SUPREME COURT OF NEW JERSEY
Docket No. 072804

NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES, Plaintiff-Respondent v. Y.N., Defendant-Petitioner In the Matter of P.A.C., a Minor	On Appeal From Superior Court Of New Jersey Appellate Division DOCKET NO. A-5880-11T2 Sat Below: Honorable Judges Graves, Espinosa, and Guadagno(t/a) CIVIL ACTION

AMENDED BRIEF OF *AMICI CURIAE* EXPERTS IN MATERNAL AND FETAL HEALTH, PUBLIC HEALTH, AND DRUG TREATMENT IN SUPPORT OF DEFENDANT-PETITIONER

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STATEMENT OF INTEREST

Amici curiae are experts in maternal and fetal health, child welfare, public health, and drug treatment, as well as advocacy groups committed to the rights and health of pregnant and parenting women and their children (collectively "*amici*").[1] *Amici* seek to assist the Court by bringing to bear relevant peer-reviewed medical and social science research, which was not considered by the courts below. This research militates against the unjustifiable expansion of *N.J.S.A.* 9:6-8.21 to pregnant women, making them legally accountable for the health conditions of their newborns. In this case, the research establishes that *N.J.S.A.* 9:6-8.21 should not be applied to newborns who experience Neonatal Abstinence Syndrome ("NAS") because their mothers received methadone maintenance treatment ("MMT") prescribed by their health care providers and offered to pregnant women by the State of New Jersey.

In so arguing, *amici* do not assert that there are no health risks associated with drugs used by pregnant women, whether or not they are legally prescribed; nor do *amici* endorse the non-medicinal use of drugs, including alcohol or tobacco, during pregnancy. But *amici* respectfully contend that judicial findings in cases like this one, implicating medical, scientific, and social science questions, should be informed by relevant scientific evidence, and aided by expert testimony

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[1] Statements of interest for each expert are included as Appendix A.

where appropriate. Here, the lower courts erred by failing to apply this principle to the scientific and medical questions raised by this case, which included (1) the value and effect of MMT and similar medical treatments for pregnant women and their future children; (2) the nature of NAS and the post-birth medical practices that influence whether and to what extent symptoms of NAS appear; (3) whether NAS that may result from methadone and other medical treatments during pregnancy is properly considered "harm" within the meaning of the statute; and (4) whether requiring pregnant women to refuse medical treatment, no matter how beneficial, or face being charged with abuse and neglect, advances maternal, fetal, or child health. For the reasons set forth below, *amici* respectfully submit that the lower courts' failure to consider the established science with regard to these issues requires that the judgment below be reversed.

PRELIMINARY STATEMENT

The court below concluded that a finding of abuse and neglect under *N.J.S.A.* 9:6-8.21 may be based solely upon evidence that a woman, while pregnant, used a prescribed medication -- in this case, methadone -- which resulted in predictable, treatable, and transitory side effects after birth. In finding that Y.N. committed abuse and neglect, the lower courts not only applied an erroneous construction of *N.J.S.A.* 9:6-8.21 that directly conflicts with New Jersey's own health and welfare policies encouraging MMT and specifically making it

available for pregnant women; they also relied upon scientifically unsupported assumptions about medical decision-making during pregnancy in general, MMT in particular, and the risks of harm associated with parents who use or have used illicit substances.

Even more fundamentally, the ruling of the court below effectively rewrites Title 9 to apply to pregnant women in relation to their fetuses and future children. The plain text of *N.J.S.A.* 9:6-8.21 makes reference only to a "parent or guardian" and her or his child; it says nothing about "pregnant women" or their "fetuses."[2] Nor does *N.J.S.A.* 9:6-8.21 define harm to include the health condition of children at birth. This Court has repeatedly rejected attempts to expand the scope of both Title 9 and Title 30 to allow evidence of what a woman does or does not do during pregnancy to provide the basis for a finding of child abuse or neglect, or grounds for termination of parental rights. See *N.J. Dep't of Children & Families v. A.L.*, 213 *N.J.* 1, 28 (2013)(refusing to allow the Division of Child Protection and Permanency ("DCPP") to expand the scope of its jurisdiction to women who have used a controlled substance during pregnancy and given birth to healthy children); *N.J. Div. of Youth & Family Servs. v. V.M.*, 408 *N.J. Super.* 222, 249 (App. Div. 2009) (Carchman, *J.*, concurring) (clarifying that DCPP's jurisdiction does not extend to pregnant women who refuse to

[2] *N.J. Div. of Youth & Family Services v. L.V., 382 N.J. Super.* 582 (Ch. Div. 2005) (N.J.S.A. 9:6-8.21(c) "clearly does not expressly include a fetus in its definition of a child.")

pre-authorize cesarean surgery); *N.J. Div. of Youth & Family Services v. L.V.*, 382 *N.J. Super.* 582 (Ch. Div. 2005) (refusing to allow DCPP to expand the scope of its jurisdiction to pregnant women who make informed refusals of medication intended to prevent maternal-child HIV transmission). In this case, the lower court opinion radically expands the jurisdiction of DCPP and the scope of *N.J.S.A.* 9:6-8.21 by making it applicable to pregnant women and by creating a new definition of harm. According to the lower court, harm now encompasses the health conditions of a newborn, including the side effects of medications legally prescribed to women during pregnancy. As *amici* explain below, this judicial expansion lacks basis in both science and the law.

Indeed, as set forth below, the lower courts here failed to consider the existing scientific and medical consensus recognizing that MMT is the optimal course of care for pregnant women who are opioid[3] dependent and that threats of child welfare interventions undermine maternal, fetal, and child health. Indeed, such threats are recognized as likely to deter pregnant women from seeking health care at all. In this case, the deterrent effect is explicit and perverse: pregnant women will

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[3] *Amici* use the term "opioid" rather than "opiate" because the latter term is properly limited to the naturally occurring chemical compounds found in the opium poppy plant, while opioid refers both to opiates and to synthetic medications, including methadone, hydrocodone, and naloxone. Nat'l Laboratory Cert. Program, Drug Testing Matters Newsletter, *Opiates History and Chemical Structures* (Dec. 2011), *available at* http://datia.org/eNews/2011/NLCP_DTM_Bourland_Opiates_Part1_12Dec2011.pdf.

effectively be precluded from receiving medication that has for decades been regarded as the "gold standard" of treatment for opioid-dependent pregnant women. Health care providers and others who recommend and provide such treatment would, in effect, be facilitating child abuse.

Further, and perhaps more profoundly, in concluding that *N.J.S.A.* 9:6-8.21 applies to the health of babies at birth, the Appellate Division offered no principled basis for distinguishing MMT from any other medical treatment or decision that may impact a newborn's health. The lower courts' rulings thus open the door to an extraordinary and unjustified expansion of the jurisdiction of DCPP, permitting a child abuse investigation and finding whenever a woman gives birth to a child who is not in perfect health. Such an expansion is not only legally unjustified and medically dangerous, leaving pregnant women and their families without guidance as to which medical risks or side effects will constitute child abuse and delegating that determination to civil servants who are not medical professionals, but is also likely to increase the already disproportionate deployment of child welfare interventions in low-income communities and communities of color. The law ought not countenance such a result, especially where it will deter, and effectively outlaw, the receipt of important medical care.

Moreover, this Court has repeatedly directed that, when a case raises scientific questions, courts should be guided by reliable scientific evidence, including expert testimony where

appropriate, in making their determinations. Yet the lower courts here simply assumed that NAS, which is the anticipated and treatable group of side effects present in some newborns exposed to opioids, is properly understood to be "harm" within the meaning of *N.J.S.A.* 9:6-8.21. The Court reached this conclusion without considering the scientific literature on the subject and without the testimony of a single qualified expert.

This was error: just as in any case implicating medical and scientific questions outside the knowledge of laypersons, judicial findings regarding medical treatment during pregnancy in general, and MMT in particular, should be informed by scientific evidence and aided by expert testimony. The Appellate Division did not adhere to this basic principle, but instead sanctioned a finding of child abuse when a pregnant woman obtains even prescribed medical treatment urged by the State and Federal government, and then gives birth to a child who experiences the predicted, treatable, and transitory side effects of that medication. This Court should reject the lower courts' reliance on assumptions in lieu of reliable scientific evidence regarding these questions.

For these reasons, the Court should reverse the Appellate Division's decision and (1) hold that the use of a prescribed medication such as methadone, even when it causes side effects in a newborn, does not alone constitute abuse or neglect within the meaning of *N.J.S.A.* 9:6-8.21; (2) reaffirm that claims concerning causation of harm or imminent risk of harm that are rooted in medicine and public health must be supported by

reliable evidence-based research; and (3) make clear that *N.J.S.A.* 9:6-8.21 does not treat the health condition of a newborn *alone* as child abuse or neglect and does not create a mechanism for depriving pregnant women of their right to medical decision-making, even when their medical decisions may have an impact on newborn health. Alternatively, the Court should appoint a special master so that the parties and *amici* may call appropriate experts and subject the academic literature regarding such significant questions to full and fair consideration.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Amici incorporate the statement of facts and procedural history from the Appellant's Petition for Certification.[4] In sum, while still pregnant, Y.N. received medically prescribed and supervised MMT. (P1). On February 18, 2011, Appellant Y.N. gave birth to P.A.C, a vigorous, full-term baby boy. Shortly after birth, P.A.C. was diagnosed with NAS, a potential side-effect of MMT, that was successfully treated. (P2).

Y.N. was reported to child welfare authorities. (P2). The trial court found that Y.N. had committed child abuse and neglect based on a hearing in which DCPP made numerous claims that are contrary to established scientific, social science, public health, and medical research, and did so without providing any scientific or medical research or testimony from a single expert in support of those claims. (P2-3). Y.N.

[4] "P" refers to Appellant's Petition for Certification.

appealed this finding to the Appellate Division, which affirmed the trial court's decision holding that evidence of NAS alone constitutes harm for purposes of a finding of child abuse and neglect. (P2-4). Y.N. then filed a petition for certification to this Court; *amici* filed a brief in support of that petition. Certification was granted by this Court on October 16, 2013.

ARGUMENT

A. Scientific research does not support either the trial court's findings or the Appellate Division's decision that methadone maintenance resulting in Neonatal Abstinence Syndrome is "harm" for purposes of Title 9.

Research on methadone maintenance treatment began in 1964 at The Rockefeller University and was funded through the Health Research Council of New York City in response to the burgeoning post-World War II heroin addiction epidemic.[5] That original research showed, and nearly fifty years of evidence-based research has proven beyond debate, that opioid substitution therapy ("OST"), including MMT, is the most effective treatment for opioid dependence.[6] More specifically, and more

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[5] Herman Joseph, *et al., Methadone Maintenance Treatment (MMT): A Review of Historical and Clinical Issues, 67 Mt. Sinai J. Med.* 347, 358 (2000).

[6] OST is defined as "the administration of thoroughly evaluated opioid agonists, by accredited medical professionals, in the framework of a recognized medical practice, to people with opioid dependence, for achieving defined treatment aims." World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (2009) [hereinafter WHO Guidelines], *available at* http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf. This term includes MMT as well as treatment with buprenorphine. *Id.* Both medications are used to treat pregnant women, and both carry the potential of neonatal

significantly for purposes of this case, OST is the optimal course of care for opioid-dependent pregnant women. Accordingly, the Appellate Division's finding that MMT -- including the treatable and transitory symptoms of Neonatal Abstinence Syndrome -- constitutes "harm" within the meaning of Title 9 is based not only on an incorrect characterization of the side effects of prenatal opioid exposure, but also ignores state, federal, and global organizations, including DCPP itself, that approve and encourage OST for pregnant women.

1. Opioid substitution therapy is the most effective treatment for opioid dependence.

Historically, addiction, including opioid dependence, was generally viewed as a choice or a matter of willpower. As recognized by the American Medical Association, however, "addiction is not simply the product of a failure of individual willpower. Instead, dependency is the product of complex hereditary and environmental factors."[7] Thus, while there has

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abstinence syndrome. *See* Hendrée E. Jones, *et al.*, *Neonatal Abstinence Syndrome After Methadone or Buprenorphine Exposure*, 363 *N. Engl. J. Med.* 2320, 2325 (2010). *Amici* use the broader term, OST, to emphasize that child welfare intervention based on a pregnant woman's enrollment in drug treatment is medically and scientifically unjustified regardless of which medication is used.

[7] Am. Med. Ass'n, *Proceedings of the House of Delegates: 137th Annual Meeting, Board of Trustees Report NNN* 236, 241, 247 (June 26-30, 1988). *See also* Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, Committee Opinion No. 473 (Jan. 2011) [hereinafter Opinion No. 473] ("Addiction is a chronic, relapsing biological and behavioral disorder with genetic components."), *available at*

been extensive debate in the treatment community regarding whether addiction is a "disease," there is no longer any dispute that it has both biological and genetic dimensions.[8] As a result, it is now widely accepted that "addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes."[9]

While a range of treatments for opioid dependence exist, the fact is that none has proven as effective as OST in attracting and retaining patients and assisting them in assuming healthy, self-fulfilling, socially productive lives.[10] And as

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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; Office of Nat'l Drug Control Policy, *2013 National Drug Control Strategy, available at* http://www.whitehouse.gov/ondcp/2013-national-drug-control-strategy (stating that "drug addiction is not a moral failing but rather a disease of the brain that can be prevented and treated").

[8] *See Linder v. United States*, 268 *U.S.* 5, 18 (1925); *Robinson v. California*, 370 *U.S.* 660, 667 (1962).

[9] Opinion No. 473, *supra* note 7 at 1 ("Addiction is a chronic, relapsing biological and behavioral disorder with genetic components.").

[10] Ctrs. for Disease Control & Prevention, Nat'l Center for HIV, STD, and TB Prevention, *Methadone Maintenance Treatment* (Feb. 2002) (stating that the benefits of methadone include "improved family stability and employment potential") at 1 [hereinafter CDC], *available at* http://www.cdc.gov/idu/facts/methadonefin.pdf; Nat'l Insts. of Health Consensus Statement, *Effective Medical Treatment of Opiate Addiction* (1997) (stating that MMT is effective in enhancing social productivity) [hereinafter Effective *Treatment*], *available at* http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdd; Michael Scimeca, *et al.*, *Treatment of Pain in Methadone-Maintained Patients*, 67 *Mt. Sinai J. Med.* 412, 414 (2000) (stating that MMT "permits the user to focus on life activities

detailed below, of the treatments available, no treatment has proven as effective for opioid dependence as OST including MMT in particular.

Methadone is a synthetic opioid medication that enables people to stop the use of addictive drugs such as heroin and other opioids.[11] While MMT is considered a substitution therapy, it is not, as one common myth asserts,[12] a matter of simply switching one drug for another. Rather, the term "substitution" refers to the drug's mechanism of action within the brain,[13] but is commonly misunderstood by laypeople to mean "replacing" one high with another.[14] To the contrary, when methadone is taken in appropriate daily dosages, patients develop a tolerance not only to the effects of methadone itself, but to all drugs in the opioid class.[15] In other words, methadone blocks the euphoric and sedating effects of opioids, prevents withdrawal symptoms,

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unrelated to obtaining and using drugs, resulting in gradual return to normal function and a productive lifestyle").

[11] CDC, *supra* note 10 at 1.

[12] Joseph, *et al.*, *supra* note 5 ("From the beginning of MMT, the program has been stigmatized by the belief that methadone treatment merely substitutes one drug for another.").

[13] CDC, *supra* note 10 at 1 ("Methadone is a synthetic agent that works by 'occupying' the brain receptor sites affected by heroin and other opiates."); Gilberto Gerra, *et al.*, *Long-Acting Opioid-Agonists in the Treatment of Heroin Addiction: Why Should We Call Them "Substitution"?*, 44 *Substance Use & Misuse* 663 (2009).

[14] Gerra, *et al.*, *supra* note 13.

[15] White House Office of Nat'l Drug Control Policy, Healthcare Brief, *Medication-Assisted Treatment for Opioid Addiction* (Sept. 2012) (stating that methadone "blocks the effects of heroin and other drugs containing opiates") [hereinafter ONDCP Brief], *available at* http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/medication_assisted_treatment_9-21-2012.pdf.

and markedly reduces, or eliminates entirely, the "craving" for opioids.[16] These characteristics make it an ideal medication for treating opioid dependence.[17]

In fact, the clinical effectiveness of OST, particularly MMT, has been documented in hundreds of published research studies, and it has consistently proven successful in significantly reducing opioid and other drug use, improving treatment retention, and reducing criminal activity.[18] The National Institute on Drug Abuse summarizes it well: "Methadone is a rigorously well-tested medication that has been safely used to treat opioid addiction in the United States for more than 40 years."[19]

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[16] CDC, *supra* note 10 (stating that methadone "blocks the euphoric and sedating effects of opiates; relieves the craving for opiates that is a major factor in relapse; relieves symptoms associated with withdrawal from opiates; does not cause euphoria or intoxication"); ONDCP Brief, *supra* note 15 (stating that methadone "blocks the effects of heroin and other drugs containing opiates"). *See also* WHO Guidelines, *supra* note 6.

[17] WHO Guidelines, *supra* note 6; World Health Organization, *WHO/UNODC/UNAIDS Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention* (2004) [hereinafter WHO/UNODC/UNAIDS], *available at* http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf; Effective *Treatment, supra* note 10.

[18] WHO/UNODC/UNAIDS, *supra* note 17 at 13; WHO Guidelines, *supra* note 6; R.P. Mattick, *et al.*, *Methadone Maintenance Therapy Versus No Opioid Replacement Therapy For Opioid Dependence*, 3 *The Cochrane Database of Systematic Revs.* 1, 2 (2009); Lisa Marsch, *The Efficacy Of Methadone Maintenance Interventions In Reducing Illicit Opiate Use, HIV Risk Behavior and Criminality: a Meta-Analysis*, 93 *Addiction* 515 (1998).

[19] Nat'l Insts. on Drug Abuse, Int'l Program, *Methadone Research Web Guide*, Part A-8 (2006), *available at* http://www.drugabuse.gov/sites/default/files/pdf/methadoneresearchwebguide.pdf.

Thus, MMT is endorsed and recommended by America's foremost experts on addiction. For example, a 1997 consensus panel of experts convened by the National Institutes of Health ("NIH") stated that the "safety and efficacy of [MMT] has been unequivocally established,"[20] and acknowledged that MMT is effective in reducing criminal activity[21] and illicit opiate use.[22] It is likewise endorsed by the White House Office of National Drug Control Policy, which encourages insurers and policy makers "to learn about available medicines and promote policies that ensure that use of [OST] is covered as part of a comprehensive approach to treating prescription and illicit drug dependence."[23]

The efficacy and safety of OST have been documented worldwide, and it is accordingly endorsed by the World Health Organization ("WHO"), the United Nations Office on Drugs and Crime, and the Joint United Nations Programme on HIV/AIDS. Since 2005, the WHO has included methadone on its "Essential Medicines List;" this list is created based on evidence of efficacy and safety, disease prevalence, and comparative cost-effectiveness, toward the end of promoting health equity around

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[20] Effective Treatment, *supra* note 10 at 3.
[21] *Id.* at 7 ("Over the past two decades, clear and convincing evidence has been collected from multiple studies that effective treatment of opiate dependence markedly reduces the rates of criminal activity.").
[22] *Id.* ("Multiple studies conducted over several decades and in different countries demonstrate clearly that MMT results in a marked decrease in illicit opiate use.").
[23] ONDCP Brief, *supra* note 15.

the globe.[24] In its position paper, the WHO concludes that "[s]ubstitution maintenance treatment is an effective, safe and cost-effective modality for the management of opioid dependence" that benefits "society as a whole."[25]

So significant and accepted is OST, that a 2013 United Nations report condemned addiction treatment policies in some parts of the world, or the lack thereof, as "tantamount to torture or cruel, inhuman or degrading treatment."[26] The report stated that a "particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment," which is considered a human rights violation when it occurs in jails and prisons.[27] This well researched, highly regarded, and beneficial form of medical treatment should not, then, be denied to pregnant women in New Jersey.

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[24] World Health Organization, *WHO Model List of Essential Medicines*, 18th List (Oct. 2013), *available at* http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf. *See also* World Health Organization, *Medicines: Essential Medicines*, Fact Sheet No. 325 (June 2010), *available at* http://www.who.int/mediacentre/factsheets/fs325/en/.

[25] WHO/UNODC/UNAIDS, *supra* note 17 at 32; WHO Guidelines, *supra* note 6.

[26] U.N. Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, U.N. Doc. A/HRC/22/53 (Feb. 2013), *available at* http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

[27] *Id.*

2. More than 40 years of evidence-based research have shown opioid substitution therapy, specifically methadone maintenance treatment, to be the optimal course of care for opioid-dependent pregnant women.

Decades of evidence-based research establishes that MMT during pregnancy "remains the gold standard" for opioid-dependent women.[28] Specifically, OST reduces the likelihood of obstetrical complications and produces much better fetal outcomes than are realized by mothers who simply cease the use of opioids entirely during pregnancy.[29] In particular, OST allows for stabilization and management of the levels of opioids in the pregnant woman's system,[30] eases withdrawal symptoms, and

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[28] Stacy Seikel, *Methadone Treatment in Pregnancy . . . That Can't Be Right, Can It?*, 63 *N.E. Fla. Med.* 28, 29 (2012).

[29] *Id.* at 28; John J. McCarthy, *et al.*, *High Dose Methadone Maintenance in Pregnancy: Maternal and Neonatal Outcomes, 193 Am. J. Obstet. Gynecol.* 606 (2005). *See also* Stephen R. Kandall, *et al.*, *The Methadone-Maintained Pregnancy*, 26 *Clinics Perinatol.* 173, 180 (1999).

[30] The court below noted that ("[Y.N.] began with an initial daily dosage of 40 mg of methadone on January 5, 2011, *but this was increased to* 80 mg by February 7, 2011."),*N.J. Div. of Youth & Family Servs. v. Y.N.*, 431 *N.J. Super.* 74, 77 (App. Div. 2013) (emphasis added). Although the court appears to suggest that Y.N. was receiving an unnecessary or inappropriate increase in her medication, it is well established that the optimal methadone dosage for pregnant women generally increases over the course of the pregnancy. Indeed, it is oftentimes necessary to increase dosage in order to ensure that women do not experience decreased blood levels of methadone during pregnancy, which leads to withdrawal symptoms and significant discomfort. John Drozdick III, *et al.*, *Methadone Trough Levels in Pregnancy*, 187 *Am. J. Obstet. Gynecol.* 1184 (2002); Loretta Finnegan, *Licit and Illicit Drug Use During Pregnancy: Maternal, Neonatal and Early Child Consequences*, 80-81 (2013), *available at* http://www.ccsa.ca/2013%20CCSA%20Documents/CCSA-Drug-Use-during-Pregnancy-Report-2013-en.pdf. And the decrease in blood levels of methadone can be accounted for by the physiological changes in a pregnant woman's body: increased fluid space, a large

provides the opportunity for women to obtain comprehensive prenatal care and other support services that they might not otherwise seek, all of which advances maternal, fetal, and child health.[31]

In fact, since the early 1970s, "[OST] has been used successfully with pregnant women."[32] Indeed, for no subgroup of

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tissue reservoir that can store methadone, and increased rates of metabolism and circulating blood volume. WHO Guidelines, *supra* note 6. Therefore, while 60-100 mg of methadone daily is associated with optimal outcomes for most patients, *see* Eric C. Strain, *et al.*, *Moderate vs High-Dose Methadone in the Treatment of Opioid Dependence*, 281 *J. Am. Med. Ass'n* 1000 (1999), *available at* http://jama.jamanetwork.com/data/Journals/JAMA/4609/JOC81302.pdf , higher doses are generally required during pregnancy, *see* John J. McCarthy, Addiction Treatment Forum, *Methadone Dosing During Pregnancy: Does Anyone Have a Clue?* (Oct. 2012) [hereinafter Treatment Forum] (stating that "these increases do not necessarily increase fetal exposure to methadone"), *available at* http://atforum.com/news/2012/10/methadone-dosing-during-pregnancy-does-anyone-have-a-clue-john-j-mccarthy-md-guest-author/.

[31] Kandall, *et al.*, *supra* note 29 at 180. *See also* WHO/UNODC/UNAIDS, *supra* note 17; Substance Abuse & Mental Health Services Admin., U.S. Dep't of Health & Human Servs., Pub. No. [SMA] 06-4124, *Methadone Treatment for Pregnant Women* (2006) [hereinafter SAMHSA Brochure] (citing Vincenzo Berghella, *et al.*, *Maternal Methadone Dose and Neonatal Withdrawal*, 189 *Am. J. Obstet. Gynecol.* 312 (2003)), *available at* http://www.atforum.com/addiction-resources/documents/SAMHSAbrochurePregnantWomen2006.080904-39-5315-04-44.pdf; Opinion No. 473, *supra* note 7 at 1 (stating that "[d]rug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus"). *See also* Lena M. Lundgren, *et al.*, *Medication Assisted Drug Treatment and Child Well-Being*, 29 *Children and Youth Servs. Rev.* 1051 (2007)(addressing the value of methadone treatment services as part of child welfare programs and concluding that "[n]ow is the time to recognize that MM is an underused resource that could better the lives of opiate-dependent parents and their children").

[32] Nat'l Insts. on Drug Abuse, *supra* note 19 at Part B-40.

the opioid-dependent population is OST as urgently recommended as for pregnant women.[33] Thus, the WHO, which is responsible for providing leadership on global health matters and promoting evidence-based treatment standards, states:

> For women who are pregnant or breastfeeding, opioid agonist maintenance with methadone is seen as the most appropriate treatment, taking into consideration effects on the fetus, neonatal abstinence syndrome, and impacts on antenatal care and parenting of young children. Opioid-dependent women not in treatment should be encouraged to start opioid agonist maintenance treatment with methadone or buprenorphine.
>
> [WHO Guidelines, *supra* note 6.]

The Substance Abuse and Mental Health Services Administration ("SAMHSA"), likewise sends a message to pregnant women that is both clear and urgent:

> If you're pregnant and using drugs such as heroin or abusing opioid prescription pain killers, it's important that you get help for yourself and your unborn baby. Methadone maintenance treatment can help you stop using those drugs. It is safe for the baby, keeps you free of withdrawal, and gives you a chance to take care of yourself.
>
> [SAMHSA Brochure, *supra* note 31.]

Medical research shows that OST is not only appropriate for opioid-dependent pregnant women, but also can be lifesaving, as abrupt discontinuation of opioids during pregnancy may cause fetal distress and pregnancy loss.[34] Leading national and

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[33] WHO Guidelines, *supra* note 6.

[34] Am. Coll. of Obstetricians and Gynecologists, Comm. on Health Care for Underserved Women, *Nonmedical Use of Prescription Drugs*, Committee Opinion No. 538 (Oct. 2012), *available at*

international experts thus urge pregnant women to seek treatment in lieu of stopping opioid intake altogether, and the WHO stresses:

> Pregnant women who are taking opioid agonist maintenance treatment should be encouraged not to cease it while they are pregnant. Although many women want to cease using opioids when they find out they are pregnant, opioid withdrawal is a high-risk option because . . . severe opioid withdrawal symptoms may induce a spontaneous abortion in the first trimester of pregnancy, or premature labour in the third trimester.
>
> [WHO Guidelines, *supra* note 6.]

Federal regulations not only recognize the vital role that OST can play in protecting the health and well-being of the opioid-dependent pregnant woman and her expectant child, but also establish priorities for access to treatment for pregnant women. For example, the federal opioid treatment standards, established by the U.S. Department of Health and Human Services, require that there be "a preference for pregnant women in admitting patients to interim maintenance [when a position is not immediately available in a comprehensive maintenance treatment program] and in transferring from interim maintenance to comprehensive maintenance treatment."[35] While federal patient admission criteria require that individuals experience an opioid addiction for at least one year prior to admission in an MMT program, this requirement is waived for pregnant women through a

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https://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Nonmedical_Use_of_Prescription_Drugs.

[35] 42 *C.F.R.* § 8.12(j)(1).

"treatment admission exception."[36] Moreover, treatment facilities that receive federal funding, including those funded through New Jersey's Division of Substance Abuse "must maintain current policies and procedures that reflect the special needs of patients who are pregnant."[37]

Perhaps most significantly, DCPP's position in this case, as well as the Appellate Division's decision accepting that position, is in direct conflict with state policy which recognizes the value of MMT and encourages its use for pregnant women.[38] For example, the New Jersey Department of Human Services, Division of Addiction Services ("DAS"), which "manages initiatives for substance abuse treatment for pregnant women with dependent children and *parents involved with the child welfare system,*" has a specific initiative that "provides a coordinated network of specialized substance abuse treatment services targeted to pregnant women and women with dependent

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[36] 42 *C.F.R.* § 8.12(e)(3).

[37] 42 *C.F.R.* § 8.12(f)(3).

[38] *Amici* note that, despite New Jersey's policy of giving pregnant women priority with respect to access to MMT, there are numerous and long-standing barriers to obtaining MMT. *See generally* Michael Massing, *The Fix: Under the Nixon Administration, American Had an Effective Drug Policy. WE SHOULD RESTORE IT. (Nixon Was Right)*, 224-26 (1998) (explaining that, although methadone is the most effective treatment for heroin addiction, government regulations largely block its prescription by primary-care physicians and its sale by pharmacies, instead limiting methadone distribution to special clinics); Robert G. Newman, *Addiction and Methadone: One American's View,* 2 *Heroin Addiction & Related Clinical Problems* 19, 22 (2000) ("Collectively, these programmes can accommodate less than 15% of those whom methadone treatment might help.").

children."[39] Significantly, the very first service listed is "methadone maintenance."[40] DAS has advised that methadone "is still the pharmacotherapy of choice for the treatment of opiate dependent pregnant patients," and should be offered as a first-line treatment.[41]

Similarly, the annual reports produced by the Governor's Council on Alcoholism and Drug Abuse highlight joint DCPP and DAS efforts that include the provision of MMT for pregnant women.[42] New Jersey regulations also expressly require that MMT programs give preference to opioid-dependent pregnant women,[43] and forbid programs from allowing pregnant women to be withdrawn from MMT during their pregnancies, except in cases of medical

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[39] State of N.J. Dep't. of Human Servs., Div. of Addiction Servs., Women and Families, *available at* http://www.state.nj.us/humanservices/das/treatment/women/ (emphasis added).

[40] *Id.*; *see* N.J. Dep't of Human Servs., OMB No. 0930-0168, *Substance Abuse Prevention and Treatment Block Grant Application* 440 (Aug. 21, 2013) (Memorandum of Understanding between N.J. Div. of Youth & Family Servs. and N.J. Div. of Mental Health & Addiction Servs.) (stating that the agencies "recognize the need to promote and provide coordinated enhanced child welfare abuse treatment services for residential, intensive outpatient, outpatient and methadone maintenance for children and families who have an open child welfare case"), *available at* http://www.state.nj.us/humanservices/divisions/dmhas/Block_Grant_Application_2014-2015.pdf.

[41] *N.J.A.C.* 10:161B app. § B (2009) (Div. of Addiction Servs., Administrative Bulletin 4-2007, Buprenorphine Guidelines).

[42] See Governor's Council on Alcoholism and Drug Abuse, *N.J. Annual Comprehensive Statewide Master Plan on Alcoholism, Tobacco, and Other Drug Abuse 2006*, 85, 87; *Master Plan 2007*, 174; *Master Plan 2008*, 36, 99, 102-103; *Master Plan 2009*, 38, 87, 99-90; *Master Plan 2010*, 35, 80, 83.

[43] *N.J.A.C.* 10:161B-11.5(a) (2009) ("Opioid treatment programs shall give preference for admission to pregnant women . . . .").

necessity.[44] Of course, no information available from DCPP or DAS anywhere warns pregnant women that some types of state-funded, recognized, and recommended treatment may be a form of child abuse.

Finally, with respect to child welfare services, a Medication-Assisted Treatment ("MAT") "Know-Your-Rights" publication, prepared for SAMHSA, explains that:

> [J]udges, prosecuting attorneys, and others in the child welfare system . . . may not single out people in MAT and require them to stop taking legally prescribed medications. Such a requirement would be no different than telling an insulin-dependent, diabetic parent that she may not have her children back unless she stops taking insulin and addresses her diabetes through nutrition and exercise alone.
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> [Substance Abuse & Mental Health Servs. Admin., Center for Substance Abuse Treatment, *Know Your Rights, Rights for Individuals on Medication-Assisted Treatments,* 12 (2009), *available at* http://partnersforrecovery.samhsa.gov/docs/know_your_rights_brochure_0110.pdf.]

The Appellate Division's decision is therefore at odds with the medical consensus regarding MMT for opioid-dependent pregnant women, as well as with the state, federal, and global policies that encourage OST generally, and MMT in particular.

In fact, in *A.L.*, after the submission of supplemental briefs addressing the scope of *N.J.S.A.* 30:4C-11, which expressly applies to unborn children, *A.L.*, 213 N.J. at 17, this

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[44] *N.J.A.C.* 10:161B-11.4(a)(4)(v)(2) (2009) ("Pregnant women shall not be voluntarily or involuntarily withdrawn from methadone during the duration of the pregnancy except for medical necessity as determined by the medical director.").

Court highlighted this statute as a mechanism by which the Division may "intervene" through the provision of services "to address the troubling problem of drug use during pregnancy when there is insufficient proof of actual harm or imminent danger to a child." *Id.* at 34. As discussed herein, *supra* at 19-22, MMT is among the services provided by DCPP and DAS to children and families in the child welfare system; nor do any New Jersey laws, regulations, or policies even suggest that MMT is excluded from the services that the state may provide to pregnant women pursuant to *N.J.S.A.* 30:4C-11. It would, then, be both ironic and counterproductive for this Court to uphold the lower court's decision effectively prohibiting exactly this kind of intervention, a voluntary, effective method of intervention so positively noted by this Court in *A.L.*

3. Neonatal Abstinence Syndrome is a treatable medical condition that may present in opioid-exposed newborns, the occurrence and severity of which is influenced by factors unrelated to a pregnant woman's medical treatment or drug use.

NAS is the treatable and transitory group of side effects that present in some newborns who have been exposed to opioids.[45] These include heroin and other unprescribed opioids, as well as opioids prescribed as part of OST, and those prescribed for the

[45] Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *Opioid Abuse, Dependence, and Addiction in Pregnancy*, Committee Opinion No. 524 (May 2012) ("[NAS] is an expected and treatable condition that follows prenatal exposure to opioid agonists.").

management of pain.[46] As with most medications -- whether they are over the counter medications such as aspirin or prescription medications such as statins -- methadone has potential side effects. For women who are pregnant, these side effects may affect her child, once born. Nonetheless, as the WHO makes clear, taking all things into consideration, including the possibility of NAS in the newborn, OST is still recognized as the most appropriate treatment for pregnant women.[47]

NAS, if it occurs, is prompted when the umbilical cord is cut and the cessation of the supply of drug results in a physiologic withdrawal.[48] As SAMHSA explains in lay terms: "Undergoing MMT while pregnant will not cause birth defects for your baby, but some infants may go through withdrawal after birth."[49] As the SAMHSA brochure explains, studies have shown that the dose of methadone the pregnant woman receives has no bearing on whether or not her baby will experience withdrawal.[50]

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[46] Significantly, "there are very few options for the treatment of severe chronic pain during pregnancy, and opioid analgesics have been relied upon as the safest alternative in conditions requiring treatment for pain." *Letter from Massachusetts Society for Addiction Medicine to Martha Coakley, Massachusetts Attorney General* (June 6, 2013), *available at* http://masam.org/yahoo_site_admin/assets/docs/Coakley_letter_BlackBox_State_AG_FDA_response.156114529.pdf.

[47] WHO Guidelines, *supra* note 6 page 51.

[48] Lauren M. Jansson, *et al.*, *The Opioid Exposed Newborn: Assessment and Pharmacologic Management, 5 J. Opioid Manag.* 47, 47 (2009).

[49] SAMHSA Brochure, *supra* note 31.

[50] SAMHSA Brochure, *supra* note 31 (citing Vincenzo Berghella, *et al., Maternal Methadone Dose and Neonatal Withdrawal,* 189 *Am. J. Obstet. Gynecol.* 312 (2003)).

Symptoms of physiologic withdrawal include excessive crying, loose stools, tremors, and irritability.[51]

Importantly, NAS is not the same as addiction. As fifty leading national and international experts recently explained: "Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. In fact, babies cannot be born 'addicted' to anything regardless of drug test results or indicia of physical dependence."[52] Likewise, the SAMHSA brochure states: "Withdrawal does not mean the baby is addicted."[53]

Maternal and fetal health experts have developed objective assessment and scoring tools to diagnose NAS. If NAS is diagnosed, these tools are used to determine what, if any, treatment is needed and, if treatment is needed, to monitor the newborn and determine when the NAS has resolved and the treatment is no longer required.[54]

The Finnegan Scale is one such tool. It lists 21 signs and symptoms most commonly observed in newborns with NAS and allows a weighted scoring of those symptoms from 1-5.[55] This scale helps health care providers assess the onset, progression, and

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[51] Jansson, *et al.*, *supra* note 48 at 50-53.
[52] Open Letter from Robert G. Newman, *et al.*, *Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opiate Use by Pregnant Women* (Mar. 11, 2013), [hereinafter Open Letter] *available at* http://idhdp.com/media/32950/rnewmanopenexpertletter_-_3.11.13.pdf.
[53] SAMHSA Brochure, *supra* note 31.
[54] Jansson, *et al.*, *supra* note 48 at 48.
[55] *Id.*

resolution of symptoms.[56] Significantly, the Finnegan Scale is also used for newborns prenatally exposed to Selective Serotonin Reuptake Inhibitors ("SSRIs"), a class of compounds typically used to treat depression.[57]

As the existence of these scoring tools suggest, NAS has significant variability[58] and does not always require pharmacologic treatment.[59] As SAMHSA explains, "Many times a quiet, comfortable environment is enough to provide comfort to your baby. If the symptoms are severe, your baby's doctor may prescribe medicine to help."[60] Such medicine may include methadone or various morphine solutions that are administered orally or intravenously.[61]

Neither NAS nor its treatment has been associated with long-term adverse consequences. In fact, "there is no evidence of long term adverse outcomes in children treated with pharmacological agents vs. infants who do not require treatment

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[56] *Id.*

[57] Finnegan, *supra* note 30 at 46.

[58] Jansson, *et al.*, *supra* note 48 at 47 ("Any opioid used by the mother during pregnancy can produce NAS in the infant . . . [and] NAS occurs with notable variability."); Brian J. Cleary, *et al.*, *Methadone Dose and Neonatal Abstinence Syndrome -- Systemic Review and Meta-Analysis*, 105 *Addiction* 2071 (Sept. 2010) (stating that "neonatal abstinence syndrome does not appear to differ" according to maternal methadone doses).

[59] SAMHSA Brochure, *supra* note 31; Treatment Forum, *supra* note 30 (stating that "in an ongoing study in our pregnancy program the majority of newborns experience NAS that is so mild it does not require treatment").

[60] SAMHSA Brochure, *supra* note 31.

[61] Subrata Sarkar & Steven M. Donn, *Management of Neonatal Abstinence Syndrome in Neonatal Intensive Care Units: a National Survey*, 26 *J. of Perinatology* 15 (2006).

for NAS."[62] As SAMHSA emphasizes to pregnant women, methadone "is safe for the baby," and "babies born to mothers on methadone do as well as other babies."[63]

Moreover, the scientific research establishes that both the occurrence and severity of NAS are affected by a variety of factors unrelated to the possible pharmacological effects of prenatal exposure to opioids. For example, one study demonstrates that when hospitals employ "rooming in" -- the practice of caring for mother and newborn together in the same room immediately from birth -- newborns have less need for treatment of NAS, shorter lengths of hospital stay, and significantly greater likelihood of being discharged home in the custody of their mothers.[64] Another peer-reviewed study found that only 11% of babies who boarded with their mothers required treatment of NAS compared to more than four times as many who were placed in a neonatal intensive care unit ("NICU").[65]

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[62] Walter K. Kraft & John N. van den Anker, *Pharmacologic Management of the Opioid Neonatal Abstinence Syndrome, 59 Ped. Clinics of N. Am.* 1147 (2012).

[63] SAMHSA Brochure, *supra* note 31 ("While it is not known for certain what long-term effects the exposure to methadone may have on babies, their health is much better than babies born to mothers on heroin. It can be reassuring to know that thousands of healthy babies born to methadone-maintained moms develop into normal children.").

[64] Ronald R. Abrahams, *et al., An Evaluation of Rooming-In Among Substance-exposed Newborns in British Columbia*, 32 *J. Obstet. Gynaecol. Can.* 866 (2010).

[65] Tolulope Saiki, *et al., Neonatal Abstinence Syndrome--Postnatal Ward Versus Neonatal Unit Management*, 169 *Eur. J. Peds.* 95 (2010).

Allowing mothers to breastfeed their newborns can also reduce the need for and length of treatment for NAS.[66]

Moreover, evidence-based research shows that location has been associated with major differences in the treatment of NAS.[67] In other words, the extent of the treatment provided is less a function of the severity of the condition and more a matter of local practice. This should not be surprising in light of two national surveys assessing the management of NAS in NICUs.[68] These studies not only highlight the inconsistency of policies that determine the presence of and treatment for NAS, but also explain that only approximately half of all NICUs have written guidelines for the management of NAS.[69]

As discussed below, *see infra* Part C.3, none of this information was considered by the lower courts, which simply presumed that the NAS exhibited in P.A.C. was solely the result of the treatment Y.N. obtained and could properly be considered

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[66] Gabrielle K. Welle-Strand, *et al.*, *Breastfeeding Reduces the Need for Withdrawal Treatment in Opioid-Exposed Infants, 102 Foundation Acta Paediatrica* 1060 (2013).

[67] For example, "to babies whose mothers received methadone [during pregnancy,] the total morphine dose administered to control neonatal abstinence syndrome averaged 4.93 mg in rural American sites, 5.04 mg in Vienna, and 34.17 mg in urban U.S. sites; the number of days of medication averaged 4.92, 9.26 and 17.91, respectively." Robert Newman & Susan Gevertz, *The Complex Factors Determining Neonatal Abstinence Syndrome and Its Management*, 18 *Eur. Addict. Res.* 322 (2012) (citing data in a publication by A. Baewert, *et al.*, 18 *Eur. Addict. Res.* 130 (2012)).

[68] Aakriti Mehta, *et al.*, *Neonatal Abstinence Syndrome Management From Prenatal Counseling to Postdischarge Follow-up Care: Results of a National Survey*, 3, 4 *Hospital Peds.* 317 (Oct. 2013); Sarkar & Donn, *supra* note 61.

[69] Mehta, *et al.*, *supra* note 68; Sarkar & Donn, *supra* note 61.

"harm" for purposes of Title 9. Given the well-researched, medically established, treatable nature of NAS, it should not be surprising that nowhere in the medical literature -- from textbooks to professional journals -- is NAS viewed as "harm," "actual harm," "impairment," or "injury." Nor, it follows, is a woman's decision to seek and obtain such treatment described as the infliction of harm. Indeed, as set forth above, it is just the opposite -- it is the effective effort to seek out the optimal course of care for herself and for her expected child.[70]

In sum, the Appellate Division's finding of NAS as "harm" is an incorrect characterization of the treatable and transitory side effects of prenatal opioid-exposure. Accordingly, the decision below should be reversed.

B. This Court should reverse the decision below to avert the harm to New Jersey women, children, and families that would result from the interpretation of *N.J.S.A.* 9:6-8.21 proposed by DCPP and accepted by the lower courts.

This Court should reverse the decision of the Appellate Division, not only because it is based upon assumptions that are unsupported, and belied, by the scientific and medical evidence, but also because of the broad and dangerous impact that decision will have on the health and well-being of New Jersey's women and children. The decision below, if allowed to stand, will effectively ban pregnant women from receiving MMT even though it is recognized to be the best treatment for maternal, fetal, and child health. Indeed, studies have consistently demonstrated

[70] *See* SAMHSA Brochure, *supra* note 31.

that the fear of being charged with abuse and neglect and of losing custody of a child deters pregnant women from pursuing drug treatment, prenatal care, and other sources of support. And the Appellate Division's decision is particularly dangerous precedent because it does not provide a principled basis for limiting its holding to MMT. As set forth below, the result is a decision that dangerously increases risks to the health and well-being of women and children, and particularly women and children in low-income communities and communities of color.

1. This Court should reverse the decision below because it would undermine maternal, fetal, and child health by precluding pregnant women from receiving methadone treatment specifically and by discouraging treatment in general for pregnant women with drug dependency problems.

Y.N. finds herself accused, subjected to intrusive and disruptive investigation, judged to have abused or neglected her child, and placed on the Child Abuse Central Registry for life[71]

[71] The consequences of a Title 9 judgment of child abuse or neglect are not trivial. *N.J.S.A.* 9:6-8.21 gives DCPP the power to remove a child and place him or her in foster care or in the custody of another "suitable person," *see, e.g., N.J.S.A.* 9:6-8.50(d), for an initial period of 12 months, which may be extended for additional year-long periods. *N.J.S.A.* 9:6-8.54(b). Judgments of child abuse or neglect can also form the basis of a Title 30 action for guardianship or termination of parental rights. *See N.J.S.A.* 30:4C-15(c). Moreover, judgments of child abuse are reported to the state's central child abuse registry, a permanent record which can impact employment and family life for the rest of a defendant parent's life. *See, e.g., In re. Allegations of Sexual Abuse at East Park High School*, 314 *N.J. Super.* 149, 157-59 (App. Div. 1998) (documenting the many limitations to employment that being listed on the central registry entails). Even a mere report of suspected abuse can subject a parent to serious intrusions by

for having followed medical advice to seek MMT during her pregnancy. By attaching legal penalties to the receipt of MMT, the Appellate Division's decision effectively bans pregnant women from obtaining one of the only therapies that has been proven safe and effective in addressing opioid dependence in pregnant women.[72] Indeed, the lower courts' rulings send an incongruous and dangerous message to pregnant women who are opioid dependent: if you avail yourself of the best possible treatment, you will be charged with abuse and neglect. And this is so notwithstanding that MMT is recommended, funded, and provided through cooperative agreements and collaborative programs between DCPP and the DAS. The decision thus allows of only one possible choice on the part of an opioid dependent pregnant woman, regardless of her doctor's advice, of the treatment recommended by State agencies and endorsed by the

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the state, including search of her home and arrest, *see N.J.S.A.* 9:6-8, and subpoena of her medical records that "pertain to the child," *N.J.S.A.* 9:6-8.93, which would include sensitive information about her drug treatment and prenatal care -- records which may also contain considerable information about her reproductive history. Additionally, intrusive, potentially humiliating interviews by hospital personnel or DCPP social workers may take place within the infant's first days of life, disrupting efforts to promote maternal-child bonding and infant comfort through measures such as breastfeeding, *see* Welle-Strand, *et al.*, *supra* note 66, and skin-to-skin "kangaroo care" when such measures are likely to be most helpful. *See* Dartmouth-Hitchcock Medical Center, *Neonatal Abstinence Syndrome: What You Need to Know* 4, *available at* http://www.nhawhonn.org/Documents/NAS%20parent%20education%20guide.pdf.

[72] Indeed, the facts bear this out: Y.N. tried non-medication based programs, but they were not effective. *See Y.N.*, 431 *N.J. Super.* at 76-77.

medical profession, and regardless of the risks of miscarriage and stillbirth: the abrupt, immediate cessation of the use of any and all opioids.

Moreover, the consensus of leading medical groups and peer-reviewed social science research establishes that threats of a finding of child abuse and neglect, and of losing custody of one's child, do not work as a mechanism to address medical issues in pregnancy, including those associated with drug dependency. Instead, they increase risks to maternal, fetal, and child health and well-being by deterring pregnant women from seeking prenatal care in general and drug treatment in particular.[73] Thus, according to a report published by the National Center on Substance Abuse and Child Welfare:

> One key reason for th[e] lack of prenatal care is fear on the part of the pregnant woman of punitive action and/or the possible loss of custody of the child as a result of her drug use. Because quality prenatal care is such a critical factor in increasing the likelihood of good birth outcomes, everything possible should be done to ensure that the physician's office is seen as a safe and supportive resource to all pregnant women.[74]

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[73] *See, e.g.*, Martha A. Jessup, *et al.*, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 *J. Drug Issues* 285 (2003); Sarah C.M. Roberts & Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, 15 *Matern. Child Health J.* 333 (2011); Sarah C.M. Roberts & Amani Nuru-Jeter, *Women's Perspectives on Screening for Alcohol and Drug Use in Prenatal Care*, 20 *Women's Health Issues* 193 (2010).

[74] Nancy K. Young, *et al.*, U.S. Dep't Health & Human Serv., Nat'l Ctr. Substance Abuse & Child Welfare, *Screening & Assessment for Family Engagement, Retention, and Recovery (SAFERR)* C8 (2006) (citing Barry M. Lester, *et al.*, *Substance Use During Pregnancy: Time for Policy to Catch up With Research*, 1 *Harm Reduction J.*

Another federal report finds that fear of losing children to the child welfare system is a significant barrier to drug treatment and prenatal care for women:

> Drug treatment and prenatal care providers told us that the increasing fear of incarceration and losing children to foster care is discouraging pregnant women from seeking care. Women are reluctant to seek treatment if there is a possibility of punishment. They also fear that if their children are placed in foster care, they will never get the children back.
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> [U.S. Gen. Accounting Office, GAO/HRD-90-138, Report to the Chairman, Comm. on Finance, U.S. Senate, *Drug-Exposed Infants: A Generation at Risk* 9 (1990), *available at* http://archive.gao.gov/d24t8/141697.pdf.]

Numerous studies have found that the fear of child welfare interventions and the loss of custody of their children are significant factors that deter drug-dependent pregnant women from disclosing drug use and seeking necessary health care.[75]

1477 (2004)), *available at* http://www.ncsacw.samhsa.gov/files/SAFERR.pdf.

[75] *See* Shelly Gehshan, Southern Reg'l Project on Infant Mortality, *A Step Toward Recovery: Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women* ii, 5 (1993); Jessup, *et al.*, *supra* note 73; Marilyn L. Poland, *et al.*, *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 *Drug & Alcohol Dependence* 199 (1993); Roberts & Pies, *supra* note 73; Roberts & Nuru-Jeter, *supra* note 73; Steven J. Ondersma, *et al.*, *Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response*, 5 *Child Maltreatment* 93, 99 (2000) ("[B]ringing high levels of coercion to bear on parents increases the likelihood that contact with outside agencies and hospitals will be avoided by pregnant mothers."); *see also Ferguson v. City of Charleston*, 532 *U.S.* 67, 78 n.14 (2001) ("[W]e have previously recognized that an intrusion [on the expectation of patient privacy regarding diagnostic tests] may have adverse consequences because it may deter patients from receiving needed medical care.").

Indeed, the harm resulting from the fear of being reported to child welfare authorities is deemed so significant that the American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women has called for the repeal of policies that require mandatory reporting of pregnant drug-using women to child welfare authorities.[76]

The decision below overlooks this broad consensus in the medical community that threats are an ineffective mechanism to reduce drug use for individuals suffering from addiction.[77] In fact, research suggests that women's efforts to change addictive behavior may be frustrated by child welfare interventions, which are adversarial in nature and provide a constrained timetable for behavioral change.[78] Moreover, treatment outcomes are greatly improved when a woman retains custody of her children during treatment (known as "family treatment").[79] Children also reap the benefit of an intact family.[80]

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[76] Opinion No. 473, *supra* note 7 at 201.

[77] *See* Opinion No. 473, *supra* note 7.

[78] Melinda M. Hohman, *et al.*, *A Comparison of Pregnant Women Presenting for Alcohol and Other Drug Treatment by CPS Status*, 27 *Child Abuse & Neglect* 303, 313 (2003) (stating that "[b]eing pregnant and a known substance user can place the . . . mother under more intense scrutiny, which in turn could be perceived as added pressure, making treatment and recovery more difficult").

[79] According to one study, almost 60% of women who retained custody of their infants completed treatment successfully, compared with only 32% of women who lost custody. Robert H. Nishimoto & Amelia C. Roberts, *Coercion and Drug Treatment for Postpartum Women*, 27 *Am. J. Drug & Alcohol Abuse* 161, 170 (2001). An evaluation of federally funded programs for postpartum women found that women whose infants lived with them during treatment had a 48% completion rate, while women who lost custody of their infants had only a 17% completion rate. H. Westley Clark, *Residential Substance Abuse Treatment for*

Allowing the lower court decisions to stand would, then, place New Jersey law directly at odds with prevailing medical and public health learning regarding the treatment of pregnant women with drug dependency problems, with potentially serious health care consequences for women and children. For this reason as well, this Court should reverse the decision of the Appellate Division.

2. The decision below has created a dramatic and legislatively unauthorized expansion of the State's power to investigate and intrude upon pregnant women and families based on medical decisions.

This Court should also reverse the Appellate Division's decision in order to prevent the extraordinary harm that would flow from the Appellate Division's radical expansion of *N.J.S.A.* 9:6-8.21(c)(4)(b), granting DCPP virtually limitless power to second-guess any medical decision by a pregnant woman and to treat her as a child abuser if her course of care may cause side effects in her newborn. Indeed, there is nothing in the decision of the court below that limits its ruling to pregnant women who receive MMT; its potential application is much broader and much more dangerous.

In fact, the majority of pregnant women experience health conditions that require medication[81] many of which have side

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Pregnant and Postpartum Women and Their Children: Treatment and Policy Implications, 80 *Child Welfare* 179, 189 (2001).

[80] Kathleen Wobie, *et al.*, *Abstract: To Have and To Hold: A Descriptive Study of Custody Status Following Prenatal Exposure to Cocaine*, 43 *Pediatric Res.* 234 (1998).

[81] *See, e.g.*, Maria A. Morgan, *et al.*, *Management of Prescription and Nonprescription Drug Use During Pregnancy, 23 J. Maternal-*

effects in the newborn.[82] In one survey, over half (56%) of pregnant women were prescribed at least one drug, many of which, like methadone, are controlled substances.[83]

For example, women with seizure disorders, including epilepsy, would be forced to choose between experiencing dangerous seizures throughout pregnancy and taking drugs to control the condition because anticonvulsants have been associated with an "increased risk of birth defects, including cleft palate, heart defects, and neural tube defects."[84] Pregnant women would also be forced to face the risks associated with untreated depression because studies have linked "fetal malformations, cardiac defects, pulmonary hypertension, and reduced birth weight to antidepressant use during pregnancy;"[85] as discussed above, NAS is also a side effect of a common medical treatment for depression, SSRIs. Women who become

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Fetal & Neonatal Med. 813, 815-17 (2010) (finding that, among surveyed obstetricians and gynecologists, "approximately a third of their pregnant patients took at least one prescription medication other than prenatal vitamins during pregnancy prior to labor").

[82] *See, e.g., The Merk Manual of Diagnosis and Therapy*, 1859, 1861 (R. Berkow ed., 16th ed. 1992) (detailing danger of aspirin, thyroid medication, and antihypertensive drugs).

[83] Erika Hyde Riley, *et al., Correlates of Prescription Drug Use During Pregnancy, 14 J. Women's Health* 401, 401 (2005).

[84] Am. Coll. of Obstetricians & Gynecologists, *Seizure Disorders in Pregnancy*, FAQ 129 (Feb. 2013), *available at* http://www.acog.org/~/media/For%20Patients/faq129.pdf?dmc=1&ts=20131220T1326091811.

[85] Am. Coll. of Obstetricians & Gynecologists, *Depression During Pregnancy: Treatment Recommendations, A Joint Report from APA and ACOG* (Aug. 2009), *available at* https://www.acog.org/About_ACOG/News_Room/News_Releases/2009/Depression_During_Pregnancy.

pregnant while taking Coumadin, (a drug used to prevent heart attacks, strokes, and blood clots in veins and arteries) have significantly increased chances of giving birth to a child with Fetal Warfarin Syndrome,[86] a condition which would certainly satisfy the lower court's standard of what constitutes "actual impairment." Indeed, DCPP would have broad powers to charge *any* woman with abuse and neglect who took *any* drug while pregnant that resulted in *any* side effect on her child after birth.

Even if a woman does not receive medical treatment or take drugs while pregnant, however, under the Appellate Division's interpretation of "actual impairment," she could nevertheless be charged under Title 9. The court held that the newborn's withdrawal sequence, "which required treatment in the NICU and numerous doses of morphine over an extended period of time, is compelling evidence of actual impairment." *N.J. Div. of Youth & Family Servs. v. Y.N.*, 431 *N.J. Super.* 74, 82 (App. Div. 2013). By this logic, every newborn that requires time in the Neonatal Intensive Care Unit may be deemed to have suffered "actual harm" under Title 9.

Similarly, the failure to use appropriate amounts of medication might also give rise to abuse and neglect. Thus, women who fail to perfectly control common conditions during their pregnancy, like asthma or diabetes, would face abuse and

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[86] Fetal Warfarin Syndrome is a condition associated with taking Warfarin (Coumadin) while pregnant, the symptoms of which include congenital heart defects, hypoplasia of the nasal bridge, growth retardation, and ventriculomegaly. Jia-Woei Hou, *Fetal Warfarin Syndrome*, 27 *Chang Gung Med. J.* 691 (2004).

neglect charges: poorly controlled diabetes can result in "serious birth defects, such as those of [the] brain, spine, and heart," while complications of poorly controlled asthma include increased "risk of perinatal mortality, preeclampsia, preterm birth, and low birth weight infants."[87] An unvaccinated woman who develops chickenpox while pregnant may likewise place both herself and her baby at high risk for potentially serious complications, including, if the chickenpox develops during the first 20 weeks of pregnancy, congenital varicella syndrome, a rare group of serious birth defects, which include low birth weight, skin lesions, neurologic defects, eye diseases, and skeletal anomalies.[88] And even poor dental care could potentially place a baby at risk, since periodontitis is associated with low birth weight, and high levels of cariogenic bacteria in mothers can lead to increased tooth decay and infections in the infant, while poor dentitis can lead to a variety of dental issues that increase the risk for preterm labor.[89] Such conditions, of course, subject women who are ill,

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[87] Am. Coll. of Obstetricians & Gynecologists, *A Healthy Pregnancy for Women With Diabetes*, FAQ 176 (Dec. 2011), *available at* http://www.acog.org/~/media/For%20Patients/faq176.pdf; Nat'l Insts. of Health, Nat'l Asthma Education and Prevention Program, *Managing Asthma During Pregnancy: Recommendations for Pharmacologic Treatment* (2004), *available at* http://www.nhlbi.nih.gov/health/prof/lung/asthma/astpreg/astpreg_qr.pdf.

[88] Ctrs. for Disease Control and Prevention, *Chickenpox and Pregnancy*, (May 2011), *available at* http://www.cdc.gov/pregnancy/infections-chickenpox.html.

[89] Lawrence W. Mills & Donna T. Moses, *Oral Health During Pregnancy*, 27 *MCN Am. J. Matern. Child Nurs.* 275, 276 (2002).

or unable to access the best health care for reasons of poverty or geography, to the increased risk of facing allegations of abuse and neglect.

In fact, there is no principled way to limit the broad powers that the Appellate Division's decision would grant to DCPP, powers that DCPP has not hesitated to exercise in the past. Thus, for example, the Division has previously alleged abuse and neglect with regard to the informed refusal of medication intended to prevent maternal-child HIV transmission, *see N.J. Div. of Youth & Family Services v. L.V.*, 382 *N.J. Super.* 582 (Ch. Div. 2005), and the refusal to pre-authorize unnecessary cesarean surgery, *see N.J. Div. of Youth & Family Services v. V.M.*, 408 *N.J. Super.* 222 (App. Div. 2009). The brief of the Law Guardian attempts to justify the judicial expansion of the statute by stating that, because "[t]here are instances where a mother's choice of medical treatment or refusal of medical treatment result in no or minimal harm to the child," women's medical decision-making remains intact. Law Guardian Br. in Response to Br. of *Amici* at 8. But it simply cannot be the law that a woman's medical decisions during pregnancy are insulated from becoming the basis of an allegation of child abuse or neglect only if she can be completely sure her decision will not affect her child once born. Indeed, such a holding would fuel yet another myth -- that pregnant women and their doctors can guarantee healthy birth outcomes.[90] A 2009

[90] The National Institutes of Health recognize that every pregnancy has some risk of problems. The risks can stem from

article that highlights specific patterns of distortion that shape perceptions, reasoning, and management of risk in pregnancy, explains the countless ways in which pregnant women are under a torrent of advice advanced in the name of "safety," but without the support of scientific evidence.

> The explicit aim of all these restrictions,[91] of course, is to safeguard the health and well-being of the fetus. For a great many restrictions, though, the exposure or activity carries no actual evidence of harm, and sometimes carries evidence of safety. Far from being based on a balanced exploration of risks and benefits, restrictions are based on an imagined or theoretical risk without due consideration of data supporting safety or even possible benefit.
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> [Anne Drapkin Lyerly, *et. al.*, *Risk and the Pregnant Body*, 39 *Hastings Cent. Rep.* 34, 38 (Nov. 2009).]

As numerous courts in a variety of contexts have recognized, the lack of a limiting principle in decisions like that of the Appellate Division subjects pregnant women's every action, inaction, and decision to state investigation, assessment, and ultimately punishment.[92] But this is not and

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conditions a woman already has or conditions she develops while pregnant and can also include being pregnant with more than one baby, previous problem pregnancies, or being over age 35. Nat'l Insts. of Health, *Health Problems in Pregnancy* (July 2012), *available at* http://www.nlm.nih.gov/medlineplus/healthproblemsinpregnancy.html.

[91] The restrictions cited in the article range from admonishing pregnant women to avoid eating an array of foods and listening to loud music, to sleeping in a specific position every night, to not changing cat litter or sitting in the bathtub for more than 10 minutes. *See, e.g.*, A. Eisenberg, *et al.*, *What to Expect When You're Expecting* 54-57 (2d ed. 1996).

[92] *See, e.g.*, *Kilmon v. State*, 905 A.2d 306, 311-12 (Md. 2006) (refusing to recognize a misdemeanor of "reckless endangerment"

cannot be the law. This Court should accordingly reject the extraordinary expansion of DCPP's power authorized by the holdings of the lower courts.

3. The proposed expansion of *N.J.S.A.* 9:6-8.21 would disparately harm low-income communities and communities of color.

The lower courts' expansion of *N.J.S.A.* 9:6-8.21 is particularly troubling because it increases the potential for discriminatory application of the child welfare laws and risks the disproportionate separation of children from their parents who are poor and of color. Indeed, social science and medical research reveals a disturbing disproportionality, on the basis of race and class, with respect to when and how alleged child abuse and neglect claims are reported to and handled by child welfare authorities. For example, in 2006, the Casey-CSSP Alliance for Racial Equity in the Child Welfare System undertook a comprehensive review of existing research studies regarding race and class disproportionality in the child welfare system.

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as applied to a pregnant woman in relation to her fetus because "virtually any injury-prone activity that, should an injury occur, might reasonably be expected to endanger the life or safety of the child" could potentially produce criminal liability, including horseback riding, too much or too little exercise, or violating traffic laws); *Stallman v. Youngquist*, 531 *N.E.*2d 355, 360 (Ill. 1988) (refusing to recognize a tort of maternal prenatal negligence and noting that "the mother's every waking and sleeping moment . . . for better or worse, shapes the prenatal environment which forms the world for the developing fetus"); *In re Valerie D.*, 613 *A.*2d 748, 765 (Conn. 1992) (refusing to apply termination of parental rights statute to cocaine use during pregnancy, and explaining that such an interpretation would have "sweeping consequences" for other maternal conduct).

It found that "[m]ost of the studies reviewed identified race as one of the primary determinants of decisions of child protective services at the stages of reporting, investigation, substantiation, placement, and exit from care."[93] Among other things, it found that: (1) most research studies suggest that race alone or race interacting with other factors is strongly related to the rate of child welfare investigations; (2) African American women were more likely than white women to be reported for child abuse when their newborns had tested positive for drug use; (3) child maltreatment is reported more often for low-income than middle- and upper-income families with similar presenting circumstances; and (4) hospitals overreport abuse and neglect among African Americans and underreport maltreatment among whites.[94]

Studies also indicate that African American women are more likely to experience intrusive child welfare interventions because their newborn children are more likely to be screened

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[93] Casey-CSSP Alliance for Racial Equity in the Child Welfare System, Robert B. Hill, *Synthesis of Research on Disproportionality in Child Welfare: An Update* 1 (2006), *available at* http://www.cssp.org/reform/child-welfare/other-resources/synthesis-of-research-on-disproportionality-robert-hill.pdf.

[94] *Id.* at 18, 20; *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 *New England J. Med.* 1202, 1205 (1990) (comparing results of universal testing with the number of cases reported to child welfare authorities and concluding that, pursuant to discretionary testing, "a significantly higher proportion of black women than white women were reported, even though we found that the rates of substance use during pregnancy were similar").

for prenatal exposure to drugs than children of other races,[95] despite the lack of any evidence-based research supporting race as a basis for screening some women and not others.[96] African American women also experience disproportionate state interventions because they are disproportionately poor and lacking in access to maternal health services, leading to greater rates of health problems among African American infants.[97] Thus, the harmful effects of interpreting *N.J.S.A.*

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[95] *See* Marc A. Ellsworth, *et al.*, *Infant Race Affects Application of Clinical Guidelines When Screening for Drugs of Abuse in Newborns*, 125 *Pediatrics* 1379 (2010) (finding that providers seemed to have used race, in addition to recognized risk criteria, as a factor in deciding whether to screen an infant for maternal illicit drug use); Brenda Warner Rotzoll, *Black Newborns Likelier to be Drug-Tested: Study*, *Chicago Sun-Times*, Mar. 16, 2001 (noting that "[b]lack babies are more likely than white babies to be tested for cocaine and to be taken away from their mothers if the drug is present, according to the March issue of the Chicago Reporter"); Troy Anderson, *Race Tilt in Foster Care Hit; Hospital Staff More Likely to Screen Minority Mothers*, *L.A. Daily News*, June 30, 2008, at A1.

[96] *See* Marylou Behnke, *et al.*, *Multiple Risk Factors Do Not Identify Cocaine Use in Rural Obstetrical Patients*, 16 *Neurotoxicology & Teratology* 479 (1993) (finding that criteria established by a hospital for testing certain women were not effective in predicting which women were more likely to have used an illegal drug).

[97] *See* Amnesty International, *Deadly Delivery: The Maternal Health Crisis in the United States* 19-20, 25-26 (2010), *available at* http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf. African American women are also less likely to receive comprehensive prenatal care due to lack of insurance coverage and an inability to take sick leave from work. *See* Marian Willinger, *et al.*, *Racial Disparities in Stillbirth Risk Across Gestation in the United States*, 201 *Am. J. Obstet. Gynecol.* 469 (2009) (African American women suffer disproportionate rates of many adverse pregnancy consequences, including stillbirths, ectopic pregnancies, infant mortality, premature labor, and low birth-weight babies); Dorothy Roberts,

9:6-8.21 to apply to the medical decisions of pregnant women, including the wise decision to enter methadone treatment instead of risking the effects of opioid withdrawal, are overwhelmingly likely to disproportionately burden African American and low-income women.

This Court has previously noted the grave concern that "society has traditionally protected the rights of parents if those parents are affluent or middle class . . . [but has] discounted the cultural backgrounds and solid parenting skills of low-income parents." *N.J. Div. of Youth & Family Servs. v. A.W.*, 103 *N.J.* 591, 601 (1986) (quoting Carol B. Stack, *Cultural Perspectives on Child Welfare*, 12 *N.Y.U. Rev. L. & Soc. Change* 539, 547 (1983-84)). The Court should continue to be vigilant in guarding against the possibility that racism and classism may thus creep into the child welfare process. The actions of DCPP and the lower courts in this case, and the position of the Law Guardian, ignore this concern and raise the very real likelihood of further burdening already vulnerable communities and exacerbating existing biases in how abuse and neglect claims are reported and pursued. For this reason as well, the lower courts' decision should be reversed.

Killing the Black Body: Race, Reproduction, and the Meaning of Liberty 172 (1997).

C. Scientific evidence is required to support the conclusion that side effects of medication taken by a pregnant woman are properly understood as harm for purposes of finding that a newborn has been abused or neglected.

It is well established that when a case raises scientific questions, a court should not rely upon myths or assumptions, but should look to reliable scientific evidence and the guidance of expert testimony in reaching its decisions. In this case, the lower courts violated this basic principle by relying on unsupported suppositions about the nature of MMT and its side effects. Specifically, the lower courts erred by failing to consider the vast body of scientific research on this issue and by failing to consider any expert testimony to aid them in assessing prescribed MMT as a form of child abuse or neglect.

1. Scientific evidence is required to support the claim that the treatable side effects of a pregnant woman's medical treatment constitute "harm" within the meaning of Title 9.

In order to sustain an abuse and neglect charge against Y.N., DCPP was required to present, and the courts were required to consider, only "competent, material and relevant evidence" of harm or the risk of harm to the child, P.A.C. *N.J.S.A.* 9:6-8.46. Instead, DCPP here rested its abuse and neglect claim on the *assumption* that a child born with NAS is, by definition, harmed, without providing any scientific evidence to support this theory. Likewise, the Law Guardian assumed that while there might be benefits to Y.N. and society from obtaining MMT, no such benefits exist for the child. Law Guardian Response to

Amici at 6. These unsupported assumptions cannot sustain DCPP's burden to prove abuse and neglect by a preponderance of the evidence, *N.J.S.A.* 9:6-8.46(b)(1); *N.J. Div. of Youth & Family Servs. v. J.L.*, 400 *N.J. Super.* 454, 470 (App. Div. 2008), particularly in a case that implicates a mother's fundamental rights to medical decision-making, to retaining custody of her child,[98] and to the equal protection of the laws,[99] as well as to a child's interest in family life.[100]

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[98] Parents have a fundamental right, under both the United States and the New Jersey Constitutions, to raise their children without state interference. *Troxel v. Granville*, 530 *U.S.* 57, 65 (2000) ("The liberty interest . . . of parents in the care, custody, and control of their children [] is perhaps the oldest of the fundamental liberty interests recognized by this Court."); *Moriarty v. Bradt*, 177 *N.J.* 84, 101 (2003) ("The right to rear one's children . . . has been identified as a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment."). This constitutional right compels "scrupulous adherence to procedural safeguards" when the State seeks to interrupt the family relationship. *N.J. Div. of Youth & Family Servs. v. G.M.*, 198 *N.J.* 382 (2009) (internal quotation marks omitted).

[99] The Fourteenth Amendment guarantee of equal protection requires an "exceedingly persuasive justification" for gender-based classifications. *United States v. Virginia*, 518 *U.S.* 515, 531 (1996). Permitting child abuse determinations to be made only for pregnant women and mothers who obtain MMT, but not for men and fathers, creates a gender-based classification that fails to advance any governmental interest. Moreover, even if Title 9 is viewed as a classification distinguishing between pregnant and non-pregnant persons, it fails even rational basis review, advancing no legitimate state interest and actually increasing the likelihood of harm to maternal, fetal, and child health. *See supra* Part B.

[100] U.S. Supreme Court jurisprudence recognizes "the sanctity of the family" as a unit. *Moore v. East Cleveland*, 431 *U.S.* 494, 503-04 (1977). New Jersey adopted a similar approach in passing the Child Placement Bill of Rights Act, *N.J.S.A.* 9:6B-1 *et seq.*, which protects the child's right to a family by requiring that a child be separated from his or her parent or guardian "only

This Court has been a national leader in recognizing that, when cases raise scientific, medical, or other technical issues, the evaluation of the issues must be informed by existing scientific knowledge, if appropriate, through expert testimony. For example, when considering the admissibility of scientific test results or other evidence that rests on a particular scientific theory, this Court has demanded that the scientific claim "be generally accepted, within the scientific community, to be reliable," *State v. Chun*, 194 *N.J.* 54, 91 (2008). This Court has, then, insisted that lower courts rigorously apply the principle that a party cannot introduce scientific or medical claims that rest on "a subjective guess or mere possibility." *Lindquist v. City of Jersey City Fire Dep't*, 175 *N.J.* 244, 281 (2003) (internal quotation marks omitted). *See generally State v. Lazo*, 209 *N.J.* 9, 26-27 (2012) (reversing defendant's conviction due to "relevant scientific evidence" regarding identifications); *State v. Henderson*, 208 *N.J.* 208, 217-18 (2011) (concluding that "scientific research about human memory" requires revisions to the test for evaluating the trustworthiness of eyewitness identifications); *State v. Chen*, 208 *N.J.* 307, 310-11 (2011) (holding that "trial judges should conduct a preliminary hearing" in certain circumstances because of "social science research" findings regarding the reliability of eyewitness identifications); *State v. Moore*, 188 *N.J.* 182,

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after the applicable department has made every reasonable effort, including the provision or arrangement of financial or other assistance and services as necessary, to enable the child to remain in his home." *N.J.S.A.* 9:6B-4.

207-08 (2006) (determining that previous Court guidelines regarding certain testimony should no longer be followed because "the scientific evidence . . . counsels another course"); *State v. Harvey*, 121 *N.J.* 407, 426-28 (1990) (estimating a person's height from the size of their shoe print is not scientifically reliable); *State v. Zola*, 112 *N.J.* 384, 412-13 (1988) (admitting expert testimony that modified-chemical test detected presence of saliva on victim); *Windmere, Inc. v. Int'l Ins. Co.*, 105 *N.J.* 373, 379 (1987) (concluding that voice-print evidence is not scientifically reliable). These basic principles are also consistent with the landmark Supreme Court ruling in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 *U.S.* 579 (1993), which, in addition to determining the standard for admitting expert testimony in federal courts, also establishes that reliable scientific evidence, including expert scientific testimony, is especially necessary when addressing health problems children experience that were allegedly caused by drugs taken by their mothers while pregnant.

DCPP and the lower courts failed to abide by these well-established principles. At the fact-finding hearing, DCPP introduced the "Division's case file, which included [P.A.C.'s] extensive medical records" apparently documenting that he had a positive toxicology screen for methadone at birth, was diagnosed with NAS, and was treated for NAS at the Morristown Memorial Hospital. The case file apparently also included information about Y.N.'s MMT including the informed consent form Y.N. signed in order to receive that treatment. *Y.N.*, 431 *N.J. Super.* at

77-78. Other than medical documentation of NAS and the assertion that NAS is by definition "harm" in the sense used by Title 9, the Division presented no evidence that P.A.C. was harmed, injured, impaired, abused, or neglected (or likely to be) in any way. Nor did DCPP present any medical or other expert testimony to interpret or explain the meaning of the medical records at issue, the treatment provided, or their outcomes for Y.N. or P.A.C. Finally, neither DCPP nor the lower courts considered the vast body of medical and social science research on questions key to this case including: (1) the nature, effects, and value of MMT during pregnancy for maternal, fetal, and child health; (2) whether NAS that results from the use of prescribed MMT is "harmful" as a matter of medical judgment or as contemplated by Title 9; (3) whether the NAS experienced by P.A.C. could have been prevented or minimized by different medical interventions; and (4) whether a pregnant woman's or parent's history of drug use establishes that she or he will pose a substantial or imminent risk of harm to a child in the future.

In fact, as discussed *supra* Part A, DCPP's and the Law Guardian's assumptions about MMT and NAS, while widely believed by laypersons, are wholly unsupported by existing scientific research and accepted medical standards. They should be rejected, and the judgment below should therefore be reversed.

2. DCPP was required to present qualified expert testimony in support of its claim that a pregnant woman who obtains methadone treatment is causing harm to her child and committing child abuse or neglect.

This Court has repeatedly recognized that expert testimony is required when a fact-finder "lacks the requisite special knowledge, technical training and background" to assess scientific or other evidence. *Rosenberg v. Cahill*, 99 *N.J.* 318, 325 (1985) (internal quotation marks omitted). It is therefore well-established that fact-finders "should not be allowed to speculate without the aid of expert testimony in an area where laypersons could not be expected to have sufficient knowledge or experience." *Kelly v. Berlin*, 300 *N.J. Super.* 256, 268 (App. Div. 1997) (quoting Biunno, *Current N.J. Rules of Evidence*, comment 2 on *N.J.R.E.* 702 (1996-97)). In *Jerista v. Murray*, 185 *N.J.* 175 (2005), for example, this Court explained that, when an alleged *res ipsa loquitur* claim "falls outside of the common knowledge of the fact-finder and depends on scientific, technical, or other specialized knowledge," a plaintiff could not raise that claim without presenting expert testimony. *Id.* at 199.

Indeed, as this Court has specifically held in the context of Title 9, "[j]udges at the trial and appellate level cannot fill in missing information on their own or take judicial notice of harm;" thus, "expert testimony may be helpful" in interpreting medical or scientific findings. *N.J. Dep't of Children & Families v. A.L.*, 213 *N.J.* at 28. *Cf. Khan v. Singh*, 200 *N.J.* 82, 92 (2009) (the ordinary medical negligence claim

calls for expert testimony to establish the applicable standard of care); *State v. Bealor*, 187 *N.J.* 574, 592 (2006) ("Expert testimony remains the preferred method of proof of marijuana intoxication."). Thus, in *N.J. Div. of Youth & Family Servs. v. V.T.*, 423 *N.J. Super.* 320 (App. Div. 2011), the Appellate Division held that the State could not "demonstrate whether or not [a parent] was impaired to the point of posing a risk to [a child]" merely by presenting the results of a positive drug test. *Id.* at 331. The Court explained that, "absent expert testimony[,] the meaning of the reported levels [of a drug in a drug test] is unclear." *Id.*[101]

Here, a decision was reached in this case without any expert testimony whatsoever; instead, the Appellate Division relied for its understanding of MMT upon an outdated and inapposite 1975 federal district court decision. *See Y.N.*, 431 *N.J. Super.* at 81 (citing *Beazer v. N.Y. City Transit Auth.*, 399 *F.Supp.* 1032 (S.D.N.Y. 1975), *modified*, 558 *F.*2d 97 (2d Cir. 1977), *rev'd on other grounds*, 440 *U.S.* 568 (1979)). That case involved a class action challenging the New York City Transit Authority's blanket policy of refusing to hire people who participate in MMT. But the case does not address MMT, either in general or for pregnant women, or its potential impact on

[101] Likewise, in *Showalter v. Barilari, Inc.*, 312 *N.J. Super.* 494 (App. Div. 1998), the Appellate Division explained that "it was inappropriate to submit unexplained scientific data [on blood alcohol levels] to the jury without expert testimony" because the "interpretation of scientific and medical data is the function of the qualified expert." *Id.* at 514 (internal quotation marks omitted).

newborns. Rather, the decision addresses methadone detoxification: the process of "gradually reducing [a patient's] doses of methadone to zero over a period of about three weeks." *Id.* at 1038. Moreover, the decision is a legal and scientific anachronism, predating the passage of the Americans with Disabilities Act of 1990 ("ADA"), P.L. 101-336, which prohibits employment discrimination against people in drug treatment; it also fails to consider decades of research, described above, which establish that OST, including MMT, is the safest and most effective available treatment for opioid dependence and is particularly beneficial for maternal, fetal, and child health. *See supra* at 9-22.

Indeed, the need for expert testimony to assist fact-finders is greatest where, as here, the evidence is particularly complicated or pervaded by misinformation. *See State v. Kelly*, 97 *N.J.* 178, 209 (1984) (noting that expert testimony about battered spouse syndrome is appropriate because the psychological and societal features of a battering relationship "are not well understood by lay observers . . . [and] are subject to a large group of myths and stereotypes"). Though, as set forth above, there is extensive, evidence-based research regarding MMT, it is nonetheless subject to irrational and unsubstantiated stereotypes that make plain the need for guidance in the form of expert testimony.

Thus, despite the decades of science unequivocally establishing the efficacy and safety of MMT, medical

professionals,[102] some government agencies,[103] media,[104] and even drug users themselves,[105] have all been susceptible to popular myths and widespread misinformation that underpin the stigma associated with MMT. The most widely held misconception is that MMT merely substitutes one destructive drug for another, conflating active addiction with supervised medical treatment.[106] Moreover, the mischaracterization of opioid users as weak-willed and irresponsible is also imposed on methadone patients.[107]

The importance of the rule that expert testimony must be considered in cases like this is demonstrated by the difference in opinions in New Jersey child welfare cases that did and did not consider such testimony. For example, in *N.J. Div. of Youth*

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[102] Joycelyn Sue Woods, *et al.*, *Reducing Stigma Through Education to Enhance Medication-Assisted Recovery*, 31(3) *J. Addictive Diseases* 226, 228 (2012) (describing distrust of and barriers to MMT caused by reluctance to view addiction as a physiological condition).

[103] *Id.*; Joseph, *et al.*, *supra* note 5.

[104] Woods, *et al.*, *supra* note 102 at 229 (chronicling pervasive inaccurate media representations of MMT).

[105] Sharon Stancliff, *et al.*, *Beliefs About Methadone in an Inner-City Methadone Clinic*, 79 *J. Urban Health* 571, 572 (2002) (in study of MMT recipients, finding that while 80% of the sample believed methadone "has helped me change my life in a good way," 78% also believed that methadone "is bad for my health").

[106] Joseph, *et al.*, *supra* note 5 at 358.

[107] Effective Treatment, *supra* note 10 at 4, 8 ("Some leaders in the Federal Government, public health officials, members of the medical community, and the public-at-large frequently conceive of opiate dependence as a self-inflicted disease of the will or as a moral flaw . . . . Many of the barriers to effective use of MMT in the treatment of opiate dependence stem from misperceptions and stigmas attached to opiate dependence, the people who are addicted, those who treat them, and the settings in which services are provided.").

& Family Servs. v. A.J., No. FN 07-346-10 (L. Div. Feb. 22, 2011),[108] after hearing testimony of two world-renowned medical experts regarding addiction and MMT during pregnancy, the court found that DCPP had failed to meet its burden to prove that a child was abused and neglected "as the evidence supports a finding that his diagnosis, at birth, of Neonate Addiction Syndrome [sic] is an outcome that is consistent with the medical standard of care for opioid addicted pregnant women." Slip. op. at 32. By contrast, cases which resulted in decisions like that of the Appellate Division here consistently failed to consider any evidence-based research or scientific evidence, but instead are based upon myths, stereotypes, and prejudices. For example, one court characterized a defendant's receipt of prescribed methadone as "an inability to eliminate a reliance on methadone, itself an addictive drug." *N.J. Div. of Youth & Family Servs. v. E.P.A.*, No. A-6169-05, slip op. at 13 (App. Div. Oct. 15, 2007). Another likened drug treatment to heroin use, finding neglect because "a woman using heroin or on methadone maintenance should find out about the risks to a child before becoming pregnant and opt to avoid that harm if the risks are great." *N.J. Div. of Youth & Family Servs. v. E.C.*, No. A-4219-06, slip op. at 12 (App. Div. Apr. 28, 2008).

Here, despite the obvious need for, and absence of, expert medical testimony, "[a]t the conclusion of the hearing, the

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[108] Pursuant to *R.* 1:36-3, copies of all of the above unpublished cases and all contrary unpublished opinions known to counsel have been included in the appendix to the supplemental brief and served upon all parties.

court found that the Division proved by a preponderance of the evidence that [Y.N.] abused or neglected [P.A.C.]" *Y.N.*, 431 *N.J. Super.* at 79. The only authorities cited by DCPP are this Court's decisions in *K.H.O.* and *A.L.*[109] DCPP's apparent position is that no medical experts or authority were needed because prior rulings of this Court establish that any symptomatology at birth, when a woman is known to have ingested a prescribed or unprescribed drug during pregnancy, constitutes "harm" within the meaning of the statute. The Appellate Division likewise concluded that "severe withdrawal symptoms" are "a recognized harm under *A.L.* and *K.H.O.*" *Y.N.*, 431 *N.J. Super.* at 83.

Of course, neither of these cases, nor any other case, establishes that MMT obtained by a pregnant woman or parent is a form of child abuse or neglect. In neither *A.L.* nor the cases referenced therein, *K.H.O.* or *Troy D.*, was the Court presented with evidence regarding either NAS or MMT.[110] Indeed, the Court

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[109] DCPP's and the Appellate Division's reliance on *State v. Tamburro*, 68 *N.J.* 414 (1975), *see Y.N.*, 431 *N.J. Super.* at 81-82, is also misplaced, as explained in Petitioner's Brief in Support of Cert. 3-4. Notably, however, *Tamburro* identifies the need for a "qualified expert" in order to determine a central issue in that case, whether a person was driving while intoxicated. *Y.N.*, 431 *N.J. Super.* at 82 (quoting *Tamburro*, 68 *N.J.* at 421).

[110] *In re Troy D.*, 263 *Cal. Rptr.* 869 (Cal. Ct. App. 1989), a California case, involved a newborn who had been prenatally exposed to opiates and amphetamines. Although the court purported to rely on expert testimony, the only testimony referenced was that of a pediatrician. *See* Steven B. Karch, *Peer Review and the Process of Publishing of Adverse Drug Event Reports*, 14 *J. Forensic & L. Med.* 79, 79 (2007) (noting that the "average medical doctor is not a trained researcher" and therefore is not qualified to draw conclusions about the effects of many drug exposures). Indeed, the decision in *Troy D.* rested

in *K.H.O.* not only did not consider MMT, but its discussion of heroin use during pregnancy and the "harm" caused to a newborn from "addiction" and "withdrawal" was not based on scientific evidence or qualified expert testimony at all, but rather, relied upon a 1991 law review article and a 1987 medical journal article about cocaine, *see K.H.O.*, 161 *N.J.* at 350, a completely different drug that does not cause "addiction" in newborns or symptoms that could be characterized as "withdrawal."[111] Moreover, the court in *K.H.O.* demanded that, to be legally cognizable, the harm from drug use during pregnancy must "be one that threatens the child's health and will likely have continuing deleterious effects on the child." *K.H.O.*, 161 *N.J.* at 352. But the question of whether a transitory, treatable condition in a newborn meets this standard cannot be assumed. Surely, expert testimony is required to answer the question of whether obtaining recommended medical treatment constitutes a failure "to exercise a minimum degree of care," and whether a pregnant woman is properly understood to be "inflicting" or "unreasonably inflicting or allowing to be inflicted harm" on her future child by receiving that care. *See N.J.S.A.* 9:6-8.21. The need for testimony from medical experts is particularly

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on exactly the same tautology rejected by this court in *A.L.*: "Mother's acts of ingesting dangerous drugs while pregnant resulted in injury to Troy, evidenced by the fact that he was born under the influence of [meaning that he tested positive for] dangerous drugs." *Id.* at 901.

[111] Open Letter to the Media from David C. Lewis, *et al.*, *Physicians, Scientists to Media: Stop Using the Term "Crack Baby"* (Feb. 25, 2004), *available at* http://advocatesforpregnantwomen.org/articles/crackbabyltr.htm.

clear here, where answers to these questions implicate the integrity of the medical profession itself, since DCPP and the Law Guardian suggest that a woman allows harm to be inflicted upon her future child when she receives recommended medical care. Such a suggestion necessarily implies that care providers are complicit in inflicting the harm, raising questions that, even in the malpractice context, where the standard of proof is lower, always require expert testimony. *Estate of Chin by Chin v. St. Barnabas Med. Ctr.*, 160 *N.J.* 454, 469 (1999); *Sanzari v. Rosenfeld*, 34 *N.J.* 128, 134-35 (1961); *Rosenberg v. Tavorath*, 352 *N.J. Super.* 385, 399 (App. Div. 2002).

Indeed, the idea that the health condition of a newborn *alone* may establish child abuse or neglect appears to be the result of the lower courts' repeated failure to require scientific evidence and expert testimony and the reliance, instead, upon frightening, and widely believed -- but medically and scientifically unsupported -- claims about the harms of prenatal drug exposure.[112] But it is just when these kinds of myths are advanced that reliable scientific evidence is needed, to debunk such fictions. Certainly, without such evidence, the lower courts should not have concluded that a pregnant woman's receipt of MMT, and the side effects of NAS that may result from

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[112] In recent years, the popular press has been suffused with highly prejudicial, inaccurate, and exaggerated information about the effect of *in utero* exposure to opiates, reminiscent of the now-debunked alarmist misinformation perpetuated about cocaine exposure. *See* Open Letter, *supra* note 52 (providing numerous examples of, and correcting, medically misleading news reports about babies prenatally exposed to opioids).

it, demonstrate harm or the risk of harm. The absence of such evidence in this case requires reversal.

3. DCPP provided no evidence-based research to support the conclusion that a pregnant woman's or parent's history of drug dependency and efforts to recover predict harm to a child.

DCPP, the Law Guardian, and the trial court -- whose ruling predated this Court's decision in *A.L.* -- merely assume that evidence of a woman's pregnancy and drug use constituted evidence of harm or likelihood of harm.[113] But DCPP failed to present any witnesses or evidence, scientific or otherwise, to establish the claim that Y.N.'s struggle with drug dependency demonstrated a likelihood that she would abuse, neglect, or otherwise harm her child. *See N.J.S.A.* 9:6-8.21(c)(4).

Indeed, there is little peer-reviewed evidence meeting the minimum requirements for scientific rigor, such as having well-matched control groups and defining key terms such as "substance abuse" or "neglect," to support the assumption that drug use by a pregnant woman, or her spouse, makes them more likely to abuse or neglect their children.[114] At the same time, there is a

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[113] *Y.N.*, 431 *N.J. Super.* at 80 ("The [trial] judge found [Y.N.] had "a long history of drugs, and that she continued to expose the child to [drugs]," and noted, "[w]hen a child is born drug exposed to illicit drugs, we routinely say that's abuse and neglect.").

[114] The source most often cited for the claim that drug use increases the likelihood of abuse is a self-published report which was not subject to peer review: National Center on Addiction and Substance Abuse at Columbia University (CASA), *No Safe Haven: Children of Substance-Abusing Parents* (1999), *available at* http://www.casacolumbia.org/articlefiles/379-No%20Safe%20Haven.pdf. Its major finding, that children whose

growing body of peer-reviewed, evidence-based research to the contrary.[115] For example, a study of Australian women in treatment for opioid addiction who had recent involvement with the child welfare system found that, "rather than severity of substance use being associated with mothers' involvement with the child protection system, other factors are of greater importance."[116] The authors suggest that "[a] focus on substance use may, in practice, obscure these other factors, [including a

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parents abuse drugs and alcohol are three times more likely to be physically or sexually assaulted and more than four times more likely to be neglected than are children of parents who are not substance abusers, was based on what amounted to an opinion survey of people working in the child welfare field. *Id.* at ii. Not only did this survey fail to qualify as reliable scientific evidence, but the report itself also noted that those who were surveyed were the least qualified to draw conclusions about causation and associations because few had any training in issues concerning drug use and addiction. *Id.* at 5. Moreover, the appendix to the CASA Report acknowledged that "reliable national data documenting the prevalence of substance abuse among child welfare cases is not available," that "[t]he data that are available suffer from . . . major methodological problems that make it impossible to confirm the prevalence of substance involvement among child welfare cases," and that "studies are inconsistent in defining whether substance involvement is the primary or causal reason for a parent's involvement with the child welfare system or whether substance involvement is an ancillary or co-occurring problem." *Id.* at 165.

[115] *See, e.g.*, Susan C. Boyd, *Mothers and Illicit Drugs: Transcending the Myth* 60 (1999) (listing studies demonstrating that women who use illicit drugs can be adequate parents); Margaret H. Kearney, *et al.*, *Mothering on Crack Cocaine: A Grounded Theory Analysis*, 38 *Soc. Sci. & Med.* 351, 355 (1994).

[116] Stephanie Taplin & Richard P. Mattick, Nat'l Drug & Alcohol Research Ctr. (Univ. New S. Wales, Sydney), *Child Protection and Mothers in Substance Abuse Treatment* 9 (Nov. 2011), *available at* http://www.idpc.net/sites/default/files/library/child-protection-and-mothers-in-substance-abuse-treatment-tech-report-320.pdf.

greater number of children, mental health problems, and less social support,] which can be ameliorated."[117] Another published study, designed to determine if drug use causes or is associated with increased risks of abuse and neglect, could not find such an association.[118] This study concluded that a "[substance-exposed infant allegation] may predict subsequent prenatal drug use, but it does not predict other types of maltreatment allegations."[119] Thus, as an article published by the American Bar Association concluded, many parents

> suffer from drug or alcohol dependence yet remain fit to care for a child. An alcohol or drug dependent parent becomes unfit only if the dependency results in mistreatment of the child, or in a failure to provide the ordinary care required for all children.
>
> [Am. Bar Ass'n, Foster Care Project, Nat'l Legal Resource Center for Child Advocacy & Protection, *Foster Children in the Courts* 206 (Mark Hardin ed. 1983).]

For these reasons, the National Council of Juvenile and Family Court Judges has concluded that "[j]uvenile and family court proceedings are not necessary, and probably not desirable in most situations involving substance-exposed infants."[120] Because no evidence, much less scientifically valid evidence, was

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[117] *Id.* at 72.

[118] Brenda D. Smith & Mark F. Testa, *The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants*, 26 *Child Abuse & Neglect* 97 (2002).

[119] *Id.* at 110.

[120] Nat'l Council of Juvenile & Family Court Judges, Permanency Planning for Children Project, *Protocol for Making Reasonable Efforts to Preserve Families in Drug-Related Dependency Cases* 17 (1992).

submitted in this case to support DCPP's claim that Y.N.'s drug use prior to receiving MMT threatened future harm, the lower courts erred both in considering those facts, and in accepting them as true.

In sum, despite widespread and commonly held beliefs and opinions about MMT, drug use and parenting, and about pregnant women's decision-making, courts are obligated, especially where such fundamental rights as those at issue here are concerned, to base their decisions on facts, not on conjecture or presumption. That did not happen here and the judgment below must therefore be reversed.

D. If this Court requires further elucidation of the scientific principles that should govern this inquiry, it should appoint a Special Master.

For the reasons set forth above and in Y.N.'s brief, the Court should not allow the decision to undertake MMT to become the basis of a finding of abuse and neglect, with the personal intrusion, stigma, and potential loss of parental rights that such a finding engenders. If, however, the Court requires further elucidation of the scientific principles discussed herein, regarding the nature and risks of MMT, including the potential consequences of NAS, then it should consider the pertinent science in a proceeding where the parties and *amici* may each call appropriate experts and subject the academic literature to the kind of full and fair consideration that such weighty issues deserve. This is particularly so because this Court's ruling will impact countless other cases. *See Harvey*,

151 *N.J.* at 167 ("In determining the general acceptance of novel scientific evidence in one case, the court generally will establish the acceptance of that evidence in other cases.").

In cases where the question presented is highly complex and requires unique scientific expertise, this Court has, in recent years, developed the salutary practice of appointing a Special Master to provide the expertise that the Court lacks in a particular, relevant area.[121] Claims, such as those at issue here, involving scientific data and expert evidence, necessarily require courts to comprehend the relevant science and to become familiar with current research, areas where a Special Master can provide invaluable assistance.[122]

Recognizing this principle, in recent years the Court appointed a Special Master to address the scientific reliability of the Alcotest in *State v. Chun*, 194 *N.J.* 54, 54 (2008), and to review the science underlying the legal standard for the admissibility of eyewitness testimony in *State v. Henderson*, 208 *N.J.* 208, 208 (2011). In *State v. Moore*, 188 *N.J.* 182, 191 (2006), the Court remanded the matter to the trial court to consider the scientific reliability of post-hypnotic memory, in connection with the admissibility of hypnotically refreshed testimony.

In each of these cases, the Court found the trial record to be inadequate for consideration of such complex scientific

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[121] Margaret G. Farrell, *The Function and Legitimacy of Special Masters*, 2 *Widener L. Symp. J.* 235, 253 n.76 (1997).
[122] Margaret G. Farrell, *Coping with Scientific Evidence: The Use of Special Masters*, 43 *Emory L.J.* 927, 929-30 (1994).

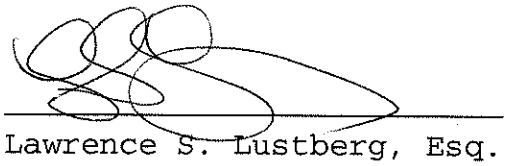
questions and directed that plenary hearings be held to determine, for example, whether the popular notion that hypnosis improves recall is supported by empirical evidence, *see Moore*, 188 *N.J.* at 209, or whether commonly held views relating to memory "remain valid and appropriate in light of recent scientific and other evidence." *Henderson*, 208 *N.J.* at 228.

The decision in this case likewise reflects commonly held but scientifically unsupported views about the advisability and efficacy of MMT, effects of prenatal exposure to methadone, and the relationship between past or present drug use and parenting, about which the trial record is patently inadequate. If this Court believes that the existing scientific evidence requires further examination in order to evaluate the propriety of the Appellate Division's decision, *amici* would welcome the opportunity to appear before a Special Master and to provide evidence regarding current science, so that the Court may determine whether that science supports the notion that a finding of abuse and neglect necessarily follows from the fact of symptoms at birth, or that expanding Title 9, in the manner suggested by the courts below, is consistent with the State's interest in promoting the health and well-being of pregnant women, mothers, and children.

CONCLUSION

For the foregoing reasons, *amici* Experts in Maternal and Fetal Health, Public Health, and Drug Treatment respectfully submit that the decision of the Appellate Division should be reversed.

Respectfully submitted,



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Dated: January 9, 2014

APPENDIX A: STATEMENTS OF INTEREST OF *AMICI CURIAE*

Institutional affiliations are for identification purposes only.

Amicus Curiae **American College of Obstetricians and Gynecologists** is a non-profit educational and professional organization founded in 1951. The College's objectives are to foster improvements in all aspects of health care of woman; to establish and maintain the highest possible standards; and to encourage contributions to medical and scientific literature. The College's companion organization, the American Congress of Obstetricians and Gynecologists, is a professional organization dedicated to the advancement of women's health and the professional interests of its members. Sharing more than 56,000 members, the College and the Congress are the leading professional associations of physicians who specialize in the healthcare of women. The New Jersey Section of the Congress has 1,903 members who provide healthcare to the women of New Jersey.

Amicus Curiae **American Psychiatric Association ("APA")**, with roughly 35,000 members, is the principal association of physicians who specialize in psychiatry. The APA advocates on behalf of pregnant women and mothers with substance abuse disorders to promote access to appropriate treatment, to enhance their parenting, to preserve the integrity of their families whenever possible, and to ensure the safety of their children. APA urges that societal resources be directed not to punitive actions, but to adequate preventive and treatment services for these women and children.

Amicus Curiae **American Public Health Association ("APHA")** is a diverse community of public health professionals who have championed the health of all people and communities. APHA aims to protect all Americans, their families and their communities from preventable, serious health threats and strives to assure community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States.

The Association represents a broad array of health professionals, including maternal and child health and substance abuse.

Amicus Curiae **American Society of Addiction Medicine ("ASAM")** is a nationwide organization of more than 3,000 of the nation's foremost physicians specializing in addiction medicine. ASAM believes that the proper, most effective solution to the problem of substance abuse during pregnancy lies in medical prevention, *i.e.* education, early intervention, treatment, and research on chemically-dependent pregnant women. ASAM further believes that state and local governments should avoid any measures defining alcohol or other drug use during pregnancy as a crime and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health services.

Amici Curiae **National Council on Alcoholism and Drug Dependence ("NCADD")** and **National Council on Alcoholism and Drug Dependence-NJ ("NCADD-NJ")** work in partnership with and on behalf of individuals, families, and communities affected by alcoholism and drug dependence to promote recovery through excellence in prevention and treatment initiatives. NCADD-NJ believes alcoholism and drug dependence are public health concerns that are preventable and treatable. NCADD-NJ lends its considerable expertise to the advancement of progressive treatment approaches that are outcome- and evidence-based, and that are integrated into a continuum of care that is responsive to the needs affected individuals. Furthermore, NCADD-NJ advocates for laws and public policies that promote recovery, eliminate discrimination, and remove systemic barriers that impede ready access to treatment.

Amicus Curiae **Medical Society of New Jersey ("MSNJ")** was established in 1766 and is the oldest professional organization in the nation. MSNJ is the largest association of physicians, residents, and medical students in the state of New Jersey. Obstetricians are among the specialists who are members, and this matter will have direct impact upon them and their patients. MSNJ's mission

is to promote the betterment of the public health and the science and the art of medicine, to enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of practitioners of medicine.

Amicus Curiae **New Jersey Obstetrical and Gynecological Society ("NJOGS")** represents the doctors, nurse midwives, nurses, residents, nursing students, and medical students in the State of New Jersey. NJOGS represents all groups participating in obstetrics and gynecology using its knowledge and political skills through their political action committee. NJOGS tries to provide knowledge and guidance to its members and the political institutions of the state and the country.

Amicus Curiae **New Jersey Psychiatric Association ("NJPA")** is a professional organization of 815 physicians qualified by training and experience in the treatment of mental illness. Founded in 1935, NJPA is a District Branch of the American Psychiatric Association and is the official voice of organized psychiatry in New Jersey. The purpose of the organization includes the promotion of the science and practice of psychiatry, maintaining professional and administrative standards in psychiatry, and promoting the welfare of those suffering from psychiatric disorders. NJPA, in conjunction with the American Psychiatric Association, advocates on behalf of pregnant women with substance abuse disorders to promote access to appropriate treatment, and also urges that societal resources be directed not to punitive actions but to adequate preventative and treatment services for these women and their children.

Amicus Curiae **Abortion Care Network ("ACN")** is the leading organization working to de-stigmatize and normalize the experiences of women who undergo an abortion. ACN offers support and training to the abortion care community, especially to counselors, advocates, clinic administrators and medical support staff, who care directly for women and their families. Founded in 2008, as a successor to the

National Coalition of Abortion Providers, ACN has created a network of independent abortion providers, supportive allied organizations, and socially conscious individuals who are deeply invested in creating an environment where women who choose to have an abortion, and those that provide care, are no longer shamed for their choices. ACN reaches millions of women across the country through its members, online venues, and quality handouts, and seeks to help its patient-members fulfill all of their reproductive and parenting needs. ACN joins this brief out of concern that women make reproductive decisions freely, rather than out of fear of punishment for carrying pregnancies to term.

Amicus Curiae **American Association for the Treatment of Opioid Dependence ("AATOD")** was founded in 1984 as the Northeast Regional Methadone Treatment Coalition, Inc. AATOD treatment providers joined together to support the legitimacy of methadone maintenance treatment for opioid dependence and to increase the availability of comprehensive treatment services to people in need of care.

Amicus Curiae **Association of Reproductive Health Professionals ("ARHP")** is a national non-profit, interdisciplinary medical association for leaders in the field of reproductive health. Founded in 1963 and comprised of physicians, nurse practitioners, physician assistants, pharmacists, researchers, and educators, ARHP serves as an important source of reproductive health education and information for health care professionals, patients, legislators, other professionals, and the public at large. ARHP is concerned that the threat of child welfare intervention and loss of child custody will undermine accepted health care standards and will interfere with the ability of physicians, nurse practitioners, and other clinicians who treat pregnant and parenting women to provide appropriate, quality health care.

Amicus Curiae **Black Women's Health Imperative** is the only national non-profit organization dedicated to the health and wellness of our nation's Black women and girls.

Amicus Curiae **Center for Gender and Justice ("CGJ")** seeks to develop gender-responsive policies and practices for women and girls who are under criminal justice supervision. The Center is committed to research and to the implementation of policies and programs that will encourage positive outcomes for this underserved population.

Amicus Curiae **Cherry Hill Women's Center (New Jersey) ("CHWC")** is a New Jersey area state licensed ambulatory surgical center specializing in first and second trimester abortion care established in the 1970s to provide women with the best possible reproductive and gynecological healthcare in a safe and comforting environment. CHWC has helped lead the way in setting a standard for women's healthcare by identifying and meeting the needs of its patients. CHWC is dedicated to meeting the diverse needs of each individual woman and her family. To do so, CHWC offers special services for language assistance, counseling, unusual insurance needs, and requests based on cultural or religious values. So that the center adheres to the highest standards in women's healthcare, its facility is equipped with the best in modern medical equipment, and is staffed by a team of medical professionals who specialize in providing reproductive health services. CHWC is made up of a diverse and experienced group of people, who are committed to furthering women's health. CHWC is concerned with the local impact of this case on the health of its patients and their families.

Amicus Curiae **Child Welfare Organizing Project ("CWOP")** was established in 1994 as an organization of New York City parents and professionals seeking reform of New York City child welfare practices through increased, meaningful parent/client involvement in child welfare decision-making at all levels, from case-planning to policy, budgets and legislation. CWOP has approximately 1,500 parent members. Most of CWOP's staff, and about half of CWOP's Board of Directors, are parents who have had direct, personal involvement with the Administration for Children's Services ("ACS"). A significant percentage of CWOP members are

mothers in recovery. A large part of CWOP's work involves debunking prevailing stereotypes about ACS-involved parents and families, putting a human face on parents who are often unfairly and inaccurately demonized, and bringing CWOP's unique insights into policy discussions. CWOP hopes this will result in more enlightened public policy that effectively identifies and addresses real problems and challenges to successful family life in New York City, ultimately protecting children by helping and strengthening their families and communities.

Amicus Curiae **Drug Policy Alliance ("DPA")** is the nation's leading advocacy organization dedicated to broadening the public debate over drug use and regulation and to advancing pragmatic drug laws and policies, grounded in science, compassion, public health, and respect for human rights. DPA pursues these goals in New Jersey and around the country. DPA is a non-profit, non-partisan organization with more than 25,000 members and active supporters nationwide. DPA maintains an office based in Trenton committed to reforming drug policies in New Jersey that are harmful and ineffective, and promoting health-centered policy approaches to problems of substance misuse in the state. DPA has actively taken part in cases in state and federal courts across the country in an effort to bring current scientific and public health data to bear on drug-related issues, and to combat irrational fears, prejudices, and misconceptions about various drug-related matters that have, with regrettable frequency, distorted sound public policies regarding drug users and their families.

Amicus Curiae **Faces & Voices of Recovery** is a national organization dedicated to organizing and mobilizing the over 20 million Americans in recovery from addiction to alcohol and other drugs, our families, friends and allies into recovery community organizations and networks, to promote the right and resources to recovery through advocacy, education and demonstrating the power and proof of long-term recovery.

Amicus Curiae **Global Lawyers and Physicians ("GLP")** is a non-profit non-governmental organization that focuses on health issues and human rights. Founded in 1996, GLP was formed to reinvigorate the collaboration of the legal, medical and public health professions in protecting the human rights and dignity of all persons. GLP's mission is to implement the health-related provisions of the Universal Declaration of Human Rights and the Covenants on Civil and Political Rights and Economic, Social, and Cultural Rights, with a focus on health and human rights, patient rights, and human experimentation.

Amicus Curiae **Harm Reduction Coalition ("HRC")** is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use. HRC was founded in 1993 and incorporated in 1994 by a working group consisting of syringe exchange providers, advocates, and drug users. Today, HRC is a diverse network of community-based organizations, service providers, researchers, policy-makers, academics, and activists challenging the persistent stigma placed on people who use drugs, and advocating for sensible policy reform. HRC advances policies and programs that help people address the adverse effects of the "War on Drugs" and drug use including overdose, HIV, Hepatitis C, addiction, and incarceration. HRC recognizes that the structures of social inequality impact the lives and options of affected communities. Since its inception in 1994, HRC has advanced harm reduction philosophy, practice, and public policy by prioritizing areas where structural inequalities and social injustice magnify drug related harm.

Amicus Curiae **Harm Reduction International** (formerly known as the International Harm Reduction Association) is the largest membership-based global harm reduction association dedicated to reducing the negative health, social and human rights impacts of drug use and drug policy, with over 8,000 members worldwide. Harm Reduction International is a non-governmental organization in Special Consultative Status with the Economic and Social Council of the United Nations,

and is engaged in globally-focused research, policy and legal analysis, and advocacy on drug use, health and human rights issues.

Amicus Curiae **HealthRight International** (Formerly Doctors of the World -- USA) is a global health and human rights organization working to build lasting access to health for excluded communities while strengthening human rights. It works closely with communities and establishes local partnerships to deliver health services, provides training and equipment and improves systems to enable its partners to deliver services on their own. Its projects address health and social crises made worse by human rights violations, with a particular focus and expertise in a number of areas, including women's access to safe and effective maternal and neonatal care. Since its founding by the late Dr. Jonathan Mann, HealthRight has worked in over 30 countries, with current projects in Asia, Africa, Eastern Europe, and the United States.

Amicus Curiae **Institute for Health and Recovery ("IHR")** is a statewide service, research, policy, and program development agency. IHR's mission is to develop a comprehensive continuum of care for individuals, youth, and families affected by alcohol, tobacco and other drug use, mental health problems and violence/trauma. IHR focuses on the development of collaborative models of service delivery and the integration of gender-specific, trauma-informed, and relational/cultural models of prevention, intervention, and treatment. IHR serves individual women and men, and families, with a continuing emphasis on serving pregnant and parenting women and their children, and on fostering family-centered, strength-based, and multiculturally competent approaches. IHR members know firsthand the fears pregnant substance-abusing women have regarding prosecution, causing them to be reluctant to seek prenatal care and substance abuse treatment.

Amicus Curiae **International Centre for Science in Drug Policy** is an organization dedicated to improving community health and safety by conducting research and public

education on best practices in drug policy while working collaboratively with communities, policy makers, law enforcement, and other stakeholders to help guide effective and evidence-based policy responses to the many problems posted by illicit drugs.

Amicus Curiae **International Centre on Human Rights and Drug Policy** is an academic project dedicated to developing and promoting innovative and high quality legal and human rights scholarship on issues related to drug laws, policy, and enforcement. The Centre pursues this mandate by publishing original, peer-reviewed research on drug issues as they relate to international human rights law, international humanitarian law, international criminal law, and public international law. The Centre fosters research on drug policy issues among postgraduate law and human rights students through its engagement with universities and colleges around the world.

Amicus Curiae **International Doctors for Healthier Drug Policies ("IDHDP")** is a global network of medical doctors from over 70 countries, supporting drug policy based on health. Its aims are to 1) protect society and the individual from drug-related death and disease; 2) promote public health instead of criminal justice; 3) improve access to essential medicines; and 4) expand access to evidence-based treatment.

Amicus Curiae **Jersey Shore Addiction Services ("JSAS") Healthcare, Inc.** is a private, non-profit outpatient substance abuse treatment program in Neptune, NJ, which serves over 750 patients and specializes in providing medication-assisted treatment (methadone) for the treatment of opioid dependence. JSAS is licensed by the NJ Department of Human Services Division of Mental Health and Addiction Services and has been in operation for over 40 years. JSAS provides "state-of-the-art" opioid dependence treatment and has been one of only two methadone treatment programs in New Jersey to operate an on-site perinatal addiction treatment program providing multi-disciplinary services for pregnant and post-partum substance abusing

women and their infants in partnership with Jersey Shore University Medical Center.

Amicus Curiae **Legal Action Center ("LAC")** is a national public interest law firm, with offices in New York and Washington, D.C., that performs legal and policy work to fight discrimination against and promote the privacy rights of individuals with criminal records, alcohol/drug histories, and/or HIV/AIDS. LAC has done a tremendous amount of policy advocacy work to expand treatment opportunities for people with alcohol/drug histories and to oppose legislation and other measures that employ a punitive approach, rather than a public health approach, to addiction. It has also represented individuals in alcohol/drug treatment programs who face discrimination based on inaccurate and outmoded stereotypes about the disease of addiction. The question posed in this case is of vital concern to LAC's constituency across the country.

Amicus Curiae **Medication Assisted Recovery Services ("MARS") Project** is a peer recovery service project. The MARS Project is comprised of persons in recovery with the assistance of methadone or buprenorphine helping other patients on methadone or buprenorphine to find recovery. The MARS Project is based on the belief that Methadone Patients who receive training to understand addiction, methadone treatment, and recovery will have a better chance at achieving sustained recovery than patients who do not receive training. The MARS Project provides peer recovery support services, not treatment. The reason that the MARS Project works is because it is patients taking ownership of their own Recovery. The MARS Project is an undertaking of the National Alliance for Medication Assisted Recovery in collaboration with Albert Einstein College of Medicine, Division of Substance Abuse and funded by the Substance Abuse and Mental Health Services Administration.

Amicus Curiae **National Alliance of Medication Assisted Recovery ("NAMA")** is an organization composed of methadone patients and health care professionals who support quality opiate agonist treatment. It has thousands of members

worldwide with a network of international affiliated organizations and chapters in many places in the United States, including the state of Connecticut. NAMA's goals include eliminating discrimination against methadone patients, including pregnant and parenting ones; creating a more positive image of methadone maintenance treatment; helping to preserve patients' dignity and rights; making treatment available on demand to every person who needs it; and empowering methadone patients with a strong public voice.

Amicus Curiae **National Alliance of Medication Assisted Recovery New Jersey Chapter ("NAMA-NJ")** is a local chapter of the National NAMA composed of methadone patients and health care advocates who support quality opiate agonist treatment. It consists of members from the state of New Jersey and functions with support from National NAMA. NAMA-NJ's goals include eliminating discrimination against methadone patients, including pregnant and parenting ones; creating a more positive image of methadone maintenance treatment in the state of New Jersey; helping to preserve patient's dignity and rights; making treatment available on demand to every person who needs it; and empowering methadone patients with a strong public voice in the state of New Jersey.

Amicus Curiae **National Latina Institute for Reproductive Health** is the only national organization working on behalf of the reproductive health and justice of the 24 million Latinas, their families and communities in the United States through public education, community mobilization, and policy advocacy. Latinas face a unique and complex array of reproductive health and rights issues that are exacerbated by poverty, gender, racial and ethnic discrimination, and xenophobia. These circumstances make it especially difficult for Latinas to access basic health care, including reproductive health care.

Amicus Curiae **National Perinatal Association ("NPA")** promotes the health and well being of mothers and infants enriching families, communities and our world. NPA is a

multi-disciplinary organization comprised of doctors, nurses, midwives, social workers, administrators, parents, and those interested in collaborating to improve perinatal health.

Amicus Curiae **National Women's Health Network ("NWHN")** improves the health of women by influencing public policy and providing health information to support decision-making by individual consumers. Founded in 1975 to give women a greater voice within the health care system, the NWHN aspires to a health care system that is guided by social justice and reflects the needs of diverse women. NWHN is committed to advancing women's health by ensuring that women have self-determination in all aspects of their reproductive and sexual health; challenging the inappropriate medicalization of women's lives; and establishing universal access to health care that meets the needs of diverse women. The core values that guide the NWHN's work include its belief that the government has an obligation to safeguard the health of all people; that it values women's descriptions of their own experiences and believes health policy should reflect the diversity of those experiences; and that it believes evidence rather than profit should determine what services and information are available to inform women's health decision-making and practices. The NWHN is a membership-based organization supported by 8,000 individuals and organizations nationwide.

Amicus Curiae **The New York Society of Addiction Medicine ("NYSAM")** is an organization of physicians in New York State from all medical specialties, dedicated to understanding and preventing addiction problems and to improving addiction treatment. NYSAM is a State Chapter of the American Society of Addiction Medicine. NYSAM believes that the proper, most effective solution to the problem of substance abuse during pregnancy lies in education, early intervention, treatment (including opioid maintenance as indicated), and research on chemically-dependent pregnant women. NYSAM further believes that state and local governments should avoid any measures defining alcohol or

other drug use during pregnancy as a crime and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health services.

Amicus Curiae **North American Society for Psychosocial Obstetrics and Gynecology ("NASPOG")** aims to foster scholarly scientific and clinical study of the biopsychosocial aspects of obstetric and gynecologic medicine. Topics of interest to members involve a wide spectrum of psychological and social issues as they pertain to pregnancy and women's health. Its aim is broadly defined to include the psychological, psychophysiological, public health, socio-cultural, ethical and other aspects of such functioning and behavior. NASPOG is comprised of approximately 200 members drawn from the fields of obstetrics and gynecology, psychiatry, psychology, nursing, social work, anthropology, and other related disciplines.

Amicus Curiae **Physicians for Reproductive Health ("PRH")** is a doctor-led national not-for-profit organization that relies upon evidence-based medicine to promote sound reproductive health care policies. Comprised of physicians, PRH brings medical expertise to discussions of public policy on issues affecting reproductive health care and advocates for the provision of comprehensive reproductive health services as part of mainstream medical care.

Amicus Curiae **Project R.E.S.P.E.C.T [Recovery, Empowerment, Social Services, Education, Community and Treatment]; Addiction Recovery in Pregnancy at Boston Medical Center** is a comprehensive, multidisciplinary team treating pregnant women with Substance Abuse Disorders in the Greater Boston Area. Dr. Kelley Saia, an Assistant Professor of Obstetrics and Gynecology at Boston University Medical School, is the director of the program. Project R.E.S.P.E.C.T has been helping and treating pregnant women for several decades; Dr. Saia has been the director since 2006. Project R.E.S.P.E.C.T cares for and treats more than 125 mother/baby pairs per year, managing their medical, obstetric, and psychiatric health. Project R.E.S.P.E.C.T.

provides opioid maintenance therapy, including methadone and buprenorphine. As one of the largest addiction treatment and obstetric clinics in the country, Project R.E.S.P.E.C.T strongly objects to the states' position in this case. Opioid maintenance therapy during pregnancy is the American College of Obstetrics and Gynecology's recommended treatment for women with opioid addiction during pregnancy. Comprehensive care for women with substance abuse disorders, specifically opioid addiction, which includes methadone or buprenorphine, has been shown to reduce preterm delivery, NICU admissions, and low birth weight, not to mention the harm reduction and reduction of morbidity for the mother.

Amicus Curiae **SisterSong Women of Color Reproductive Justice Collective ("SisterSong")** is a national organization of Indigenous women and women of color and allied organizations and individuals working for Reproductive Justice. Its core principals are threefold: it believes that every woman has the human right to choose if and when she will have a baby and the conditions under which she will give birth; the human right to decide if she will not have a baby and her options for preventing or ending a pregnancy; and the human right to parent the children she already has with the necessary social supports to do so. Through advocacy, mentoring, and support, SisterSong raises the voices of women of color impacted by human rights violations on the national, state, and local levels.

Amicus Curiae **Ronald Abrahams, MD, FCFP,** is a Family Physician in Vancouver. He is a Clinical Professor in the Department of Family Practice at UBC and Medical Director of Perinatal Addictions at BC Women's Hospital as well as Consultant Physician at the Sheway Program. He is also a member of the Prima National group. Dr. Abrahams is the founding Medical Director of the FIR (Families In Recovery) Rooming in program at BCWH-the first of its kind in North America. The unit has been named a "leading practice" by the Canadian Council of Health Accreditation, cited in the 2007 Kroeger Award for maintaining a high quality of care

and recently demonstrated peer reviewed improved outcomes. Since its inception 10 years ago, over 1200 women, their babies, and families have benefited from this program. For his work during the last 30 years he has been recognized as an invited speaker nationally and internationally for his role in developing evidenced-based Harm Reduction guidelines and protocols for women with problematic substance use in pregnancy. Dr. Abrahams is an Associate of The School of Population and Public Health at the University of British Columbia and a Clinical Investigator with The Women's Health Research Institute and he is a Consultant to The Austria-American Institute and the Open Society Institute. He received the 2008 Kaiser Foundation National Award for Excellence in Leadership for Harm Reduction Programs.

Amicus Curiae **Elizabeth M. Armstrong, PhD, MPA,** holds a joint appointment in the Department of Sociology and the Woodrow Wilson School at Princeton University and is a faculty associate at both the Office of Population Research and the Center for Health and Wellbeing. She has published articles in the scholarly literature on substance use during pregnancy, family planning, adolescent motherhood, and the sociology of pregnancy and birth. She is the author of *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Mortal Disorder* (Johns Hopkins University Press, 2003), the first book to challenge conventional wisdom about drinking during pregnancy. Her current research includes a longitudinal study of agenda setting around disease in the U.S. and a study of fetal personhood and obstetrical ethics. She has an M.P.A. from Princeton University and a Ph.D. from the University of Pennsylvania.

Amicus Curiae **Susan C. Boyd, PhD**, is Professor in Studies in Policy, University of Victoria. She is a drug policy researcher and author of numerous journal articles and books, including: *Hooked: Drug War Films from Britain, Canada, and the U.S.*; *From Witches to Crack Moms: Women, Drug Law, and Policy*; *Mothers and Illicit drugs, and co-*

editor of With Child: Substance Use During Pregnancy: A Woman-Centered Approach.

Amicus Curiae **Nancy D. Campbell, PhD,** is the author of Using Women: Gender, Drug Policy, and Social Justice (Routledge 2000), a history of how pregnant women are used to call for drug policies that are unjustifiably harsh and ill considered in terms of their social consequences.

Amicus Curiae **Wendy Chavkin, MD, MPH**, is a Professor of Clinical Public Health and Obstetrics and Gynecology at the Mailman School of Public Health and the College of Physicians and Surgeons at Columbia University. She has written extensively about women's reproductive health issues and done extensive research related to pregnant women, punishment, and barriers to care for over two decades.

Amicus Curiae **Phillip Coffin, MD, MIA,** is an Assistant Clinical Professor at the University of California San Francisco and director of Substance Use Research at the San Francisco Department of Public Health. He is a board certified internal medicine and infectious diseases clinician; specific foci of Dr. Coffin's training include HIV management, buprenorphine maintenance, addiction management, toxicology, and viral hepatitis care. Dr. Coffin oversees pharmacologic and behavioral trials as well as implementation science studies that aim to reduce medical sequelae of substance use. Dr. Coffin's interests also include screening and linkage to care for persons with hepatitis C; opioid overdose and the distribution of naloxone; mathematical modeling; clinical care for HIV, viral hepatitis, and general infectious diseases. Dr. Coffin has an established record of clinical experience, academic service, and innovative research, and his expertise in the field is evidenced by his extensive presentation and publication record.

Amicus Curiae **Nancy Day, PhD, MPH**, is Professor of Psychiatry and Epidemiology. She has studied the effects of prenatal exposures to alcohol, marijuana, cocaine, and

tobacco for over 20 years. She has multiple publications and has received grants from the National Institute of Health in support of this work. She is currently the Director of the Maternal Health Practices and Child Development Project, a consortium of projects centered on the identification of the long-term effects of prenatal substance abuse.

Amicus Curiae **Debra DeBruin, PhD**, is Director of the Center for Bioethics at the University of Minnesota. Previously, she served as a Health Policy Fellow for the United States Senate; she also worked as a consultant to the Institute of Medicine, the National Bioethics Advisory Commission, and the American College of Obstetricians and Gynecologists. She has been a member of a number of working groups relevant to public health in Minnesota. She teaches and conducts research on the ethics of research and public health policy.

Amicus Curiae **Fonda Davis Eyler, PhD**, is a Professor Emeritus in the Department of Pediatrics of the University of Florida College of Medicine and is also a licensed Developmental Psychologist. From 1988 to 2011, Dr. Eyler was Developmental Director of Early Steps, an early intervention program for children from birth to three years of age, who live in the surrounding sixteen counties and have developmental delays and disabilities. She is a Principle Investigator on a prospective, longitudinal research study that has been following a cohort of the children born to women who used cocaine during their pregnancy and a matched comparison group of pregnant women who were not addicted to cocaine and their children. Dr. Eyler brings a wealth of knowledge concerning the impact on children of drug abuse during pregnancy.

Amicus Curiae **Loretta Finnegan, MD**, is the president of Finnegan Consulting, which addresses education, research and treatment issues regarding women's health and perinatal addiction. For sixteen years she was with the National Institutes of Health in several capacities: Senior Advisor on Women's Issues, National Institute on Drug Abuse;

Director, Women's Health Initiative, Office of the Director; and Medical Advisor to the Director, Office of Research on Women's Health, Office of the Director. Dr. Finnegan was a Professor of Pediatrics in the Psychiatry and Human Behavior Department at Jefferson Medical College of Thomas Jefferson University for fourteen years. She was founder and Director of a groundbreaking program called "Family Center," a comprehensive multidisciplinary program for addicted pregnant women and their children at Jefferson Medical College and Hospital in Philadelphia. As a recognized nationally and internationally expert in the field, she has published widely and has given nearly 1,000 presentations throughout the world on clinical research and knowledge of women's health and perinatal addiction.

Amicus Curiae **Deborah A. Frank, MD**, is a Professor of Child Health and Wellbeing in the Department of Pediatric at Boston University School of Medicine. Since 1981, she has been the Director of the Failure to Thrive Program at the Boston Medical Center where she is also a staff physician in the Child Development Unit. She has provided clinical care to many newborns with narcotic abstinence syndrome. In 1993, she was named a Fellow of the Society for Pediatric Research. Dr. Frank is a recognized expert on the effect of maternal substance abuse on fetal development and newborn behavior and long-term outcomes. She has published widely on these topics, including numerous articles concerning prenatal cocaine, tobacco, alcohol, marijuana and methamphetamine exposure. In 2002, Dr. Frank testified before the United States Sentencing Commission concerning the effects of prenatal cocaine exposure. Dr. Frank comes to this Court in her capacity as *amicus curiae* in order to ensure that prevalent stigma and stereotypes about the nature of women who use drugs during pregnancy do not prevent the Court from understanding the medical issues in this case.

Amicus Curiae **Michael Franklyn, MD, CCFP,** is an Associate Professor of Family Medicine at the Northern Ontario School of Medicine (NOSM) based in Sudbury, Ontario, Canada. Dr. Franklyn's expertise in Family Medicine includes his work

in opioid dependence treatment as a co-author on a clinical practice guideline about maintenance treatment for the Centre for Addiction and Mental Health, endorsed by the College of Family Physicians of Canada.

Amicus Curiae **Peter Fried, MD**, is retired Professor Emeritus and Distinguished research professor of the Psychology Department at Carleton University has been studying the effects of marijuana and pregnancy for over 30 years. Funded primarily by the National Institute on Drug Abuse (NIDA) in Washington DC, this work has, over many decades, yielded a wealth of information that has formed the basis of several books, over 200 scientific articles and hundreds of talks to scientific and professional organizations. Dr. Fried has received several awards over the years including a NIDA Merit Award. In 2002, the May/June issue of the *Neurotoxicology and Teratology Journal* honored Dr. Fried by dedicating the issue to him for his research undertakings. From 2006-2007, Dr. Fried served as President of the Neurobehavioral Teratological Society.

Amicus Curiae **Leslie Hartley Gise, MD,** is Clinical Professor of Psychiatry at the John A. Burns School of Medicine, University of Hawai`i. She has extensive experience teaching at the professional level regarding reproductive depression, and she worked at a facility treating drug and alcohol addicted pregnant and parenting women for eight years. She is past President of the North American Society for Psychosocial Obstetrics and Gynecology under ACOG.

Amicus Curiae **Carl L. Hart, PhD**, is an Associate Professor in the Departments of Psychology and Psychiatry at Columbia University. He is also a Research Scientist in the Division of Substance Abuse at the New York State Psychiatric Institute. A major focus of his research is to understand complex interactions between drug abuse and the neurobiology and environmental factors that mediate human behavior and physiology. He is the author of the book *High Price: A neuroscientist's journey of self-discovery* that

challenges prevalent conceptions about drugs and society. He is also the author or co-author of dozens of peer-reviewed scientific articles in the area of neuropsychopharmacology and is the co-author of the textbook Drugs, Society, and Human Behavior. Hart is a member of the National Advisory Council on Drug Abuse and on the board of directors of the College on Problems of Drug Dependence and the Drug Policy Alliance.

Amicus Curiae **Cynthia Kuhn, PhD,** is a Professor of Pharmacology with 35 years of professional experience studying the effects of addictive drugs on the developing brain, from fetal exposure through young adulthood. She studied the effects of narcotics on brain function in animal models for 20 years. She has taught medical students how to use narcotic analgesics as well as about the developmental effects of all drugs, prescribed and recreational, for thirty years.

Amicus Curiae **Karol Kaltenbach, PhD**, is a Professor of Pediatrics and Professor of Psychiatry and Human Behavior at Jefferson Medical College, Thomas Jefferson University. Dr. Kaltenbach is an internationally recognized expert in the field of maternal addiction and has published extensively on the management of opioid dependence during pregnancy and neonatal abstinence syndrome (NAS); gender specific treatment for pregnant and parenting substance abusing women; and the effect of prenatal drug exposure on the perinatal and developmental outcome of children.

Amicus Curiae **Stephen R. Kandall, MD, FAAP** served as Chief of Neonatology at Beth Israel Medical Center from 1976 to 1998 and retired in 1998 as Professor of Pediatrics at the Albert Einstein College of Medicine. Most of Dr. Kandall's 90 contributions to the medical literature deal with perinatal drug use, and he has contributed chapters to many standard textbooks, including *Substance Abuse: A Comprehensive Textbook* and *Principles of Addiction Medicine*, as well as his own definitive book on the history of women and addiction in the United States, *Substance and Shadow*. Dr. Kandall has lectured throughout the United

States, as well as Belgium, Italy, Austria and Australia. He has served as president of his local medical societies, as an advisor to many commissions and panels on drug abuse (including the March of Dimes, Narcotic and Drug Research, Inc., and the Scott Newman Foundation in Los Angeles), and currently advises legislative subcommittees on perinatal health in North Carolina.

Amicus Curiae **Barry M. Lester, PhD**, is Professor of Psychiatry & Human Behavior, Professor of Pediatrics and founding director of the Center for the Study of Children at Risk, Brown University Alpert Medial School and Women and Infants Hospital. The focus of Dr. Lester's research is on mechanisms and processes that determine developmental outcome in children at risk due to biological and social factors. He has studied the effects of factors such as prematurity, growth restriction, malnutrition, prenatal substance exposure and maternal psychotropic medication during pregnancy using longitudinal, multisite, and cross-cultural designs. His work has shown that biological factors do leave their footprint on later development and that environmental factors can exaggerate or lessen the impact of biological insults. He has also translated these findings into preventive intervention programs. Dr. Lester's current work includes the study of fetal programming and epigenetic factors that affect development. Dr. Lester's research has been continuously supported by the NIH for over 30 years. He has served on NIH study sections as well as NIDA Council (National Advisory Council on Drug Abuse). Dr. Lester directs the Infant and Child Mental Health Post-Baccalaureate Certificate Program at Brown University and is past president of the International Association for Infant Mental Health. He is the author of more than 200 scientific publications and 16 edited volumes.

Amicus Curiae **Robert Lubran, MS, MPA,** has worked in the public health field within the federal government and nonprofit organizations addressing substance abuse and recovery issues for over 25 years. He has authored 5 peer-reviewed articles on topics related to the issue of

substance abuse treatment, and joins this brief out of concern that policies that treat addiction as a moral failing are detrimental to maternal, fetal, and child health.

Amicus Curiae **David J. Mair, MD,** is a psychiatrist in Minneapolis, MN. He does assertive community treatment for persons with severe and persistent mental illness, many of whom have co-occurring substance dependence. He is a clinical supervisor with the Hennepin County Medical Center/Regions Hospital Psychiatry Residency Program and is an Adjunct Assistant Professor of Psychiatry at Touro University Nevada College of Osteopathic Medicine. He is board certified in psychiatry.

Amicus Curiae **Kasia Malinowska-Sempruch, MSW**, directs the Open Society Institute's Global Drug Policy program which provides grants to initiatives advocating an evidence-based approach to drug policy worldwide and encourages greater scrutiny of current international drug policy. She has authored or co-authored dozens of policy and scientific papers for scientific journals and book chapters "Global HIV/AIDS Medicine" and "Public Health and Human Rights, Evidence-Based Approaches" as well as articles for the international press on harm reduction, women's health, HIV, medical ethics and drug use.

Amicus Curiae **David C. Marsh, MD, CCSAM,** is a Professor, Clinical Sciences, and Senior Associate Dean at the Northern Ontario School of Medicine. Dr. Marsh has worked in clinical care and research in the area of addiction treatment, and specifically treatment of opioid dependence. He has published over 50 papers, book chapters and government reports and been invited to speak nationally and internationally for the past 20 years. In 2004 he was awarded the Nyswander-Dole Award for his contributions to the field.

Amicus Curiae **Mary Faith Marshall, PhD, FCCM,** is the Emily Davie and Joseph S. Kornfeld Professor and Director of the Program in Biomedical Ethics, and Professor of Public

Health Sciences at the University of Virginia School of Medicine. Dr. Marshall is an elected fellow in the American College of Critical Care Medicine and is a former Fellow of the Kennedy Institute of Ethics at Georgetown University. She is past-president of the American Association of Bioethics and Humanities and past-president of the American Association for Bioethics. Dr. Marshall was the chairperson of the National Human Research Protections Advisory Committee, DHHS, has been an on-site reviewer for the Office for Human Research Protections, and has served on several special emphasis panels regarding clinical trials and research ethics at the National Institutes of Health. She has testified before Congress on the subject of perinatal substance abuse.

Amicus Curiae **John J. McCarthy, MD,** is the Executive/Medical Director of the Bi-Valley Medical Clinic, an outpatient addiction treatment program that specializes in the medical treatment of addiction to opiates, based in Sacramento, California. Dr. McCarthy also serves as an Assistant Professor of Psychiatry at the University of California, Davis. He has been published numerous times on the issues of opiate use impacts on maternal and perinatal health and appropriate treatment.

Amicus Curiae **Howard Minkoff, MD,** is the Chair of the Department of Obstetrics and Gynecology at Maimonides Medical Center, and a distinguished Professor of Obstetrics and Gynecology at the State University of New York Health Science Center at Brooklyn. He is a member of the Ethics Committee of the American College of Obstetricians and Gynecologists and he sits on the editorial board or is an editorial consultant to almost all of the most prominent medical journal, including *JAMA*, *New England Journal of Medicine* and *Lancet*, and has authored hundreds of articles, and is an internationally recognized expert on HIV disease and high risk pregnancy. Professor Minkoff has conducted years of grand scale research, supported by millions of dollars of grants, concerning the reproductive behaviors of low-income women, many with drug abuse problems. Through his work with these women, he has developed widely adopted

treatment protocols and ethical guidelines. Professor Minkoff brings his wealth of knowledge to this Court to ensure that it understands that punitive measures, including prosecutions and threats of loss of child custody, of pregnant women with drug abuse problems will harm both maternal and child health.

Amicus Curiae **Kenneth Minkoff, MD,** is a board-certified psychiatrist with a certificate of additional qualifications in addiction psychiatry; a dedicated community psychiatrist, and currently is a clinical assistant professor of psychiatry at Harvard Medical School and a senior systems consultant for ZiaPartners in San Rafael, CA. He is recognized as one of the nation's leading experts on recovery-oriented integrated services for individuals and families with co-occurring mental health, substance use, and health conditions, plus other complex needs (trauma, housing, legal, disability, parenting, etc.), and on the development of welcoming, recovery oriented integrated systems of care for such individuals, through the implementation of a national consensus best practice model for systems design: the Comprehensive Continuous Integrated System of Care (CCISC). In addition, Dr. Minkoff is a member of the Board of Directors of the American Association of Community Psychiatrists (AACP), and is chair of the Health Care Policy Committee. He has published numerous articles and book chapters on CCISC, integrated services, and co-occurring conditions. He also is well-known for his expertise in public managed behavioral health care, and co-edited, with David Pollack, MD, *Managed Mental Health Care in the Public Sector: A Survival Manual*. Dr. Minkoff's major professional activity is the provision of training and consultation on recovery oriented clinical services and systems design for individuals and families with mental health, substance use, and medical disorders, along with other co-occurring conditions, helping organizations and systems to become welcoming, recovery-oriented, and co-occurring or complexity capable. With his consulting partner, Christie A. Cline, MD, MBA (former Medical Director for the Behavioral Health Services Division of the

New Mexico Department of Health), Dr. Minkoff has developed a systems change toolkit for CCISC implementation with application for systems, agencies, programs, and clinicians. Dr. Minkoff and/or Dr. Cline are currently providing (or have provided) consultation for CCISC implementation in over 35 states, 4 Canadian provinces, and 3 Australian states, working with every aspect of state level systems, county level systems, tribal entities, and providers of all types.

Amicus Curiae **Susan F. Neshin, MD,** has been working in addiction treatment and specifically opioid dependence treatment since 1983. She is certified in Addiction Medicine by the American Board of Addiction Medicine and has been Medical Director of JSAS Healthcare, Inc., an outpatient medication-assisted treatment program, since 1986. Her areas of clinical expertise are the treatment of co-occurring psychiatric and addictive disorders and the treatment of the pregnant opioid addict. She has been on the faculty of the American Association for the Treatment of Opioid Dependence's (AATOD) Clinician's Course since its inception and in 1997 received AATOD's Nyswander-Dole Award for outstanding contributions in the field of methadone treatment. Dr. Neshin lectures on topics in addiction medicine both locally and nationally and is a member of the Professional Advisory Committee to the New Jersey Division of Mental Health and Addiction Services.

Amicus Curiae **Daniel R. Neuspiel, MD, MPH,** is Director of Ambulatory Pediatrics at Levine Children's Hospital and Clinical Professor of Pediatrics at University of North Carolina School of Medicine in Charlotte, NC. As a pediatrician, he has cared for hundreds of drug-affected infants and children, has published research on the impact of maternal substance use and abuse on infants, and has lectured widely as an expert on this topic.

Amicus Curiae **Robert G. Newman, MD, MPH,** is President Emeritus of Continuum Health Partners, Inc., a $2.2 billion hospital network controlling three major academic medical centers. He was CEO of the Beth Israel Health Care System

for 20 years prior to the creation of Continuum in 1997; he retired from Continuum in 2001. From 2001 until June of 2013, Dr. Newman served as Director of the Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center. For over 40 years Dr. Newman has played a major role in planning and directing some of the largest addiction treatment programs in the world - including the New York City Methadone Maintenance and Ambulatory Detoxification Programs, which in the 1970s served 33,000 patients annually. He has also been a strong addiction treatment advocate in Europe, Australia, and Asia. Throughout his career he has championed the right of drug-dependent persons to treatment access and choice of provider, and the right to be cared for under the same conditions as apply to the management of all other chronic medical conditions.

Amicus Curiae **Steven J. Ondersma, PhD**, is a clinical psychologist and Associate Professor in the Department of Psychiatry and Behavioral Neurosciences of the Wayne State University School of Medicine. He is also on the faculty of the Merrill Palmer Skillman Institute at Wayne State. His primary interest is in brief computer delivered motivational interventions for substance use and other risk factors among high-risk parents, especially pregnant and post-partum women. He is a former Editor of the journal Child Maltreatment, a member of the Motivational Interviewing Network of Trainers, and has been PI on numerous NIH/CDC research grants focusing on the development and validation of technology-based brief interventions.

Amicus Curiae **Dorothy E. Roberts, JD,** is the fourteenth Penn Integrates Knowledge Professor, George A. Weiss University Professor, and the inaugural Raymond Pace and Sadie Tanner Mossell Alexander Professor of Civil Rights at University of Pennsylvania, where she holds appointments in the Law School and Departments of Africana Studies and Sociology. An internationally recognized scholar, public intellectual, and social justice advocate, she has written and lectured extensively on the interplay of gender, race,

and class in legal issues and has been a leader in transforming public thinking and policy on reproductive health, child welfare, and bioethics. Professor Roberts is the author of the award-winning books *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (Random House/Pantheon, 1997) and *Shattered Bonds: The Color of Child Welfare* (Basic Books/Civitas, 2002), as well as co-editor of six books on constitutional law and gender. She has also published more than eighty articles and essays in books and scholarly journals, including the *Harvard Law Review*, *Yale Law Journal*, and *Stanford Law Review*. Her latest book, *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century*, was published by the New Press in July 2011. Among her many public interest positions, Roberts is the chair of the Board of Directors of the Black Women's Health Imperative.

Amicus Curiae **Robert Roose, MD, MPH,** is the Chief Medical Officer of Addiction Services of the Sisters of Providence Health System in Holyoke, MA. He is dually Board certified in Family Medicine and Addiction Medicine and an expert in the treatment of opioid dependence, particularly using methadone and buprenorphine. He has provided and supervised care for thousands of patients, conducted research, and done extensive clinical teaching on medication-assisted treatment and the integration of medical and addiction care.

Amicus Curiae **Sharon Stancliff, MD, FAAFP,** is the Medical Director of the Harm Reduction Coalition. She oversees SKOOP, which provides overdose prevention services both directly in New York City and through education and capacity building nationally and internationally. She has been the Medical Director of a large methadone program and, as a Family Practitioner she has provided prenatal care for many women including those in drug treatment. Dr. Stancliff also consults on drug related problems for the AIDS Institute, New York State Department of Health and for several international organizations.

Amicus Curiae **Mishka Terplan, MD, MPH, FACOG,** is Assistant Professor of Obstetrics, Gynecology & Reproductive Sciences and Epidemiology & Public Health at the University of Maryland School of Medicine. He is board certified in both OB/Gyn and Addiction Medicine and has done extensive research related to pregnant women with drug and alcohol problems.

Amicus Curiae **Nina B.L. Urban, MD, MSc** is an Assistant Professor in the Department of Psychiatry at Columbia University. She is a Research Psychiatrist in the Division of Substance Abuse at the New York State Psychiatric Institute and an attending psychiatrist at New York Presbyterian Hospital. Her research focuses on neurochemical changes contributing to drug addictions and experimental treatments thereof, with focus on cocaine, alcohol and cannabis abuse. As a diplomate of the American Board of Addiction Medicine, she is providing clinical treatment for patients with substance use disorders and psychiatric comorbidities in underserved populations of upper Manhattan. She is also the author or co-author of multiple peer-reviewed scientific articles in the area of neuroimaging and brain stimulation and is a co-author of the textbook *Behavioral Neurobiology of Schizophrenia and its Treatment*. Dr. Urban is an executive member of the New York County District Branch of the American Psychiatric Association and chair of its research committee and is on the Board of directors of the Global Bioethics Initiative.

Amicus Curiae **Linda L.M. Worley, MD,** is a professor of Psychiatry with a secondary appointment in Obstetrics and Gynecology in the College of Medicine at the University of Arkansas for Medical Sciences (UAMS) and is an Adjunct Clinical Professor of Medicine at the Vanderbilt School of Medicine. She is a board certified Psychiatrist with sub-specialization in Psychosomatic Medicine and is the current President of the Academy of Psychosomatic Medicine. She received the American Psychiatric Association Gold Award for directing a model program for the nation for addiction treatment for women with their children.

APPENDIX B: UNPUBLISHED OPINIONS

NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES,[1] Plaintiff-Respondent, v. J.D., Defendant-Appellant, and C.B, Defendant. IN THE MATTER OF THE GUARDIANSHIP OF A.M.B. and N.B., Minors.

1 On June 29, 2012, the Governor signed into law A-3101, which reorganizes the Department of Children and Families. The reorganization includes the renaming of the New Jersey Division of Youth and Family Services as the Division of Child Protection and Permanency. *L.* 2012, c. 16, eff. June 29, 2012.

DOCKET NO. A-5400-11T3

SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

2013 N.J. Super. Unpub. LEXIS 1149

April 17, 2013, Submitted
May 14, 2013, Decided

NOTICE: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY *RULE 1:36-3* FOR CITATION OF UNPUBLISHED OPINIONS.

PRIOR HISTORY: [*1]
On appeal from Superior Court of New Jersey, Chancery Division, Family Part, Passaic County, Docket No. FG-16-10-12.

COUNSEL: Joseph E. Krakora, Public Defender, attorney for appellant (Angelo G. Garubo, Designated Counsel, on the brief).

Jeffrey S. Chiesa, Attorney General, attorney for respondent (Andrea M. Silkowitz, Assistant Attorney General, of counsel; Kimberly Gunning-Marcantonio, Deputy Attorney General, on the brief).

Joseph E. Krakora, Public Defender, Law Guardian, attorney for minors (Todd Wilson, Designated Counsel, on the brief).

JUDGES: Before Judges Grall and Accurso.

OPINION

PER CURIAM

J.D. is the biological mother of A.M.B. and N.B., and she appeals a judgment terminating her parental rights to the children. The judgment also terminates the parental rights of the children's father, C.B., but he has not appealed.

J.D. contends that the Division of Youth and Family Services (Division) failed to establish that its efforts to place her children with relatives were reasonable; the trial court failed to consider alternatives to termination; and that the evidence was inadequate to support the conclusion that termination of her parental rights would not do her children more harm than good. *N.J.S.A. 30:4C-15.1(a)(3)-(4).* [*2] She does not claim the trial court erred in determining that her children were endangered by her parental relationship with them or in concluding that she is unwilling or unable to eliminate the harm. *N.J.S.A. 30:4C-15.1(a)(1)-(2).*

The Division and the children's Law Guardian contend that there was clear and convincing evidence establishing each of the four statutory criteria that are essential to support the conclusion that termination of J.D.'s parental rights is in the best interests of her children. *N.J.S.A. 30:4C-15.1(a)(1)-(4).* We agree and affirm for the reasons stated by Judge Portelli as amplified here. The judge's factual findings "are supported by 'adequate, substantial and credible evidence' on the record," *N.J. Div. of Youth & Family Servs. v. M.M., 189 N.J. 261, 279, 914 A.2d 1265 (2007)* (quoting *In re Guardianship of J.T., 269 N.J. Super. 172, 188, 634 A.2d 1361 (App. Div. 1993))*, and his legal conclusions are wholly consistent with *New Jersey Division of Youth & Family Services v. K.L.W., 419 N.J. Super. 568, 577, 18 A.3d 193 (App. Div. 2011).*

J.D. gave birth to A.M.B. in February 2010. Both A.M.B. and J.D. tested positive for marijuana when the baby was born. Within a day of her birth, A.M.B. had symptoms of [*3] withdrawal from methadone attributable to J.D.'s use of prescribed methadone during her pregnancy. A.M.B. was given morphine to address her withdrawal, which required the baby's hospitalization until she was weaned from the morphine.

J.D.'s first visit with a caseworker for the Division was in the hospital, and J.D. admitted to using marijuana and abusing Xanax while taking prescribed methadone during her pregnancy. But J.D. had a plan to address her addictions in place. She advised the caseworker that she had spoken with a counselor at the Paterson Community Counseling Center about enrolling in an inpatient "Mommy and Me" program at Renaissance House in Newark who had made arrangements for her admission.

A.M.B.'s father, C.B., and her maternal and paternal grandmothers were aware and supportive of J.D.'s plan to go to Renaissance House with the baby. Both grandmothers said they were willing to do what they could to help the new parents.

When A.M.B. was born, C.B. had recently lost his job and was receiving unemployment benefits, and J.D. was receiving public assistance. The parents were living in a basement apartment that was clean, without hazards and equipped with things the baby would [*4] need. J.D.'s relatives, including one of her cousins, had organized a baby shower so that the couple would have things for the baby. In short, despite A.M.B.'s condition, prospects for her future seemed bright.

J.D. went to Renaissance House as planned. By March 8, 2010, A.M.B. was ready for release and joined J.D. at Renaissance House. They did well there until early July, when J.D. tested positive for cocaine and left the program. Had J.D. stayed, she would have completed the program in about a week and been able to leave with A.M.B., who was then about five months old.

While staying at Renaissance House, J.D. had been provided with group counseling, lectures, parenting group sessions, NA meetings and individual counseling once a week. She also had methadone detox treatment and was taking Suboxone. In contrast, C.B., who had denied substance abuse, tested positive for cocaine. J.D.'s discharge summary from Renaissance House indicates a "fair" prognosis, explaining that J.D. was returning to a relationship with an active user of drugs and had a minimal sober support system.

When J.D. left Renaissance House, she went to her mother's home. A caseworker visited her there and suggested that [*5] J.D. return to and complete the program, but J.D. complained about how the staff treated her and A.M.B. and refused. J.D.'s mother agreed to have J.D. and A.M.B. stay with her but only temporarily; she noted that she did not want to enable J.D. The Division approved the temporary plan despite the fact that J.D.'s mother was living in a one-room attic apartment equipped with a single twin bed and without a crib for the baby.

Within three days, J.D. left her mother's home and took A.M.B. with her. C.B. said they could not come to his apartment because he was sharing it with a roommate who was the subject of active arrest warrants. He contacted friends and relatives but did not find anyone willing to shelter his family. On J.D.'s agreement to maintain her sobriety, she and A.M.B. were placed in a motel. The Division arranged for supervision by ECAP, an emergency child aid program. ECAP's supervisors' reported observations of J.D.'s interactions with A.M.B. were generally positive but their observations about J.D.'s interactions with her mother were not.

The Division's initial approval of J.D. and A.M.B. living with J.D.'s mother had been conditioned on all three adults agreeing to submit [*6] urine samples for drug screens. The results of those tests were obtained while J.D. and A.M.B. were living in the motel. The maternal grandmother had told the caseworker that her sample would be positive for prescribed Xanax and methadone, but the sample she submitted was not urine. The samples J.D. and C.B. provided were positive for alcohol and cocaine.

Upon receipt of the results of the drug tests, the Division removed A.M.B. from J.D.'s care, and on July 27, 2010, the Division filed a complaint and order to show cause to obtain custody and care of A.M.B. A.M.B. has not been in the care of J.D., C.B. or a relative since that removal.

The Division filed a complaint for guardianship and termination of parental rights on July 29, 2011. Between A.M.B.'s removal in July 2010 and the Guardianship trial in May 2012, both parents tested positive for drugs on multiple occasions, missed appointments for evaluations, services and visitation, and were admitted to but either discharged from or dropped out of multiple treatment programs arranged by the Division. Because J.D. does not challenge the Division's effort to provide her with the services she needed to address the problems that led to [*7] A.M.B.'s removal, there is no reason to detail the Division's efforts or J.D.'s actions and omissions demonstrating her unwillingness or inability to benefit from them.

It is important to note, however, that J.D. continued her pattern of non-compliance even after she learned she was seven weeks into her second pregnancy in late January 2011. Although J.D. did not have a prescription for methadone or other controlled substances at the time, on March 8 she tested positive for multiple drugs, including methadone and heroin. She was discharged from one of the several drug programs she attended on March 17. She also tested positive for methadone on March 21 and 24 and April 7, 13, and 20. J.D. submitted at least two of those positive samples when she appeared for supervised visitation with A.M.B., and on one of those occasions, the supervisor noted J.D. acted as if she lacked the energy to keep up with A.M.B. Despite J.D.'s continued use of controlled substances, the Division continued its efforts to help her overcome her addiction during her second pregnancy.

When N.B. was born in September, he suffered from withdrawal and was treated as his sister A.M.B. had been. Consequently, he was hospitalized [*8] for five weeks. At that time, A.M.B. was living with foster parents, and those parents cared for both children for a few days before realizing that they were unable to meet the needs of both children. By October 29, 2011, the Division found experienced foster parents who were willing and able to care for them together. Those foster parents intend to adopt A.M.B. and N.B.

On March 5, 2012, the Division's expert psychologist, Dr. Robert Kanen, Psy. D., concluded that A.M.B. was securely attached and bonded with her foster parents and that N.B. was in the process of developing a bond with them. In his opinion, both children would suffer serious and enduring harm if not allowed to remain with these adults who were already providing the care and stability the children needed and were willing to do so on a permanent basis.

Dr. Kanen had assessed the bond between the children and their parents in November 2011. He found that both parents were very positive, interactive and appropriate with the children and that the children were comfortable with them. Nevertheless, in his opinion, A.M.B. had no more than an insecure attachment with J.D. and C.B. and did not view either as a parental figure. [*9] With respect to N.B., who was just under three months old, Dr. Kanen noted that because of his age and his parents unavailability to him on a daily basis, N.B. had no way to develop a bond or attachment with them.

During this meeting with Dr. Kanen, the parents claimed to be very interested in raising their children but at the same time acknowledged that they had not addressed their drug problems and admitted that they were supposed to be in treatment programs but had not started them. J.D. said, "I've been wasting time."

The parents told Dr. Kanen they did not have any family members who were willing or able to take the children. In Dr. Kanen's opinion the children would not suffer enduring harm if their relationship with J.D. and C.B. were severed and the parents had not made advances toward gaining the capacity to care for the children and becoming a source of stability in their lives.

The following month, December 2011, C.B. was admitted to a residential treatment program, which he left after a few days, and J.D. missed three consecutive opportunities for supervised visitation with her children. At that point, the Division discontinued supervised visitation.

J.D. and C.B. did not identify [*10] a relative or anyone else willing to care for A.M.B. or N.B. until March 12, 2012. Prior to that C.B. had suggested his mother, brother and aunt. But the paternal grandmother declined to assume responsibility on the ground that her health did not permit it, and C.B.'s brother said he was not interested. His aunt said she could not care for the children. The Division had ruled out the children's maternal grandmother because of her housing and because she had submitted a substance other than urine when she submitted to the drug screen. As previously noted, J.D.'s mother indicated that she was willing to provide only temporary assistance to J.D. after she left Renaissance House in July 2010.

On March 20, 2012, J.D.'s cousin contacted the Division and indicated that she and her husband were willing to provide the children with a home and adopt them. This cousin was one of the relatives who organized the baby shower before A.M.B.'s birth, and she saw A.M.B. in the hospital and on one other occasion after that. She had not had any other contact with A.M.B., however, and she had never seen N.B. At trial, J.D.'s cousin testified that she had assumed that A.M.B. had been in foster homes since [*11] the Division obtained custody.

The Division checked the respective backgrounds of J.D.'s cousin and her cousin's husband and found no problems, but the Division discovered that the cousin's mother, with whom they were living, had two prior findings of substantiated child abuse. The Division did not rely on the substantiated abuse, however, in denying their request to assume responsibility for the children.

The Division relied on Dr. Kanen's March 5, 2012 report stating his opinion that the children would be harmed if they were removed from the home of their foster parents. On that basis, the Division determined that placement with J.D.'s relatives at this late date would not be in the children's best interests. The Division's letter advising the couple of that determination is dated April 13, 2012, one month before the first day of the termination trial.

The letter explained that the couple had twenty days to appeal the determination, and they contacted a lawyer. It is not clear whether the lawyer filed an appeal, because the court concluded that his testimony on that point was immaterial.

The judge determined that the Division established that termination of parental rights is in the [*12] best interests of A.M.B. and N.B. In his oral decision, the judge set forth detailed findings of fact and explained why the evidence clearly and convincingly established each of the four criteria essential to his conclusion that termination is in the children's best interests. *N.J.S.A. 30:4C-15.1(a)(1)-(4)*. There is no question that the judgment "is based on findings of fact which are adequately supported by evidence," *R. 2:11-3(e)(1)(A)*, and on a proper application of the statute as interpreted by our courts.

That said, J.D.'s arguments challenging the adequacy of the Division's efforts to locate relatives, the court's consideration of alternatives to termination and the balance of harm and good this termination will bring to the children do not require extended discussion beyond that included in the trial judge's oral decision. *R. 2:11-3(e)(1)(E)*. Brief comments on J.D.'s objections to the Division's and the judge's consideration of relatives are all that is required.

The unfortunate reality is that prior to March 20, 2012, the Division had no reason to know that there were any relatives willing or able to care for the children and there were no alternatives to termination for the [*13] judge to consider. And by the time J.D.'s cousin contacted the Division, the children had and were developing a bond with foster parents who were willing to adopt them.

In *K.L.W.*, we concluded that the Division failed to comply with its statutory obligation to contact relatives of a child in its custody. *419 N.J. Super. at 577-83*; *see N.J.S.A. 30:4C-12.1*. But this case is not comparable to *K.L.W.* in any way.

In *K.L.W.* the Division, at the mother's request, had declined to contact the maternal grandparents even though the Division knew that those grandparents were caring for the mother's other children. *Id. at 571-72*. We held that *N.J.S.A. 30:4C-12.1* "does not permit the Division to embark on a course set for termination of parental rights and adoption by a foster parent without at least first exploring available relative placements." *Id. at 580*.

The Division did not make that mistake in this case. Here, the maternal and paternal grandmothers initially expressed their respective interest in doing what they could to help the new parents care for their first child. But within weeks of the baby's birth, the maternal grandmother was not willing to open her home to J.D. and her baby on more [*14] than a temporary basis. Her position was quite understandable given the accommodations she had to offer and the fact that she had provided a substance other than urine after agreeing to submit to a drug screen. Similarly, the paternal grandmother, who also expressed willingness to do all she could to help, and C.B.'s brother and aunt all recognized and reported to the Division their inability to care for A.M.B.

In *K.L.W.*, we made it clear that our holding had no relevance to cases in which relatives unknown to and not reasonably discoverable by the Division come forward at the eleventh hour, as J.D.'s cousin did in this case. We cautioned:

> Our conclusion that the Division violated its statutory obligation in this case should not be misunderstood to provide a last minute defense to termination for a

> parent who identifies a relative, previously unknown and not reasonably known to the Division, after the guardianship complaint has been filed. Delay of permanency or reversal of termination based on the Division's noncompliance with its statutory obligations is warranted only when it is in the best interests of the child. *See [N.J. Div. of Youth & Family Servs. v. M.F., 357 N.J. Super. 515, 527, 815 A.2d 1029 (App. Div. 2003)]*; [*15] *In re Guardianship of J.R., 174 N.J. Super. 211, 221-25, 416 A.2d 62 (App. Div.), certif. denied, 85 N.J. 102, 425 A.2d 266 (1980)* (affirming a judgment of guardianship even though the Division failed to provide a parent with visitation, because termination was in the child's best interests).
>
> [*K.L.W., supra, 419 N.J. Super. at 581.*]

The Division's decision to reject J.D.'s cousin's late offer to care for the children, grounded on Dr. Kanen's opinion that they would be harmed if removed from the home of their foster parents, was wholly consistent with the foregoing guidance and with the Division's obligation to act in the children's best interests. Accordingly, the trial court did not err by failing to conclude that placement with J.D.'s cousin and her husband was a viable alternative to termination. Indeed, because the foster parents and J.D.'s cousin and her husband indicated a willingness to adopt, kinship legal guardianship would not have been available as an alternative to termination. *See N.J. Div. of Youth & Family Servs. v. P.P., 180 N.J. 494, 513, 852 A.2d 1093 (2004).*

J.D.'s objections to the trial court's balancing of the relative harm and good termination will likely bring to J.D.'s children lack sufficient merit to [*16] warrant any discussion beyond what Judge Portelli stated in his oral decision of May 17, 2012. *R. 2:11-3(e)(1)(E).*

Affirmed.

NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES, Plaintiff-Respondent, v. S.J. and I.G., Defendants-Appellants. IN THE MATTER OF THE GUARDIANSHIP OF I.G., III, a Minor.

DOCKET NO. A-2506-11T3, A-2508-11T3

SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

2013 N.J. Super. Unpub. LEXIS 886

April 8, 2013, Argued
April 22, 2013, Decided

NOTICE: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY *RULE 1:36-3* FOR CITATION OF UNPUBLISHED OPINIONS.

PRIOR HISTORY: [*1]
On appeal from the Superior Court of New Jersey, Chancery Division, Family Part, Passaic County, Docket No. FG-16-48-11.

COUNSEL: Ryan T. Clark, Designated Counsel, argued the cause for appellant S.J. (Joseph E. Krakora, Public Defender, attorney; Mr. Clark, on the brief).

Markis M. Abraham, Designated Counsel, argued the cause for appellant I.G. (Joseph E. Krakora, Public Defender, attorney; Mr. Abraham, on the brief).

Christian A. Arnold, Deputy Attorney General, argued the cause for respondent (Jeffrey S. Chiesa, Attorney General, attorney; Andrea M. Silkowitz, Assistant Attorney General, of counsel; Yudelka R. Felipe, Deputy Attorney General, on the brief).

Cory H. Cassar, Assistant Deputy Public Defender, argued the cause for minor I.G., III (Joseph E. Krakora, Public Defender, Law Guardian, attorney; Mr. Cassar, on the brief).

JUDGES: Before Judges Parrillo, Sabatino, and Carroll.

OPINION

PER CURIAM

Defendants I.G. and S.J., the biological parents of I.G. III ("Ivan")[1] born in March 2010, appeal separately from the December 14, 2011 judgment terminating their respective parental rights to Ivan. On these appeals, which we have consolidated, defendants contend that the Division of Youth and Family Services[2] (Division) [*2] did not prove by clear and convincing evidence the four prongs of the termination statute. The Law Guardian supports the termination on appeal, as it did before the trial court.

1 Fictional names are used to protect the privacy of the children and for ease of reference.

2 On June 29, 2012, the Governor signed into law A-3101, which reorganized the Department of Children and Families, including the renaming of the Division as the Division of Child Protection and Permanency. *L.* 2012, *c.* 16, eff. June 29, 2012.

Based on our review of the record and applicable law, we are satisfied the evidence in favor of the guardianship petition adequately supports the termination of defendants' parental rights. *See, e.g., N.J. Div. of Youth & Family Servs. v. M.M., 189 N.J. 261, 279 (2009)* (holding that a reviewing court should uphold the factual findings respecting the termination of parental rights if they are supported by substantial and credible evidence in the record as a whole). Accordingly, we affirm.

I

S.J. (the mother), born in 1983, and I.G. (the father), born in 1982, have three children together: A.M.G. ("Alyssa"), born in March 2007; A.G. ("Amy"), born in May 2009; and Ivan.[3]

3 S.J. also has two [*3] children from prior relationships, both of whom now live with their maternal grandmother in Puerto Rico and are not at issue in this appeal.

A.

The family first came to the attention of the Division in May 2009, after it received a referral, the allegations of which were later found to be unsubstantiated, stating that S.J. had admitted to using heroin and marijuana during her pregnancy with Amy. S.J. tested negative for all drugs when she gave delivery, yet Amy was born prematurely and was treated for methadone withdrawal. At the time, S.J., I.G., Alyssa, and H. (one of S.J.'s other children) were residing in a home in Paterson. S.J. and I.G. were both unemployed. A Division worker met with S.J. and I.G. at the hospital the day of the referral. According to the Division, S.J. admitted to a prior drug history, and that she had recently relapsed. S.J. further stated that she sought treatment and began a methadone treatment program. S.J. and I.G. were referred for drug and alcohol assessments, and S.J. was referred to an intensive outpatient program.

S.J. then attended a substance abuse assessment with Preferred Children's Services. She admitted to a long history of substance abuse, including [*4] alcohol, marijuana, heroin, cocaine, and crack. S.J. had completed a long-term recovery program from 2005 to 2008, but then relapsed in 2008 when she moved to Paterson. In December 2008, when she learned she was pregnant with Amy, S.J. sought treatment from the Paterson Counseling Center. However, she continued using heroin until February 2009, when her methadone dosage was increased.

I.G. also attended a substance abuse assessment in May 2009, and was then referred for an extended assessment. In July 2009, a Division caseworker met with S.J. and I.G., and provided S.J. with a bus pass and reminded I.G. to attend his substance abuse assessments. Nevertheless, I.G. failed to appear for three consecutive substance abuse assessments in July 2009. In August 2009, I.G. apparently left the Paterson home and moved to New York to live with his mother for work purposes.

In September 2009, a Division caseworker sent I.G. a letter informing him of the Division's concern about his non-compliance with the substance abuse assessments. A Division caseworker later visited S.J.'s home, where I.G. also was staying at the time. I.G. "came out of the bedroom yelling at the [case]worker" and stated he was [*5] "tired of the nonsense." He also expressed that he did not live with [S.J.] and continues to live in [New York] . . . [and] did not understand why he needs to comply with a . . . drug assessment." On October 9, 2009 S.J. tested positive for

cocaine and opiates. On October 16, 2009, I.G. tested positive for cocaine and opiates, and again on October 20 he tested positive for opiates.

On October 20, 2009, the Division filed an Order to Show Cause seeking custody of Alyssa and Amy. Consequently, on October 21, Alyssa and Amy were removed from the parents' custody and placed in a foster home. The court ordered S.J. and I.G. to comply with all recommendations of the substance abuse assessments and complete a parenting assessment.

On October 26, 2009, the Division sent a request to the New York State Registry to explore the paternal grandmother (E.N.) as a potential caretaker for Alyssa and Amy. The Division also referred I.G. to the Challenge Program for treatment. On October 30 I.G. informed an assessment counselor of his continued use of heroin, and was referred for detoxification treatment at Bergen Regional Medical Center, where he was admitted on November 4, 2009. However, I.G. left the [*6] same day, "against medical advice," because he claimed there were no beds.

On November 10, 2009, Beatrice Reyes, a Division caseworker, received a call from S.J.'s counselor at the Paterson Counseling Center, advising her that S.J. stopped participating in counseling, and failed to submit to urine screens. On November 18, S.J. was ordered to attend substance abuse treatment, and I.G. was ordered to complete psychological, psychiatric, and substance abuse evaluations.

Pursuant to the November 18, 2009 order, S.J. entered the Straight and Narrow Mommy and Me program in December 2009, and was given an anticipated discharge date of June 2010. On January 20, 2010, upon Straight and Narrow's recommendation, Alyssa was reunified with S.J. in the Straight and Narrow Program. It was further recommended that S.J. be granted overnight weekend visits with Amy.

In December 2009, I.G. was evaluated by Alison Winston, Ph.D. at the Division's behest. I.G. admitted to using cocaine and heroin for two to three months in the late summer and early fall. Dr. Winston noted her concern that I.G. was not engaged in any treatment, nor participating in Narcotics Anonymous. Subsequently, I.G. was referred to Eva's [*7] Village for residential treatment. However, he was discharged on January 10, 2010 because he "failed to comply with treatment." On January 6, 2010, I.G. provided a urine sample to the Division that tested positive for opiates. Additionally, at a February 4, 2010 substance abuse assessment, I.G. admitted to recently using heroin, and requested a referral for treatment. I.G. then entered into a twenty-eight-day residential treatment program at Turning Point, which he successfully completed on March 12, 2010.

In March 2010, S.J. gave birth to Ivan, and the hospital's referral stated that both S.J. and Ivan tested negative for all drugs. However, Ivan was born prematurely, was severely underweight, and was not breathing on his own. As a result, Ivan was not discharged from the hospital until April 20, 2010. Ivan was placed directly into a Special Home Service Provider (SHSP) foster home, where he has since remained. On March 23, 2010, the Division filed an amended complaint, also seeking custody of Ivan.

On March 25, 2010, S.J. and I.G. stipulated that "[S.J.] used heroin & cocaine at or about the time of the [Dodd] removal[4] [October 19, 2009] in the presence of her children and to the detriment [*8] of her ability to care for [them]." The court ordered S.J. to attend substance abuse treatment, and both parents to submit to urine screenings, attend individual counseling, and attend parenting skills training.

4 A "Dodd removal" refers to the emergency removal of a child from the home without a court order, pursuant to the Dodd Act, which, as amended, is found at *N.J.S.A. 9:6-8.21 to -8.82*.

On March 23, 2010, I.G. was referred for intensive outpatient substance treatment, five days per week, at Options Counseling. I.G. was admitted on April 1. However, he was discharged on July 7, because he "neglect[ed] to attend [the] program on a consistent basis. Attempts to reengage [I.G.] occurred on at least a weekly basis. [I.G.] did not respond to communication attempts." I.G.'s discharge summary indicated that his failure to attend the program was due to his residency in New York and financial inadequacies. However, the summary noted that I.G. collected welfare in New Jersey, and refused attempts by the program to secure him housing in New Jersey.

S.J., who was still enrolled in the Mommy and Me Program at Straight and Narrow, left that program on April 13, 2010. This was deemed a discharge [*9] from the program. S.J. was found later that day by Reyes at Eva's Village, a transitional living facility. Eva's Village was able to accommodate S.J., after Reyes spoke with the Director; this allowed S.J. to continue living with Amy.

At a compliance review hearing on April 14, 2010, S.J. and I.G. were both ordered to attend substance abuse treatment, submit to random urine screenings, attend individual counseling, and attend parenting skills training.

In May 2010, a Substance Abuse Initiative report indicated that S.J. tested negative for her last four drug tests. However, the report commented that she had "an extremely poor attitude in treatment . . . with poor participation . . . continued poor participation will result in her being referred to a more intensive inpatient program."

I.G. attended another substance abuse assessment in July 2010, during which he admitted prior alcohol, heroin, and cocaine use, but contended that he had been clean since January 2010. He was referred to the Challenge Program, where he was admitted on August 12, 2010. He was discharged on September 22, due to non-compliance. I.G. was re-admitted on September 27, but again discharged in early October for non-compliance. [*10] A Division contact sheet indicated that he had not given a urine sample since August 2010.

In August 2010, a social worker at Eva's Village indicated that S.J. "has shown improvement in her behavior and has been keeping up with all appointments and requirements." The social worker also recommended weekend overnight-supervised visits with Amy at Eva's Village. In September the social worker reported that S.J. was attending Narcotics Anonymous meetings, parenting classes, and domestic violence counseling. As of early October, the Division planned to request reunification of Amy with S.J., and to "work with returning [Ivan]."

Unfortunately, S.J.'s progress quickly halted. On October 12, 2010, S.J. was exposed by another group member at Eva's Village for missing her group counseling sessions for three prior weeks, and being late for her outpatient programs. In response, S.J. twice threatened physical force against the client who had divulged this information. On October 20, S.J. was discharged from Eva's Village because "[S.J.] has been consistent with displaying behaviors not consistent and conducive to treatment (violations of cardinal rules)." Alyssa was subsequently placed in foster [*11] care with Amy.

B.

A permanency order was entered on October 26, 2010. It listed, among other reasons, why it would not be safe to return the children home:

> [B]oth parents have failed to complete a substance abuse program and both parents are homeless at this time. [S.J.] needs anger management, counseling, parenting. I.G. needs anger management, counseling, parenting. Both parents need

to successfully complete a substance abuse program and maintain sobriety and need housing.

The order explained that termination of parental rights followed by adoption was the appropriate plan because "neither parent can currently care for the children safely due to unaddressed housing, substance and parenting issues." The order also indicated that the Division had "provided reasonable efforts to finalize the permanent plan, including reunification where appropriate by referring the parents to the following programs: Straight & Narrow, Paterson Counseling, Eva's Challenge, Turning Point, Bergen Regional, [and] Options, as well as psychological evaluations, psychiatric evaluations ([S.J.]), medication monitoring ([S.J.]), visitation, bus passes, housing referrals ([I.G.])." The court further ordered the removal [*12] of Alyssa from S.J.'s physical custody. Both parents were again ordered to attend substance abuse evaluations, submit to drug screenings, and attend individual counseling/anger management. Notably, the order also directed the Division "to pursue expedited interstate [study] as to [Ivan] and [Amy]."

On October 29, 2010, the Division referred S.J. for a substance abuse evaluation. S.J. then began attending Options for treatment. However, in December, S.J. tested positive for amphetamines and benzodiazipines, and she again tested positive for opiates, benzodiazipines, and methadone on January 3, 2011. At that point S.J. stopped attending Options.

In January 2011, Alyssa and Amy began living with their paternal grandmother, E.N., in New York. However, Ivan remained in the care of his foster family because E.N. expressed reservations about her ability to meet Ivan's substantial medical needs. Amy and Alyssa were able to attend day care while E.N. worked, but Ivan's considerable medical needs rendered day care inappropriate for him. Ivan was deemed "medically fragile." As noted, following his release from the hospital seven weeks after birth, Ivan went directly into a specialized home where [*13] the foster parents were trained to manage the high level of care that he needed. Ivan's foster parents have since arranged to provide speech, physical, and occupational therapy for him. Ivan also saw a neurologist, an ophthalmologist, and a feeding therapist.

In March 2011, S.J. expressed a desire for inpatient care, and sought welfare benefits because she would soon be homeless. S.J. further expressed her desire to reunify with her children. In April 2011, Joy Winnik, an adoption specialist with the Division, was advised that S.J. was admitted to a six-to-fifteen-month in-patient program. However, in May 2011, Winnik was informed that S.J. left Daytop "against the advice of [Daytop's] [c]linical [s]taff . . . [and] is no longer considered a resident of Daytop Village[.]"

In April 2011, I.G. was admitted to an in-patient program at the Daytop Program in Queens, New York. However, in May 2011, after having been rotated to a different residence at Daytop Village, I.G. left the program.

On June 9, 2011, S.J. enrolled in a non-intensive outpatient program at CIS Addiction. Winnik testified that S.J. did not complete that program because it apparently closed. S.J. failed to appear for court-ordered [*14] psychological evaluations with Robert Kanen, Psy.D. on June 29, 2011. Additionally, between June 30 and October 5, 2011, S.J. and I.G. missed ten of their weekly visits with Ivan at his foster home.

S.J. next enrolled in the Addiction Institute of New York in August 2011. In September she notified the Division that she had completed the program. However, when the caseworker called to confirm, she was informed that S.J. did not want to continue in the program, and had been referred to an outpatient program.

On September 29 and October 21, 2011, S.J. completed a psychological evaluation with Dr. Kanen. S.J. desired that E.N. take care of Ivan because his condition had improved. However,

according to Dr. Kanen, S.J. "has no plan to care for the children on her own," and S.J. informed Dr. Kanen that "I'm having difficulty staying stable and in one place. Once I'm in a place, a couple of months, I just take off. My bipolar disorder and depression have me all over the place."

Also of import, the week before the trial, E.N. informed Winnik that she was now in a position to take Ivan into her care because her daughter (I.G.'s sister) stopped working in February 2011, and would be in a position [*15] to provide full-time care for Ivan.

C.

The guardianship trial was held on November 9 and 10, 2011. S.J. and I.G. voluntarily surrendered their parental rights to Alyssa and Amy to E.N. The Division then presented the testimony of two caseworkers, Reyes and Winnik, and the expert testimony of Dr. Kanen. The court also heard testimony from E.N., offered by S.J.'s attorney.[5] The court admitted the Division's substantial record, which included expert reports, including psychological assessments of both parents by Dr. Winston, and the psychological evaluations and bonding evaluations performed by Dr. Kanen.

5 The only testimony offered by S.J. and I.G. at the trial was limited to discussion of their voluntary surrender of parental rights to Alyssa and Amy.

Dr. Kanen testified that S.J. told him she was on methadone when she gave birth to Ivan, and that her drug problem had disrupted her life. S.J. also told him she had been diagnosed with bi-polar disorder, which Dr. Kanen stated frequently co-occurs with drug abuse issues and is difficult to treat.

Dr. Kanen opined that S.J. "has some cognitive impairment", which he believed was partially attributable to her substance abuse. This impairment [*16] raised a concern about her ability to parent because Ivan has multiple developmental delays, and requires someone who can pay attention to his many needs. "If you have a child who has multiple developmental delays with a parent who has short-term memory deficits . . . there becomes a very high risk for errors."

As a result of his evaluation of S.J., Dr. Kanen concluded:

> My opinion is at the present time she has severe parenting deficits. She's not able to provide [Ivan] with a permanent, safe, and secure home. My opinion was that returning [Ivan] to her care would expose [Ivan] to an unnecessary risk of harm. She's not adequately addressed her problems. And so she's got a long way to go.

Dr. Kanen testified that although S.J.'s recent enrollment in another treatment program was a "good step," it was not sufficient to change his opinion about her ability to parent.[6] He further testified that S.J. "has to learn more about . . . the various developmental delays [Ivan] has and to learn what types of services he needs and then has to be responsible and dependable enough to follow through on those services."

6 Dr. Kanen indicated that given S.J.'s substance abuse history and her mental illness [*17] issues, it could require five years of sobriety before S.J. would be able to parent.

With respect to I.G., whom Dr. Kanen had also evaluated, Dr. Kanen first noted that I.G. initially failed to appear for his evaluation, and offered no explanation for his absence. When he did appear, I.G. was hostile during the evaluation and "would not give the address as to where he lives[.]" When discussing the services that the Division wanted I.G. to complete, Dr. Kanen described I.G. as "very, very angry," and that I.G. said "me and [the Division] don't get along." Dr. Kanen described I.G.'s demeanor while answering questions about his drug history as "very,

very irritable and angry, very hostile." At one point during the cognitive testing I.G. "wouldn't continue. He . . . got so angry and he left."[7]

7 On cross-examination, Dr. Kanen stated that "[i]n 500 evaluations . . . there might have been one other person that acted like [I.G. did]."

Although I.G. acknowledged that Ivan was born medically fragile, he "offered no plan to take care of the children on his own . . . he said he was waiting for medical records on [Ivan] and . . . indicated that [they would] give him an idea of . . . how much care [*18] [Ivan] required." Dr. Kanen concluded:

> [I.G.] was so easily provoked in the evaluation . . . so irritable and so impatient. . . . [I]t's a behavioral sample of how he deals with what he consider[s] to be a stressful event. . . .
>
> . . . [T]he fact that [Ivan's] functioning is impaired makes demands that a normal child doesn't present to parents. So a special needs child requires much more patience and sensitivity and sound judgment . . . than a normal child. It's . . . exponentially more difficult to take care of a special needs child.
>
> . . . .
>
> At the time I saw [I.G] I didn't think he had any ability to . . . to provide adequate parenting to the child. . . . [H]e had very, very limited ability to provide for the child.

Even assuming that I.G. also recently enrolled in another substance abuse treatment program, Dr. Kanen considered it "a positive first step but there's still a long road ahead." He stated his long-term prognosis for I.G. was "[v]ery poor" because:

> [H]e's so unstable. He doesn't have a home. He's got psychiatric problems. He's got serious personality problems. He's . . . prone to angry outbursts. He's very unstable. He's got a substance abuse history[.] . . . All of those factors [*19] combined he couldn't provide a child with a permanent safe and secure home.

Dr. Kanen next testified about the bonding evaluation he conducted between Ivan and his biological parents. He concluded "that there was no bond [between Ivan and his biological parents]. The child . . . does not see them as parental figures in any way. They're pretty much strangers to him[.]"

To the contrary, based on his bonding evaluation of Ivan and his foster parents, Dr. Kanen concluded that Ivan is:

> attached and bonded to [his foster parents]. They've cared for [Ivan] since he was released from the hospital, so it was from the time he was approximately six weeks old. [Ivan] perceives them as his parents. He perceives them as the people who meet his needs and care for him every day of the week. And they're very committed to him and very knowledgeable and very capable of providing him with a permanent, safe, and secure home.

Concerning the effect of removing Ivan from his foster family, Dr. Kanen opined that:

> you would be removing a child from the only parents he's known, so it could -- would be devastating to him. You would probably see regressions in the gains that

> he had made. It's likely to be very difficult [*20] [ ] to find somebody who is that committed in terms of multiple therapies and following through on those therapies at the home which is what the foster mother does. So my view is he would suffer serious harm if removed[.]

Dr. Kanen noted that Ivan is old enough "to definitely know that [the foster parents] are the primary caretakers" and in light of Ivan's development and nervous system-based delays, removal "would be a shock to him." In contrast, Dr. Kanen did not think eliminating contact between Ivan and his biological parents would have any effect on him. Dr. Kanen reiterated that the harm resulting from removing Ivan from his foster parents would be "serious and enduring[.]"

Reyes, who is a permanency worker with the Division, testified about both parents' "minimal" compliance, and their multiple failed attempts at completing their respective substance abuse treatment programs. In addition, Winnik testified that she was at times unable to maintain contact with S.J. and I.G. Winnik also noted that both failed to attend certain appointments for psychological and bonding evaluations.

With respect to the parents' visitation with the children, Winnik noted that before Alyssa and Amy moved [*21] to E.N.'s home in New York, the visits were "pretty consistent." Thereafter, however, these visits became more "sporadic."

Winnik testified that Ivan is "globally delayed," and is still classified as "medically fragile." However, she also acknowledged that Ivan has not "been given any type of definitive diagnosis that would explain all of his delays[.]" According to Winnik, Ivan's needs are still the same as they have always been. Winnik testified that Ivan typically has five or six appointments every month.

Winnik acknowledged that E.N. recently approached her and "said that she was now prepared to fight for [Ivan] and . . . that her daughter would stay home and care for him." She noted, however, that prior to E.N.'s decision to come forward immediately prior to trial, E.N. never previously advised the Division that she was willing and able to provide full-time care to Ivan. As to her perception of E.N.'s ability to care for Ivan, Winnik stated:

> I'm not sure if I would say we have any concerns for her, per se. What I have gotten from the conversations I've had with her is that she can't provide the type of care that's being provided in the other foster home as far as she would like -- [*22] well, she would love to be able to care for him because that's her grandson but she also works and wasn't sure how she would meet like all of the needs of all of the doctors' appointments and . . . we didn't get into it specifically because she said . . . I can't do it right now[.]

Finally, Winnik testified that on multiple occasions, S.J. and I.G. failed to comply with the Division's requests for a urine screen. This most recently occurred on the day of their bonding evaluations. S.J. and I.G. also failed to complete the services that the Division recommended to enable them to provide a safe and secure home for Ivan.

E.N. testified next and explained that when she first inquired about having Ivan live with her, she was told that "he needed someone to stay home with him . . . because he couldn't go to daycare because he was not capable." She testified that she had wanted to have custody of Ivan from the beginning; however, because Ivan's medical needs prevented him from attending daycare, she would not be able to care for him due to her work schedule. E.N. testified that she requested a diagnosis of Ivan's condition and why he was unable to attend daycare, but that the Division only [*23] told her that Ivan was "fragile," and never offered her a further explanation.

E.N. also testified that through her independent relationship with Ivan's foster mother, Ivan visits twice a month, and during those visits he gets to see his sisters. E.N. also readily acknowledged that she witnessed a positive change in Ivan's condition through the care he has received from his foster family.

D.

After considering the testimony of these witnesses, the documentary evidence submitted, and written summations from the parties, the trial judge issued an oral decision on December 14, 2011. The judge found that the Division met its burden of proof by clear and convincing evidence as to all four prongs of *N.J.S.A. 30:4C-15.1*, and as a result, the judge terminated both defendants' parental rights. On appeal, I.G. argues that the Division failed to satisfy each of those prongs by clear and convincing evidence. S.J. acknowledges that she harmed Ivan, but disputes the Judge's findings on prongs two, three and four of *N.J.S.A. 30:4C-15.1*.

II

The law governing our analysis is well established. "The burden rests on the party seeking to terminate parental rights 'to demonstrate by clear and convincing evidence' [*24] that risk of 'serious and lasting [future] harm to the child' is sufficiently great as to require severance of parental ties." *In re Adoption of a Child by W.P. & M.P., 308 N.J. Super. 376, 383, 706 A.2d 198* (App. Div. 1998) (alteration in original) (quoting *In re Guardianship of J.C., 129 N.J. 1, 10, 608 A.2d 1312 (1992))*. The question for the court "focuses upon what course serves the 'best interests' of the child." *Ibid.*

In evaluating the best interests of the child, courts follow a four-prong standard, articulated in *N.J. Division of Youth & Family Services v. A.W., 103 N.J. 591, 604-11 (1986)* and codified in *N.J.S.A. 30:4C-15.1(a)*. This standard allows for termination when the Division proves, by clear and convincing evidence, that:

> (1) The child's safety, health or development has been or will continue to be endangered by the parental relationship;
>
> (2) The parent is unwilling or unable to eliminate the harm facing the child or is unable or unwilling to provide a safe and stable home for the child and the delay of permanent placement will add to the harm. Such harm may include evidence that separating the child from his resource family parents would cause serious and enduring emotional or psychological harm [*25] to the child;
>
> (3) The Division has made reasonable efforts to provide services to help the parent correct the circumstances which led to the child's placement outside the home and the court has considered alternatives to termination of parental rights; and
>
> (4) Termination of parental rights will not do more harm than good.
>
> [*N.J.S.A. 30:4C-15.1(a)*.]

These criteria are neither separate nor discrete. *In re Guardianship of K.H.O., 161 N.J. 337, 348, 736 A.2d 1246 (1999)*. They overlap to provide a composite picture of what may be necessary to advance the best interests of the child. *Ibid.* "The considerations involved in determinations of parental fitness are 'extremely fact sensitive' and require particularized evidence that address the specific circumstances in the given case." *Ibid.* (quoting *In re Adoption of Children by L.A.S., 134 N.J. 127, 139, 631 A.2d 928 (1993))*.

The scope of our review of a trial court's decision to terminate parental rights is limited. *In re Guardianship of J.N.H., 172 N.J. 440, 472, 799 A.2d 518 (2002)*. Because of the Family Part's special jurisdiction and expertise in family matters, we accord deference to the trial court's fact-finding and the conclusions that flow logically from those findings of fact. *Cesare v. Cesare, 154 N.J. 394, 413, 713 A.2d 390 (1998)*. [*26] We are further obliged to defer to the trial judge's credibility determinations and the judge's "'feel of the case' based upon the opportunity of the judge to see and hear the witnesses." *N.J. Div. of Youth & Family Servs. v. A.R.G., 361 N.J. Super. 46, 78, 824 A.2d 213 (App. Div. 2003)* (citing *Cesare, supra, 154 N.J. at 411-12*; *Pascale v. Pascale, 113 N.J. 20, 33, 549 A.2d 782 (1988)), aff'd in part and modified in part, 179 N.J. 264, 845 A.2d 106 (2004)*. "When the credibility of witnesses is an important factor, the trial court's conclusions must be given great weight and must be accepted by the appellate court unless clearly lacking in reasonable support." *N.J. Div. of Youth & Family Servs. v. F.M., 375 N.J. Super. 235, 259, 867 A.2d 499 (App. Div. 2005)* (citing *In re Guardianship of D.M.H., 161 N.J. 365, 382, 736 A.2d 1261 (1999))*.

When the trial court's findings of fact are supported by adequate, substantial, and credible evidence, they are binding on appeal. *See Rova Farms Resort, Inc. v. Investors Ins. Co. of Am., 65 N.J. 474, 484, 323 A.2d 495 (1974)* (holding an appellate court is not to disturb the factual findings and legal conclusions of the trial judge unless they are "so manifestly unsupported by or inconsistent with the competent, relevant and reasonably [*27] credible evidence as to offend the interests of justice"). Reversal is required only in those circumstances in which the trial court's findings are "so wide of the mark that a mistake must have been made." *M.M., supra, 189 N.J. at 279* (internal quotation marks omitted).

Applying this standard, we discern sufficient evidence in the record to support the judge's conclusions that Ivan's best interests required termination of defendants' parental rights.

To meet the first prong of the termination statute, the Division must show there is a harm that threatened the child's health and that such harm will likely have continuing deleterious effects on the child. *K.H.O., supra, 161 N.J. at 352*. Even though "a particularly egregious single harm can trigger the standard, the focus is on the effect of harms arising from the parent-child relationship over time on the child's health and development." *Id. at 348*.

Prongs one and two are related, as the second prong considers the parent's failure to provide even minimal parenting to his or her child. *D.M.H., supra, 161 N.J. at 379*. The second prong of the statute is "aimed at determining whether the parent has cured and overcome the initial harm that endangered [*28] the health, safety, or welfare of the child, and is able to continue a parental relationship without recurrent harm to the child," or alternatively, "that the parent is unable to provide a safe and stable home for the child and that the delay in securing permanency continues or adds to the child's harm." *K.H.O., supra, 161 N.J. at 348-49*. This prong "may be met by indications of parental dereliction and irresponsibility, such as . . . the parent's continued or recurrent drug abuse, [and] the inability to provide a stable and protective home[.]" *Id. at 353*.

A.

The trial judge found the first two prongs of the best interests test were met by clear and convincing evidence. As to S.J., the judge found that the first prong was met when Ivan was born prematurely and declared medically fragile due to his intrauterine exposure to methadone. This finding of harm did not rest entirely on S.J.'s substance abuse prior to Ivan's birth. *See N.J. Dep't of Children & Families v. A.L., 213 N.J. 1 (2013)* (holding that drug use during pregnancy, without more, does not establish abuse or neglect as defined in Title Nine). Rather, at the time she gave birth to Ivan, S.J. was still enrolled in the Straight [*29] and Narrow Program. She was clearly unable to provide Ivan with the safe and secure home, along with the specialized attention,

that Ivan required upon his release from the hospital. On appeal, S.J. does not challenge the court's finding that she caused harm to Ivan.

I.G. argues that Dr. Winston examined both parents and determined that while S.J. presented a risk of harm and physical abuse to the children, I.G. presented only a very low risk of physical harm. However, "[t]he absence of physical abuse or neglect is not conclusive on the issue of custody. The trial court must consider the potential for serious psychological damage to the child inferential from the proofs." *In re Guardianship of R. 155 N.J. Super. 186, 194, 382 A.2d 654 (App. Div. 1977).*

Here, the evidence indisputably demonstrates that, by the time of Ivan's birth in March 2010, I.G. tested positive for opiates and admitted to using heroin. When Ivan was born, I.G. was enrolled in the residential treatment program at Turning Point. Thereafter, I.G. was apparently travelling back and forth between New Jersey and New York. In April, I.G. was admitted into the five-day per week intensive outpatient program at Options, from which he was [*30] discharged in July. We find ample support in the record for the trial court's conclusion that "neither [of] the defendants was available and capable of providing a safe and secure home to . . . prevent [Ivan's] placement[,] and accordingly that is another harm that occurred which satisfies the elements of the first prong."[8]

8 Importantly, Dr. Winston's more favorable report was prepared in December 2009, prior to Ivan's birth.

B.

The trial judge made the following well-supported findings as to prong two:

> [E]ach of the defendants has entered four or five substance abuse programs without achieving any degree of sobriety that would enable either to safely parent [Ivan], nor did either of the defendants achieve any degree of stability or capability that would enable either to provide a safe and secure housing and ability to provide for [Ivan].
>
> . . . .
>
> At the beginning of the trial the defendants, in an acknowledgement of their respective . . . incapacities to safely parent the children, effectuated the identified surrender to [E.N.], and placed themselves into the [treatment] programs . . . so that even on the date of trial the . . . defendants were not available to take custody of [Ivan] and [*31] were not available or capable of providing him with appropriate parenting in terms of safely providing for [Ivan].
>
> So that the harm that occurred upon birth and satisfied the elements of the first prong continued right through to the first day of trial, namely the defendants having placed themselves in these programs.

With respect to S.J., the judge noted that she began using drugs at a very young age. She was using heroin by eighteen, and, according to Dr. Kanen's expert opinion, her prognosis for ever achieving sobriety was poor based upon her drug history, placement of her other four children, and her string of failures regarding the services made available to her by the Division.

The judge further noted Dr. Kanen's findings that S.J. has "severe parenting deficits," is mentally ill with bipolar disorder and severe depression, has longstanding personality problems, and cognitive limitations. Additionally, the judge noted that S.J. shows:

> [M]ajor impairment in several areas of functioning, including parenting, difficulty maintaining stable housing, inability to work, inability to honor her family obligations . . . [she has] an estimated full-scale IQ of 71 . . . .
>
> She shows severe deficits [*32] in thinking, reasoning, judgment, and memory. She is not capable of providing for her children with a permanent, safe, and secure home now or in the foreseeable future.

The judge stated that "the expert's finding satisfies the requirement of the second prong as well as the fourth prong . . . because [S.J.] does not have the capacity to safely parent her children as testified to by the expert."

The trial judge's findings that the Division also satisfied the second prong as to I.G. are equally supported by the record. The judge accepted Dr. Kanen's unrebutted expert testimony that I.G.'s future prognosis was poor, and that I.G. lacks the capacity to safely parent Ivan because he failed to cooperate with the Division, complete the programs to which he was assigned, or maintain sobriety. I.G. never demonstrated established or appropriate housing, or a willingness or ability to properly attend to Ivan's substantial medical and developmental needs.

C.

The third prong of the statutory test "contemplates efforts that focus on reunification of the parent with the child and assistance to the parent to correct and overcome those circumstances that necessitated the placement of the child into foster [*33] care." *K.H.O., supra, 161 N.J. at 354.* The judge noted that the services offered to defendants by the Division included: "drug assessments, drug treatment programs, psychological evaluations, placement programs of [Alyssa] with [S.J.], bus passes, transportation, parenting classes, anger management, medical and occupation services together with early intervention services."

We agree that the proofs were clear and convincing that the defendants' persistent problems were a result of their resistance to the Division's recommendations, rather than a failure by the Division to provide them with appropriate services and opportunities. "[The Division's] efforts to provide services is not measured by their success." *N.J. Div. of Youth & Fam. Servs. v. A.R., 405 N.J. Super. 418, 441, 965 A.2d 174 (App. Div. 2009)* (internal quotation marks and citation omitted).

The third prong also requires that the court consider "alternatives to the termination of parental rights." *N.J.S.A. 30:4C-15.1(a)(3).* Here, the court found that:

> [O]ne person was referenced by the parties as a resource relative, and that is [E.N.]. . . . [T]he testimony at the trial from [ ] Winnik indicates she spoke to [E.N.], the paternal grandfather, [*34] and the paternal aunt when they were redoing an interview for the . . . defendants and there's no indication that [E.N.] ever said that she wanted to do the full-time care for [Ivan].
>
> . . . .
>
> When [Ivan] was born he had to be placed and he had special needs, and those types of special needs required a lot of care and attention, thereby creating a set of circumstances where at least anecdotally this [c]ourt could . . . make the observation that attachment would certainly begin very soon and it would become a deep attachment because of [Ivan's] needs to be nurtured, administered to, not only on a daily basis but virtually on an hourly basis.

> It was up to [E.N.] to come forward at that time . . . to become involved with [Ivan], to visit regularly, but more importantly to take custody and placement of [Ivan].
>
> To wait [twenty-one] months after Ivan had bonded so significantly [with the foster parents] amounts almost to an abandonment of [Ivan]. It was . . . a delay that was based not on the needs of [Ivan] but was a delay based on the needs of [E.N.]. She was the one that had the issue. She didn't want to stay at home.
>
> . . . [E.N.] has the greatest of intentions but she was not able to do it [*35] because of her . . . personal circumstances.

We do not share the trial court's characterization of E.N.'s circumstances as tantamount to an abandonment of Ivan. To the contrary, E.N. appears to have exhibited a genuine desire to keep the three children together, as evidenced by the visits between Ivan, Alyssa, and Amy, which E.N. coordinated with Ivan's foster family.

However, we do find ample support in the record to conclude that E.N., while certainly well-intentioned, until the time of trial never committed to assuming Ivan's care. Winnik testified that when this case was transferred to her in November 2010, she discussed Ivan's possible placement with E.N. E.N. indicated that she felt she was unable to meet Ivan's needs at that time. Winnik then paid monthly visits to E.N. in connection with E.N.'s custody of Alyssa and Amy. During these visits, Winnik continued to discuss Ivan's care with E.N. While E.N. indicated that she would love to care for Ivan, E.N. told Winnik "on several occasions that she was not able to care for [Ivan] because she worked full[-]time and needed to continue working full[-]time."

E.N. similarly testified at trial that if Ivan's fragile medical state prevented [*36] him from attending daycare, she would be unable to care for Ivan because she was working, and not due to any lack of care or concern. E.N. further testified:

> Q. When did you indicate to the Division that if [Ivan] could not go to daycare you couldn't care for him?
>
> A. From day one.
>
> Q. Is that still your position?
>
> A. Yes it is.

It was further undisputed that it was only on the eve of trial that E.N. told Winnik that "she was now prepared to fight for [Ivan]," and that her adult daughter, D.G., would stay home and care for him. By that time, Ivan had bonded with his foster family. According to Dr. Kanen's unrefuted expert testimony, Ivan's removal from his foster family would then be devastating to him. This harm would not be ameliorated even if Ivan was removed and placed with "someone that was as committed as the foster parents."

The Division has a statutory obligation to contact relatives of a child in its custody. *N.J. Div. of Youth & Family Servs. v. K.L.W., 419 N.J. Super. 568, 577, 18 A.3d 193 (App. Div. 2011). N.J.S.A. 30:4C-12.1* provides:

> a. In any case in which the Department of Children and Families accepts a child in its care or custody, including placement, the department *shall initiate a search* [*37] *for relatives who may be willing and able to provide the care and support required by the child.* The search shall be initiated within 30 days of the department's acceptance of the child in its care or custody. The search will be completed when all sources contacted have either responded to the inquiry or failed

to respond within 45 days. The department shall complete an assessment of each interested relative's ability to provide the care and support, including placement, required by the child.

b. If the department determines that the relative is unwilling or unable to assume the care of the child, the department shall not be required to re-evaluate the relative. The department shall inform the relative in writing of:

(1) the reasons for the department's determination;

(2) the responsibility of the relative to inform the department if there is a change in the circumstances upon which the determination was made;

(3) the possibility that termination of parental rights may occur if the child remains in resource family care for more than six months; and

(4) the right to seek review by the department of such determination.

c. The department may decide to pursue the termination of parental rights [*38] if the department determines that termination of parental rights is in the child's best interests.

[(Emphasis added).]

In *K.L.W., supra, 419 N.J. Super. at 577-81*, we found that the Division failed to meet its statutory obligation to identify and assess capable relatives. Accordingly, we remanded the case to the trial court to reconsider placement with the child's maternal grandparents, in lieu of termination. *Id. at 583*. Defendants urge us to reach that same result here. We decline to do so, however, as we conclude that, when contacted, E.N. advised the Division, both initially and thereafter, that she was unable to assume Ivan's care. Accordingly, the Division was not required to further re-evaluate E.N. *N.J.S.A. 30:4C-12.1(b)*.[9]

9 The Division did not inform E.N. in writing of its determination. The Division's counsel concedes that it should have done so. Nonetheless, even if the Division's failure to provide E.N. with such written notice violated *N.J.S.A. 30:4C-12.1(b)*, "delay of permanency or reversal of termination based on the Division's noncompliance with its statutory obligations is warranted only when it is in the best interests of the child." *K.L.W., supra, 419 N.J. Super. at 581*.

D.

Pursuant [*39] to the fourth prong, the Division must show that the "termination of parental rights will not do more harm than good to the child." *K.H.O., supra, 161 N.J. at 354-55*. This prong "'serves as a fail-safe against termination even where the remaining standards have been met.'" *N.J. Div. of Youth & Family Servs. v. E.P., 196 N.J. 88, 108 (2008)* (quoting *N.J. Div. of Youth & Family Servs. v. G.L., 191 N.J. 596, 609 (2007))*. The Supreme Court has stated that "[t]he question ultimately is not whether a biological mother or father is a worthy parent, but whether a child's interest will best be served by completely terminating the child's relationship with the parent." *E.P., supra, 196 N.J. at 108*.

Dr. Kanen's undisputed expert testimony was that no bond existed between Ivan and S.J. or I.G. Ivan "has been out of their care since birth. The child . . . does not see them as parental figures in any way. They're pretty much strangers to him."

With respect to the bond which existed between Ivan and his foster parents, Dr. Kanen testified:

Q. And after your evaluation of them together, what was your opinion as to whether a bond exists between [Ivan] and his foster parents?

A. My opinion was that he's [*40] attached and bonded to them. They've cared for [Ivan] since he was released from the hospital, so it was from the time he was approximately six weeks old. He perceives them as his parents. He perceives them as the people who meet his needs and care for him every day of the week. And they're very committed to him and very knowledgeable and very capable of providing him with a permanent, safe, and secure home.

Q. And what effect, if any, do you think there would be on [Ivan] if he were to be removed from their care?

A. Well, you would be removing a child from the only parents he's known, so it . . . would be devastating to him. You would probably see regressions in the gains that he had made. It's likely to be very difficult [] to find somebody who is that committed in terms of multiple therapies and following through on those therapies at the home, which is what the foster mother does. So my view is he would suffer serious harm if removed from them.

Q. And given that he's, you know, approximately 18 months old, what, if any, effect does his age play on the effect that the . . . that removal would have on him?

A. Well, he's old enough to definitely know that they are the primary caretakers, [*41] so it would be . . . he already has, you know, developmental delays suggesting, you know, nervous system based delays. He's . . . this would be a shock to him.

Q. By contrast, what . . . what effect, if any, do you think it would have on [Ivan] if his . . . if he was not to have contact with his biological parents anymore?

A. I don't think it would have any effect on him.

Q. Dr. Kanen, in your expert opinion what is in the best interest of [Ivan] going forward?

A. To stay with the foster parents.

We acknowledge E.N.'s continued wish to keep Ivan, Alyssa, and Amy intact, and the last-minute expression of her willingness and recently-gained alleged capacity to assume Ivan's care. We are further mindful that the Supreme Court has observed that the "we cannot underestimate the value of nurturing and sustaining sibling relationships." *N.J. Div. of Youth and Family Servs. v. S.S., 187 N.J. 556, 561 (2006)* (also discussing the Division's policy and statutes recognizing sibling relationships). However, even if E.N. is as committed to Ivan's care as are Ivan's foster parents, the unrefuted evidence is that Ivan's best interests are served by remaining with his foster parents, under whose substantial [*42] and continuous care he has undeniably prospered, and that Ivan would be harmed should he be removed from their care.

Affirmed.

NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES,[1] Plaintiff-Respondent, v. M.K., Defendant-Appellant, and N.S., Defendant. IN THE MATTER OF M.S., a minor.

1 On June 29, 2012, the Governor signed into law A-3101, which reorganizes the Department of Children and Families, which includes the renaming of the Division as the Division of Child Protection and Permanency.*L.* 2012,*c.* 16, eff. June 29, 2012.

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SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

2013 N.J. Super. Unpub. LEXIS 76

October 31, 2012, Submitted January 14, 2013, Decided

NOTICE: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY *RULE 1:36-3* FOR CITATION OF UNPUBLISHED OPINIONS.

PRIOR HISTORY: [*1] On appeal from Superior Court of New Jersey, Chancery Division, Family Part, Burlington County, Docket No. FN-03-86-11.

COUNSEL: Joseph E. Krakora, Public Defender, attorney for appellant (Robert McGuigan, Designated Counsel, on the brief).

Jeffrey S. Chiesa, Attorney General, attorney for respondent (Lewis A. Scheindlin, Assistant Attorney General, of counsel; Vanessa G. Cardwell, Deputy Attorney General, on the brief).

Joseph E. Krakora, Public Defender, Law Guardian, attorney for minor-respondent (Olivia Belfatto Crisp, Assistant Deputy Public Defender, on the brief).

JUDGES: Before Judges Grall and Accurso.

OPINION

PER CURIAMFollowing a fact-finding hearing, defendant M.K. appeals from an order of the Family Part finding that she abused and neglected her new-born daughter Mattie[2] in violation of *N.J.S.A. 9:6-8.21*. Because we agree that Mattie's medical records, admitted without objection, and defendant's admissions of illicit drug use throughout her pregnancy provided substantial credible evidence to support the trial judge's finding of abuse and neglect, we affirm.

2 This name is fictitious.

On September 28, 2011, the Division of Youth and Family Services (Division) received a child protective services referral [*2] from Virtua Memorial Hospital reporting that defendant, twenty-five years old, had given birth to her first child, Mattie, and that both mother and daughter had tested positive for opiates. Mattie's meconium also revealed the presence of buprenorphine, a prescription medication sold under the brand name of Subutex or Suboxone (when combined with naloxone), to relieve the symptoms of opiate withdrawal.A Division caseworker was dispatched

to interview defendant, who admitted using Vicodin, Subutex, and Percocet throughout her pregnancy. Defendant explained to the caseworker that she had been prescribed Percocet for pain related to kidney stones and Vicodin for tooth pain and that she had used both medications for the first five months of her pregnancy, after which she stopped. She began to have severe back pain when she was six and a half months pregnant, however, and again started taking Vicodin and Percocet, which she acquired from friends. Defendant admitted to taking two Suboxone tablets two weeks before Mattie was born and two Percocet three days before Mattie's birth. In response to the caseworker's inquiry regarding the needle tracks on defendant's arms, defendant also acknowledged [*3] a history of intravenous heroin use prior to learning of her pregnancy. Defendant also told the caseworker that she "did Roxys" four times during her pregnancy, most recently a month before, explaining that she would crush Roxicet (oxycodone and acetaminophen) tablets, mix it with water, and inject it into her arms. The caseworker was subsequently advised by a nurse in the hospital's special care nursery that Mattie had been started on phenobarbine morphine for withdrawal symptoms the day she was born.The Division filed a verified complaint for custody of Mattie a week later, while the baby was still undergoing treatment at the hospital.[3] Upon Mattie's release from the hospital, fourteen days after her birth, she was placed with defendant's parents, and defendant began drug treatment.

3 Mattie's father, N.S., twenty-six years old, was also named as a defendant in the complaint. He died from undisclosed causes prior to the fact-finding hearing and was dismissed from the litigation.

At the fact-finding hearing four months later, defendant stipulated to the admissions she made regarding her drug use during her pregnancy and did not object to the admission into evidence of the Division's [*4] two screening summaries, the Division's investigation report, and four pages of Mattie's medical record certified by the record custodian for Virtua Memorial Hospital. The Division presented the only witness to testify, the caseworker responsible for the file, who had not been the caseworker who responded to the hospital and conducted the initial investigation that led to the filing of the complaint.The caseworker testified very briefly about the contents of the Division's investigation report. When she began to recount the statements of hospital personnel regarding Mattie's symptoms and treatment, counsel for defendant objected on hearsay grounds. After briefly arguing the issue, counsel for the Division agreed to rely on the certified medical record and move on. A few moments later, the issue arose again when the caseworker was asked to review Mattie's medical record and relate the condition for which medication had been prescribed. Defense counsel objected to the caseworker testifying to the reasons certain medications had been prescribed. The deputy renewed her argument that defendant had consented to the admission of the medical record. Defense counsel reiterated that he had no [*5] objection to the admission of the medical record and acknowledged that the record reflected that Mattie had been prescribed certain drugs, but objected to the caseworker repeating why those medications had been prescribed. The court instructed the deputy to direct the witness to specific sections of the medical record, "which [defense counsel] doesn't object to, and rely upon that." The deputy did so and the testimony was quickly concluded.Relying on the evidence in the record, Judge Philip Haines found "that [Mattie] tested positive for opiates at birth, that [defendant] admitted to taking Vicodin, Percocet, and Subutex during her pregnancy, that both [defendant] and [Mattie] . . . tested positive for opiates, and [Mattie had also] tested positive for Subutex." Referring specifically to Mattie's medical record in evidence, the judge found that Mattie had been diagnosed with Neonatal Abstinence Syndrome, that she showed signs of withdrawal, and that she was prescribed phenobarbital and morphine. Finding "an easy inference" that the morphine and phenobarbital were connected to Mattie's symptoms of withdrawal, the judge concluded that the Division had proved abuse and neglect by a preponderance [*6] of the evidence in accordance with *In re Guardianship of K.H.O., 161 N.J. 337, 349, 736 A.2d 1246 (1999)*.After

the fact-finding hearing, defendant continued in drug treatment. She regained legal and physical custody of Mattie in October 2011, following a disposition hearing terminating the litigation. This appeal followed.On appeal, defendant renews her argument to the trial court that Mattie's medical record lacked substantial detail necessary to support a finding of abuse and neglect and that an expert witness was required to explain its meaning. We disagree.Our review of the trial court's factual findings in a Title 9 abuse and neglect proceeding is limited to determining whether those findings are supported by adequate, substantial, and credible evidence in the record. *N.J. Div. of Youth & Family Servs. v. Z.P.R., 351 N.J. Super. 427, 433, 798 A.2d 673 (App. Div. 2002)*. If the findings have such support in the record, we are bound by them in deciding the appeal. *Rova Farms Resort, Inc. v. Investors Ins. Co. of Am., 65 N.J. 474, 484, 323 A.2d 495 (1974)*.Here, Mattie's medical record, on which Judge Haines relied in making his factual findings, reveals meconium stained fluid as a complication attending her otherwise normal [*7] delivery. The record states that the meconium screen was positive for opiates and buprenorphine and that Mattie was moved to the special care nursery for further management. Defendant is noted as testing positive for opiates as well. The record further notes under the heading of physical exam, "[n]eurological: [i]ncreased tone, tremor." In the clinical summary, Mattie's diagnosis is listed as "Neonatal Abstin[e]nce Syndrome ([c]onfirmed)," procedures performed include "Abstin[e]nce Scoring (14 days)," and medications include "[p]henobarbital (8 days)" and "[m]orphine (12 days)." Mattie's physical exam upon discharge notes, "[n]eurological: [n]ormal tone and reflexes for gestational age."A review of Mattie's medical record leaves no doubt that Judge Haines' factual findings that Mattie was born testing positive for opiates and showing signs of withdrawal upon which she was diagnosed as suffering from Neonatal Abstinence Syndrome and prescribed phenobarbital and morphine to treat her withdrawal symptoms are supported by substantial, credible evidence, and are thus binding on appeal.We are likewise not persuaded that the court erred in admitting Mattie's medical record in the absence [*8] of an expert to interpret it for the court. Because defense counsel repeatedly advised the trial judge that defendant had no objection to the Division's admission of Mattie's certified medical record, we review this claim under the doctrine of invited error. *N.J. Div. of Youth & Family Servs. v. M.C. III, 201 N.J. 328, 340-42, 990 A.2d 1097 (2010)* (holding that where defense counsel makes strategic decision to try the case on the Division's documents instead of facing witness's direct testimony, reviewing court will not reverse in the absence of fundamental injustice).Mattie's medical record was admissible under *N.J.R.E. 803(c)(6)* as a business record of the hospital, and admissible specifically under *N.J.S.A. 9:6-8.46(a)(3)* governing evidence in abuse and neglect proceedings. As in *M.C. III*, defendant's consent to the admission of the medical record deprived the Division of the opportunity to overcome any objection that might have been sustained by presenting a qualified witness in place of the document. *M.C. III, supra, 201 N.J. at 341*. Accordingly, defendant is barred by the doctrine of invited error from now contesting the admission of Mattie's certified medical record in the absence of expert [*9] testimony to interpret it. Further, we are well satisfied that the hospital record here was sufficiently clear and unequivocal in stating that Mattie was born testing positive for opiates and buprenorphine and suffering from withdrawal symptoms for which she was prescribed phenobarbital and morphine, that no interpretation by an expert witness was necessary.The Supreme Court in *K.H.O.* held that "a child born addicted to drugs and suffering from the symptoms of drug withdrawal as a result of her mother's substance abuse during pregnancy has been harmed by her mother and that harm endangers the child's health and development." *K.H.O., supra, 161 N.J. at 349*. Based on the evidence in the record, we are satisfied that Judge Haines correctly found that defendant committed an act of abuse by exposing Mattie to opiates and buprenorphine, causing her to suffer withdrawal symptoms at birth that impaired her physical well-being.Affirmed.

NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES, Plaintiff-Respondent, v. B.K., Defendant-Appellant. IN THE MATTER OF THE GUARDIANSHIP OF A.K., a minor.

DOCKET NO. A-3089-09T2

SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

2010 N.J. Super. Unpub. LEXIS 3083

November 3, 2010, Submitted December 23, 2010, Decided

NOTICE: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY *RULE 1:36-3* FOR CITATION OF UNPUBLISHED OPINIONS.

PRIOR HISTORY: [*1] On appeal from Superior Court of New Jersey, Chancery Division, Family Part Essex County, No. FG-07-60-09.

COUNSEL: Yvonne Smith Segars, Public Defender, attorney for appellant (Mark Tabakman, Designated Counsel, of counsel and on the brief).

Paula T. Dow, Attorney General, attorney for respondent (Andrea M. Silkowitz, Assistant Attorney General, of counsel; Wilbur Van Houten, Deputy Attorney General, on the brief).

Yvonne Smith Segars, Public Defender, Law Guardian, attorney for minor respondent A.K. (Christopher A. Huling, Assistant Deputy Public Defender, on the brief).

JUDGES: Before Judges Wefing, Payne and Baxter.

OPINION

PER CURIAMB.K. appeals from a trial court judgment terminating her parental rights to her daughter A.K., now four years of age. After reviewing the record presented on appeal, we affirm.B.K. has five other children; none are in her care. Her parental rights to two of her children have been terminated. She pled guilty to aggravated assault and endangering the welfare of a child after having shaken one of these children when he was only months old because he would not stop crying. She shares legal custody of three of her children with her mother, but the children reside with their grandmother, [*2] not with B.K. They range in age from eighteen to sixteen years old; the oldest has two young children of her own.B.K. has a long-standing problem with substance abuse. At least three of her older children tested positive for narcotics at birth. When A.K. was born in September 2006, she tested positive for cocaine and methadone and experienced withdrawal symptoms. She was also tested positive for exposure to Hepatitis C, which she had contracted from B.K. A.K. was classified as "medically fragile" and remained in the hospital for more than a month after her birth. The New Jersey Division of Youth and Family Services ("DYFS") was granted custody of A.K. when she was discharged from the hospital.DYFS's initial goal with respect to A.K. was to place her with a family member while B.K. obtained treatment for her drug problems. To this end, it arranged for B.K. to receive a drug evaluation, drug treatment, a psychological evaluation and supervised bi-weekly visits with A.K. She missed a great many of her visitations, however. The case worker who testified at trial had

been in charge of the matter for more than a year; she said that in that time B.K. visited with A.K. approximately ten times. [*3] B.K. also regularly failed to attend appointments that had been scheduled for drug evaluation. DYFS assessed her level of cooperation as "poor."In August 2007, when A.K. was nearly one year old, B.K. had a psychological evaluation performed by Albert R. Griffith, Ed.D. She told Dr. Griffith that she had remained drug free for six months, but she had made no plans for A.K.'s care. Approximately six weeks later, B.K. tested positive for cocaine, heroin and benzodiazepines.Three months after B.K.'s psychological evaluation, DYFS arranged for a psychological evaluation of her mother, to evaluate whether she was a suitable care giver for the infant A.K. This evaluation was performed by Mark Singer, Ed.D. The results of this evaluation showed that she was illiterate, had an IQ substantially below average, was emotionally immature and had "difficulty dealing with ambiguity." Dr. Singer testified that B.K.'s mother tended to "see the world in black and white . . . . it's all good or all bad." In Dr. Singer's opinion, while she could care for older children, "she would have significant difficulty caring independently for a young child with special needs."In January 2008, DYFS notified B.K.'s [*4] mother that it had eliminated her as a potential caregiver for A.K. It cited the results of the recent psychological evaluation, its concern that she would not restrict B.K. from having access to A.K. and the fact that her age (65 at the time), combined with her responsibilities for the older children, would make caring for a child such as A.K. even more difficult.B.K. continued to miss appointments for a drug abuse evaluation. In July 2008, she attended a court hearing and was tested for narcotics. The results were positive for cocaine and methamphetamine. As a result, the trial court entered an order exempting DYFS from making further efforts to reunite B.K. with her daughter, A.K., who by then was nearly two years old. In September 2008, DYFS filed a complaint seeking to terminate B.K.'s parental rights with respect to A.K.Dr. Griffith performed another psychological evaluation of B.K. in December 2008. At that point she told him she had been drug-free for two months. Dr. Griffith concluded that in light of her minimal progress in overcoming her substance abuse and her repeated relapses, the prognosis for reunification between B.K. and A.K. was poor. Dr. Griffith also conducted [*5] a bonding evaluation between B.K. and A.K. He reported that A.K. saw B.K. as a familiar face but did not look to her for nurturance, security or protection. He noted that A.K. easily separated from her in contrast to the anxiety she initially displayed when her foster mother left the room. In Dr. Griffith's opinion, A.K. would not suffer irreparable harm if B.K.'s parental rights were terminated.In January 2009, DYFS found it necessary to transfer A.K. to another foster family because the family with whom she had been residing had inadequate housing. A.K. has remained with this foster family, and they are committed to her adoption. This is her third placement. In April 2009, Dr. Griffith conducted a bonding evaluation between A.K. and this foster family. He found her to be "emotionally attached" to them and that her foster parents "appear[ed] to provide a loving and supportive home" for her. He noted that A.K. was "less resilient" than other children in light of her developmental delays and was at risk of being damaged by an attempted reunification that ultimately failed.Also in April 2009, Dr. Singer conducted another evaluation of B.K.'s mother to determine again whether she was [*6] a viable candidate to care for A.K. He again noted her limitations as well as the fact that she admitted to him that she permitted B.K. to have unsupervised visits with the older children despite her knowledge of B.K.'s drug abuse.A number of other evaluations were performed prior to the trial of this matter. On May 16, 2009, Gerard A. Figurelli, Ph.D., examined B.K.'s mother at the request of B.K.'s attorney. His report noted that she was then 67 years old and was caring for B.K.'s three children as well as the two young great grandchildren in her three-bedroom apartment. He noted that despite her limitations, she was able to function independently. Dr. Figurelli concluded that B.K.'s mother "possesses the capacity to act adequately in a parenting role," but should "participate in parenting skills or education" to help her parent a child such as A.K.In July 2009, Dr. Figurelli also performed a bonding evaluation of A.K. with her grandmother, who brought her great-grandchild with her, and he observed that A.K. ran after the two of them when they left the room. He concluded that A.K. had

a "significant positive emotional attachment" with her grandmother and that there is a "basis for [*7] the development of a full reciprocally bonded relationship" between them but that it had not yet been developed.A few days later, Dr. Figurelli assessed the bond between A.K. and her foster parents. He noted that A.K. consistently referred to her foster mother as "Mommy," was much more verbal with them than she was with her grandmother, and that she appeared to be thriving in their care. Dr. Figurelli concluded that A.K. was developing a "positive emotional attachment" to her foster parents and that the basis for a full reciprocally bonded relationship was there but had not yet been developed since A.K. had only been with them for seven months. In his opinion, A.K. could "be removed from the care of her foster parents and placed with [her grandmother] without experiencing harm that is severe or enduring in nature." He stated further that, if ties to her biological family were severed, A.K. would experience severe "psychological harm" later on in life.In September 2009, Dr. Singer conducted a bonding evaluation of A.K. with her grandmother. He observed that three-year-old A.K. did not speak or babble at all in her grandmother's presence and that being comfortable enough to speak indicates [*8] attachment. He also noted that, when he asked the grandmother to leave the room to test how A.K. would detach from her, she repeatedly called A.K. to come to her. When A.K. did not come and, instead, moved closer to Dr. Singer, the grandmother said: "I'm going to leave you. You didn't come to me." Thereafter, the grandmother appeared to feel rejected by A.K. and did not engage or speak to the child for the rest of the session. Thus, Dr. Singer concluded that a secure, mutual attachment had not been developed between A.K. and her grandmother.Later, Dr. Griffith conducted a third updated psychological evaluation of B.K. He noted that B.K. remained "immature, impulsive and relatively self-centered." B.K. appeared unaware of A.K.'s speech delay. However, Dr. Griffith did note that, according to B.K., she had made some progress in addressing her drug abuse by attending Narcotics Anonymous and outpatient therapy. Although B.K. made a "grandiose statement of desire to get custody of all her children," he noted this was not supported by her efforts; she had not made any realistic plan to care for A.K. other than leaving her with B.K.'s mother, who was already caring for five children. Accordingly, [*9] his conclusion about B.K.'s inability to parent A.K. remained the same.Dr. Griffith also performed a second bonding evaluation of B.K. with A.K. He noted B.K.'s lack of recognition of A.K.'s speech impairment and the fact that A.K. was too uncomfortable to speak around B.K., as she did with her foster mother. Dr. Griffith concluded:

> She has some attachment to [B.K.]. It is not a significant bonding. She separates easily, is a passive participant with [B.K.] and does not appear to look to her for protection. Given any change a child with limited resiliency must be seen as being placed at risk. This mother has still not demonstrated stability after 2 years. Her case for reunification appears to rest more on hope than reality. The risk of harm from adoption by the [foster parents] appears less than the risk of harm from a failed placement with [B.K.].

That same day, Dr. Griffith also assessed the bond between A.K. and her foster mother. He noted that A.K. repeatedly addressed her as "Mommy" and that the foster mother had been diligent in arranging for A.K. to receive the speech therapy that she required. Dr. Griffith determined that A.K. was developing a growing attachment to her foster [*10] mother and was building some security in their home. He concluded:

> [A.K.] has already been transferred from one home. If she has to go to a home and that placement fails, her loss will then become very substantial.
>
> [A.K.] has made progress in her present home. [B.K.] is still not ready for custody and there is reason to doubt that she will become ready in the immediate future. Given that circumstance, it would be better to terminate custody and let the child be adopted by the

[foster parents]. It is unlikely that [A.K.] will suffer any loss if she no longer sees [B.K.] since she has played such a tangential role in her life.

Drs. Griffith, Singer and Figurelli all testified at trial, setting forth the conclusions they had each reached in their earlier reports, and the reasons they had for reaching those conclusions. Dr. Griffith, who had conducted bonding evaluations of A.K. with B.K. and with her foster parents, testified that in his opinion A.K. would suffer irreparable harm if she were separated from her current foster placement and, further, would suffer no harm if B.K.'s parental rights were terminated.B.K. and her mother both testified as well. B.K. recognized that she was unable [*11] to care for A.K. but said she wished the child to be with her mother because she knew her mother would "raise my daughter right," and she wanted to be able to continue to see the girl. B.K.'s mother testified that she considered herself able to raise A.K. She noted that she was able to give the older children their asthma medications when they needed them. She said the fact that there were already six people living in her three-bedroom apartment ranging in age from eighteen years to nine months was not a problem; she said she would get a folding bed for A.K. and put it in her room. She was not aware that A.K. had any delays in her development and minimized B.K.'s substance abuse problem, saying she only had a problem with "little drugs." After the conclusion of the trial, the trial court placed its decision on the record, concluding that B.K.'s parental rights to A.K. should be terminated.On appeal, B.K. raises the following contentions.

POINT I

THE TRIAL COURT ERRED IN RULING THAT DEFENDANT'S PARENTAL RIGHTS SHOULD BE TERMINATED AS THE STATE FAILED TO PROVE, BEYOND THE REQUIRED CLEAR AND CONVINCING EVIDENCE, THAT TERMINATION OF THE PARENTAL RIGHTS WAS APPROPRIATE.A. The Child's Health [*12] and Development Was Not Endangered By The Parental Relationship.B. The Defendant Was Able and Willing To Eliminate The Harm Facing The Child And Was Able And Willing To Provide A Safe And Stable Home For The Child.C. The Division Did Not Make Reasonable Efforts To Provide Services To Correct The Circumstances Which Led To The Child's Placement Outside The Home.D. Termination of Parental Rights Will Do More Harm Than Good

We first note the legal principles that govern our consideration of these arguments."[P]arents have a constitutionally-protected, fundamental liberty interest in raising their biological children, even if those children have been placed in foster care." *N.J. Div. of Youth & Family Servs. v. I.S., 202 N.J. 145, 166, 996 A.2d 986 (2010)* (quoting *In re Guardianship of J.C., 129 N.J. 1, 9, 608 A.2d 1312 (1992))*. In view of that, the law "clearly favors keeping children with their natural parents and resolving care and custody problems within the family." *Id. at 165* (citation omitted).However, parental rights are not absolute; the State also has a "*parens patrie* responsibility to protect the welfare of children" in situations where the child's parent is unfit or the child has been neglected or harmed. [*13] *Id. at 166* (citation omitted); *see also In re Guardianship of K.H.O., 161 N.J. 337, 347, 736 A.2d 1246 (1999)*. Accordingly, the State may petition to terminate parental rights on the grounds that it is in the "best interests of the child" to do so. To prevail on its claim, the State must establish, by clear and convincing evidence, four statutory factors:

(1) The child's safety, health, or development has been or will continue to be endangered by the parental relationship;

(2) The parent is unwilling or unable to eliminate the harm facing the child or is unable or unwilling to provide a safe and stable home for the child and the delay of permanent

placement will add to the harm. Such harm may include evidence that separating the child from his resource family parents would cause serious and enduring emotional or psychological harm to the child;(3) The division has made reasonable efforts to provide services to help the parent correct the circumstances which led to the child's placement outside the home and the court has considered alternatives to termination of parental rights; and(4) Termination of parental rights will not do more harm than good.[*N.J.S.A. 30:4C-15.1(a).*]

The four prongs of the best [*14] interests standard "are not discrete and separate, but relate to and overlap with one another to provide a comprehensive standard that identifies a child's best interests." *I.S., supra, 202 N.J. at 167* (citations omitted). When the child's biological parents resist termination of their parental rights, the "cornerstone of the inquiry" is not whether they are fit, but whether they "can cease causing their child harm." *Ibid.* (quoting *In re J.C., supra, 129 N.J. at 10*). DYFS has the burden to prove "that the natural parent has not cured the initial cause of harm and will continue to cause serious and lasting harm to the child." *In re J.C., supra, 129 N.J. at 10* (citation omitted).Given a parent's constitutional right to raise his or her own child, the burden of proof required before that right can be terminated is high -- DYFS must prove each of the four prongs by "clear and convincing evidence." *I.S., supra, 202 N.J. at 168* (citing *N.J. Div. of Youth & Family Servs. v. A.W., 103 N.J. 591, 612, 512 A.2d 438 (1986)).* The burden of proving a case by clear and convincing evidence is an intermediate one, that is, proof greater than by the preponderance of the evidence and yet not proof beyond a reasonable [*15] doubt. "The clear and convincing standard 'should produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established.'" *Liberty Mut. Ins. Co. v. Land, 186 N.J. 163, 169, 892 A.2d 1240 (2006)* (quoting *Aiello v. Knoll Golf Club, 64 N.J. Super. 156, 162, 165 A.2d 531 (App. Div. 1960)).* Here, the trial court determined, after a two-day trial, that DYFS had proven all four prongs by clear and convincing evidence.Appellate review of a trial court's decision to terminate parental rights is limited. *N.J. Div. of Youth & Family Servs. v. G.L., 191 N.J. 596, 605, 926 A.2d 320 (2007)* (citing *In re Guardianship of J.N.H., 172 N.J. 440, 472, 799 A.2d 518 (2002)).* In general, the trial court's findings will not be disturbed on appeal if they are supported by "substantial credible evidence in the record." *N.J. Div. of Youth & Family Servs. v. E.P., 196 N.J. 88, 104, 952 A.2d 436 (2008)* (citing *In re J.N.H., supra, 172 N.J. at 472*); *see also Cesare v. Cesare, 154 N.J. 394, 412, 713 A.2d 390 (1998).*Furthermore, the fact-finding of the Family Part is entitled to particular deference given their "special expertise in the field of domestic relations." *Cesare, supra, 154 N.J. at 413.* Deference is also especially appropriate "when [*16] the evidence is largely testimonial and involves questions of credibility," since the trial court had the opportunity to see and hear the witnesses testify firsthand. *Id. at 412* (quoting *In re Return of Weapons to J.W.D., 149 N.J. 108, 117, 693 A.2d 92 (1997)).*Guided by these principles, we are firmly satisfied that B.K.'s contentions lack merit and that the trial court's judgment should be affirmed. The record is replete with evidence that establishes the first prong, that A.K.'s safety, health or development was endangered by her relationship with B.K. *N.J.S.A. 30:4C-15.1(a)(1).* A.K. tested positive at her birth for cocaine and methadone and had to go through withdrawal. She also had Hepatitis C and was initially classified "medically fragile." In addition, she has various developmental delays.In *K.H.O.*, the New Jersey Supreme Court specifically held:

> [A] child born addicted to drugs and suffering from the symptoms of drug withdrawal as a result of her mother's substance abuse during pregnancy has been harmed by her mother and that harm endangers the child's health and development. That determination satisfies the first prong of the best interests standard.
>
> [*In re K.H.O., supra, 161 N.J. at 349.*]

Under [*17] the second prong, DYFS must show that B.K. is unwilling or unable to eliminate the harm that her drug abuse posed to A.K. *N.J.S.A. 30:4C-15.1(a)(2).* Alternatively, DYFS could also show that B.K. has failed to provide "a safe and stable home" for A.K. and that a "delay in permanent placement" will further harm the child. *Ibid.*

The New Jersey Supreme Court had held that this prong may be satisfied in several ways. For one, it may be met by:

> indications of parental dereliction and irresponsibility, such as the parent's continued or recurrent drug abuse, the inability to provide a stable and protective home, the withholding of parental attention and care, and the diversion of family resources in order to support a drug habit, with the resultant neglect and lack of nurture for the child.
>
> [*In re K.H.O., supra, 161 N.J. at 353.*]

It may also be met by showing that "the child will suffer substantially from a lack of stability and a permanent placement and from the disruption of her bond with foster parents." *Id. at 363.*Here, the trial court found that the second prong was met because:

> [B.K.] has been unable to care for her daughter or any of her children. During the pendency of this litigation, [*18] she was incarcerated on outstanding warrants. She continues to have starts and stops with drug abuse. Her visits have been inconsistent and interfere with her daughter's attempts to grow closer to her.
>
> The bonding evaluation suggests that there's a significant emotional attachment between [A.K.] and the foster parents. More specifically, [A.K.] and the foster mother. There's another child in the home with whom [A.K.] is developing a relationship. She has been in this home for approximately a year. Her attachment to her foster parents is such that she would be harmed if she were to be removed from their care.[A.K.] has been diagnosed with developmental delays. Further delaying a permanent placement with her foster parents may exacerbate the harm already suffered by this child who has had several placements.

Defendant argues that the trial judge erred in finding that the second prong was met because: (1) she gave too much weight to the evaluations of Dr. Singer and Dr. Griffith and not enough weight to Dr. Figurelli's evaluations; (2) B.K. had made some progress in addressing her drug abuse issue by attending a drug treatment program; and (3) B.K. had offered her mother's home as a safe [*19] and stable home for A.K.First, to the extent that defendant is disputing the weight that the trial judge accorded to various experts' testimony, deference ought to be granted to the trial judge's credibility determinations in this case. *N.J. Div. of Youth & Family Servs. v. M.M., 382 N.J. Super. 264, 271, 888 A.2d 512 (App. Div. 2006)* (citing *Cesare, supra, 154 N.J. at 411-13*). Quite simply, a trial court is in a better position than an appellate court to evaluate an expert witness' credibility, qualifications, and the weight to be accorded to his testimony. *N.J. Div. of Youth & Family Servs. v. F.M., 375 N.J. Super. 235, 259, 867 A.2d 499 (App. Div. 2005)* (citing *In re Guardianship of D.M.H., 161 N.J. 365, 382, 736 A.2d 1261 (1999)).*Second, the trial court did duly consider that B.K. had made some progress in addressing her drug abuse issue; however, her long history of relapse and the fact that she had relapsed and tested positive twice during the pendency of this litigation, gave the trial court and Dr. Griffith little hope that B.K. could remain drug-free for long. In *K.H.O.*, the Court was faced with a mother who had a similar history of "chronic, unresolved drug abuse" and who had likewise shown some progress in her rehabilitation. [*20] *In re K.H.O., supra, 161 N.J. at 353.* However, the Court found that her pattern of relapse and positive drug test in court gave "no indication that [she] will successfully

rehabilitate herself sufficiently to care for her daughter." *Ibid.* Considering this, along with the fact that waiting to permanently place the child until the mother could "assume a responsible parental role" would harm the child by disrupting her relationship with her foster parents, the Court found that the second prong was met. *Id. at 354.*Third, defendant also argues that the fact that she had offered her mother's home as a safe and stable home for A.K. should negate this prong. That argument misses the mark, however. It does not address whether B.K.'s parental rights should be terminated, the question before the trial court.Thus, there was substantial, credible evidence in the record from which the trial judge could have determined that the second prong was satisfied under both alternative routes contained in the statute: (1) B.K. was unable to overcome her drug addiction; and (2) B.K. failed to provide a "safe and stable home" for A.K. that would eliminate the harm that B.K. poses to A.K. and delaying permanent [*21] placement until the grandmother's home could be re-evaluated or B.K. recovers from her drug addiction would further harm A.K.Under the third prong, DYFS must show that: (1) it made "reasonable efforts" to provide B.K. with services to correct her drug abuse so that family reunification may be possible; and (2) that the court has considered alternatives to terminating B.K.'s parental rights. *N.J.S.A. 30:4C-15.1(a)(3).*As for the first part of that prong, "reasonable efforts" are defined by the statute to mean:

> [A]ttempts by an agency authorized by the division to assist the parents in remedying the circumstances and conditions that led to the placement of the child and in reinforcing the family structure, including, but not limited to:
>
> (1) consultation and cooperation with the parent in developing a plan for appropriate services;(2) providing services that have been agreed upon, to the family, in order to further the goal of family reunification;(3) informing the parent at appropriate intervals of the child's progress, development and health; and(4) facilitating appropriate visitation.[*N.J.S.A. 30:4C-15.1(c).*]

However, DYFS is not required to provide "reasonable efforts" aimed at family [*22] reunification if one of three statutory exceptions applies. *N.J.S.A. 30:4C-15.1(d).* One of those exceptions is where "[t]he rights of the parent to another of the parent's children have been involuntarily terminated." *N.J.S.A. 30:4C-11.3(c).*

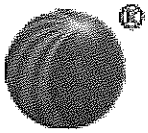
Here, the trial court noted that on July 18, 2008, DYFS was exempted from providing further reasonable efforts to reunite B.K. with A.K. when it was determined that *N.J.S.A. 30:4C-11.3(c)* applied. Despite that exemption, the trial court listed the various reasonable efforts that DYFS had made to reunite A.K. with her family, including consulting B.K. on an appropriate plan, offering B.K. services to remedy her drug addiction, arranging visitation with A.K. for B.K. and the grandmother, conducting psychological and bonding evaluations, and assessing potential relative resources for A.K.B.K. concedes that DYFS was exempted from the "reasonable efforts" part of the third prong. Instead, B.K. argues that the trial court erred in finding that the second part of the third prong was met because the court failed to consider alternatives to termination of parental rights. First, B.K. argues that, in this case, there was a "glaringly clear alternative -- [*23] placement with the maternal grandmother," but that DYFS denied her sufficient visitation to form a bond with A.K. In this regard, B.K. criticizes the trial court's failure to address "the inadequate nature" of the visitation her mother had with A.K. Second, she argues that the trial court also erred in failing to consider a Kinship Legal Guardianship ("KLG") arrangement as another alternative to termination of parental rights. We reject both contentions.Here, there was ample evidence from which the trial court could have concluded that DYFS both properly considered B.K.'s mother as a possible caregiver for A.K. and properly ruled her out based on a credible expert's opinion.DYFS arranged for B.K.'s mother to have visitation with A.K. For the first few years of A.K.'s life, the grandmother was allowed overnight weekend visits, but, in August 2008, visitation was reduced to bi-weekly supervised visits. Under DYFS' regulations,

visits may be made supervised if DYFS "finds a need for supervision." *N.J.A.C. 10:122D-1.10(b)*. In addition, visitation may be reduced if the visit will be harmful to the child. *N.J.A.C. 10:122D-1.15(a)*. Here, DYFS gave the following reasons for the reduction of [*24] the grandmother's visitation: (1) A.K. had developed thrush and an ear infection while in her grandmother's care; (2) A.K. had been left in the care of her eldest sibling, who was busy caring for her own child; (3) concerns about the grandmother's ability to care for a child with developmental delay; and (4) the lack of space for A.K. in her grandmother's already-crowded apartment.In addition, Dr. Singer and DYFS raised numerous other issues with regards to the unsuitability of A.K.'s grandmother as a caregiver: (1) that she has a "substantially below average" IQ, is illiterate, and cannot decipher the labels on prescription bottles, which would limit her ability to work with A.K.'s speech therapists, doctors, and teachers; (2) that she has "difficulty dealing with ambiguous situations" such that she would unable to independently care for a young child with special needs; (3) that she is currently 67 years old and caring for a now 4-year-old child would be increasingly difficult as she ages; and (4) that the grandmother would likely allow inappropriate contact between A.K. and B.K., since she has repeatedly left B.K. alone with her other children in the past. Thus, the trial court [*25] was well within her discretion in finding that DYFS had properly ruled out A.K.'s grandmother as a potential placement for A.K. based on valid reasons set forth by Dr. Singer's expert testimony.Further, since KLG is inappropriate when adoption is available, as it is here, the trial court was correct in not considering it as an alternative to termination of B.K.'s parental rights.When adoption of a child is "*neither likely nor feasible*," the Kinship Act provides for an "alternative, permanent legal arrangement" in the form of a court-ordered kinship legal guardianship. *N.J.S.A. 3B:12A-1* (emphasis added). The statute is expressly aimed at addressing the needs of grandparents and other relatives who provide long-term care for a child because the parents are unable to do so and who are unlikely or unwilling to seek termination of parental rights in order to adopt the child. *Ibid.* Thus, "when the permanency provided by adoption is available, kinship legal guardianship cannot be used as a defense to termination of parental rights under [the third prong]." *I.S., supra, 202 N.J. at 211* (quoting *N.J. Div. of Youth & Family Servs. v. P.P., 180 N.J. 494, 513, 852 A.2d 1093 (2004)).*Accordingly, in a termination [*26] of parental rights case in which the foster parents want to adopt the child, as is the situation here, KLG is not available and it cannot be argued that the trial court failed to consider KLG as an alternative to termination of parental rights. *I.S., supra, 202 N.J. at 211*; *P.P., supra, 180 N.J. at 512-13*. Here, A.K.'s foster parents expressed their desire to adopt A.K. B.K. also offered to terminate her parental rights so that her mother could adopt A.K. Thus, adoption was available, and KLG was not an appropriate alternative in this case.Under the fourth prong, DYFS must show that termination of B.K.'s parental rights would not do more harm to A.K. than good. *N.J.S.A. 30:4C-15.1(a)(4)*. Here, DYFS should offer "testimony of a 'well qualified expert who has had full opportunity to make a comprehensive, objective, and informed evaluation' of the child's relationship with both the natural parents and the foster parents." *N.J. Div. of Youth & Family Sers. v. M.M., 189 N.J. 261, 281 (2007)* (quoting *In re J.C., supra, 129 N.J. at 19*). Under this prong, the child's need for permanency is an important consideration. *Ibid.* (citing *In re K.H.O., supra, 161 N.J. at 357-58*). The fourth prong [*27] may be satisfied by a showing that the "bond with foster parents is strong and, in comparison, the bond with the natural parent is not as strong." *In re K.H.O., supra, 161 N.J. at 363*.In this case, the trial judge held that this prong was met because of A.K.'s need for permanency and because of the comparatively stronger bond she has with her foster parents:

> Keeping this child in limbo, hoping for some long term reunification plan would be a misapplication of the law. [*N.J. Div. of Youth & Family Servs. v. A.G., 344 N.J. Super. 418, 438, 782 A.2d 458 (App. Div. 2001).*]

> Were we waiting for the mother to demonstrate a renewed commitment to sobriety, or were we waiting to revisit the fitness of the maternal grandmother and, then, have to develop a transitional plan, whereby [A.K.] would could [sic] leave her foster parents and return to her grandmother, both are scenarios that are contraindicated . . . .Here, the Court finds that the disruption of a relationship with her foster parent would cause [A.K.] to suffer greater harm than from the termination of the ties with her natural parents, her natural grandmother and her natural siblings.

This finding is fully supported by the testimony of both Dr. Griffith [*28] and Dr. Singer. There was no error by the trial court in finding their testimony more persuasive than that offered by Dr. Figurelli.The judgment under review is affirmed.



DIVISION OF YOUTH AND FAMILY SERVICES, Plaintiff-Respondent, v. N.P., Defendant-Appellant, IN THE MATTER OF THE GUARDIANSHIP OF L.P.C., A Minor. DIVISION OF YOUTH AND FAMILY SERVICES, Plaintiff-Respondent, v. B.A.C., Defendant-Appellant, IN THE MATTER OF THE GUARDIANSHIP OF L.P.C., A Minor.

DOCKET NO. A-4839-07T4, A-4840-07T4

SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

2009 N.J. Super. Unpub. LEXIS 578

February 10, 2009, Submitted
March 25, 2009, Decided

NOTICE: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY RULE 1:36-3 FOR CITATION OF UNPUBLISHED OPINIONS.

SUBSEQUENT HISTORY: Certification denied by *New Jersey Div. of Youth & Family Servs. v. N.P. (In re L.P.C.), 199 N.J. 540, 973 A.2d 944, 2009 N.J. LEXIS 721 (N.J., June 1, 2009)* Certification denied by *New Jersey Div. of Youth & Family Servs. v. B.A.C. (In re L.P.C.), 199 N.J. 540, 973 A.2d 944, 2009 N.J. LEXIS 773 (N.J., June 1, 2009)*

PRIOR HISTORY: [*1]
On appeal from the Superior Court of New Jersey, Chancery Division, Family Part, Camden County, Docket No. FG-04-65-08.

COUNSEL: Yvonne Smith Segars, Public Defender, attorney for appellant N.P. (Beth Anne Hahn, Designated Counsel, on the brief).

Yvonne Smith Segars, Public Defender, attorney for appellant B.A.C. (Miles Lessem, Designated Counsel, on the brief).

Anne Milgram, Attorney General, attorney for respondent Division of Youth and Family Services (Lewis A. Scheindlin, Assistant Attorney General, of counsel; Lisa Godfrey, Deputy Attorney General, on the brief).

Yvonne Smith Segars, Public Defender, Law Guardian, attorney for minor L.P.C. (Lisa M. Black, Designated Counsel, on the brief).

JUDGES: Before Judges Winkelstein, Fuentes and Chambers.

OPINION

PER CURIAM

In this consolidated appeal, we review the judgment of the Family Part terminating the parental rights of defendants N.P. (father) and B.A.C. (mother) to their biological daughter, L.P.C. Defendants jointly argue that the Division of Youth and Family Services ("DYFS or the Division") failed to prove, by clear and convincing evidence, the four prongs of the statutory test for termination of parental rights in *N.J.S.A. 30:4C-15.1*. B.A.C. also specifically [*2] argues that the trial court improperly considered evidence concerning the circumstances surrounding the birth of her youngest child, a boy, who is not part of this termination action.

After carefully reviewing the record, and in light of prevailing legal standards, we affirm substantially for the reasons expressed by Judge Donaldson in her memorandum of opinion. Because the relevant facts are set out in detail in Judge Donaldson's written opinion, we incorporate them by reference here. In the interest of clarity, we will nonetheless briefly outline the most salient facts.

B.A.C. was born in 1973; she is currently thirty-five years old; N.P. was born in 1961, and was forty-seven years old when this appeal was filed. Defendants' oldest child L.P., a boy, was born prematurely in May 2003, and was declared clinically dead at birth. Both B.A.C. and the infant tested positive for cocaine and heroin at the time. The boy survived this ordeal with intensive medical intervention, and was immediately placed in the custody of the Division. The court terminated B.A.C.'s parental rights to this child on October 14, 2005. N.P. surrendered his parental rights to L.P. on November 10, 2005. The boy was [*3] thereafter adopted by a cousin of N.P.

L.P.C., the child involved in this termination action, was born on July 26, 2006. She was exposed to methadone and cocaine in utero, and was diagnosed as addicted to methadone at birth. Her addiction required immediate medical intervention to treat the symptoms of withdrawal. This included morphine injections every three hours. When this approach proved ineffectual, the treatment was supplemented with Phenobarbital. Like her older brother, L.P.C. was immediately placed in the custody of the Division, where she has remained to date.

The record at trial shows that both defendants are chronic substance abusers. Their decisions to have children while addicted to illicit drugs have caused their children, including L.P.C., serious harm. As Judge Donaldson found, L.P.C. is developmentally delayed, has exhibited symptoms of neurological deficits, and continues to be at risk for further complications. All of the child's medical problems are directly linked to defendants' addiction to illicit drugs.

Commencing with the birth of their first child, DFYS has given defendants multiple opportunities to address their substance abuse problem to no avail. Defendants' [*4] addiction has caused direct harm to L.P.C., and continues to pose a threat to her physical and emotional wellbeing.

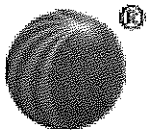
The standards governing our review of the trial court's opinion are well-settled. In reviewing a trial court's decision to terminate parental rights, we must determine whether the trial judge's findings of fact are supported by adequate, substantial, and credible evidence in the record. *N.J. Div. of Youth & Family Servs. v. G.L., 191 N.J. 596, 605, 926 A.2d 320 (2007)* (citing *In re Guardianship of J.T., 269 N.J. Super. 172, 188, 634 A.2d 1361 (App. Div. 1993))*. The review process is, of necessity, extremely fact sensitive, requiring that each particularized piece of evidence match up to the specific circumstance for which it is offered. *N.J. Div. of Youth & Family Servs. v. M.M., 189 N.J. 261, 280, 914 A.2d 1265 (2007)*.

To terminate parental rights, DYFS must demonstrate the following four statutory elements by clear and convincing evidence:

> (1) The child's safety, health or development has been or will continue to be endangered by the parental relationship;
>
> (2) The parent is unwilling or unable to eliminate the harm facing the child or is unable or unwilling to provide a safe and stable home for the child and the [*5] delay of permanent placement will add to the harm. Such harm may include evidence that separating the child from his resource family parents would cause serious and enduring emotional or psychological harm to the child;
>
> (3) The division has made reasonable efforts to provide services to help the parent correct the circumstances which led to the child's placement outside the home and the court has considered alternatives to termination of parental rights; and
>
> (4) Termination of parental rights will not do more harm than good.
>
> [*N.J.S.A. 30:4C-15.1(a)*; *DYFS v. M.M., supra, 189 N.J. at 280.*]

After carefully reviewing the record before us, and mindful of the legal standards described, we reject the arguments advanced by defendants, and affirm substantially for the reasons expressed by Judge Donaldson in her well-reasoned, comprehensive memorandum of opinion dated April 7, 2008.

Affirmed.



NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES, Plaintiff-Respondent, v. E.C., Defendant-Appellant. IN THE MATTER OF THE GUARDIANSHIP OF S.R., D.R. and J.M., Minors. NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES, Plaintiff-Respondent, v. R.M., Defendant-Appellant. IN THE MATTER OF THE GUARDIANSHIP OF J.M., Minor.

DOCKET NO. A-4219-06T4, A-6053-06T4

SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

2008 N.J. Super. Unpub. LEXIS 2783

April 8, 2008, Submitted
April 28, 2008, Decided

NOTICE: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY RULE 1:36-3 FOR CITATION OF UNPUBLISHED OPINIONS.

PRIOR HISTORY: [*1]
On appeal from Superior Court of New Jersey, Chancery Division, Family Part, Hudson County, FG-09-258-06.

COUNSEL: Yvonne Smith Segars, Public Defender, attorney for appellants, E.C. and R.M. (Anna F. Patras, Designated Counsel, of counsel and on the brief in A-4219-06T4; Carleen M. Steward, Designated Counsel, of counsel and on the brief in A-6053-06T4).

Anne Milgram, Attorney General, attorney for respondent (Andrea M. Silkowitz, Assistant Attorney General, of counsel and on the brief).

Yvonne Smith Segars, Public Defender, Law Guardian for minor, J.M. (Nancy E. Scott, Assistant Deputy Public Defender, on the brief).

JUDGES: Before Judges Fuentes and Grall.

OPINION

PER CURIAM

E.C. and R.M. both appeal from orders terminating their respective parental rights to their son J.M. On our own motion, we consolidated the appeals. Because the trial court's decision is "based on clear and convincing evidence supported by the record," we affirm. *N.J. Div. of Youth and Family Servs. v. P.P., 180 N.J. 494, 511, 852 A.2d 1093 (2004).*

E.C. and R.M. are the biological parents of J.M. E.C. also has two older children, D.R. and S.R. Although the Division of Youth and Family Services (DYFS) also sought termination of E.C.'s rights to D.R. and S.R., [*2] the trial court concluded that DYFS did not establish that termination was in the best interest of those children. [1]

1 In a brief submitted on behalf of DYFS on this appeal, we are advised that D.R. and S.R. were subsequently placed in the custody of their father.

According to E.C., she first tried heroin in 2004 after observing R.M. use the drug. Prior to that time, her drug of choice was alcohol, which she started using at age fourteen and abusing shortly thereafter. E.C. admits that she quickly became dependent on heroin. When R.M. and E.C. met, he was serving a sentence of probation imposed as a consequence of his conviction for possession of a controlled dangerous substance on two separate occasions, once in 1999 and once in 2003. In July 2004, E.C. enrolled in a methadone maintenance program.

J.M. was born in March 2005. He tested positive for amphetamines and methadone at birth. Neither E.C. nor R.M. could explain why E.C. tested positive for amphetamines. Because J.M. suffered from tremors due to withdrawal from methadone after his birth, he was not discharged from the hospital with his mother. DYFS was notified.

DYFS assigned a caseworker, who learned that E.C. had received prenatal [*3] care and participated in a methadone maintenance program at Kaleidoscope during her pregnancy. E.C. had not tested positive for substances other than methadone since she first attended the program in July 2004, and her counselor described her compliance with the program as "good."

The caseworker spoke to E.C.'s older children, D.R. and S.R., and found them to be happy and well nurtured. They were of age-appropriate weight and height and were both enrolled in school. They told the caseworker that E.C. always gave them breakfast and helped them get ready for school. When asked about punishment, they said they were sent to their rooms. D.R. also said, however, that his mother hit him with a belt once a long time ago. Both children denied ever seeing their mother giving herself a needle or taking any "powder."

The caseworker visited E.C.'s home, a three bedroom apartment. The apartment was "well kept"; sleeping arrangements were "appropriate"; there was "plenty" of food; and a crib, pampers and clothes had been readied for the arrival of a new baby.

In late March 2005, DYFS proposed a plan for the family, which E.C. and R.M. agreed to accept. The parents were to "live [*4] in a drug-free environment," accept homemaker assistance and undergo substance abuse evaluations. E.C. had a substance abuse evaluation, but R.M. did not. On April 1, 2005, E.C. presented a urine specimen for testing; the test showed alcohol at a rate of 91mg/dl. [2] On three subsequent occasions in April, E.C. was unable to provide a urine sample.

2 Although nothing in the record explains the significance of this reading with respect to legal standards for intoxication, DYFS asserted that E.C.'s test showed that the concentration was above the legal limit, presumably meaning the legal limit for driving. There is no adequate foundation for that assertion in the record.

In April 2005, DYFS received a report that D.R. had a bruise on his cheek, which the child had told the "caller" was caused by E.C.'s hitting him with a belt. The caseworker saw a scratch

on D.R.'s face, which he explained was caused by his plastic Spiderman glasses. The school nurse, who had seen D.R. a week before at the request of the "caller," told the caseworker that she had seen nothing but a "faint" red mark, which the child dismissed as "nothing." Upon examining D.R. and his sister S.R., the caseworker saw no other [*5] marks or bruises indicative of abuse. DYFS concluded that the allegation was unfounded.

By complaint filed on April 27, 2005, DYFS sought and was granted custody, care and supervision of E.C.'s three children. D.R. and S.R. were placed with a relative with whom they remained throughout this proceeding. J.M., who had been designated as "medically fragile," was placed with Hudson Cradle. In November 2005, when J.M. was no longer deemed "medically fragile," he was placed in the care of E.C.'s mother, H.R. In August 2006, after his maternal grandmother was diagnosed with and given surgical and chemical treatment for cancer, J.M. was removed from H.R.'s home and placed in a foster home where he has remained. According to the caseworker, the foster parent is "very much interested" in adopting J.M., and he is "very lovable towards" his foster parent and appears to be unhappy when separated from the home for visitations.

After E.C.'s children were removed from her custody, E.C. did not take prompt action to address her addiction. On May 23, 2005, she told the court that she had used cocaine on May 4 and 21, 2005. The court entered an order directing E.C. to enter a detoxification program. E.C. [*6] attended two detoxification programs between May 23 and July 26, 2005. She left both after a one-day stay.

R.M. visited J.M. with E.C. at Hudson Cradle during the months of June and July. R.M., however, was arrested on July 27, 2005, and at a review hearing held on that date, E.C. admitted recent heroin use. The court ordered R.M. to contact DYFS upon his release and directed DYFS to offer services to him at that time if his paternity was confirmed and if he offered himself as a caretaker for J.M. The court ordered E.C. to submit to a psychological evaluation and random drug screens.

Although E.C. continued to visit J.M. at Hudson Cradle until October 15, 2005, she had no contact with DYFS between September 9 and December 28, 2005. She failed to appear in court for a review hearing on November 2, 2005. On December 29, 2005, she went to the DYFS office and reported that she had been living in Pennsylvania. She declined to submit a urine sample for testing.

R.M. remained in jail. On October 7, 2005, his probation was terminated, and he was sentenced to a four-year term of imprisonment. In addition to the crimes for which he was sentenced, R.M. had additional prior convictions for possession [*7] of a controlled dangerous substance in 1986 and 1988 and a prior conviction for bribery in 1994.

On January 11, 2006, the court again ordered E.C. to submit to random urine screens. The order included a warning that any refusal to submit a specimen for testing would be considered a positive screen for drugs.

On January 20, 2006, E.C. entered an intensive methadone maintenance program at Spectrum. She was using cocaine and heroin at the time. E.C. was placed on methadone maintenance and given counseling, but she did not make immediate progress. Spectrum staff recommended a higher dosage of methadone, but E.C. declined. Between January 20 and May 31, 2006, E.C. had twelve positive and two negative drug tests.

On April 5, 2006, the court approved DYFS's plan to seek termination of E.C.'s parental rights.

In June 2006, E.C. tested positive for tuberculosis. As a consequence, Spectrum was not permitted to allow her to attend any sessions. Spectrum could do no more than deliver methadone to E.C. outside the building. When E.C. appeared for a court hearing that month, her caseworker detected the odor of alcohol on her breath.

In August 2006, E.C. was cleared to return to Spectrum and agreed to [*8] take a higher dosage of methadone. The Spectrum program in which E.C. was enrolled included individual counseling, group therapy, relapse prevention and parenting classes. Between August 11, 2006, and February 2007, Spectrum screened E.C.'s urine twenty-six times. Twenty-five of the reports were negative, and one was positive. The positive report was on a specimen taken on December 8, 2006, which indicated her use of cocaine. Three of E.C.'s twenty-five negative tests showed the presence of "creatine." According to John Cox, Spectrum's clinical director, the presence of "creatine" indicated either use of alcohol or tampering with the urine specimen.

At trial, which was held in late February 2007, Cox described the significant progress E.C. made in dealing with her addiction between August 2006 and February 2007. She faithfully attended the programs available, except for a two-week period in the fall of 2006 during which funding for her participation in Spectrum's program was in question. E.C. also successfully completed Spectrum's parenting program, and, at her request, was permitted to continue in that program after her "graduation." In addition, she regularly attended her counseling [*9] and group sessions. Cox described E.C. as having a "burning desire to become drug free" without taking methadone. Accordingly, Spectrum had reduced her dosage of methadone from eighty to thirty milligrams. Cox admitted that he was concerned by the urine screens that showed "creatine" and by E.C.'s failure to provide a urine sample on February 26, 2007. He found "comfort" when informed that a screen done by the court on February 27, 2007, was negative for alcohol and drugs other than methadone. In Cox's opinion, despite E.C.'s progress, she was not ready for discharge from Spectrum.

E.C. admitted to use of drugs and alcohol on occasions between August 2006 and February 2007 in addition to those confirmed by the positive drug screens. She used methadone she obtained illegally without prescription during the two-week period in October when she did not attend Spectrum. In February 2007, within weeks of the trial, E.C. told a caseworker that she had been drinking heavily the night before.

By the time of trial, E.C. was reportedly earning money by cleaning houses and babysitting. She was paid in cash. The record does not indicate where she was living at that time. As of August 16, 2006, E.C. [*10] was still living in the same apartment she occupied in March 2005.

Licensed psychologists who evaluated E.C. and her children were in substantial agreement about her ability to parent her children. She was seen by Dr. Ernesto Perdomo for psychological and bonding evaluations on July 26 and August 16, 2006. Dr. Matthew Johnson saw E.C. on September 15, October 25, and November 1, 2006, for the purpose of evaluating the bond between E.C. and her children.

Dr. Perdomo's diagnoses were: opiod dependency in remission but on methadone maintenance; alcohol dependency in remission; personality disorder not otherwise specified with some obsessive-compulsive, histrionic and narcissistic characteristics; and psychological stressors due to separation from her children and involvement with DYFS. Dr. Perdomo found no indication of any affective or thought disorders, psychosis, central nervous system disorder, learning disability or depression. He concluded that E.C. has a grasp of reality and an ability to organize her life and work and establish adequate interpersonal relationships. He found "significant reasonable psychological evidence" of a bond between E.C. and D.R. and S.R. and a "good [*11] relationship" between E.C. and J.M., which could not be considered a "bond" because J.M. was too young to have developed a bond. Although Dr. Perdomo recommended that

DYFS "proceed cautiously if unifying [E.C.] with her children," he noted that E.C. has "certain abilities that may help her to provide effective parenting to the children, as long as she keeps off drugs." Dr. Perdomo did not evaluate J.M.'s bond with his foster family. He noted that J.M. had just reached the age when he would start to develop a bond with his primary caretaker and could internalize within the next six months.

Dr. Johnson found a positive bond between E.C. and D.R. and S.R. He also concluded that J.M., due to his age and separation from E.C. at birth, had not bonded with E.C. In Dr. Johnson's opinion, E.C.'s maintenance of a stable and fulfilling home for D.R. and S.R. indicated that her children would benefit if returned to her. Acknowledging E.C.'s difficulty in recovering from substance abuse, he concluded that E.C.'s continual commitment and effort to that goal were apparent. He recommended E.C. attend a twelve-step program to learn more about recovery. Dr. Johnson concluded that E.C.'s children should [*12] be returned to her upon her demonstration of her stability on methadone maintenance, without use of alcohol or illegal drugs, for a period of no less than six months.

R.M. had limited contact with DYFS after his arrest in July 2005. DYFS arranged for an evaluation of R.M. by Dr. Perdomo while R.M. was completing service of his sentence in a halfway house. His diagnoses were: poly-substance dependence, "possibly" in remission; and personality disorder, not otherwise specified, with narcissistic and antisocial characteristics. Dr. Perdomo concluded that R.M. was a "rather immature individual[,] who may lose control under emotional stimulation" and was in need of parenting classes and long-term individual therapy. In Dr. Perdomo's opinion, even with those services, R.M. would have problems parenting a child with a history of medical fragility and was not "a viable primary caretaker."

R.M. had no contact with J.M. after July 2005. Although he had told Dr. Perdomo he would complete service of his sentence in the halfway house in October 2006, he did not contact DYFS or the child after his release. According to the records maintained by the Department of Corrections, R.M. was not re-incarcerated [*13] until February 2, 2007. Although he was confined at the time of trial, arrangements were made for him to attend. R.M. did not testify and offered no explanation for his failure to contact DYFS or visit J.M. when he was not confined.

R.M. had no plan for J.M.'s care other than placement with his sister, M.M. DYFS determined that J.M. could not be placed with M.M. because of her prior history. M.M. previously had assumed guardianship of a relative's child, which she relinquished by leaving the child at a DYFS office. The trial court denied R.M.'s request to present his sister's testimony to rebut DYFS's reasons for concluding she could not care for J.M.

The trial court's decision to terminate E.C.'s parental rights was based on her addiction, which harmed the child, her inability to address her addiction even with the reasonable assistance provided by DYFS, and the absence of a bond between mother and child. The court found that J.M. suffered harm, withdrawal symptoms, because E.C. used methadone during pregnancy. Recognizing that E.C.'s methadone was prescribed, the court determined that a woman using heroin or on methadone maintenance should find out about the risks to a child before [*14] becoming pregnant and opt to avoid that harm if the risks are great. The court also found harm based on E.C.'s failure to rehabilitate herself, despite reasonable efforts by DYFS, and her continued need for an indefinite period of time to become stable in her recovery. The court concluded that her need for an indefinite recovery period continued to endanger J.M.'s health and development by preventing E.C. from providing the stability, parental attention and permanency J.M. needed. Because J.M. had not developed a bond with E.C., the court determined that termination of his mother's parental rights would not do more harm than good.

The court's termination of R.M.'s parental rights was based on the father's consistent and continued failure and inability to care for J.M. Although DYFS did not provide services to R.M.,

the court concluded that DYFS was unable to assist R.M. due to his incarceration and his own failure to contact DYFS upon his release. The court further concluded that termination of R.M.'s parental rights would not do more harm than good, because the child had no relationship or bond with R.M.

"[A] reviewing court must determine whether a trial court's decision in respect [*15] of termination of parental rights was based on clear and convincing evidence supported by the record before the court." *P.P., supra, 180 N.J. at 511.* "[T]he trial court's factual findings 'should not be disturbed unless they are so wholly unsupportable as to result in a denial of justice.'" *In re Guardianship of J.N.H., 172 N.J. 440, 472, 799 A.2d 518 (2002)* (quoting *In re Guardianship of J.T., 269 N.J. Super. 172, 188, 634 A.2d 1361 (App. Div. 1993))*. Even where a parent alleges error based on implications drawn from the facts, we defer unless the trial court "went so wide of the mark that a mistake must have been made." *New Jersey Div. of Youth and Family Services v. M.M., 189 N.J. 261, 279 (2007)*. Our review of this record in accordance with the foregoing standards convinces us that there is no adequate basis for us to disturb the trial court's decision to terminate the rights of either R.M. or E.C.

Termination of parental rights requires clear and convincing evidence of the following:

> (1) The child's safety, health or development has been or will continue to be endangered by the parental relationship;
>
> (2) The parent is unwilling or unable to eliminate the harm facing the child or is unable or unwilling to provide a safe [*16] and stable home for the child and the delay of permanent placement will add to the harm. Such harm may include evidence that separating the child from his resource family parents would cause serious and enduring emotional or psychological harm to the child;
>
> (3) The division has made reasonable efforts to provide services to help the parent correct the circumstances which led to the child's placement outside the home and the court has considered alternatives to termination of parental rights; and
>
> (4) Termination of parental rights will not do more harm than good.
>
> [*N.J.S.A. 30:4C-15.1a.*]

These four statutory criteria "are not discrete and separate . . . [but] provide a comprehensive standard that identifies a child's best interests." *In re Guardianship of K.H.O., 161 N.J. 337, 348, 736 A.2d 1246 (1999).*

The harm required by paragraph one "involves the endangerment of the child's health and development resulting from the parental relationship." *Ibid.* "Although a particularly egregious single harm can trigger the standard, the focus is on the effect of harms arising from the parent-child relationship over time on the child's health and development." *Ibid.* "That requirement is reinforced by the second prong [*17] of the statutory standard, which focuses on the parent's ability to overcome the harm to the child." *Id. at 352* (finding that the child's symptoms of withdrawal, coupled with her mother's failure to provide continuing care or take measures to help the child, met the first prong of the statutory test). Evidence that supports one of these prongs may support the evidence that supports the other "as part of the comprehensive basis for determining the best interests of the child." *In re Guardianship of D.M.H., 161 N.J. 365, 379, 736 A.2d 1261 (1999).*

Paragraph two of the statute requires a showing that the harm "continue[s] because the parent is unable or unwilling to overcome or remove the harm." *K.H.O., supra, 161 N.J. at 348.* Its focus

is "on conduct that equates with parental unfitness." *D.M.H. supra, 161 N.J. at 379.* The State may establish the requisite continued harm addressed in paragraph two in two ways: evidence that the parent has not cured the initial harm and is unable to continue a parental relationship without recurrent harm that endangers the health, safety, or welfare of the child; or evidence "that the parent is unable to provide a safe and stable home for the child and that the delay [*18] in securing permanency continues or adds to the child's harm." *K.H.O., supra, 161 N.J. at 348-49* (explaining *N.J.S.A. 30:4C-15.1a(2)*). "[T]he second prong may be met by indications of parental dereliction and irresponsibility, such as the parent's continued or recurrent drug abuse, the inability to provide a stable and protective home, [and] the withholding of parental attention and care . . . ." *Id. at 353.*

In this case, the trial court found that J.M. was harmed by his relationship with E.C., within the meaning of paragraph one of the statute, because J.M. suffered symptoms of withdrawal from methadone after his birth and was unable to provide a safe and stable home during the twenty-three months following the child's birth. That finding is amply supported by the record. [3]

> 3 The trial court's alternate bases for finding harm, which were based on allegations of E.C.'s hitting D.R. with a belt and J.M.'s having tested positive for amphetamines at birth, are not supported by clear and convincing evidence. DYFS concluded that the allegations about the belt were unsubstantiated, and there was no evidence of harm attributable to the amphetamines.

The trial court's conclusion that withdrawal [*19] is a "harm" within the meaning of the statute is also consistent with precedent. The Supreme Court has held "that a child born addicted to drugs and suffering from the symptoms of drug withdrawal as a result of [the] mother's substance abuse during pregnancy has been harmed . . . and that [the] harm endangers the child's health and development." *K.H.O., supra, 161 N.J. at 349.*

We need not endorse the trial court's conclusion about the duty a woman taking heroin or methadone owes to a child yet not conceived to conclude that J.M. was harmed by his mother's addiction. As a consequence of E.C.'s need for methadone, prescribed or otherwise, J.M. suffered from tremors after his birth, needed medication to address the symptoms of withdrawal, was deemed to be "medically fragile" and required specialized care for several months, which neither parent could provide. That harm is attributable to the parental relationship. *Id. at 347.* Blameworthiness is not determinative. In a termination case, the best interests of the child, not fault and punishment, are at issue. *Id. at 350-51.*

This court previously considered a case involving an infant who suffered symptoms of withdrawal apparently attributable [*20] to the mother's use of prescribed methadone. *N.J. Div. of Youth and Family Servs. v. S.A., 382 N.J. Super. 525, 528-29, 889 A.2d 1120 (App. Div. 2006).* Although the court reversed the order of termination on the ground that the termination proceeding, held only six months after the child's birth, was "unjustifiably rushed," we did not conclude that the child was not harmed within the meaning of *N.J.S.A. 30:4C-15.1a(1). Id. at 538*; *see also P.P., supra, 180 N.J. at 499-500* (addressing termination in a case involving two children who suffered withdrawal symptoms at birth; the mother was participating in methadone maintenance during the second pregnancy and, although the mother admitted heroin use within days of the birth, the infant tested positive for methadone, not heroin).

The trial court also found that J.M. would continue to be endangered by the parental relationship with E.C. because she had not addressed her addiction and remained unwilling or unable to provide a safe and stable home for the child while the delay of permanent placement added to the harm. That finding was amply supported by the record. Although E.C. eventually made significant progress toward achieving stability on methadone, she [*21] had little or no

success until after DYFS decided to seek termination of her parental rights more than a year after J.M.'s removal from her custody. According to the expert testimony most favorable to E.C., a period of stability of at least six months would be required before she could be considered sufficiently stable to care for J.M. Due to E.C.'s acknowledgment of alcohol consumption weeks before the trial, which was inconsistent with the requisite stability, the six-month period had just commenced. That period overlapped with the period during which J.M. could develop a bond with a primary caretaker, but E.C., due to her failure to achieve stability on methadone, was not available to J.M. to fulfill that need or otherwise care for the child.

R.M., like E.C., endangered the health, safety and well being of J.M. by failing to provide care for or take measures to help the child after he was born suffering from withdrawal. *K.H.O., supra, 161 N.J. at 352*; *see ibid.* (stressing that the importance of measures taken by the parent "to foster an environment leading to normal child development"). As the trial court found, after gaining leave to serve a portion of his sentence for drug crimes [*22] in a halfway house and being released from that program, R.M. did not contact DYFS to seek services, as directed by the court, or make any effort to see J.M. By the time of trial, R.M. was re-incarcerated. During the twenty-three months of J.M.'s life, including periods during which he was not confined, R.M. had not made any effort to care for the child and twice became wholly unavailable because of conduct subsequent to J.M.'s birth that resulted in incarceration. *See D.M.H., supra, 161 N.J. at 379* (noting that a parent's withdrawal of "solicitude, nurture, and care for an extended period of time is in itself a harm that endangers the health and development of the child.").

The Supreme Court's decision in *P.P.* is instructive. In that case the parents entered drug treatment programs near the time that DYFS filed a guardianship complaint and about one year after the children were removed from their custody following the birth of their youngest child, who tested positive for methadone. *180 N.J. at 499-500, 512.* Although the parents "were persisting in their rehabilitation efforts at the time of trial approximately ten months later," neither had completed the programs or was in position [*23] to provide a stable home for the children. *Id. at 512.* The evidence did not establish how long it would take the parents to be in a position to meet the children's needs. *Ibid.*

On those facts, the Supreme Court held:

> The trial court's finding under the statute that "[t]he parent is unwilling or unable to eliminate the harm facing the child or is unable or unwilling to provide a safe and stable home for the child and the delay of permanent placement will add to the harm," *N.J.S.A. 30:4C-15.1a(2)*, will not be disturbed on this record.
>
> [*Ibid.*]

Following *P.P.*, we see no basis for disturbing the trial court's findings: J.M. was and continued to be harmed by the parental relationship with E.C. and R.M.; the parents remained unable or unwilling to provide a safe and stable home; and the harm of their unavailability to nurture and care for the child would be increased by further delay of permanent placement.

E.C. and R.M. argue that DYFS failed to make the diligent efforts required by *N.J.S.A. 30:4C-15.1a(3)* to reunite them with J.M. and provide the court with alternatives to termination. The arguments lack merit.

After J.M. no longer required specialized care at Hudson Cradle, DYFS successfully [*24] placed him with his maternal grandmother. He remained in her care until she became too ill to continue providing for him. Although the grandmother was invited to notify DYFS when she was able to resume the responsibility of caring for J.M., she never did.

With assistance from DYFS, E.C. maintained regular contact with her children. Also with assistance from DYFS, E.C. attended, without success, two detoxification programs and, then, for a period of several months, left the State of New Jersey. On her return, DYFS arranged for E.C. to participate in an intensive methadone maintenance program that included individual and group therapy, drug screening, relapse prevention and parenting classes. Nothing that was recommended went undone. The trial court found that DYFS was providing all of the treatment, other than Alcoholics Anonymous or Narcotics Anonymous, recommended for E.C. by Dr. Johnson through Spectrum's intensive methadone maintenance program. The court also found that E.C. required no assistance from DYFS to participate in Alcoholics Anonymous or Narcotics Anonymous. Diligent efforts require no more than reasonable "attempts . . . to assist the parents in remedying the circumstances [*25] and conditions that led to the placement . . . and in reinforcing the family structure." *N.J.S.A. 30:4C-15.1c*; *D.M.H., supra, 161 N.J. at 386-91* (discussing the efforts required).

With respect to R.M., DYFS could not reasonably provide services to him while he was in custody. As the trial court found, R.M. was responsible for DYFS's inability to provide services to him upon his release. The trial court directed R.M. to contact DYFS when no longer confined, but he did not comply.

The trial court's findings on diligent efforts are adequately supported by the record.

The record also provides adequate support for the trial court's conclusion that termination of E.C.'s and R.M.'s parental rights would not do more harm than good. J.M. was not bonded with either parent. While the child was too young to have developed a bond with his foster family, J.M. was at an age where he could establish a bond if permitted to build upon the good relationship he enjoyed with the foster parent who had become his primary caretaker and wanted to adopt him. The good, which outweighed the harm of termination, was the opportunity for permanency that neither parent was able or willing to provide at the time of trial [*26] or at a future date that could be determined with any certainty. *See P.P., supra, 180 N.J. at 513.* This is not a case in which there is any evidence that the foster parent has wavered from the plan to adopt or that either parent has turned their life around. *See ibid.*; *J.N.H., supra, 172 N.J. at 479.*

Because the trial court's decisions on termination are based on a proper application of the law and factual findings that are supported by substantial, credible evidence in the record, we affirm.

R.M. and E.C. argue, for the first time on appeal, that DYFS records admitted into evidence improperly include entries that were not made at or near the time of the caseworker's observations. Because neither E.C. nor R.M. present any argument demonstrating a relationship between the entries they deem inadmissible for failure to comply with *N.J.R.E. 803(b)(5)* and the court's decision to terminate their respective parental rights, neither establish plain error. *R. 2:10-2.*

R.M. argues that the court erred in precluding him from presenting the testimony of his sister M.M., which he offered to rebut DYFS's finding that J.M. could not be placed with her. Even if we were to assume that it was error to exclude [*27] M.M.'s testimony, that error could not have had any impact on the trial court's decision to terminate R.M.'s parental rights. *R. 2:10-2.* Because J.M.'s adoption by his foster parent was likely, kinship legal guardianship was not available as an alternative to termination. *See P.P., supra, 180 N.J. at 512-13.*

E.C. argues, for the first time on appeal, that J.M. should have been placed with D.R. and S.R. and that post-adoption visitation between the children should resume immediately. This argument, not raised below, lacks sufficient merit to warrant discussion. *R. 2:11-3(e)(1)(E).*

Affirmed.

NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES, Plaintiff-Respondent, v. E.P.A., Defendant-Appellant, IN THE MATTER OF THE GUARDIANSHIP OF E.A., A Minor.

DOCKET NO. A-6169-05T4

SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

2007 N.J. Super. Unpub. LEXIS 1407

September 11, 2007, Submitted
October 15, 2007, Decided

NOTICE: NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE APPELLATE DIVISION.

PLEASE CONSULT NEW JERSEY RULE 1:36-3 FOR CITATION OF UNPUBLISHED OPINIONS.

SUBSEQUENT HISTORY: Certification denied by *New Jersey Div. of Youth and Family Services v. E.P.A., 194 N.J. 272, 944 A.2d 32, 2008 N.J. LEXIS 276 (2008)*

PRIOR HISTORY: [*1]
On appeal from Superior Court of New Jersey, Chancery Division-Family Part, Essex County, FG-07-268-05.

COUNSEL: Yvonne Smith Segars, Public Defender, attorney for appellant (Dianne Glenn, Designated Counsel, on the brief).

Anne Milgram, Attorney General, attorney for respondent (Andrea M. Silkowitz, Assistant Attorney General, of counsel; Patricia L. Parker, Deputy Attorney General, on the brief).

Yvonne Smith Segars, Public Defender, Law Guardian for minor child (Phyllis G. Warren, Assistant Deputy Public Defender, on the brief).

JUDGES: Before Judges PAYNE and MESSANO.

OPINION

PER CURIAM

E.P.A., the natural mother of a five-year-old daughter, E.A. (fictitiously, Edie), appeals from an order of a judge of the Family Part terminating her parental rights to the child following a contested four-day hearing. D.A., the natural father of the child and husband of E.P.A., has not appealed.

On appeal, the mother concedes that the trial judge addressed each of the interrelated statutory prongs of *N.J.S.A. 30:4C-15.1* that govern the matter, [1] but she contends that the judge's findings of fact and conclusions of law were manifestly unsupported by and inconsistent with the competent, relevant and reasonably credible evidence, [*2] and thus that reversal is required. In a broad-based challenge to the court's ruling, the mother raises the following arguments: (1) the court's determination of lack of parental fitness was inconsistent with the fact that she had been permitted to retain custody of a later-born son; (2) she had complied with the requirements of DYFS and resolved concerns regarding her parenting by the time of a court hearing on September 20, 2004, but reunification did not occur; (3) thereafter, a changing, new and unnecessary array of requirements were imposed in a fashion that unreasonably served to prevent reunification; and (4) the decision by the Division of Youth and Family Services (DFYS) to seek termination was inconsistent with the opinions of its own experts and of social service workers. Following a review of the record and arguments of counsel in light of governing law, we affirm.

1 The statute, which embodies the best interests of the child standard articulated in *New Jersey Div. of Youth & Fam. Serv's v. A.W., 103 N.J. 591, 512 A.2d 438 (1986)*, permits parental rights to be severed upon clear and convincing evidence that (1) the child's health and development have been endangered by the parental relationship; [*3] (2) the parent is unwilling or unable to eliminate the harm facing the child; (3) the Division of Youth and Family Services has made diligent efforts to help correct the circumstances leading to the child's placement outside the home and has considered other alternatives to termination of parental rights; and (4) termination of parental rights will not do more harm than good.

The record discloses that Edie was born on June 12, 2001. Both she and her mother tested positive for cocaine, methadone and opiates at the time of birth. Prior to the birth of Edie, E.P.A. had given birth to three other children. In 1990, she gave birth to her first child at the age of sixteen; to a second, premature, child in 1991 who died after nine days; and to her third child in 1998. Before Edie's birth, the two older children had been placed with a maternal grandmother, and upon the grandmother's death, with a maternal aunt and great-aunt, after repeated verified reports of neglect, homelessness, penury, and drug use by E.P.A. On February 15, 2002, eight months after Edie's birth, E.P.A. entered into a voluntary identified surrender of her parental rights to the two older children, and they have been adopted [*4] by relatives. A son, born on October 11, 2002, remains in E.P.A.'s custody.

E.P.A. herself had experienced a troubled youth while living at home with an alcoholic mother and incorrigible brothers, one of whom was eventually murdered. In 1986, E.P.A. took an overdose of pills following a fight with her mother. In 1988, when E.P.A. was almost fourteen, her mother requested her removal from the home because of behavioral problems. By 1989, when E.P.A. was fifteen, her school had reported to DYFS that E.P.A. was a suspected drug user. She dropped out of school while in the ninth grade, and has not returned.

E.P.A.'s use of drugs continued, and she identified marijuana, and later, heroin, as her habitual drugs of choice, with occasional use of cocaine and alcohol. Multiple opportunities for drug treatment were rejected. In 2000, E.P.A. completed a drug treatment program at Turning Point, but relapsed on the day after her graduation. She then entered a methadone program, but did not follow through with its services. In September 2001, after the birth of Edie, E.P.A. was again enrolled in a methadone-maintenance program administered by the Essex Substance Abuse Treatment Center. Although she [*5] has remained largely drug-free thereafter, she tested

positive for opiates and benzocaine on December 13, 2002 and January 2, 2003. E.P.A. has contested an additional test that was positive for heroin, occurring on March 4, 2003, and claimed that she ceased drug use in November 2001. At the time of her son's birth on October 11, 2002, E.P.A. tested positive only for methadone, and in a letter dated June 25, 2003, the Essex Treatment Center stated that E.P.A. had refrained from drug use, except methadone, for seventeen months.

Although the court sought a decrease in and eventual cessation of E.P.A.'s use of methadone, there is little evidence that E.P.A. has achieved that goal, except for one reference in a January 6, 2006 case management order to a drug test conducted on November 18, 2005, which was negative for that substance. Additionally, a December 15, 2005 drug test was negative for methadone, although E.P.A. stated to the test administrator that she was using methadone at the time. No clear evidence exists in the record as to whether E.P.A. remained on methadone maintenance at the time of trial. However, psychologist Leslie Williams noted in his February 2006 report, two months [*6] before trial, E.P.A.'s statement that she remained on methadone and went to the Essex Substance Abuse Treatment Center twice a week to procure it.

Edie's father, D.A., tested positive for cocaine in September 2005, and he was terminated from the Essex Substance Abuse program upon incarceration in December 2005.

In addition to her drug addiction, E.P.A. has had criminal involvement. Although the record is not entirely clear, it appears that E.P.A. has a history of five arrests, three indictable convictions, [2] and two violations of probation. Her convictions include one, in 1995, for third-degree distribution of CDS in a school zone and a conviction, in 1998, on a charge of first-degree robbery. She has spent more than one year in jail and state prison. Open warrants for the arrest of E.P.A. as the result of violations of probation on the robbery charge and the CDS offense remained unresolved until April 2005. A 2001 charge of simple assault was resolved on December 23, 2004. Additionally, open warrants remained for a lengthy period for the arrest of Edie's father, D.A., on charges of criminal trespass, panhandling, and possession and distribution of a hypodermic needle. [3] Fingerprinting [*7] of E.P.A. and D.A., initially sought on November 17, 2004 and then on January 19, 2005, still had not been completed by the parents on March 30, 2005.

2 Charges of possession of CDS may, on one occasion, have been downgraded.

3 D.A. has a criminal history of fourteen arrests, with no indictable convictions, but eight disorderly persons convictions. He was incarcerated as recently as December 2005.

At the time of Edie's birth in 2001, E.P.A. was living with D.A. at a "welfare hotel" in Newark, where the child was born without medical assistance. Neither E.P.A. nor D.A. was employed, neither had permanent housing, and D.A., like E.P.A., was drug-addicted. In late October 2002, housing was approved for the family, and they remained in the same apartment at time of trial, receiving temporary rental assistance in order to meet rental obligations.

On December 2, 2002, E.P.A. and D.A. entered into an Islamic marriage. The family now receives the welfare benefits to which it is entitled. However, eligibility for various benefits was long clouded by the parents' receipt of general assistance under a program designed for single, childless adults -- a circumstance that resulted from the parents' failure [*8] to disclose their marriage or the existence of a resident child. After the nondisclosure was discovered by DYFS, the parents failed to provide the Division with suitable information regarding their welfare status, despite court orders that they do so, and that status remained unclear throughout most of the year 2004. By the time of trial, however, the natural parents' welfare benefits had been regularized. Little or no income exists other than that provided through welfare, and it is unclear how rental

payments will be made once temporary rental assistance, available for a three-year period, is terminated.

Edie has never permanently resided with E.P.A. and D.A. DYFS was granted custody of the child, following substantiation of parental neglect, shortly after her birth, and on August 31, 2001, Edie was placed in the home of her current foster mother, where she had resided for almost five years at the time of trial. [4] Although services, including visitation, were offered by DYFS to E.P.A., for the first five months of Edie's life, E.P.A. was noncompliant. By March 19, 2002, she had only seen the child on two occasions. During much of this period, D.A. could not be located.

4 No family members [*9] willing to provide long-term care have been identified.

On May 3, 2002, a weekly supervised visitation schedule was established through an agency known as Family Connections. In a report from that agency dated September 9, 2002, it was noted that both parents had regularly attended visitation, although they were frequently late, and they had established a good relationship with Edie. However, the report also noted that the natural parents had been inconsistent in their attendance at parenting training, attending only five sessions since June.

On June 6, 2003, unsupervised weekly visitation was scheduled between the hours of 11:00 a.m. and 6:00 p.m. On March 26, 2004, extended overnight visits were scheduled. However, when bite marks and scratches likely caused by Edie's younger brother were detected after the first five visits, on April 27, 2004, the court suspended the overnight visits because of safety concerns. Although weekly supervised visitation continued, a November 14, 2005 letter from Family Connections disclosed that, since July 2005, visitation had been erratic and only five visits had occurred. E.P.A. had not attended a visit since September 27, 2005. Not all of the missed [*10] visits were the fault of the natural parents. However, at least eight missed visits resulted from the parents' failure to confirm or appear, raising "serious concern[s]." Family Connections' letter continued:

> It is clear that [E.P.A.] and [D.A.] truly love their daughter [Edie]. It is also evident that [Edie] loves and has a strong attachment to her parents. However there is some concern regarding [E.P.A.'s] and [D.A.'s] ability to manage the multiple systems involved in parenting their daughter. This is evident in their ongoing struggles with present systems, i.e. DYFS, Family and Criminal court. There have been multiple factors that have made it difficult for [E.P.A.] and [D.A.] to achieve reunification. However, after three years, it is concerning that they have not yet developed the skills necessary to manage or overcome these obstacles to promote reunification with their daughter.
>
> Due to these identified concerns reunification cannot be supported at this time.

The [*11] trial judge observed that, even during trial, the parents had failed to visit E.P.A. on May 23 and May 30, 2006. Additionally, the parents had failed to cooperate in any respect with requests for evaluation by the law guardian.

Edie has been diagnosed as a special needs child, with speech and developmental delays, as well as substantial behavioral problems including aggressive conduct, anger control problems and hyperactive behavior. She has also been observed to be self-injurious. A neurodevelopmental pediatrician at the Children's Specialized Hospital initially recommended that Edie undergo a child study team evaluation to assess enrollment in a five-day-per-week pre-school handicapped program, obtain occupational therapy one or two times a week, have speech therapy two to three

times per week, and undergo both speech and audiological evaluations. Edie has been diagnosed as suffering from attention deficit/hyperactivity disorder, language disorder, possible mild mental retardation, static encephalopathy, secondary to pre-natal drug exposure, and stress related to her visitation with her natural family. Despite her handicaps, Edie's foster mother seeks to adopt her.

The complex procedural [*12] history of this matter demonstrates extensive efforts at reunification. An existing protective services complaint relating to E.P.A.'s two older children was amended on June 25, 2001 to add Edie, who had been born two weeks earlier. Reunification was sought. However, on September 20, 2002, DYFS filed a complaint seeking termination of parental rights as the result of the natural parents' lack of housing and continued methadone use. At that time, Edie's foster mother advised DYFS of her willingness to adopt. A December 20, 2002, report stated that E.P.A. "does not appear interested in reuniting with [Edie]. She continues in her drug use, transient life style, and failure to maintain contact with the Division."

However, on April 15, 2003, following positive reports by Family Connections, psychologist Jessica Pesantez, and the Essex Substance Abuse Center, reunification again became the goal. At the time, E.P.A. was attending parenting skills classes, was maintaining weekly supervised visitation, and was remaining free of illicit drugs. On May 21, 2003, the guardianship complaint was dismissed. However, it was re-filed on May 23, 2005, as a result of the parents' lack of progress in maintaining [*13] stability.

On March 20, 2006, when the matter was initially scheduled for trial, both natural parents failed to appear, defaults were entered, and a proof hearing took place. The defaults were later vacated, and trial occurred between April 4, 2006 and June 1, 2006. The court issued a decision from the bench terminating the natural parents' rights on June 15, 2006, a result sought both by DYFS and Edie's law guardian.

In his decision, the Family Part judge carefully recited the history set forth in this opinion, discussed the four interrelated factors of *N.J.S.A. 30:4C-15.1* as they applied to Edie and her natural parents, and concluded that termination of parental rights was in Edie's best interests and would not do more harm than good.

In assessing Edie's best interests, the judge relied in large measure upon the updated reports and testimony of psychologist Leslie Williams, who had previously evaluated the natural parents in June and July 2004 and in May 2005, providing positive evaluations. However, in a February 2006 report, Dr. Williams stated:

> As noted in my previous reports, I had been in favor of reunification between [Edie] and [E.P.A. and D.A.]. However, my opinion was based [*14] on not being aware of a number of issues regarding [D.A.'s] and [E.P.A.'s] drug use, criminal records, and allegedly engaging in fraudulent activities. [E.P.A.] denied problems and said that outstanding issues had been cleared up.
>
> In my report on [Edie's] updated bonding with her foster mother, A.H., done on October 5, 2005, I opined that [Edie] was securely bonded with A.H. and had come to see her as her psychological parent . . . . This is still my opinion. After reviewing the case record and seeing [E.P.A.] [5] for an updated psychological evaluation, I do not believe that she or [D.A.] is capable of providing adequate parenting of [Edie].
>
> 5 D.A. failed to appear for his scheduled appointment with Dr. Williams and arrived at a rescheduled appointment fifty minutes late. For that reason, no updated evaluation occurred.

As the result of evaluations of the bonding between Edie and both her natural parents and foster mother, Dr. Williams stated that, whereas he had previously believed reunification between Edie and her natural parents was a viable option, the doctor now had "some concerns regarding this recommendation." Edie had come to view her foster parent as her biological mother, and [*15] had developed a strong and secure bond with her. The doctor continued:

> While [Edie] certainly knows [D.A.] and [E.P.A.], I believe that she clearly sees Ms. H. as her parent. I believe that [Edie] would suffer severe and enduring psychological harm if removed from Ms. H. In light of the problems that [E.P.A.] and [D.A.] have had in fully complying with DYFS, and with the length of time that [Edie] has been with Ms. H, I have serious concerns both in terms of removing [Edie] from Ms. H. and with [E.P.A.'s] and [D.A.'s] abilities to emotionally meet [Edie's] needs.

At trial, Dr. Williams indicated that Edie would suffer severe and enduring harm if separated from her foster mother and, although she would experience loss upon severance of parental ties, the foster mother would be able to remediate the harm. Removal of Edie, a special needs child, from her present home would severely impact upon her development and would cause her to regress behaviorally. According to Dr. Williams, Edie was in need of the permanency that her foster home provided, and the plan of foster parent adoption was appropriate.

As the result of the testimony of Dr. Williams, as well as the other evidence adduced at [*16] the termination hearing with respect to the relevant statutory factors, the Family Part judge concluded that DYFS had established by clear and convincing evidence that the parental rights of E.P.A. and D.A. to Edie should be terminated, and that relief was ordered. The present appeal by E.P.A. followed.

It is unquestionable that, in this case, the termination of the parental rights of E.P.A. and D.A. to Edie was a prolonged process. We attribute the length of the process, in part, to the laudatory efforts of the biological parents to obtain reunification with Edie and the efforts of the court and DYFS to support that goal. In part, its length also can be attributed to a well-founded concern by the court and DYFS that the parents, while developing a bond with their daughter, had not otherwise demonstrated their fitness to engage in her care. While it may have seemed to the parents that, particularly after September 20, 2004, reunification should have occurred, the Family Part judge overseeing the case prior to trial did not view matters in that fashion, and we have no cause to contest her judgment. *Cesare v. Cesare, 154 N.J. 394, 411-13, 713 A.2d 390 (1998)*; *Rova Farms Resort, Inc. v. Investors Ins. Co., 65 N.J. 474, 484, 323 A.2d 495 (1974)*.

An [*17] examination of E.P.A.'s history demonstrates her own troubled upbringing, her inability to care for her two older children, and her long-term addiction to illicit drugs coupled with an inability to eliminate a reliance on methadone, itself an addictive drug, albeit one utilized in some drug treatment regimes. This history suggests that caution on the part of DYFS and the court in proceeding with plans for reunification was appropriate, and demonstrates the necessity of assurances that E.P.A. and D.A. could properly care for Edie if she were returned.

The record additionally suggests that E.P.A. and D.A. had misrepresented their status when obtaining welfare benefits, giving rise to a legitimate concern on the part of DYFS and the court that the parents had committed welfare fraud, potentially endangering their right to continued benefits. Moreover, the parent's sole source of rent was temporary rental assistance benefits that, by their nature, were designed to be of short duration. Although by August 2004, DYFS had received proof that the rental assistance would be continued for a thirty-six-month, no housing plan was proffered for the period after rental assistance ceased. Further, [*18] although the

parents' welfare status was eventually regularized, a commitment to obtaining gainful employment was far from evident. A legitimate concern existed that housing would again become unstable, as it had been in the period surrounding Edie's birth, and that the family would be unsuccessful in leaving the welfare system.

The parents' criminal records posed additional concerns. By 2004, E.P.A.'s relatively significant criminal history appears likely to have been a past matter. However, outstanding warrants for E.P.A.'s arrest existed until April 2005, and both she and D.A. resisted requests for fingerprinting. As the record reflects, D.A. was again incarcerated in December 2005, tested positive for cocaine in this period, and was terminated from his methadone maintenance program. The manifest and continued unfitness of D.A. to parent Edie, [6] provides an independent basis for termination of parental rights, arising from the result of the marital relationship of D.A. and E.P.A. and Edie's potential continued contact with both parents upon reunification. *New Jersey Div. of Youth & Fam. Serv's. v. M.M., 189 N.J. 261, 288-89, 914 A.2d 1265 (2007).*

6 D.A. also failed to attend court hearings and psychological [*19] evaluations and, in general, was far less compliant than E.P.A. with DYFS's efforts to obtain reunification.

Given the facts that we have recounted, we cannot fault either the court or DYFS for imposing additional requirements on the parents after September 2004, or for delaying reunification, despite psychological and other reports that had previously indicated that this goal remained a possibility. The record at the time of trial reflected no clear plans by the parents for the care of Edie, were she to be returned to their custody. Yet, Edie was a special needs child whose care undoubtedly would require a greater degree of planning and preparation than would be necessary for a child who lacked Edie's developmental and behavioral handicaps. Thus, the fact that the parents retain custody of their youngest son is not dispositive of their fitness to care for Edie.

Moreover, during the lengthy periods while reunification remained under consideration, Edie was aging, and her bond to her foster mother was strengthening. The court recognized that, despite the initially positive reports of psychologists and social workers regarding reunification, by trial, the conclusion that it was in Edie's [*20] best interest to remain in her foster mother's care, and that she would be irreparably injured by severance of that relationship, had ample support in the record. Children such as Edie retain the right to a permanent home. *In re Guardianship of J.P. and B.P., 180 N.J. 494, 505, 852 A.2d 1093 (2004).* It was time that she be given that home. *New Jersey Div. of Youth & Fam. Serv's v. C.S., 367 N.J. Super. 76, 111, 842 A.2d 215 (App. Div.)* (noting the shift of focus to an expeditious, permanent placement to promote the child's well-being), *certif. denied, 180 N.J. 456, 852 A.2d 192 (2004).*

In sum, we are in agreement with the trial judge that DYFS proved by clear and convincing evidence that Edie's biological parents are incapable of raising her without causing the child further harm, *In re Guardianship of J.C., 129 N.J. 1, 10, 608 A.2d 1312 (1992)*, and that it is in Edie' best interest that she remain permanently with her foster mother.

Accordingly, the judgment of the trial court is affirmed.

SUPERIOR COURT OF NEW JERSEY

CIVIL DIVISION
ESSEX VICINAGE

CHAMBERS OF
VERNA G. LEATH, J.S.C.

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February 22, 2011

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RE: DYFS v [redacted]
IMO: [redacted]
Docket No. FN [redacted]

Dear Counsel:

The court having reviewed the proofs and the submissions by the parties, now renders the within decision.

[redacted] are the parents of [redacted] who was born on April 9, 2010. On April 23, 2010 the Division of Youth and Family Services

(Division) filed a Verified Complaint seeking care, custody and supervision. The Division alleges that [redacted], is an abused and neglected child as the defendant mother, [redacted] took prescribed methadone throughout her pregnancy causing the infant to present with Neonatal Addiction Syndrome (NAS) at birth. The Division further alleges that [redacted] is an abused and neglected child because the defendant [redacted] has an extensive drug history, has had her parental rights involuntarily terminated to five of her nine children, and that none of her nine children are in her custody. As to [redacted] the Division alleges that he has admitted past drug use. As to each defendant the Division alleges that neither has completed a drug treatment program.

Defendant [redacted] filed a motion to dismiss the complaint on August 23, 2010. The court denied the motion on September 27, 2010. On that same date the court began the fact finding hearing. The hearing continued on October 1. On October 7 Emma S. Ketteringham, Director of Legal Advocacy, National Advocates for Pregnant Women filed a motion to appear pro hac vice as co-counsel with Claire Pellerito, defense counsel for [redacted] Ms. Ketteringham is an attorney who is licensed in New York. Over the objection of the Division, the court granted the application. See R 1:21-2 The hearing continued on November 18 and November 29, 2010. At the hearing Division caseworker Robin Fierson testified. Justine Laurelli, MD, Emanuel Ekulide, M.D. a Robert Newman, M.D., Loretta P. Finnegan, M.D., Verline Parkes and Tunisia Crosby testified on behalf of [redacted] Counsel submitted written summations on or before December 13, 2010. [redacted] remains in the physical custody of the defendant parents.

The issue before the court is whether the Division has established by a preponderance of the evidence, that [redacted] is an abused and neglected child as defined in Title 9:6-8.47.

Fact Finding Hearing

Title 9 cases require proof by a preponderance of the believable evidence. See N.J.S.A. 9:6-8.46(b)(1) A litigant must establish that a desired inference is more probable than not. If the evidence is in equipoise, the burden has not been met. Liberty Mutual Ins. Co. v. Land, 186 N.J. 163, 169 (2006) (quoting Biunno, Current N.J. Rules of Evidence, Comment 5a on NJRE 101 (b)(1) (2010)). The evidence must demonstrate that the offered hypothesis is a rational inference, that it permits the trier of fact to arrive at a conclusion grounded in a preponderance of probabilities according to common experience." In re Estate of Reininger, 388 NJ Super. 289, 298 (Ch. Div 2006) (citing Joseph v. Passaic Hosp. Ass'n, 26 NJ 557 574-575 (1958). The burden of producing evidence obligates a party to introduce evidence to avoid the risk of a finding against such party on an issue of fact. NJRE 101(b) (2) The burden of persuasion obligates a party to prove such fact by a preponderance of the evidence. (NJRE 101(b)(1)) While the burden of proof does not switch between the parties, the burden of going forward may shift several times within the context of one trial. Where a party fails to meet the burden of going forward and/or fails to meet the proofs needed to establish their action or defense the party does not prevail. Evidence offered at fact-finding hearings must be material, relevant and competent. To determine whether the abuse or neglect alleged actually occurred, the evidence must be competent as incompetent evidence precludes a

fair and accurate inquiry that seeks to protect the child from abuse and neglect, and yet not violate the due process rights of the parents or caregivers. The state must establish by a preponderance of the evidence that the child is an abused or neglected child.

[redacted] Defendant Mother

[redacted], a long term abuser of controlled dangerous substances voluntarily enrolled in a methadone maintenance program at the Lennard Clinic in May 2009. In September, 2009 when she learned that she was pregnant with her son [redacted], she was faced with several choices. She could have opted to continue abusing heroin, her drug of choice, throughout her pregnancy. She could have opted to go cold turkey and to stop taking any controlled dangerous substance. She could have opted to terminate the pregnancy. She could, and did opt to continue to participate in medically assisted abstinence from heroin by continuing her daily regimen of therapeutic methadone. The director of the methadone maintenance program is a physician. Her methadone levels were monitored throughout her pregnancy. She attended her program five days a week and on weekends she self administered the dose that had been prescribed by her physician. She had prenatal care throughout her pregnancy. When she gave birth to [redacted] he presented with certain complications including Neonatal Abstinence Syndrome (NAS).[1] One of the allegations, the Division was required to prove by a preponderance of the evidence, is that [redacted] is an abused and neglected child because he presented at birth with NAS.

It is instructive to take a moment to review [redacted] background. [redacted] is a thirty nine year old woman. She was raped when she was a child. When the

[1] Summary of testimony at trial.

rapist was released from custody he murdered her parents reportedly in retaliation for their having reported him to the police. [redacted] then went to live with a relative who was a drug dealer. The relative introduced her to drugs and she began a lifelong dependency on cocaine and heroin. She gave birth to her first child when she was in the ninth grade. She dropped out of school and in so doing ended her formal education. After the first pregnancy she gave birth to eight more children. She first became involved with the Division in 1994. Her parental rights were involuntary terminated to five of her children and a sixth child was placed in long term foster care. Her life continued as an odyssey punctuated by homelessness, prostitution, and subsequent rapes. Approximately 10 years ago she met [redacted] after a spate of homelessness were finally able to rent a subsidized apartment. They married in October 2009.[2]

[redacted] began treatment in the methadone program at the Lennard Clinic in Newark New Jersey, on May 29, 2009. By October 2009, according to the records of the Lennard Clinic her urine drug screens[3] were negative for all substances other than methadone and methadone metabolite.[4] On April 4, 2010 at 35 weeks gestation, Ms. [redacted] was admitted to the hospital and diagnosed with pregnancy related hypertension and preeclampsia, a common but serious complication of pregnancy. [redacted] was delivered by caesarean section on April 9, 2010. Both Ms. [redacted] and [redacted] tested positive for methadone at his birth. [redacted] was placed in a neonatal intensive care unit. He presented with tremors, high-pitched crying and increased tone. He was placed on

[2] Summary of defendant background in the report of Dr. Arnold Apolito, M.D. September 12, 2010 (D-12).
[3] Report from The Lennard Clinic dated July 9, 2010 (D-4); Records from The Lennard Clinic -methadone treatment (D-5)
[4] Certified Hospital Records - [redacted] birth records and OBGYN records – University Hospital of Medicine and Dentistry (D-8).

opium drops. [redacted] was discharged from the hospital on April 26, 2010 and was classified by the Division as medically fragile. Ms. [redacted] continued to comply with her methadone treatment and fully complied with numerous reports for drug screening. [5]

Argument

The relevant provisions of the New Jersey Child Abuse and Neglect law define an "abused or neglected child" as a child, less than eighteen years of age, whose parent:

> (1) Inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ; (2) creates or allows to be created a substantial or ongoing risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement; (3) commits or allows to be committed an act of sexual abuse against the child; (4) or 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 (1) in supplying the child with adequate food, clothing, shelter, education, medical or surgical care though financially able to do so or though offered financial or other reasonable means to do so or (b) in providing the child with proper supervision and guardianship, by unreasonably inflicting or allowing to be inflicted harm, or substantial risk thereof, including the infliction of excessive corporal punishment; or by any other acts of a similarly serious nature requiring the aid of the court. N.J.S.A. 9:6-8.21(c) (4). A court may find that a child is abused or neglected if DYFS has met its burden of proof by a preponderance of the evidence. New Jersey Div. of Youth & Family Services v. G.M., 198 N.J. 382, 398 (2009)

The courts have held that a woman's "(d) rug use during pregnancy, in and of itself, does not constitute a harm to the child" for purposes of a termination-of-parental-rights proceeding and "(p) renatal drug use does not, without more, establish parental unfitness or an inability to parent." In re Guardianship of K.H.O., 161 N.J. 337, 349, 736

[5] Trial testimony

A. 2d 1246 (1999). The K.H.O. rational has been held to apply to abuse and neglect litigation. New Jersey Div. of Youth and Family Services v. L.V., 382 N.J. Super. 582, 589-90, 889 A. 2d 1153 (Ch,. Div. 2005). In New Jersey Div of Youth and Family Services v. B.M. (In re Z.T.T.B.), the courts held that a newborn who tested positive for cocaine after birth but displayed stable vital signs and normal "physical findings," did not suffer harm under N.J.S.A. 30:4C-15.1(a)(1). citing K.H.O., the appellate panel held that harm may be found only when that drug use during pregnancy "results in the child being born addicted to drugs with the attendant suffering caused by such addiction." The court noted that the detection of cocaine in the child's system would not be sufficient, by itself, to support a finding that his "health or development (had) been or will continue to be endangered by the parental relationship(.)" N.J.S.A. 30:4C-15.1(a)(1). New Jersey Div. of Youth and Family Services v. B.M. (In re Z.T.T.B.). 413 N.J. Super 118, 128 (App. Div. 2010) The Division argues that "due to [redacted] suffering from symptoms of withdrawal from methadone, he experienced actual harm that is entirely attributable to the mother's action".

Standard for Expert Testimony

As finder of fact the court can make findings based on the testimony of expert witnesses. NJRE 702

Frye v United States, decided in 1923, provided the standard that governed the introduction of expert evidence for more than half a century. Frye v United States, 293 F. 1013 (D.C. Cir. 1923) The Frye test requires that for expert testimony to admissible, it must be based on scientific methods that are sufficiently established to have gained general acceptance in the particular field in which it belongs. Id In the case of United

States v. Downing. The court considered the admissibility of expert testimony concerning the reliability of eyewitness identification. State v. Downing, 753 F.2d 1224 (1985). Downing instructed the district courts to undertake a preliminary inquiry as to the soundness of the theory or technique on which proffered scientific evidence was based. The court permitted, but did not require, the identification of a relevant scientific community and a determination of the degree of acceptance within that community. Additional factors that district courts could consider included the novelty of the technique and its relationship to established modes of scientific analysis, the existence of specialized literature dealing with the technique, the likelihood that the scientific basis of the new technique has been exposed to critical scientific scrutiny, the qualifications and professional stature of the expert witness, and the potential and actual non-judicial uses of the scientific technique.

In Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993) the Supreme Court addressed issues of the reliability, acceptance and relevancy of expert testimony. Daubert is one of a stream of products liability cases where plaintiffs alleged that the drug Benedectin caused birth defects. In Daubert plaintiffs, Jason Daubert and Eric Schuller were minor children who were born with serious birth defects. They sued Merrell Dow alleging that Benedectin caused their injuries. The primary issue presented in Daubert was whether the adoption of Federal Rule of Evidence 702 eliminated the general acceptance test of Frye for the admission of scientific evidence. The Court was also asked to consider whether, if Frye remained valid, Rule 702 required that expert scientific testimony undergo peer review to be admissible in evidence.

The Court in Daubert found that the adoption of the Federal Rules of Evidence superseded Frye. The court articulated a two-part test, assigning to the court the task of ensuring that an expert's testimony both rests on a reliable foundation and is relevant to the test at hand. Id., at 597 Daubert set forth a non-exclusive checklist for trial courts to use in assessing the reliability of scientific expert testimony. The specific factors articulated by the Daubert Court are (1) whether the expert's technique or theory can be or has been tested – that is, whether the expert's theory can be challenged in some objective sense, or whether it is instead simply a subjective, conclusory approach that cannot reasonably be assessed for reliability; (2) whether the technique or theory has been subject to peer review and publication; (3) the known or potential rate of error of the technique or theory when applied; (4) the existence and maintenance of standards and controls; and (5) whether the technique or theory has been generally accepted in the scientific community. Id., at 593, 594. The Court in Kumho Tire Co. v. Carmichael, held that these factors might also be applicable in assessing the reliability of non-scientific expert testimony depending upon the particular circumstances of the particular case at issue. 119 S. Ct. 1167, 1175 (1999)

The Federal Rules of Evidence Rule 702 governs the admission of expert testimony. Rule 702 permits the introduction of scientific evidence which "will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise". The intent of the Rule is to liberalize the admissibility standards for expert testimony. See Daubert, e.g. (noting that cross examination rather than exclusion, is the correct means of dealing with "shaky" expert

testimony). Rule 702 requires that the expert possess some specialized knowledge, skill, or education that is not in the possession of the jurors. The specialized knowledge may be derived from experience a well as from education or training. See, e.g. Satcher v. Honda Motor Co., 52 F. 3d 1311 (5th Cir. 1995) (finding no error in permitting a former Miami police chief to testify that motorcycle crash guards are effective in reducing injuries; while the witness had no scientific or engineering expertise in motorcycle design, he had been on the police motor squad for nine years and had investigated hundreds of motorcycle accidents).

Federal Rule of Evidence 703 provides that "expert opinions based on otherwise inadmissible hearsay are to be admitted only if the facts or data are of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject." The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data deed not be admissible in evidence in order for the opinion or inference to be admitted. Facts or data that are not otherwise inadmissible shall not be disclosed to the jury by the proponent of the opinion or inference unless the court determines that their probative value in assisting the jury to evaluate the expert's opinion substantially outweighs their prejudicial effect.

State medical certainty standards and Fed. R. Evid. 702 are not in direct conflict, because state medical certainty standards in general are essentially substantive, and Rule 702 seeks to ensure that expert testimony is based on credible and reliable science; thus, if a witness is deemed competent to testify to a substantive issue in a case, such as

standard of care, testimony should then be screened by Rule 702 to determine if it is otherwise admissible expert testimony, and if there is no conflict be admitted.

Rule 703 departs from the common law in permitting an expert to form an opinion based on facts or data that are not admissible in evidence. The Advisory Committee's Note states that the Rule is intended to "broaden the basis for expert opinions beyond that current in many jurisdictions and to bring the judicial practice into line with the practice of the experts themselves when not in court." Notes of Advisory Committee on Rules (Jan. 2, 1975, P.C. 93-595, §1, 88 Stat. 1937; Mar. 2, 1987 eff. Oct. 1, 1987). An expert should be allowed to use the same information in Court that she would use in real life. See, e.g. South Cent. Petr., Inc. v. Long Bros. Oil Co., 974 F. 2d 1015 (5th Cir. 1992) (finding no abuse of discretion when an expert in a mineral rights case was permitted to make revenue projections based on multiple hearsay about the oil well in question, as the underlying information was reasonably relied on by experts in the field and only the expert's opinion, not the underlying information, was admitted into evidence).

The Rule provides that if the facts or data are of a type reasonably relied upon by experts in the particular field of expertise, than the expert is permitted to use this information as a basis for her opinion. An example offered by the Advisory Committee is that of a physician who forms a diagnosis based on (1) information from numerous sources, including statements by patients and relatives, and (2) reports and opinions from nurses, technicians, and other doctors. See also United States v. Posey, 647 F. 2d 1048 (10th Cir. 1981) (in a drug prosecution, it was permissible for one chemist to rely upon tests run by another in testifying that the tested substance was cocaine; "It is quite reasonable for a chemist to review another chemist's analysis when forming an opinion

as to the veracity of the latter's test results". Under Rule 703, the trial judge must determine the "reasonable reliance" question : whether the expert relies on information which, though inadmissible, is the information that other experts in the field reasonably rely on. If the expert takes into account inadmissible information that other experts in the field would not rely upon, the opinion is subject to exclusion under the Rule. See, e.g. Redman v. John D. Brush & Co., 111 F3d 1174 (4th Cir. 1997)

Under Frye testimony is admissible if it has gained general acceptance by the relevant scientific community. Under Daubert, testimony is liberally admitted if it is scientifically reliable and helpful to the trier of fact. See (Kumho) Daubert makes the judge the gatekeeper for admissibility. As noted within, the court in Daubert found that the adoption of the Federal Rules of Evidence superseded Frye Supra 509 U.S. 579, 113 S.Ct. 2786, 125 L. Ed. 2d 469 (1993).

As noted within, the court in Daubert found that the adoption of the Federal Rules of Evidence superseded Frye. Supra 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993). In this jurisdiction however "with the exception of toxic tort litigation, Frye remains the standard." (citing Harvey, 151 N.J. at 169-170, p. 13). The standard set in the originally enacted 1967 Evidence Rule 56(2) governing the admission of expert testimony, provides that an expert may testify "as to matters requiring scientific, technical or other specialized knowledge if such testimony will assist the trier of fact to understand the evidence or determine a fact in issue." State v. Cavallo, 88 N.J. 508, 516, A 20 1020 (1982). To qualify as an expert the witness must possess" peculiar knowledge or experience not common to the world which renders their opinions founded in such

knowledge or experience" helpful to a trier of fact in deciding a fact in issue. Renefer v. Deerfield Packing Corp., 4 N.J. 135, 142 72 A.2d

NJRE 702 requires that an expert be qualified by knowledge, skill, experience, training or education. Rule 702 of the New Jersey Rules of Evidence dovetail Federal Rule 702 and incorporates New Jersey case law establishing the general criteria for admissibility of expert testimony articulated by the court in State v. Kelly, (Ibid at 208). As restated by the court in Landrigan v. The Celotex Corporation, (1992), these criteria include the requirements that "(1) the intended testimony must concern a subject matter that is beyond the ken of the average juror; (2) the field testified to must be at a state of the art such that an expert's testimony could be sufficiently reliable; and (3) the witness must have sufficient expertise to offer the intended testimony." Kelly requires that the court first determine that the subject matter of testimony is relevant, that it bears upon the subject matter that is the subject of the claim and that the testimony is reliable.

In New Jersey "a subject matter that is so esoteric that it is beyond the ken of the average person typically qualifies as an appropriate subject for expert testimony" State v. Kelly, 97 N.J. 178, 2091 (1984); NJRE 702 provides that expert testimony will only be admissible if it "will assist the trier of fact to understand the evidence or determine a fact in issue." Biunno Current, N.J. Rules of Evidence, NJRE 702 Comment 1. New Jersey courts have held that "a jury should not be allowed to speculate without the aid of expert testimony available in an area where lay persons could not be expected to have sufficient knowledge or experience." Kelly v. Berlin, 300 N.J. Super 256, 268 (App. 1997) at p. 12, R. 702 Accord, State v. Doriguizzi, 334 N.J. Super. 530, 538 (App. Div. 2000) "...where jurors of common judgment and experience cannot form a valid judgment" as

to the fact in issue without such testimony. Butler v. Acme Markets, Inc. 89 N.J. 270, 283 (1982). See also Hake v. Manchester Twp., 98 N.J. 302, 313-314 (1985); Vargo v. National Exchange, 876 N.J. Super. 864, 380 (App. Div. 2005); State v. Clowney, 299 N.J. Super. 1, 19 (App. Div.), certif., den. 151 N.J. 77 (1997) ("esoteric, abstruse and especial nature"). Biunno Current N.J. Rules of Evidence, Comment 2 on N.J.R.E. 702 (2010)

The courts have held that the three methods of demonstrating the reliability of scientific evidence are expert testimony, authoritative scientific literature and persuasive judicial decisions. See also State v. King, 387 N.J. Super. 552, 542 (App. Div. 2006); Hisenaj v. Kuehner, 387 N.J. 1 Super. 262, 270 (App. Div. 2006) certif., Granted 189 N.J. 427 (2007); State v. Foley, 370 N.J. Super. 341, 349-350 (Law Div. 2003).

Where the court determines that the testimony is generally accepted, and that the findings are reliable, Frye requires that the court also determine whether there are judicial opinions that indicate the expert's premises have gained general acceptance. However, the absence of judicial opinions, will not, by itself, foreclose a finding of general scientific acceptance. See Wilkerson v. Pearson, 291 N.J. Super 333, 336 (Ch. Div. 1984).

In the within matter the court finds that the subject matter, essential to the disposition of the state's claim is to determine whether Neonatal Addiction Syndrome (NAS) that results from the use of prescribed methadone maintenance, is harmful as contemplated by Title 9; a subject that contemplates expert testimony.

The experts presented by the defense are each doctors who have been recognized in the medical community as experts in the area of addictive medicine, particularly the

standard of treatment for pregnant women who are addicted to opiods. Doctors Finnegan and Newman each have peculiar knowledge and experience in assessing the potential harm to an infant who is exposed in utero to methadone when compared with the potential harm to an infant who is exposed in utero to other drugs or who is exposed to the physical environment in utero that is created when the mother withdraws from heroin before the birth of the child.

Dr. Robert Newman is the director of The Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center in New York. He is recognized as a world renowned addiction specialist. A professor epidemiology and social medicine and psychiatry. He has more than 40 years of experience in the field of opiate dependence and its treatment, particularly treatment involving methadone. He was the ultimately responsible physician for every aspect of the treatment with methadone of the New York City Methadone Maintenance and Ambulatory Detoxification Program. He is recognized both domestically and internationally as an expert in the study of the pharmacological basis for methadone treatment of opiate dependent individuals, including pregnant women. Dr. Newman is extensively published in professional journals and lay publications.[6]

Dr. Loretta P. Finnegan, M.D. is President of Finnegan Consulting, LLC. Finnegan Consulting is a consultant firm in education research and treatment in issues relating to women's health and prenatal addiction. Dr. Finnegan is also a retired professor of pediatrics, psychiatry and human behavior from Thomas Jefferson University. Dr. Finnegan is the retired former medical advisor to the Director, Office of Research on Women's Health, National Institutes of Health, DHHS. She is currently a

[6] C-V Robert G. Newman, M.D., M.P.H. D-1

consultant in education, research and treatment in issues relating to women's health and perinatal addiction. Dr. Finnegan is also the founder and former director of Family Center for Pregnant Drug Dependent Women Philadelphia Pennsylvania. Dr. Finnegan is certified by the National Board of Medical Examiners for the State of Pennsylvania and the American Board of Pediatrics.[7]

Dr. Finnegan worked to develop a scoring system for evaluation and treatment of neonatal abstinence syndrome, the Finnegan Neonatal Abstinence Scoring Tool (FNAST). She is also a co-author of Drug Withdrawal in the Neonate in Merenstein & Gardner's Handbook of Neonatal Intensive Care. (7th Edition, Carter, B and Gardner S. (Eds.) 2010. In her C.V. we note that she has authored or co-authored 173 scientific publications and has spoken at scientific conferences where she has given 1000 presentations on topics related to health issues in women and children. She has provided technical consultation to UNICEF, WHO, UNADS, and UNODC. Dr. Finnegan has been the recipient of numerous treatment and research grants from institutions such as the National Institute on Drug Abuse and Coordinating Office of Drug and Alcohol Abuse Program of the City of Philadelphia.

Medical Standard of Care

The medical standard of care "is a case and time-specific analytical process in medical decision making, reflecting a clinical benchmark of acceptable quality medical care. This benchmark, which is used to evaluate and guide the practice of medicine, encompasses the learning, skill and clinical judgment ordinarily possessed and used by prudent health care providers or payors of food standing in similar circumstances. The

[7] C-V Robert G. Newman, M.D., M.P.H. D-1

standard of care must reflect the art (consensus of opinion of clinical judgment and science (published peer reviewed literature) of medicine and must be uniform for all health care personnel whether they are providing direct clinical care of reviewing the medical necessity of past, present or future medical care. A violation of the standard of care may result in under utilization of medical care but also occurs when unnecessary (over-utilization) is provided. The standard of care has a national and clinical basis rather than a local provider community or payor review basis. 61 AM.Jur. 2nd Physicians & Surgeons Sec. 110 Methadone maintenance, according to each expert is a form of medication assisted withdrawal that has been used by addition specialists for more than 40 years.

Methadone Maintenance and Pregnant Women

In the within matter the court finds that the testimony of defense experts that methadone maintenance is the preferred standard of care for the treatment of pregnant women who are opioid dependent is generally accepted in the profession of addiction medicine and that the premises on which the experts based their analysis is generally accepted within the community of addiction specialists.

Dr. Finnegan testified that research studies have shown that methadone has positive effects when utilized during pregnancy preventing fluctuation of drug levels and decreasing morbidity and mortality for the mother and newborn. With pharmacotherapy and comprehensive services, it has been shown that the daily routines of the mother can be stabilized and therefore she can prepare for the birth of the child physically, psychologically and nutritionally. She maintains that when using methadone in pregnancy the way the medication is metabolized in pregnancy should be known by the

physician and the proper methods of dosing utilized in order to decrease under or overdosing the woman and therefore not disrupting the intrauterine environment.

In the report that she prepared in connection with this litigation Dr. Finnegan writes:

> ...methadone maintenance requires that the expectant mother is monitored by a physician. The National Institute on Drug Abuse recommends that dosages be individually determined which keep the woman and fetus subjectively comfortable and clinically stable. The data suggests that pregnant women may need increasing methadone doses during gestation and that lowering the dosage in an attempt to minimize neonatal abstinence would be medically inappropriate. (D-14)

Dr. Finnegan identified the major risk with methadone maintenance during pregnancy is that 60-80% of neonates exposed in utero to methadone are reported to have symptoms of neonatal abstinence with 60% of those needing treatment. She explained that the research shows that babies who are born premature appear less likely to experience withdrawal than babies born full term. She continued to say that it is recognized that although neonatal abstinence is potentially a serious medical condition that presents morbidity for the neonate, it is not lethal and not as serious as the side effects of prematurity as in the case of heroin dependent women. When contrasting methadone with heroin, many aspects are improved such as decreased fetal and neonatal complications, increased term births and higher birth weights. She cautioned that medical withdrawal from methadone during pregnancy should not be considered except in an emergency. Furthermore, she testified that there is no correlation between a mother's receipt of methadone during pregnancy and birth defects or long term cognitive or health problems in the child. With proper assessment and treatment, babies born with signs of NAS at birth will do as well as babies born without it.

Dr. Newman too opines that methadone maintenance as a treatment modality for opiod addicts is recognized as a standard and preferred practice. He testified that although addiction is not curable that it is "possible to treat addiction to opiates with significant efficacy through a variety of means". He further opines that while there are many forms of treatment, "...none has proven as effective a methadone maintenance in attracting and retaining patients and assisting them in assuming health, self-fulfilling socially productive lives. He notes that both the National Institute on Drug Abuse and the World Health Organization agree that "substitution therapies such as methadone remain the most promising method of reducing drug dependence." In discussing the preferred form of treatment for pregnant addicts Dr. Newman, as noted within references the Federal guidelines governing opiate treatment programs that require ... a preference for pregnant women in admitting patients to interim maintenance and transferring patients from interim maintenance to comprehensive treatment. 42 CFR 8:12(j).

Both Doctor Finnegan and Doctor Newman present scientific and legal writings indicating that the scientific community accepts the premises underlying the proffered testimony. Dr. Newman supports his findings in a report submitted to the court that references Federal guidelines governing opiate addiction and its treatment in the pregnant patient. Dr. Loretta Finnegan in her testimony refers to numerous studies that she relied upon rendering her opinion. These references include studies that were published by the American Academy of Pediatrics, Committee on substance abuse: Neonatal Drug Withdrawal, the American Journal Obstetrics and Gynecology, and the Journal of American Medical Association; the International Journal of Clinical Pharmacology and

Biopharmacology. She references several published studies of her research that are documented in professional journals.

Based on the findings and presentation of Doctors Finnegan and Newman and the supporting publications referenced in their testimony the court finds that medication maintenance comports with the generally accepted medical standard of care within the community of addiction specialists. The experts presented by the defense are each doctors who have been recognized in the medical community as experts in the area of addictive medicine, particularly the standard of treatment for pregnant women who are addicted to opioids. They each have peculiar knowledge and experience in assessing the potential harm to an infant who is exposed in utero to methadone when compared with the potential harm to an infant who is exposed in utero to other drugs or who is exposed to the physical environment in utero that is created when the mother withdraws from heroin before the birth of the child.

NAS/Harm

The Division says that [redacted] is an abused and neglected child because he suffered from symptoms of withdrawal from methadone; that he experienced actual harm that is entirely attributable to the mother's actions.

The evidence shows that Ms. [redacted] did have prenatal care. By the time that she became pregnant with [redacted] she had a history of heroin and cocaine dependence that dated back 19 years. When she became pregnant with [redacted] she had been free of all controlled dangerous substances since October 2009. Beginning on April 4 she was treated with benzathine, penicillin, 2.4 million units IM weekly for 3 doses for a rising liter and 105 milligrams of methadone daily. On April 9, 2010 Ms. [redacted] was admitted

to the hospital with a blood pressure of 169/103 and the fetus was in the breech position. She underwent an uncomplicated repeat low transverse cesarean section and bilateral tubal ligation via pfannensteil incision. She was discharged on April 12, 2010.

Baby [redacted] was born weighing 3295 grams with an Apgar Score of 8. He had a spontaneous cry with poor tone and acrocyanosis. He admitted to NICU with a diagnosis of respiratory distress syndrome, sepsis, prematurity, large for gestational age, neonatal abstinence syndrome (NAS). The sepsis was later ruled out by negative cultures. He was treated conventionally with CPAP, antibiotics for 2 days since recovery occurred and the blood cultures were reported negative. [redacted]s urine toxicology was reported positive for only methadone. He was stared on continuous assessment of neonatal abstinence symptoms with the Finnegan Neonatal Abstinence Score on day one of life. His scores began to escalate with 24 hours and Diluted Tincture of Opium was commenced and continued at 6 drops per dose until the 6th day of life at which time weaning began with decreasing doses until day 9 at which time it was discontinued. He was discharged on his 17th day of life.

The Division contends that the state has established by a preponderance of the evidence that [redacted] suffered actual harm when he went through withdrawal from methadone after his birth and that this withdrawal is contemplated by the language of the statute as "...proof of injuries sustained by a child or a condition of a child of such a nature would ordinarily not be sustained or exist except by reasons of the acts or omissions of the parent or guardian and is prima facie evidence that a child of... such a person is an abused or neglected child." In support of its argument that the fact that [redacted] presented at birth with NAS as a consequence of withdrawal from

methadone the Division relies upon several unpublished cases. The rules of court are clear that an unpublished opinion shall not constitute precedent or be binding upon any court. R.1:36-3. Although the parties may bring unpublished opinions to the attention of the court, the court itself may not cite any unpublished opinion except to the limited extent required by the application of preclusionary legal principles or case history. Newark Ins. v. Acupack Packing, 328 N.J. Super 385, 394, N.J. 4 (App. Div. 2000)

The unpublished opinions submitted by the Division, as noted by the defense, re opinions where the court did not have the advantage of testimony from any expert "regarding the therapeutic use and value of methadone treatment during pregnancy and its anticipated side effects." (Defense A.J. summation p. 2). The cases presented by the Division are factually distinguishable as [redacted], only tested positive for methadone, and no other controlled dangerous substance at birth. In the published opinion In re Z.T.T.B., the court citing K.H.O. held that harm may be found when drug use during pregnancy "results in the child being born addicted to drugs with the attendant suffering caused by such addiction. supra In re Z.T.T.B, 413 N.J. (App. Div. 2010) Z.T.T.B is a case where the infant was born with a positive toxicology to cocaine, not methadone that was administered by a physician. There was not expert testimony by an expert in the field of addictive medicine. Finally, as noted by the defense, the use of the term "addicted when referring to newborns is inaccurate.[8]

Neonatal Abstinence Syndrome

The expert evidence at trial is that neonatal abstinence is a term that describes an outcome where neonates who are born to mothers who are chronic opiate users are

[8] The value and necessity of expert testimony on methadone maintenance as the preferred treatment for pregnant women, therefore informs the court.

frequently born with a passive dependency to those specific agents. It happens as a result of the passage of drugs transplacentally from mother to fetus. The cutting of the umbilical cord stops the supply of drugs, setting the state for neonatal abstinence. The variables that affect the amount of fetal exposure conclude the amount and purity of the drugs taken by the mother, length of drug use, maternal drug metabolism and the individual kinetics of placental drug transfer. Neonatal abstinence is usually apparent within the first 24-72 hours of life. Since methadone is longer-acting and stored in fetal tissues; the occurrence, timing and severity of abstinence signs are more variable. The signs of neonatal abstinence are present in multiple systems of the body. Babies who are born with neonatal abstinence present with irritability, persistent high pitched crying, hypertonia and tremulousness (central nervous system); vomiting and diarrhea (gastrointestinal) tachypnea, hyperpnoea, cyanosis and apnea (respiratory signs) sneezing, tearing, lacrimation, yawning, sweating and hypothermia (autonomic nervous system.

Dr. Finnegan opined that NAS is not harm or abuse, but rather, is a known and anticipated side effect of a medical treatment. She analogized the receipt of methadone and the resulting NAS effect to pregnant women receiving medications for a host of to her conditions or diseases during pregnancy – all of which have anticipated and corresponding side effects on the newborn. In rendering this opinion, Dr. Finnegan relied, in part, on the research she directed which compared children born to women receiving methadone and children born to mothers not receiving methadone of the same socioeconomic class. Dr. Finnegan while director at the Family Center in Philadelphia also directed research which compared the birth outcomes of women who used heroin

during pregnancy with women who are receiving methadone. That research demonstrated that for the women who received methadone the incidence of preterm birth was 18% while for the women who were addicted to heroin and not treated, the rate of preterm birth was 48%. Dr. Finnegan testified that the risks of a woman stopping her methadone treatment during her pregnancy were miscarriages during the first and second trimesters or preterm birth during the third. She further explained that evidence-based research demonstrates that the positive effects of methadone in the pregnant patient are that the baby as a greater chance of being carried to term, which is crucial for a healthy outcome.

The Division characterizes the testimony of Dr. Finnegan that methadone treatment is akin to the treatment of other diseases such as diabetes or depression: as "ridiculous". The Division argues that addiction is not "an unavoidable medical condition but a direct result of life choices made by the defendant Ms. [redacted]." The Division's assertion that drug addiction is not an illness is inapposite the position of the United States Supreme Court and the medical profession. The United States Supreme Court, as well as leading medical groups such as the American Medical Association, the American Psychiatric Association, and the National Institute on Drug Abuse, have long recognized that drug addition is an illness that generally cannot be overcome with appropriate treatment and support. See Linder v. United States, 268 U.S. 5, 18 (1925). Dr. Newman testified that opiate addiction is recognized in the U.S. and internationally as a disease.

As a pregnant woman who suffers from the disease of addiction Ms. [redacted]' decision to accept or to refuse medical treatment while pregnant is a constitutionally

protected right. New Jersey Division of Youth and Family Services v. L.V., 382 N.J. Super, 582, 590-92 (Ch. Div. 2005) (citing Planned Parenthood of Cent. New Jersey v. Farmer, 165 N.J. 609, 632, 762 A.2d 620 (2000).

Doctor Justine Laurelli, M.D. is the corporate medical director of the Lennard Clinic, a methadone maintenance program located in New and Elizabeth New Jersey. Ms. [redacted] began treatment with the program on may 29, 2009. Dr. Emanuel Ekulide is also a physician at the Lennard Clinic. They testified that Ms. [redacted] chose to participate in a methadone maintenance program at the Lennard Clinic before she was pregnant and continued to participate in the methadone maintenance program during her pregnancy. The testimony is undisputed that Ms. [redacted] in consultation with her treating physician chose to take methadone under the supervision of a physician and as a participant in methadone maintenance program.

Dr. Laurelli and Dr. Ekulide testified that Ms. [redacted] was a compliant participant in the clinic program. The explained the methodology used by the Lennard clinic to monitor the progress of the clients and to determine the appropriate dosage. They explained the treatment goals for the patients and verified that Ms. [redacted] did not test positive for any substance other than methadone after October, 2009. They testified that she was complaint with treatment.

The Division challenges Ms. [redacted] compliance with the methadone maintenance program. They cite Ms. [redacted] history of 19 years of substance abuse. At the time of her admission to the program she was using 15 bags of heroin a day intravenously and smoking one vial of cocaine per day. (P-3)..The Division argues and the evidence supports a finding that Ms. [redacted] enrolled at the Lennard Clinic in late May 2009. (P-3).

In June 2009 the notes from the clinic show that she was taking 6-7 bags of heroin every day. On July 28, 2009 she tested positive for methadone, opiates, benzodiazepines and cocaine. (P-3) She did not provide any urine screens in August 2009. On September 23, 2009 she tested positive for methadone and cocaine (P-3) She continued testing positive for controlled dangerous substances in addition to methadone through September 2009. The Division writes that "for the first four months of her treatment at the Lennard Clinic, Ms. [redacted] was non-compliant because she continued using other illegal substances on top of her methadone." The Division does not, however, offer any expert testimony to support its finding that Ms. [redacted] was non compliant with the treatment goals of the clinic. Giving the plaintiff the benefit of all favorable inferences the evidence does show that for the first four months of the program Ms. [redacted] was still abusing other substances. To say that she was non compliant with the treatment goals is not however, supported by the evidence, if the treatment goal was to ultimately substitute methadone for all other controlled dangerous substances.

Dr. Newman reviewed Ms. [redacted] record from The Bridge program and the Lennard Clinic. He reviewed the reports and pleading filed by the Division. Dr. Newman testified that, according to his review of the records from the Lennard Clinic and The Bridge, Ms. [redacted] had responded extremely well to methadone maintenance treatment and it was proving to be an effective treatment. Dr. Newman testified that, according to his review of the records from the Lennard Clinic and the Bridge, Ms. [redacted] had responded extremely well to methadone maintenance treatment and it was proving to be an effective treatment.

Dr. Newman also testified that methadone has been endorsed in the pregnant patient. He found that in taking prescribed methadone while participating in a methadone maintenance program that Ms. [redacted] acted in a "highly responsible way and complied with sound medical advice." He states that Ms. [redacted]' choice to receive methadone maintenance during her pregnancy is strongly endorsed by the highest substance abuse authorities in America. MMT during pregnancy posed the least risk and offered the greatest likelihood of benefit to her fetus and the child once born. He notes that the fact that [redacted] was born positive to methadone to be the "expected consequence of treatment that was appropriately (and successfully) provided to [redacted]." Finally he found with a reasonable degree of medical certainty that Ms. [redacted] did not harm or place her child at risk of harm by successfully complying with her physicians' prescribed methadone treatment. Based on his review of the records in this case he found that nothing in the records justifies denial of custody of baby [redacted] to his mother, Ms. [redacted]. He found that to the contrary, the records give every indication of exemplary motivation on the part of Ms. [redacted] to provide a safe and loving home for [redacted].

[redacted]

When Dr. Finnegan reviewed the medical records of Ms. [redacted] and [redacted] she differentiated the symptoms that [redacted] experienced that are a function of NAS from the symptoms that [redacted] experienced that are attributable to other causes. [redacted] was diagnosed with respiratory distress syndrome. According to Dr. Finnegan babies who are delivered by c-section are at a higher risk for transient tachpnea (TTN), also called Type II respiratory distress syndrome. The baby does not undergo the usual squeezing and hormone changes of vaginal birth so they tend to have more fluid than normal in their

lungs when they take their first breaths. [redacted] was also exposed to magnesium sulfate. She says that rare side effects of exposure to magnesium sulfate include low Apgar scores at birth, low blood pressure, and build-up of fluid in the lungs (pulmonary edema). It also affects the fetus' central nervous system.

Dr. Finnegan concludes that Baby [redacted] had a transient respiratory problem possibly secondary to his delivery by c-section with a breech presentation and possibly by exposure to magnesium sulfate necessary to treat Mrs. [redacted] underlying hypertension. Both of these contributory factors, she finds, were necessary to save both mother and baby so in spite of the potential side effects, they were essential. The later diagnoses had nothing to do with the mother's methadone treatment. She found that the baby had a good Apgar score and was otherwise a healthy baby except for the withdrawal from methadone. Dr. Finnegan testified that there may be a correlation between the metabolic activity of the baby and NAS. She describes his NAS as mild to moderate NAS secondary to methadone exposure and the he responded to therapy rapidly. She further opined that [redacted] should do well post discharge with the recommendations regarding his care.

The Division urges the court to give little weight to Dr. Finnegan's testimony except to the extent that she confirmed the harm suffered by this child. The Division urges that the court should not give any weight to the testimony or the report of Dr. Finnegan who opines that the withdrawal suffered by [redacted] is not harmful as this is a legal conclusion that she is not qualified to make." The court rejects this position. 1) Dr. Finnegan's qualifications were accepted by the court and have been detailed earlier in this decision 2) the doctor's opinion is based on facts or data reasonably relied upon by

experts in her particular field of expertise. The court finds that the doctor's opinion is reliable.

Defense does not deny that the infant after birth experienced withdrawal from methadone. Defense argues that if Ms. [redacted] had not used methadone, the withdrawal and its sequalae would have been more involved, and more devastating for her child. The testimony of the experts presented by the defense, not rebutted by the state, is that if Ms. [redacted] had stopped using heroin when she learned that she was pregnant or had stopped using heroin during her pregnancy, and she were not taking methadone, that [redacted] would have suffered greater harm.

Risk of Harm

The Division further alleges that [redacted] is an abused and neglected child because Ms. [redacted] has a long history with the Division, resulting in the involuntary termination of her parental rights to five of her nine children and the placement of a sixth child into long term foster card (P-4 – P-7) At the time of her birth Ms. [redacted] did not have any of her other children in her care. The Division notes that the time of [redacted] birth, Ms. [redacted] had only been free of on prescribed controlled dangerous substances, for seven months, and that in the wake of her 19 years of history of substance abuse tat seven months is not enough "clean time" and "stabilization". There is no allegation that Ms. [redacted] used any illegal drugs during her pregnancy with [redacted]. There is no allegation that Ms. [redacted] failed to have prenatal care during her pregnancy. There is no allegation that Ms. [redacted] was not in a position to plan for [redacted] when he was born.

The allegation as to [redacted] is that he has an admitted history of drug abuse and that he (1) has not completed a drug program. (2) Mr. [redacted] had tested positive

for oxycodone two weeks before [redacted] was born and (3) Mr. [redacted] had a heart attack and the Division cites his ill health as a risk.

N.J.S.A. 9:6-821 (1) defines an abused or neglected child as a child less than 18 years of age whose parent or guardian, as herein defined inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or created a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ.

The courts have held that risk of harm is sufficient for a finding of abuse and neglect. In the Guardianship of D.M.H., In the Guardianship of D.M.H., 161 N.J. 365, 383 (1999) citing New Jersey Division of Youth and Family Services v. A.W., 103 N.J. 591, 616 n. 14 (1986) ("it would make no sense to wait until (the child) had been injured to decide the "issue of parental fitness"). See also, New Jersey Division of Youth and Family Services v. I.H.C and D.C., 415 N.J. Super. 551, 575-576 (App. Div. 2010). The court must therefore assess risk to the child, as risk of harm is relevant to determining whether a child is an abused or neglected child.

In fact finding hearing any determination that the child is an abused or neglected child must be based upon a preponderance of the evidence and the only competent, material and relevant evidence may be admitted. The focus centers upon the question of whether the parent under consideration caused injury to the child and, if not whether the parent is likely to do so in the future. N.J. 382 N.J. Super 582 (2005)

At 39, Ms. [redacted] she has given birth to nine children and that her parental rights to five of those children have been involuntarily terminated. The courts have held that

proof of the abuse or neglect to one child shall be admissible evidence on the issue of abuse or neglect of any other child or the responsibility of the parent or guardian N.J.S.A 30:4c-11-12 states that the Division "shall not be required to provide reasonable efforts to prevent placement of the child if...(a)(3) the rights of the parent to another of the parent's children have been voluntarily terminated. The theory underlying the admission of evidence of the abuse or neglect of one child, in assessing the risk of harm to another is, as the division argues, that history can be a predictor of future behavior.

In this case when [redacted] was born, neither Ms. [redacted] her husband, co-defendant [redacted] or her newborn son tested positive for any substance other than methadone. The record supports a find that this time, Ms. [redacted] voluntarily enrolled in a drug program before she learned she was pregnant, and continued in that program throughout her pregnancy. While in the program Ms. [redacted] participated in and completed a parenting program. She also participated in individual and group therapy. Ms. [redacted] and Mr. [redacted] had housing for the baby, income to support the baby, to purchase food and other furnishings. She and Mr. [redacted] married in October 2009. Mr. [redacted] although he did admit to a Division investigator that he had been battling with substance abuse for many ears, he too was enrolled in the Lennard clinic and at the time of [redacted] birth, and, thereafter, he has tested negative for all illegal substances. As to Ms. [redacted] Ms. Verline Parks, a counselor at the Lennard Clinic testified that Ms. [redacted] was a very good patient in the clinic. She also testified that Ms. [redacted] had become a role model to other patients of the clinic. She confirmed Ms. [redacted] substantial progress. Ms. [redacted] enrolled in a second program for dependent persons. The Bridge, the evidence shows

that Ms. [redacted] has emerged as a group leader and serves as a role model to other group participants."

Bother Doctor Finnegan and Dr. Newman found that Ms. [redacted] did not present a risk of harm to [redacted]. Dr. Newman found with a reasonable degree of medical certainty that "nothing in the records reviewed justifies the denial of custody of baby [redacted] to his mother, Ms. [redacted]. To the contrary, the records give every indication of exemplary motivation on the part of Ms. [redacted] to provide a safe and loving home for [redacted]. The Division fails to present any lay or expert testimony supporting any allegation that Mr. [redacted] presents a risk of harm to his son [redacted]. Although he has not completed a drug program, he remains in treatment and he has not tested positive. There has been no proffer by the Division documenting how Mr. [redacted] heart condition would adversely affect his ability to parent [redacted].

Conclusion

The court finds that the Division has failed to establish by a preponderance of the evidence that [redacted] is an abused and neglected child as the evidence supports a finding that his diagnosis, at birth, of Neonate Addiction Symptom is an outcome that is consistent with the medical standard of care for opioid addicted pregnant women.

The court finds that the Division failed to establish by a preponderance of the evidence that [redacted] is an abused and neglected child as the evidence supports a finding that certain conditions that [redacted] presented with at birth are because he was delivered by caesarean section and that he was exposed to magnesium sulfate, necessary to protect the health of the mother and the baby.

The court finds that the Division failed to establish by a preponderance of the evidence that Ms. [redacted] history of involuntary terminations and chronic substance abuse militate the removal of [redacted] from Ms. [redacted] as Ms. [redacted] did take substantive and effective steps to address her addiction, to ameliorate the harm to her unborn child caused by her addiction and was in a position to plan for her child. Further Ms. [redacted] and Mr. [redacted] are married and living together, and Mr. [redacted] does not have a history with the division.

The court finds that the Division fails to establish by a preponderance of the evidence that Mr. [redacted] presents a risk of harm to [redacted] as Mr. [redacted] is in a position to plan for his child and is actively participating in a methadone maintenance program.

The court finds that as the Division has failed to establish abuse and neglect by a preponderance of the evidence that the complaint as to Ms. [redacted] and the complaint as to Mr. [redacted] is hereby dismissed.

J.S.C.

HON. VERNA G. LEATH J.S.C.