

132 See *Tandy v. City of Wichita*, 380 F.3d 1277, 1277 (10th Cir. 2004).

133 See *Thompson v. Davis*, 295 F.3d 890, 893–94 (9th Cir. 2002).

134 *Innovative Health Sys. v. City of White Plains*, 117 F.3d 37, 45 (2d Cir. 1997).

135 42 U.S.C. §12102(1) (2012).

136 *Id.* § 12102(1)(A)–(C).

137 Then known as the Americans with Disabilities Act of 1989.

138 S. REP. NO. 101-116, at 22 (1989) (discussing the application of the term physical or mental impairment. While the ADA differs in some regards from the Senate bill explained in the report, this portion of the Senate bill did not change. The Senate’s report about the bill provides a non-exhaustive list of examples of “physical or mental impairment”: “such conditions, diseases, and infections as: orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, infection with [HIV], cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, *drug addiction*, and alcoholism.”) (emphasis added).

139 42 U.S.C. § 12114(a).

140 *Id.* § 12114(b)(1–3).

Courts have applied this language to protect individuals who have fully recovered from drug addiction or are in a rehabilitation program to recover from drug addiction.¹⁴¹

When methadone is prescribed by a licensed medical professional, the methadone, and use thereof, is not illegal.¹⁴² In cases, such as *Y.N.*, when the state child protection agency removes a child from the mother's custody because of her prescribed methadone use, the agency's action falls outside of the "currently engaging in" exception, and accordingly, violates Title II of the ADA.

A woman undergoing MMT is a "qualified individual with a disability" under Title II of the ADA. Drug addiction is a form of mental impairment, and while a woman is undergoing MMT, the woman does not fall under the "currently engaged in the illegal use of drugs" exception. Additionally, a state child services department qualifies as a "public entity" within Title II. However, it is less clear whether the state's child removal action would be considered Title II "discrimination." Courts have held that in order for an individual to state a claim that he or she has been "subjected to discrimination" by a public entity, a plaintiff must prove that he or she was either "excluded from participation in or denied the benefits of some public entity's services, programs, or activities, or was otherwise discriminated against by the public entity," and, "that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff's disability."¹⁴³ A plaintiff must satisfy both elements of this two-part test in order to properly state a Title II claim.¹⁴⁴

V. EXTENDING TRADITIONAL APPLICATIONS OF TITLE II TO COVER PRENANT WOMEN PARTICIPATING IN MMT

Individuals participating in methadone maintenance treatment already qualify as individuals with a disability under Title II of the ADA. Several federal appellate courts have recognized that MMT patients are protected from discrimination based on their disability.¹⁴⁵

¹⁴¹ See, e.g., *United States v. S. Mgmt. Corp.*, 955 F.2d 914, 922 (4th Cir. 1992).

¹⁴² See RICHARD A. RETTIG & ADAM YARMOLINSKY, *FEDERAL REGULATION OF METHADONE TREATMENT* 2 (1995).

¹⁴³ *Gohier v. Enright*, 186 F.3d 1216, 1219 (10th Cir. 1999) (citing *Tyler v. City of Manhattan*, 894 F.Supp. 1429 (D.Kan. 1994)); see also *Weinreich v. L.A. Cnty. Metro. Transp. Auth.*, 114 F.3d 976, 978 (9th Cir. 1997).

¹⁴⁴ See *Does 1-5 v. Chandler*, 83 F.3d 1150, 1155 (9th Cir. 1996).

¹⁴⁵ See, e.g., *New Directors Treatment Servs. v. City of Reading*, 490 F.3d 293 (3d Cir. 2007); see also *MX Grp., Inc. v. City of Covington*, 293 F.3d 326 (6th Cir. 2002) (holding that a methadone clinic bringing a suit on behalf of its patients was bringing suit on behalf of people with a disability who were protected by ADA Title II); *Bay Area Addiction Res. & Treatment, Inc. v. City of Antioch*, 179 F.3d 725 (9th Cir. 1999).

Child protection agencies are state agencies, and, as such, are subject to the provisions of Title II of the ADA.¹⁴⁶ Child protective services “is a specialized part of the child welfare system,”¹⁴⁷ which is funded and supervised by the state.¹⁴⁸ The Supreme Court’s acknowledgment of the breadth of Title II of the ADA¹⁴⁹ further proves that child protection agencies fall within the scope of Title II public entities. New Jersey’s child welfare agency, the Department of Children and Families (DCF), receives its budget from both state (general) funds, and federal funds.¹⁵⁰ In 2010, New Jersey’s Child Protection and Permanency Services, a division of DCF, expended a majority of its money from federal funds.¹⁵¹ New Jersey’s DCF is a state agency, which falls well within the Title II’s broad definition of “public entity.”

Applying the two-part test to determine whether a woman whose infant was removed as a result of her participation in MMT while pregnant was “subjected to discrimination” by child protection agencies reveals that this practice violates Title II of the ADA. First, women who have their newborn children removed by a state agency are subjected to discrimination by the agency because women who do not participate in a drug rehabilitation program do not suffer the same consequence. This satisfies the first prong of a Title II discrimination claim. Second, the discrimination against women participating in MMT by state child protection agencies is solely on the basis of the disability, that is, the woman’s status as a drug rehabilitation program participant. Even if there is ambiguity as to whether these women should be protected by Title II of the ADA, any ambiguity should be resolved in favor of the medical consensus on the issue.

A problem many states may encounter in trying to comply with Title II of the ADA, as applied to pregnant women, is the Child Abuse Prevention and Treatment Act (CAPTA).¹⁵² CAPTA is a federal statute that requires health care providers who care for infants to report to child protective services any cases of infants born that are affected by illicit drug use or exhibit symptoms of withdrawal.¹⁵³ Through CAPTA, states are provided with federal funding to develop state child abuse and neglect programs.¹⁵⁴ CAPTA fails to distinguish between infants who are affected by

¹⁴⁶ Chapter 5: *The Child Welfare System: Removal, Reunification, and Termination*, NAT’L COUNCIL DISABILITY (2012), <http://www.ncd.gov/publications/2012/Sep272012/Ch5>.

¹⁴⁷ *Id.*

¹⁴⁸ See *Department of Children and Families*, ST. N.J. DEP’T TREASURY (Jan. 6, 2015), <http://www.state.nj.us/treasury/omb/publications/12budget/pdf/16.pdf>.

¹⁴⁹ Pa. Dep’t of Corrs. v. Yeskey, 524 U.S. 206, 212 (1998) (citing *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 499 (1985) (holding the “public entity” requirement of Title II of the ADA applies to state prisons)).

¹⁵⁰ *Department of Children and Families*, *supra* note 148.

¹⁵¹ *Id.* (\$233,521 was expended from federal funds; \$192,231 was expended from general funds).

¹⁵² Child Abuse Prevention and Treatment Act, Pub. L. No. 93-247, 88 Stat. 4 (codified as amended at 42 U.S.C. §§ 5101-06 (2012)).

¹⁵³ Keeping Children and Families Safe Act of 2003, Pub. L. No. 108-36, 117 Stat. 800 (codified in scattered sections of 42 U.S.C.); see also C. § 5106a(b)(2)(A)(ii) (2012).

¹⁵⁴ See Ellen M. Weber, *Child Welfare Interventions for Drug-Dependent Pregnant Women: Limitations of a Non-Public Health Response*, 75 UMKC L. REV. 789, 792 (2007).

their mothers' illegal drug use and infants who are affected by their mothers' participation in a rehabilitation program, such as MMT. In failing to acknowledge this critical difference, CAPTA overreaches and subjects all women who undergo MMT to state intervention upon the birth of their infant.¹⁵⁵

While CAPTA requires mandatory reporting by health care providers, it provides child welfare services with the discretion to decide whether to file an abuse or neglect charge.¹⁵⁶ Therefore, once an infant is reported to the state child welfare services, in compliance with CAPTA, the state still has the opportunity to comply with Title II of the ADA. The state's child welfare services can investigate the report, determine that the cause of the report is due to a mother's proscribed MMT treatment, and then decline to continue further proceedings. However, should a State decide to file an abuse or neglect charge upon receiving a report under CAPTA on the sole basis of the mother's use of MMT during her pregnancy, the state child welfare services would violate Title II of the ADA.

Any concerns that permitting methadone use during pregnancy would lead to permitting or encouraging illegal drug use can be dismissed, as Title II of the ADA would only reach medical care that is prescribed by a doctor to genuinely treat a drug addiction.¹⁵⁷ Many prescription drugs have the possibility of being abused, but for these situations, the doctor plays a pivotal role in deciding what medication use is *bona fide*.¹⁵⁸

CONCLUSION

The Supreme Court of New Jersey decision in *Y.N.* complies with the ADA Title II nondiscrimination by public entity provision and should serve as an example for other state courts to follow. The Supreme Court of New Jersey properly held that a finding of child abuse and neglect cannot be sustained based solely on a newborn's withdrawal symptoms due to a pregnant woman's methadone use when it is part of a prescribed methadone maintenance program. Additionally, the New Jersey child abuse and neglect statute cannot be applied in a broad, discriminatory manner

¹⁵⁵ Annie J. Rohan, Catherine Monk, Karen Marder & Nancy Reame, *Prenatal Toxicology Screening for Substance Abuse in Research: Codes and Consequences*, 32 SUBST. ABUSE 159, 160 (2011) ("In other states (South Carolina, Illinois, Iowa), it is presumed that a newborn has been neglected and is removed from maternal custody when infant toxicology tests at birth demonstrate the presence of a non-prescription controlled substance.").

¹⁵⁶ See, e.g., Steven J. Ondersma, Lorraine Halinka Malcoe & Sharon M. Simpson, *Child Protective Services' Response to Prenatal Drug Exposure: Results From a Nationwide Survey*, 25 CHILD ABUSE & NEGLECT 657, 661 (2001).

¹⁵⁷ See 42 U.S.C.S. § 12114(a) (2012).

¹⁵⁸ See *Morlino v. Med. Ctr. of Ocean Cnty.*, 706 A.2d 721, 732 (N.J. 1998). In this medical malpractice case, the Supreme Court of New Jersey stated, "[i]n making diagnoses and selecting among treatment options, doctors must rely on their training and experience, as well as such considerations as the patient's age, gender, and physical or mental condition. When evaluating those variables, physicians should not act mechanically, but with due regard for the individual needs of each patient. . . . Not recognizing the role of judgment in making a diagnosis or in deciding on a course of treatment would be to deny an essential element in the practice of medicine." *Id.*

against pregnant women who participate in a drug rehabilitation program without violating Title II of the ADA.

The Supreme Court of New Jersey recognized the errors made by the appellate court in conflating prescribed methadone treatment with illicit drug use, and stressed the importance of “[s]trict adherence to the statutory standards” of the New Jersey child abuse and neglect statute because of the high stakes of abuse or neglect findings.¹⁵⁹

In doing so, the Supreme Court of New Jersey properly took into account the wealth of relevant medical and scientific research on MMT.¹⁶⁰ Twenty-nine experts in law, public health, drug treatment, children’s welfare, and maternal and fetal health,¹⁶¹ and twenty-six reputable institutions¹⁶² wrote an amicus brief in support of the mother in the case of *N.J. Division of Youth & Family Services v. Y.N.*,¹⁶³ urging the Supreme Court of New Jersey to grant certiorari. The Supreme Court of New Jersey considered the arguments made by the amicus curiae, which stressed the importance and effectiveness of methadone treatment for drug addiction.¹⁶⁴

In applying the New Jersey child abuse and neglect statute in an unjustifiably broad manner, the appellate court left pregnant women without guidance as to

159 *N.J. Div. of Child Prot. & Permanency v. Y.N.*, 104 A.3d 244, 252 (N.J. 2014) (explaining the serious consequences of a finding of abuse or neglect, such as termination of a parent’s custodial rights to a child and the parent’s name and information kept on file by the Department of Children and Families).

160 Methadone has been researched and proved effective for over four decades. See Brief of Proposed *Amici Curiae*, *supra* note 42, at 6–10.

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162 American College of Obstetricians and Gynecologists, American Society of Addiction Medicine (ASAM), National Council on Alcoholism and Drug Dependence (NCADD), National Council on Alcoholism and Drug Dependence-NJ (NCADD-NJ), Abortion Care Network (ACN), Association of Reproductive Health Professionals (ARHP), Black Women’s Health Imperative, Center for Gender and Justice (CGJ), Child Welfare Organizing Project (CWOP), Cherry Hill Women’s Center (New Jersey) (CHWC), Drug Policy Alliance (DPA), Faces & Voices of Recovery, Global Lawyers and Physicians (GLP), Harm Reduction Coalition (HRC), Harm Reduction International, HealthRight International, Institute for Health and Recovery (IHR), International Centre for Science in Drug Policy, International Centre on Human Rights and Drug Policy, Legal Action Center (LAC), National Latina Institute for Reproductive Health, National Perinatal Association (NPA), National Women’s Health Network (NWHN), The New York Society of Addiction Medicine (NYSAM), Physicians for Reproductive Health (PRH), Project R.E.S.P.E.C.T. (Recovery, Empowerment, Social Services, Education, Community and Treatment): Addiction Recovery in Pregnancy at Boston Medical Center, & Sistersong Women of Color Reproductive Justice Collective (Sistersong).

163 See Brief of Proposed *Amici Curiae*, *supra* note 42 at 15.

164 See *id.* at 6–10.

which medical decisions made during pregnancy will constitute child abuse or neglect. This uncertainty acts as a strong deterrent to pregnant women seeking necessary, and often life-saving, medical care.¹⁶⁵ The Supreme Court of New Jersey condemned the detrimental reasoning of the appellate court as a “perverse disincentive for a pregnant woman to seek medical help and enter a bona fide detoxification treatment program that will address her and her baby’s health needs.”¹⁶⁶

While the newborn in the case of Y.N. suffered withdrawal symptoms, the harm was not unreasonable.¹⁶⁷ The expected and manageable harm caused to infants from MMT is not evidence of child abuse or neglect. As in Y.N.’s case, an infant suffering from NAS does not experience unreasonable harm under New Jersey’s child abuse statute. A pregnant woman’s adherence to a bona fide medical treatment should never be characterized as *de jure* abuse or neglect.

Furthermore, Y.N.’s use of methadone maintenance during pregnancy was reasonable, as the research in support of methadone treatment for pregnant women is clear and unambiguous.¹⁶⁸ Medical research proves that methadone maintenance during pregnancy, rather than the cessation of the use of opiates entirely, reduces the likelihood of obstetrical complications and benefits fetal health.¹⁶⁹ The withdrawal symptoms, characterized as harm by the Division of Child Protection and Permanency, are treatable with medical care.¹⁷⁰ Infants who develop NAS, such as the infant in this case, experience “minimal to no long-term” consequences.¹⁷¹

Title II of the ADA specifically prohibits public entities from discriminating against qualified individuals with a disability based on their disability. In the case of Y.N., the New Jersey Division of Youth and Family Services discriminated against the mother, in violation of Title II, because of her participation in a MMT program. The public entity (1) discriminated against Y.N. and, (2) such discrimination was by reason of Y.N.’s disability. As a result, the Supreme Court of New Jersey accurately found that the appellate court improperly applied the child abuse and neglect statute. Otherwise, the consequences of upholding the appellate court’s ruling would continue to negatively affect all pregnant women and their families. Pregnant women frequently experience medical conditions that require medication, and most of these medications have side effects.¹⁷² If the appellate court’s decision stood, any

165 *See id.* at 3.

166 N.J. Div. of Child Prot. & Permanency v. Y.N., 104 A.3d 244, 255 (N.J. 2014).

167 Considering Y.N.’s options as a drug-addicted pregnant woman—continue using Percocet, quit “cold turkey,” or seek medical rehabilitation—displays that Y.N. did not make a choice that consisted of unreasonable harm to the newborn.

168 The National Institutes of Health and the Institute of Medicine regard methadone maintenance treatment as “the most effective treatment” for pregnant women who are addicted to opiates. Brief of Proposed *Amici Curiae*, *supra* note 42, at 7–8.

169 *See id.* at 6.

170 *See* Dryden et al., *supra* note 56, at 666.

171 Brief of Proposed *Amici Curiae*, *supra* note 42, at 9–10.

172 *Id.* at 19.

medical treatment or refusal of such treatment by pregnant women could serve as the grounds for a finding of child abuse or neglect.

As shown in the case of *Y.N.*, removing a child from his or her mother on the basis of the mother's use of prescribed methadone treatment during pregnancy violates a woman's rights under Title II of the ADA. MMT is the optimal treatment for opiate addiction in pregnant women. MMT also promotes the public interest of fetal and maternal health. Legislative policies should reflect the findings of the medical community and should serve the purpose of promoting public health.

Upholding the ruling of the appellate court would have been in violation of Title II of the ADA. Title II expressly protects individuals participating in drug rehabilitation programs from discrimination by public entities. The removal of children from women on the basis of the woman's participation in MMT during pregnancy violates this nondiscrimination provision.