NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES,

Plaintiff-Respondent

v.

A.L.,

Defendant-Petitioner

In the Matter of T.L. and A.D.

SUPREME COURT OF NEW JERSEY
DOCKET NO.: 068542

On Appeal From Superior Court Of New Jersey Appellate Division
DOCKET NO. A-5799-09T3

Sat Below:
Honorable Judges
Wefing, Payne and Baxter

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

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STATEMENT OF INTEREST

Amici curiae include 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

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[1] Statements of interest for each are included as Appendix A. *Amici* are: American Academy of Addiction Psychiatry, American College of Obstetricians and Gynecologists, American Society of Addiction Medicine, Global Lawyers and Physicians, National Council on Alcoholism and Drug Dependence - NJ, National Perinatal Association, Abortion Care Network, Addiction Science Research and Education Center, American Association of Birth Centers, American Civil Liberties Union, American Civil Liberties Union - New Jersey, Association of Reproductive Health Professionals, Baron Edmond de Rothschild Chemical Dependency Institute of the Beth Israel Medical Center (International Center for Advancement of Addiction Treatment), Black Women's Health Imperative, Center for Children of Incarcerated Parents, Center for Gender and Justice, Cherry Hill Women's Center, Child Welfare Organizing Project, Children's Justice Foundation, Drug Policy Alliance, Faces and Voices of Recovery, Harm Reduction Coalition, Harm Reduction International, HealthRight International, Institute for Health and Recovery, International Centre on Human Rights and Drug Policy, International Centre for Science in Drug Policy, International Doctors for Healthy Drug Policies, Legal Action Center, National Association of Nurse Practitioners in Women's Health, National Coalition for Child Protection Reform, National Latina Institute for Reproductive Health, National Organization for Women of New Jersey - Morris County, National Women's Health Network, New Jersey State Affiliate of the National Organization of Women, Physicians and Lawyers for National Drug Policy, M. Douglas Anglin, PhD, Elizabeth M. Armstrong, PhD, MPA, Susan Boyd, PhD, Nancy Day, MD, MPH, Deborah A. Frank, MD, Peter Fried, MD, Leslie Hartley Gise, MD, Carl L. Hart, PhD, Stephen R. Kandall, MD, Barry M. Lester, PhD, Howard Minkoff, MD, Robert G. Newman, MD, Steven J. Ondersma, PhD, Dorothy E. Roberts, Linda L. M. Worley, MD, PLLC, Lynn Singer, PhD, Treecia Wouldes, PhD., Tricia E. Wright, MD, MS.

peer-reviewed medical and social science research, which was never presented to or considered by the courts below, and which militates against the abuse and neglect finding in the instant case and against the judicial expansion of *N.J.S.A.* 9:6-8.21(c)(4)(b) to apply to a pregnant woman in relation to the fetus she carries and sustains.[2]

In so arguing, *amici* do not assert that there are no health risks associated with the use of cocaine or other controlled substances during pregnancy, or endorse the non-medicinal use of drugs, including alcohol or tobacco, during pregnancy.[3] But *amici* strongly believe that judicial findings like those at issue here, which implicate medical, scientific, and social science questions, must be informed by the relevant scientific evidence, and aided by expert testimony where appropriate. The lower courts erred in failing to apply this principle to the scientific and medical questions raised by this case, including the effect of prenatal exposure to drugs, the risks posed by parental use of drugs, the validity and reliability of drug tests for anything other than determining that a person used a

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[2] *Amici* do not state an interest in, or take position as to, that part of the Appellate Division's decision affirming a finding of neglect based upon the violation of a protective order as between the parents in this case.

[3] Nor do *amici* purport to address the question of whether and when a new parent or newborn may be subject to reporting to child welfare authorities.

drug, and the efficacy of using punitive measures to address drug use or any other perceived threats to fetal and child health by a pregnant woman.

PRELIMINARY STATEMENT

In finding that A.L. committed abuse and neglect, the lower courts not only applied an erroneous construction of *N.J.S.A.* 9:6-8.21, as explained by Appellant in her briefs to this Court, but also relied upon scientifically discredited myths regarding drug use and pregnancy. 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 prenatal drug exposure establishes harm or a substantial risk of harm to a child -- a medical and scientific question -- without the benefit of expert testimony and without considering the vast scientific literature on the subject. There is, in fact, an overwhelming scientific consensus that the use of illegal drugs during pregnancy cannot, as a matter of science, be singled out from innumerable other actions, inactions, and exposures that pose potential risks to a fetus or to a child once born. Similarly, while the lower courts assumed that a positive drug test on a pregnant woman or newborn establishes that the newborn has been harmed or subjected to substantial risk of harm, and that a positive drug

test on a pregnant woman or newborn establishes that a mother is likely to abuse or neglect her child, none of these assumptions is supported by evidence-based research. This Court should reject the lower courts' reliance on myths and assumptions in lieu of reliable scientific evidence regarding these questions.

In expanding the scope of *N.J.S.A.* 9:6-8.21 to pregnant women, the lower courts also failed to consider the existing scientific consensus that threats of loss of child custody through the child welfare system undermine maternal, fetal, and child health. Such threats are much more likely to deter women from seeking health care, thus dangerously increasing maternal, fetal, and child health risks, than they are to protect children, reduce the use of illegal drugs, or further the state's public policy of "combat[ting] the dangerous effects of narcotics" or reducing "drug trafficking." *N.J. Div. of Youth & Family Servs. v. A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490, at *14-15 (App. Div. June 10, 2011) (citing *N.J.S.A.* 2C:35-1.1(c)), attached hereto at B-1. Nor is there any principled basis for limiting the lower courts' expansion of *N.J.S.A.* 9:6-8.21 to illegal drugs, given that countless other legal and illegal activities pose similar levels of risk to fetuses and children. The lower courts' rulings thus open the door to an extraordinary -- and unjustified -- expansion of DYFS's jurisdiction, an

expansion that is likely to disproportionately burden low-income communities and communities of color.

For these reasons and the reasons that follow, this Court should reverse the Appellate Decision and (1) clarify 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; (2) hold that the use of a controlled substance during pregnancy does not alone constitute abuse or neglect within the meaning of *N.J.S.A.* 9:6-8.21(c) and that a finding of abuse or neglect must be based on evidence of harm to the baby once born; and (3) rule that *N.J.S.A.* 9:6-8.21 was not intended to apply to pregnant women in relation to the fetuses they carry, nurture, and sustain. Alternatively, if necessary, the Court should appoint a special master so that the parties may each call appropriate experts and subject the academic literature regarding such significant questions to the kind of full and fair consideration that they deserve.

PROCEDURAL HISTORY

Amici adopt and incorporate by reference the Procedural History set forth in the Brief for the Appellant, previously filed with the Court.

STATEMENT OF FACTS

Amici likewise adopt and incorporate by reference the Statement of Facts set forth in the Brief of the Appellant, previously filed with the Court.

ARGUMENT

I. THE COURT SHOULD REVERSE THE DECISION OF THE APPELLATE DIVISION AND CLARIFY THAT FINDINGS THAT THE USE OF DRUGS BY A WOMAN DURING PREGNANCY CAUSED OR IS LIKELY TO CAUSE HARM TO A CHILD MUST BE BASED UPON RELIABLE SCIENTIFIC EVIDENCE.

It is well established that when a case raises scientific questions, a court cannot rely upon myths or assumptions in making its determinations -- it must look to reliable scientific evidence, guided by expert testimony where appropriate. The lower courts violated this basic principle, relying upon unsupported myths about the impact of drug use during pregnancy to conclude that the mere fact of prenatal drug use, without any specific evidence of harm or the substantial risk of harm, constituted abuse and neglect. Specifically, the lower courts erred by failing to consider the vast body of scientific research on this issue and failing to consider any testimony, expert or otherwise, to aid them in assessing the harm or risk of harm from A.L.'s conduct.

A. Scientific Evidence is Required to Support the Claim That a Drug Taken by a Pregnant Woman Caused or is Likely to Cause Harm to Her Child.

In order to sustain an abuse and neglect charge against A.L., DYFS 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 A.D. *N.J.S.A.* 9:6-8.46. Yet DYFS rested its abuse and neglect claim on an assumption about the impact of A.L.'s drug use while pregnant on A.D. -- a scientific and medical question -- without providing any evidence, scientific or otherwise, to support its theory. These unsupported assumptions cannot sustain DYFS'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 interest in retaining custody of her child, as well as a child's interest in family life.[4]

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[4] 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 DYFS 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). Moreover, U.S. Supreme Court jurisprudence recognizes "the sanctity of the family" as a unit, and not solely as a function of parents' right to care for their children. *Moore v. East Cleveland*, 431 *U.S.* 494, 503-04 (1977) ("Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and

This Court has been a national leader in recognizing that when cases raise scientific, medical, or other technical issues, the evaluation of these issues must be informed by existing scientific knowledge, including expert testimony. The Court has thus firmly rejected the presentation in judicial proceedings of "unsubstantiated personal beliefs couched in scientific terminology." *Kemp v. State*, 174 *N.J.* 412, 427 (2002) (holding that expert testimony on scientific issues should be permitted only when "the expert's opinion is based on scientifically sound reasoning"). When considering the admissibility of scientific test results, new scientific technologies, or other evidence that rests on a particular scientific theory, this Court has demanded that the scientific claim "be generally accepted, within the relevant scientific community, to be reliable," *State v. Chun*, 194 *N.J.* 54, 91 (2008), or, in limited situations where it is not feasible to establish that a scientific claim is generally accepted, that it "is based on a sound, adequately-founded scientific methodology involving data and information of the type reasonably relied on by experts in the scientific

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tradition."). 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 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.

field." *Kemp*, 174 *N.J.* at 430 (internal quotation marks omitted).

New Jersey courts therefore 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). In *State v. Henderson*, for example, this Court recently concluded that the "vast body of scientific research about human memory . . . . casts doubt on some commonly held views relating to memory," thus requiring revisions to the test for evaluating the trustworthiness of eyewitness identifications. 208 *N.J.* 208, 217-18 (2011). The Court emphasized that while practices may evolve "as we learn more about variables that affect memory," new approaches "must be based on reliable scientific evidence that experts generally accept." *Id.* at 219. Likewise, in *State v. Moore*, 188 *N.J.* 182 (2006), the Court considered expert testimony on the reliability of hypnotically refreshed testimony, and determined that previous guidelines laid out by the Court regarding such testimony should no longer be followed. *Id.* at 184-85 (discussing *State v. Hurd*, 86 *N.J.* 525 (1981)). The Court explained that "we had become convinced that the scientific evidence . . . counsels another course," and concluded that hypnotically refreshed testimony of a witness in a criminal

trial should be generally inadmissible. *Id.* at 207-08. *See also Chun*, 194 *N.J.* at 65 (Alcotest breathalyzer test generally scientifically reliable); *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 not scientifically reliable); *State v. Kelly*, 97 *N.J.* 178, 211 (1984) (holding that "battered woman's syndrome has a sufficient scientific basis to produce uniform and reasonably reliable results," as required for the admission of expert testimony).

The basic principle that scientific questions must be informed by reliable scientific evidence also underlies *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, a case best known as the landmark Supreme Court ruling on the admissibility of expert testimony, 509 *U.S.* 579 (1993), but which also stands for the proposition that reliable scientific evidence, including expert scientific testimony, is necessary to prove a causal link between *in utero* drug exposure and harm to a child after birth. In *Daubert*, two minors claimed that they suffered limb reduction birth defects because their mothers had taken Bendectin, a morning sickness drug produced by Merrell Dow Pharmaceuticals,

and Merrell Dow sought summary judgment. *See* 43 *F.*3d 1311, 1313 (9th Cir. 1995). Every court that reviewed Merrell Dow's summary judgment motion concluded that unless plaintiffs could support their allegations of a causal link between Bendectin and birth defects with reliable scientific evidence, including expert testimony, their case should not be permitted to proceed. *Id.* at 1315. Although the Supreme Court eventually modified the standard for admitting expert testimony,[5] both before and after the Supreme Court's ruling, the lower courts concluded that plaintiffs had not provided evidence, grounded in science, to support the alleged causal link, and accordingly granted summary judgment to Merrell Dow. *See* 43 *F.*3d at 1316 (post-Supreme Court decision affirming summary judgment because, *inter alia*, the proposed expert testimony did not reflect "scientific knowledge," did not constitute "good science," and was not

[5] Under the previous test, which was established in *Frye v. United States*, 509 *F.* 1013 (D.C. Cir. 1923), for expert testimony based on a purported scientific method to be admissible, that method must have "gained general acceptance" in the relevant scientific community. *Id.* at 1014. In *Daubert*, the Supreme Court held that *Frye*'s "general acceptance" test was superceded by the adoption of the Federal Rules of Evidence, and provided for the more "liberal" admission of expert testimony, 509 *U.S.* at 587, based on whether the reasoning or methodology underlying the testimony is scientifically valid and whether that reasoning or methodology properly can be applied to the facts of the case, 509 *U.S.* at 592. *See also Fed. R. Evid.* 702. New Jersey state courts generally still apply the more rigorous *Frye* standard. *State v. Doriguzzi*, 334 *N.J. Super.* 530, 539 (App. Div. 2000) ("[W]ith the exception of toxic tort litigation, *Frye* remains the standard." (citing *State v. Harvey*, 151 *N.J.* 117, 169-70 (1997))).

"derived by the scientific method"); 951 *F.*2d 1128, 1131 (9th Cir. 1991) (pre-Supreme Court decision affirming summary judgment because plaintiffs' proposed scientific evidence was not "generally accepted by the scientific community").

DYFS and the lower courts failed to abide by these well-established principles. The only evidence presented by DYFS at trial were medical documents stating that A.D. tested positive for cocaine at birth; that, according to a hospital social worker, A.L. had tested positive for marijuana in her fifth month of pregnancy; and that A.L. denied having used drugs. DYFS presented no evidence that A.D. had suffered any actual injury at birth or at any time after birth, and presented no witnesses with expertise regarding cocaine, drug testing or what drug results mean, the effects of prenatal exposure to cocaine, or the association between a pregnant woman's drug use and a likelihood of abuse or neglect of a child once born. Nor did DYFS present or the lower courts consider the vast body of medical and social science research on these questions.[6]

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[6] In its briefing to the Appellate Division, the State cited, for the first time, two outdated studies in support of its abuse and neglect claim. *See* Joseph J. Volpe, *Effect of Cocaine Use on the Fetus*, 327 *New England J. Med.* 399 (1992); Ira J. Chasnoff *et al.*, *Cocaine Use in Pregnancy*, 313 *New England J. Med.* 666 (1985). The latter study was based on a sample of only 23 infants. *See infra* note 19. The Appellate Division did not refer to or discuss either study in its opinion.

Rather, DYFS rested its abuse and neglect claim on the assumption that based on the positive drug tests, "the danger and risk of harm is self-evident" and "should be obvious" and within the "common knowledge of the reasonable person." (Appellant's Pet. Cert. 11.)[7] Yet DYFS's abuse and neglect claim raised numerous scientific questions about which courts lack expertise: (1) whether A.L.'s ingestion of a drug while pregnant created a "substantial" or "imminent" risk of harm to A.D. before or after he was born; (2) whether positive drug tests on meconium, blood, or urine constitute reliable tests that may be validly used (a) to determine harm to a child, (b) to diagnosis a parent's drug dependency or addiction, (c) to determine a person's ability to parent, or (d) to determine anything other than the fact that a person used a drug; and (3) whether a pregnant woman or parent's use of drugs establishes that she or he will pose a substantial or imminent risk of harm to a child in the future. DYFS rested on assumptions that each of these questions should be answered in the affirmative, without presenting any evidence in support of them.[8] In fact, as discussed *infra* Part II, DYFS's assumptions

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[7] *Amici* rely on the language quoted and cited in Appellant's Petition for Certification for the troubling unsupported assertions presented in the Division's brief in the Appellate Division.

[8] *Amici* also note that DYFS and the lower courts incorrectly referred to cocaine as a narcotic drug. In fact, narcotics are

about prenatal exposure to cocaine, while widely believed among laypersons, are wholly unsupported by existing scientific research.

Indeed, the only authority cited by the Appellate Division regarding the effect of prenatal exposure to cocaine was a wholly inaccurate description of the decision in *In re Guardianship of K.H.O.*, 161 *N.J.* 337 (1999). The Appellate Division relied on *K.H.O.* for the proposition that "a mother's use of cocaine during pregnancy, which resulted in her child being born addicted to cocaine, was sufficient to establish the first prong of the termination of parental rights standard." *A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490, at *15. In fact, *K.H.O.* involved a pregnant woman's alleged use of heroin, not cocaine, which resulted in a child born with symptoms of Neonatal Abstinence Syndrome,[9] a treatable condition that is *not*

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opioid drugs, while cocaine is a central nervous system stimulant. Carl Hart *et al.*, *Drugs, Society and Human Behavior* glossary, at 456, 461 (13th ed. 2009) (defining "cocaine" and "narcotic"), attached hereto at B-2. While not, perhaps, significant, this is an indicator of the need to bring scientific expertise to bear when claims are made about the effects of drugs.

[9] Although the Court in *K.H.O.* described the baby as being born "addicted," *amici* respectfully note that characterizing an infant as "addicted" is contrary to the scientific meaning of the word. *See* David C. Lewis *et al.*, *Meth Science Not Stigma: Open Letter to the Media* (2005) ("Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. By definition, babies cannot be 'addicted' to methamphetamines or anything else."), *available at* http://www.november.org/stayinfo/breaking3/MethMyths.html.

associated with prenatal exposure to cocaine.[10] 161 *N.J.* at 344 ("K.H.O. was born on August 31, 1993, suffering from heroin withdrawal . . . ."). Moreover, *K.H.O.*'s description of the injury to children that purportedly results from drug withdrawal symptoms itself rests on outdated research that has been overwhelmingly rejected by subsequent studies.[11] *K.H.O.*'s only reference to the effects of prenatal exposure to cocaine was a citation to a law review article and a single medical journal article from 1987. *Id.* at 350 (citing Judith Larsen *et al.*, *Medical Evidence in Cases of Intrauterine Drug and Alcohol*

Moreover, as discussed, *infra*, the determination that Neonatal Abstinence Syndrome constitutes a harm was made without the benefit of the necessary medical and scientific expert testimony.

[10] Bertis B. Little *et al.*, *Is There a Cocaine Syndrome? Dysmorphic and Anthropometric Assessment of Infants Exposed to Cocaine*, 54 *Teratology* 145 (1996) (finding no evidence of a "fetal cocaine syndrome"), attached hereto at B-3.

[11] Research makes clear that prenatal exposure to opiates, most commonly heroin and oxycodone, is not associated with birth defects. Gary D. Helmbrecht & Siva Thiagarajah, *Management of Addiction Disorders in Pregnancy*, 2 *J. Addiction Med.* 1, 9 (2008), attached hereto at B-4. To be sure, some newborns exposed prenatally to opiates experience an abstinence (withdrawal) syndrome at birth. But, for those babies who do experience withdrawal syndrome, safe and effective treatment can be instituted in the nursery setting. Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *Methadone Treatment for Pregnant Women*, Pub. No. SMA 06-4124 (2006), attached hereto at B-5 Likewise, for pregnant women, withdrawal symptoms are known to cause uterine contractions, miscarriage, or early labor, but these symptoms can be prevented through methadone maintenance treatment, the medically approved treatment for opiate addiction that is particularly recommended during pregnancy. *Id.*

Exposure, 18 *Pepp. L. Rev.* 279, 292-94 (1991); Scott N. MacGregor *et al.*, *Cocaine Use During Pregnancy: Adverse Perinatal Outcome*, 157 *Am. J. Obstetrics & Gynecology* 686 (1987)). *K.H.O.* thus fails, by virtue of its timing, to consider or address any of the vast contemporary scientific literature on this subject. Finally, and most significantly, *K.H.O* held that in the context of termination of parental rights pursuant to *N.J.S.A.* 30:4C-15.1(a)(1), "[d]rug use during pregnancy, in and of itself, does not constitute a harm to the child," 161 *N.J.* at 349, and that 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," *id.* at 352. But the Appellate Division failed to consider any evidence that A.D.'s prenatal drug exposure had any such effects.

In sum, absent any reliable scientific evidence to support DYFS's claims, the lower courts should have concluded that DYFS's mere speculation that the positive drug tests in this case demonstrated harm or the risk of harm was insufficient to establish abuse or neglect. Their failure to do so requires reversal.

B. DYFS Was Required to Present Qualified Expert Testimony in Support of its Claim that Prenatal Exposure to Cocaine Causes Harm or a Substantial Risk of Harm.

In addition to the lower courts' general failure to consider whether DYFS's claims were supported by reliable scientific evidence, the lower courts also erred in accepting DYFS's speculation without the benefit of expert testimony, especially given the widespread misperceptions that exist about the effects of prenatal exposure to cocaine.

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 factfinder and depends on scientific, technical, or other specialized knowledge," a plaintiff could

not raise that claim without presenting expert testimony. *Id.* at 199.

The impact of drug use, an issue rife with popular misconceptions and about which there is a vast body of research literature, *see infra* Part II.A, is exactly the kind of area where laypersons require expert guidance. In *N.J. Div. of Youth & Family Servs. v. V.T.*, No. A-2571-10T4, 2011 *N.J. Super Lexis* 221 (App. Div. Dec. 21, 2011), attached hereto at B-6, for example, 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 *15. The Court explained that "absent expert testimony[,] the meaning of the reported levels [of an illegal drug in a drug test] is unclear." *Id.* 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). *See also Kelly*, 97 *N.J.* at 209 (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 "subject to a large group of myths and stereotypes").

Here, the lower courts plainly lacked the "training, skill, or knowledge" to assess the relevant harms and risk of harm to A.D. without guidance from an expert familiar with the applicable science.[12] *Berlin*, 300 *N.J. Super.* at 267. Under these circumstances, neither the trial court nor the Appellate Division should have, or as a matter of science could have, found that A.L.'s drug use while pregnant constituted abuse and neglect, nor concluded that the risks of harm from prenatal exposure to criminalized drugs provides a justification for judicially expanding the scope of *N.J.S.A.* 9:6-8.21(c).

II. SCIENTIFIC RESEARCH DOES NOT SUPPORT EITHER THE TRIAL COURT'S FINDINGS OR THE APPELLATE DIVISION'S DECISION.

In finding that A.L. committed abuse and neglect, DYFS and the lower courts relied upon myths and discredited assumptions about the effect of prenatal exposure to cocaine. Had the lower courts considered whether DYFS's claims were backed by reliable scientific evidence, they would have found that there is a broad scientific consensus that evidence of prenatal drug exposure, on

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[12] *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), attached hereto at B-7.

its own, does *not* in fact establish harm or substantial risk of harm after birth.

A. Current Research Does Not Support the Conclusion that Exposure to Cocaine Poses a Greater Risk to a Fetus Than Many Other Actions, Conditions, or Circumstances.

For nearly two decades, the popular press was replete with stories about cocaine. For example, in 1986, when crack cocaine began to attract substantial media attention, six prestigious national news magazines and newspapers featured over one thousand stories about crack, "*Time* and *Newsweek* each ran five 'crack crisis' cover stories. . . . [T]hree major network television stations ran 74 stories about crack cocaine in six months. . . . Fifteen million Americans watched CBS' prime-time documentary '48 Hours on Crack Street.' "[13]

As noted by Professor of Law and Sociology, Laura E. Gómez, "[q]uite early in the media feeding frenzy over 'the crack crisis,' reporters singled out female crack users -- especially those who were Black or Latina -- as presenting special concerns."[14] Among these concerns were their alleged inability to parent and the harm they were allegedly causing their

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[13] Laura E. Gómez, *Misconceiving Mothers: Legislators, Prosecutors, and the Politics of Prenatal Drug Exposure* 14 (1997), attached hereto at B-8. *See also* John P. Morgan & Lynn Zimmer, *The Social Pharmacology of Smokeable Cocaine*, in *Crack In America: Demon Drugs And Social Justice* 131, 152 (Craig Reinarman & Harry G. Levine eds., 1997), attached hereto at B-9.

[14] Gómez, *supra* note 13, at 15.

children. According to Professor Gómez, "[m]others, drugs, and babies combined to produce an especially effective form of sensationalism."[15] Thus, numerous researchers have noted that media coverage of maternal cocaine use was distorted and often erroneous: "When the networks covered the story, they simplified, overstated and mystified harm, creating the distortions that escalated concerns about maternal cocaine use to the level of legal threat."[16] Reporting was inaccurate and misleading in multiples ways, including presenting individual stories as typical or representative,[17] highlighting "horror stories,"[18] reporting preliminary data and initial research on extremely small samples[19] or on animals as conclusive findings

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[15] *Id.* at 16.

[16] Drew Humphries, *Crack Mothers: Pregnancy Drugs, and the Media* 63 (1999) [hereinafter *Crack Mothers*], attached hereto at B-10; *see also* Drew Humphries, *Crack Mothers at 6: Prime Time News, Crack/Cocaine, and Women, Violence Against Women*, Feb. 1998, at 45 ("Socially constructed as Black and urban, the media demonized crack mothers as the threatening symbols for everything that was wrong with America"), attached hereto at B-11.

[17] Gómez, *supra* note 13, at 15-16.

[18] *Id.* at 16. *See also* Humphries, *Crack Mothers*, *supra* note 16, at 63, 64-65 (describing news stories).

[19] Rachel Roth, *Making Women Pay: The Hidden Costs of Fetal Rights* 142 (2000) ("The widely publicized 1985 study credited with starting the 'crack baby' myth is based on a total of twenty-three infants born to women who used cocaine and thirty born to women who did not." (referencing Ira J. Chasnoff *et al.*, *Cocaine Use in Pregnancy*, 313 *New England J. of Med.* 666 (1985)), attached hereto at B-12.

linking prenatal exposure to cocaine to various harms,[20] and inventing and promoting non-scientific and highly stigmatizing terms such as "crack baby."[21]

The lower courts in this case relied upon this mythology of severe risk regarding prenatal exposure to cocaine,[22] assuming that the use of cocaine during pregnancy is "dangerous, under all circumstances," and poses a "grave risk of harm" to a child. *A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490 at *14, 16. Although perhaps conventional wisdom, these assumptions are not supported by science: Research has consistently found *no* detectable or consistent increase in the rate or severity of birth defects associated with cocaine use during pregnancy.[23] Likewise, babies

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[20] Morgan & Zimmer, *supra* note 13, at 149-151.

[21] Humphries, *Crack Mothers*, *supra* note 16, at 63; Gómez, *supra* note 13, at 15-16.

[22] *See* Barry M. Lester *et al.*, *Data Base on Studies of Prenatal Cocaine Exposure and Child Outcome*, 27 *J. Drug Issues* 487 (1997) (concluding that knowledge about the existence or extent of effects of prenatal cocaine exposure on child outcome was limited, scattered, and compromised by methodological shortcomings), attached hereto at B-13. In 2009 the *New York Times* sought to set the record straight, as did the *Washington Post* in 2010. *See* Susan Oakie, *The Epidemic That Wasn't*, *N.Y. Times*, Jan. 27, 2009, at D1, *available at* http://www.nytimes.com/2009/01/27/health/27coca.html; Theresa Vargas, *Once Written Off, 'Crack Babies' Have Grown into Success Stories*, *Wash. Post*, Apr. 18, 2010, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2010/04/15/AR2010041502434.html.

[23] *See, e.g.*, Albert J. Tuboku-Metzger *et al.*, *Cardiovascular Effects of Cocaine in Neonates Exposed Prenatally*, 13 *Am. J. of Perinatology* 1 (1996) (study of chronic cocaine use among pregnant subjects finding no direct effects on the health or

exposed to cocaine prenatally "do not exhibit symptoms of drug withdrawal" or symptoms of drug dependence such as "craving" or "compulsion."[24] Moreover, studies have found that in individual cases, it is impossible to disentangle whether harms that are identified were caused by cocaine use or by a range of other associated risks.[25]

Indeed, in 2001, the *Journal of the American Medical Association* ("*JAMA*") published a comprehensive analysis of the developmental consequences of prenatal exposure to cocaine.[26]

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development of newborns), attached hereto at B-14; Mishka Terplan & Tricia Wright, *The Effects of Cocaine and Amphetamine Use During Pregnancy on the Newborn: Myth Versus Reality*, 30 *J. of Addictive Diseases* 1, 3 (2010) (review article concluding that no "well-designed cohort studies" or "systematic reviews . . . have shown an association with cocaine and anomalies"), attached hereto at B-15; Charles R. Bauer *et al.*, *Acute Neonatal Effects of Cocaine Exposure During Pregnancy*, 159 *Arch Pediatric Adolescent Med.* 824, 825 (2005) (study of newborn infants prenatally exposed to cocaine finding no "abnormal anatomic outcomes"), attached hereto at B-16; Ruth Rose-Jacobs *et al.*, *Do "We Just Know?": Masked Assessors' Ability to Identify Children with Prenatal Cocaine Exposure*, 23 *Devel. & Behav. Pediatrics* 340 (2002), attached hereto at B-17.

[24] Morgan & Zimmer, *supra* note 13, at 152; *see also* Gómez, *supra* note 13, at 23-24 (reporting that without knowing that cocaine was used by their mothers, clinicians could not distinguish so-called crack-addicted babies from babies born to comparable mothers who had never used cocaine or crack); Rose-Jacobs *et al.*, *supra* note 23.

[25] John P. Ackerman *et al.*, *A Review of the Effects of Prenatal Cocaine Exposure Among School-Aged Children*, 125 *Pediatrics* 554 (2010), attached hereto at B-18.

[26] Deborah A. Frank *et al.*, *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure*, 285 *JAMA* 1613 (2001), attached hereto at B-19.

This article, published in one of the world's leading medical journals, concluded that:

> Among children aged 6 years or younger, there is no convincing evidence that prenatal cocaine exposure is associated with developmental toxic effects that are different in severity, scope, or kind from the sequelae of multiple other risk factors. Many findings once thought to be specific effects of *in utero* cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana, or alcohol, and the quality of the child's environment.[27]

The authors of the study condemned as "irrational[]" policies that selectively "demonize" *in utero* cocaine exposure.[28]

Likewise, in 2004, thirty of the leading doctors and researchers in the field of prenatal exposure to illegal drugs signed an open letter criticizing the media's perpetuation of the "crack baby" myth. Virtually every expert in the field joined this letter, explaining:

> Throughout almost 20 years of research, none of us has identified a recognizable condition, syndrome or disorder that should be termed "crack baby." Some of our published research finds subtle effects of prenatal cocaine exposure in selected developmental domains, while other of our research publications do not. . . . The term "crack addicted baby" is no less defensible. Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. By definition, babies cannot be

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[27] *Id.* at 1613-14.

[28] *Id.* at 1620. *See also* Wendy Chavkin, *Commentary: Cocaine and Pregnancy - Time to Look at the Evidence*, 285 *JAMA* 1626 (2001), attached hereto at B-20; Antonio Addis *et al.*, *Fetal Effects of Cocaine: An Updated Meta-Analysis*, 15 *Reproductive Toxicology* 341 (2001), attached hereto at B-21.

> "addicted" to crack or anything else. *In utero* physiologic dependence on opiates (*not* addiction), known as Neonatal Narcotic Abstinence Syndrome, is readily diagnosed, but no such symptoms have been found to occur following prenatal cocaine exposure.[29]

Significantly, researchers joined this letter, in large measure, out of concern for the dangerous effect that non-scientific medical misinformation had on children. The letter particularly referenced the highly publicized 2003 case in Collingswood, New Jersey, in which Vanessa and Raymond Jackson were accused of nearly starving to death four adopted children. The researchers who joined the letter noted that the parents' assertion that their children had been prenatally exposed to cocaine deflected and delayed efforts to intervene and protect the four boys, ages 9 to 19, who each weighed less than 50 pounds.[30] The case led to

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

[30] *Id.* *See also* Maia Szalavitz, *The Demon Seed That Wasn't: Debunking the "Crack Baby" Myth*, *City Limits Monthly*, Mar. 2004, *available at* http://advocatesforpregnantwomen.org/issues/pregnancy_and_drug_use_the_facts/the_demon_seed_that_wasnt_debunking_the_crack_baby_myth.php; Lydia Polgreen, *Uneven Care Not Unusual in Families, N.Y. Times*, Oct. 28, 2003 ("In the Jacksons' case, the couple told friends, neighbors and people who went to their church that the four brothers had been born addicted to crack cocaine and had an eating disorder"), *available at* http://www.nytimes.com/2003/10/28/nyregion/uneven-care-not-unusual-in-families-experts-say.html; Leslie Kaufman & Richard Lezin Jones, *Amid Images of Love and Starvation, A More Nuanced Picture Emerges*, *N.Y. Times*, Nov. 2, 2003 ("[I]f anyone asked about the little ones, they were told that the children had some fetal alcohol and crack baby syndromes, and that's why they would never grow."), *available at*

an investigation of DYFS and a report by the Office of the Child Advocate. In addition to recommendations regarding numerous failures of New Jersey's child welfare system, the report found that there was no evidence to suggest the Jackson boys suffered from any medical conditions prior to their adoption.[31]

Government agencies and courts also confirm this scientific consensus that the harms from prenatal exposure to cocaine have been wildly overstated. As the National Institute for Drug Abuse has reported, "'crack babies,' or babies born to mothers who abused crack cocaine while pregnant, were at one time written off as a lost generation. . . . It was later found that this was a gross exaggeration."[32] Indeed, the United States Sentencing Commission, in adjusting the penalties associated with crack-related offenses, did so, in part, because it likewise concluded that "the negative effects from prenatal

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http://www.nytimes.com/2003/11/02/nyregion/amid-images-of-love-and-starvation-a-more-nuanced-picture-emerges.html?pagewanted=all.

[31] Kevin M. Ryan *et al.*, Office of the Child Advocate, Preliminary Report, *Jackson Investigation, An Examination of Failures of New Jersey's Child Protection System and Recommendations for Reform* 2-3 (2004), *available at* http://www.judiciary.state.nj.us/conferences/1A-10/Ryan%20OCA%202-12-04%20Jackson%20Family.pdf; Susan K. Livio & Mary Jo Patterson, Child Advocate's Report on Collingswood Family Case Lists Years of Poor Judgment by Agency, *Newark Star-Ledger*, Feb. 13, 2004, *available at* http://www.nj.com/news/ledger/stories/20040213_childabuse_collingswood_report.html.

[32] Nat'l Inst. on Drug Abuse, Research Report Series, *Cocaine: Abuse and Addiction* 6 (May 2009), available at http://www.drugabuse.gov/PDF/RRCocaine.pdf.

exposure to cocaine, in fact, are significantly less severe than previously believed" and that those negative effects are similarly correlated with the effects of prenatal exposure to other drugs, both legal and illegal.[33] *See also United States v. Smith*, 359 *F. Supp.* 2d 771, 780 n.6 (E.D. Wis. 2005) (discussing "myths" regarding the impact of prenatal exposure to cocaine). Similar consideration of current scientific research led a unanimous South Carolina Supreme Court to reverse the conviction of a woman who, under South Carolina law, had been convicted of homicide by child abuse based upon evidence that she had suffered a stillbirth and also tested positive for cocaine. *See McKnight v. State,* 661 *S.E.*2d 354 (S.C. 2008). Finding that the research upon which the prosecution relied was "outdated," *id.* at 361, the court held that trial counsel had inadequately represented her client by failing to call experts who would have testified to "recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor," *id.* at 358 n.2.

Thus, medical research makes clear that numerous other substances, conditions, and circumstances raise similar or

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[33] U.S. Sentencing Comm'n, *Report to Congress: Cocaine and Federal Sentencing Policy* 68 (2007), *available at* http://www.ussc.gov/Legislative_and_Public_Affairs/Congressional_Testimony_and_Reports/Drug_Topics/200705_RtC_Cocaine_Sentencing_Policy.pdf.

greater risks to fetuses as prenatal exposure to cocaine. For example, prescription drugs prescribed to pregnant women,[34] including anticonvulsants, mood-stabilizers, benzodiazepines (a class which includes Valium, Librium and Xanax), as well as some antibacterial, anticoagulant, and antihypertensive drugs, are all associated with harms and risks of harms to fetuses.[35] Accutane, a popular anti-acne medication, has been called "the most widely prescribed birth-defect causing medicine in the United States."[36] Women who take fertility drugs and choose to carry three or more embryos to term often experience pregnancy loss and risk severe, lifelong harm to the children who survive,[37] and women ages 35 and older who bear children have a

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[34] Erika Hyde Riley *et al.*, *Correlates of Prescription Drug Use During Pregnancy*, 14 *J. Women's Health* 401, 404, 407 (2005), attached hereto at B-22.

[35] *See* Martin J. Whittle & Kevin P. Hanretty, *Prescribing in Pregnancy: Identifying Abnormalities,* 293 *Br. Med. J.* 1485 (1986), attached hereto at B-23; The Merck Manual Online for Health Care Professionals, *Risk Factors for Complications During Pregnancy, available at* http://www.merckmanuals.com/professional/gynecology_and_obstetrics/high-risk_pregnancy/risk_factors_for_complications_during_pregnancy.html.

[36] Ellen Rafshoon, *What Price Beauty?, Boston Globe Magazine*, Apr. 27, 2003, at 15 ("Some of these children died before they reached their first birthdays because of major organ system failures. The most seriously affected babies have been institutionalized. The rest live with a variety of severe defects, ranging from heart and central nervous system abnormalities to missing or malformed ears, asymmetrical facial features, and mental retardation."), attached hereto at B-24.

[37] Arlene Judith Klotzko, *Medical Miracle or Medical Mischief? The Saga of the McCaughey Septuplets, Hastings Ctr. Rep.*, May-June 1998, at 5, 6 ("Children born in numbers greater than three

significantly increased risk of giving birth to low birth weight babies and may have increased risk of stillbirth.[38] Women who suffer from hyperthyroidism and other diseases,[39] and women who work with chemicals or solvents, likewise face heightened risks. *See Int'l Union v. Johnson Controls*, 499 *U.S.* 187, 205 (1991) (noting that "[e]mployment late in pregnancy often imposes risks on the unborn child"); *see also Int'l Union v. Johnson Controls*, 886 *F.*2d 871, 914 & n.7 (7th Cir. 1989) (Easterbrook, J., dissenting) (noting that an estimated 15 to 20 million jobs entail exposure to chemicals that pose fetal risk).[40]

And to take an especially important example, it is doubtful that there is any medical basis on which New Jersey's child

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often suffer from illnesses including chronic lung disease, strokes, mental retardation, and blindness."), attached hereto at B-25.

[38] *See* Suzanne C. Tough *et al.*, *Delayed Childbearing and Its Impact on Population Rate Changes in Lower Birth Weight, Multiple Birth, and Preterm Delivery*, 109 *Pediatrics* 399 (2002), attached hereto at B-26.

[39] *See, e.g.*, Paul Atkins *et al.*, *Drug Therapy for Hyperthyroidism in Pregnancy*, 23 *Drug Safety* 229 (2000), attached hereto at B-27.

[40] *See also* Gloria D. Jahnke *et al.*, *Center for the Evaluation of Risks to Human Reproduction: The First Five Years*, 74 *Birth Defects Res.* 1 (2005) (summarizing research establishing adverse effects from exposure to 1-bromopropane, methanol, diethylhelxphthalate and other widely-used industrial chemicals), attached hereto at B-28; Sohail Khattak *et al.*, *Pregnancy Outcome Following Gestational Exposure to Organic Solvents*, 281 *JAMA* 1106, 1109 (1999) (finding that pregnant women exposed to organic solvents on the job have a 13-times greater risk of giving birth to babies with major malformations than those not exposed), attached hereto at B-29.

welfare law, if it covered this case, could exclude the cases of children born to women who smoked cigarettes while pregnant. The dangers of cigarette smoking are serious, unusually well-established, and widely known. *See* 15 *U.S.C.* § 1333(a)(1) (describing required content of cigarette warning labels: "SURGEON GENERAL'S WARNING: Smoking By Pregnant Women May Result in Fetal Injury, Premature Birth, And Low Birth Weight").[41]

None of these facts are meant to suggest that prenatal exposure to criminalized drugs is benign. However, the current scientific evidence simply does not support judicially re-writing state law to allow for a *per se* finding of abuse or neglect under *N.J.S.A.* 9:6-8.21(c)(4)(b), based solely on evidence of a woman's use of cocaine or other criminalized drugs during pregnancy.[42] The lower courts erred in ignoring the

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[41] *See also* Kirsten Wisborg *et al.*, *Exposure to Tobacco Smoke in Utero and the Risk of Stillbirth and Death in the First Year of Life*, 154 *Am. J. Epidemiology* 322 (2001), attached hereto at B-30.

[42] The evidence that A.L. tested positive for marijuana in her fifth month of pregnancy also does not justify a finding of abuse and neglect. The scientific literature uniformly acknowledges that any evidence of the impact of prenatal exposure to marijuana on fetal or child development is inconsistent and inconclusive. *See, e.g.*, David M. Fergusson *et al.*, *Maternal Use of Cannabis and Pregnancy Outcome*, 109 *BJOG: Int'l J. Obstetrics & Gynecology* 21, 21-22 (2002), attached hereto at B-31; Peter A. Fried *et al.*, *Growth and Pubertal Milestones During Adolescence in Offspring Prenatally Exposed to Cigarettes and Marihuana*, 23 *Neurotoxicology & Teratology* 431, 432 (2001), attached hereto at B-32; P.A. Fried & A.M. Smith, *A Literature Review of the Consequences of Prenatal Marihuana Exposure*, 23 *Neurotoxicology & Teratology* 1 (2001), attached

overwhelming scientific consensus on this issue, and relying instead on discredited myths and assumptions about the impact of prenatal exposure to cocaine.

B. DYFS Presented No Reliable Scientific Evidence that a Positive Drug Test on a Pregnant Woman or a Newborn Establishes Harm, Substantial Risk of Harm, or Likelihood of Future Harm.

In addition to relying upon myths about the harm from prenatal exposure to cocaine, DYFS and the lower courts also drew the scientifically unsupported conclusion that the fact that a pregnant woman and baby have tested positive for an

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hereto at B-33; D.R. English *et al.*, *Maternal Cannabis Use and Birth Weight: A Meta-Analysis*, 92 *Addiction* 1553, 1558-1559 (1997), attached hereto at B-34; Melanie C. Dreher *et al.*, *Prenatal Marijuana Exposure and Neonatal Outcomes in Jamaica*, 93 *Pediatrics* 254, 254-56 (1994), attached hereto at B-35. Thus, some researchers have found no correlation between maternal marijuana consumption and pregnancy outcomes. *See, e.g.*, Fried *et al.*, *supra*, at 436; Susan J. Astley *et al.*, *Analysis of Facial Shape in Children Gestationally Exposed to Marijuana, Alcohol, and/or Cocaine*, 89 *Pediatrics* 67 (1992), attached hereto at B-36. Other studies have found a correlation between maternal marijuana use and small negative effects on birth weight or certain developmental markers. For example, one study indicated a possible correlation between marijuana smoking and a decrease in birth weight, although the author and others recognized that this correlation disappeared after correcting for confounding factors, such as tobacco smoking and poverty. Fergusson *et al.*, *supra*, at 23-26; Dreher *et al.*, *supra*, at 254-60; Katherine Tennes *et al.*, *Marijuana: Prenatal and Postnatal Exposure in the Human*, 59 *NIDA Res. Monogr.* 48, 53-54 (1985), attached hereto at B-37. In fact, some researchers have found some slight beneficial correlation with birth weight or infant development. Fergusson *et al.*, *supra*, at 25; Tennes, *supra*. Peter Fried, the most published researcher in this field, however, has acknowledged that any definitive statement of the consequences of prenatal exposure to marijuana would be "problematic, presumptuous, and foolhardy." Fried & Smith, *supra*, at 8.

illegal drug conclusively establishes that the newborn has been harmed or subjected to substantial risk of harm.[43] *See, e.g.*, *A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490, at *4-5 ("The agency asserted that A.L. exposed A.D. to a substantial risk of harm by ingesting controlled dangerous substances while she was pregnant, resulting in A.D.'s meconium testing positive for cocaine.").[44]

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[43] The lower courts apparently presumed that the drug tests in this case were accurate. Notably, however, an expert panel convened in 1993 by the U.S. Department of Health and Human Services Substance Abuse Mental Health Services Administration recommended that health care institutions that conduct alcohol and drug testing on pregnant women and new mothers do so in accordance with the standards used for drug testing in the workplace, as prescribed by the federal workplace drug testing guidelines, including safeguards such as established cut off levels, a confirmatory test, and the opportunity for a re-test. Ctr. for Substance Abuse Treatment, Substance Abuse & Mental Health Servs. Admin., U.S. Dep't of Health and Human Servs., DHHS Publication No. (SMA) 95-3056, *Medical Guidelines for Pregnant, Substance-Using Women,* in *Treatment Improvement Protocol (TIP) Series 2* (1993), *available at* http://www.ncbi.nlm.nih.gov/books/NBK26232/; *see also* Substance Abuse & Mental Health Serv. Admin., Dep't Health & Human Serv., *Mandatory Guidelines for Federal Workplace Drug Testing Programs*, 73 *F.R.* 71858 (2008). No evidence was presented that such procedures were followed in this case and, indeed, pregnant women, new mothers and newborns are generally not afforded the benefit of these safeguards. *See, e.g.*, Troy Anderson, *False Positives Are Common in Drug Tests on New Moms*, *L.A. Daily News*, June 28, 2008.

[44] *Amici* note that DYFS presented no information about what the test on A.D.'s meconium actually revealed. Drug tests may not find the drug itself but rather metabolites of the drug. Metabolites are what is left once the drug itself has been broken down or inactivated by enzymes in the body, and may indicate that drugs were used in the past, but not recently. There is also no indication that DYFS presented any evidence

Amici do not challenge the reliability or validity of drug tests as indicators of drug use. However, if positive drug tests for pregnant women or newborns are to be used as a basis for establishing that a child has been harmed or faces a substantial risk of harm, then the state must prove that the drug test is, as a matter of science, also valid and reliable as a means of demonstrating harm or risk of harm. As the United States Department of Justice explains, "Drug tests detect drug use but not impairment. A positive test result, even when confirmed, only indicates that a particular substance is present in the test subject's body tissue. It does not indicate abuse or addiction; recency; frequency, or amount of use; or impairment."[45] A positive drug test thus cannot determine whether a person occasionally uses a drug, is addicted, suffers any physical or emotional disability from that addiction, or is more or less likely, if they are parents, to abuse or neglect their children.[46]

Neither DYFS nor the courts below cited a single source of scientific evidence for the proposition that drug tests of pregnant women, mothers, or babies, whether based upon meconium,

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that A.D. was ever exposed to cocaine in a form that was biologically active.

[45] U.S. Dept. of Justice, *Drugs, Crime, and the Justice System: A National Report from the Bureau of Justice Statistics* 119 (1992), attached hereto at B-38.

[46] *Id.*

blood, or urine, provide valid and reliable information about harm or risk of harm to children. Likewise, *amici* have found no research establishing that a positive drug test of a parent or newborn alone provides any evidence of harm. Indeed, it is precisely for this reason that the Staff for the Center for the Future of Children recommended that "[a]n identified drug-exposed infant should be reported to child protective services only if factors in addition to prenatal drug exposure show that the infant is at risk for abuse or neglect."[47]

Thus, DYFS and the lower courts erred in using drug test results to conclusively establish harm or risk of harm -- a purpose for which the tests were not designed and for which there is no scientific evidence supporting their validity or reliability. In relying on no more than the "mere possibility" that the positive drug test results established harm or a risk of harm, *Lindquist*, 175 *N.J.* at 281, DYFS and the lower courts failed to meet the rigorous standards that New Jersey requires for the use of scientific evidence in judicial proceedings.

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[47] Ctr. for the Future of Children, *Analysis*, *Future of Children*, Spring 1991, at 9, 13 (1991), *available at* http://futureofchildren.org/futureofchildren/publications/docs/01_01_FullJournal.pdf.

C. DYFS Provided No Evidence-Based Research to Support the Conclusion That Evidence of Drug Use by a Pregnant Woman or Parent Predicts Harm to a Child.

DYFS also failed to present any evidence, scientific or otherwise, to establish that the mere fact that A.L. used drugs while pregnant demonstrated a likelihood that she would abuse, neglect, or otherwise harm her child. *See N.J.S.A.* 9:6-8.21(c)(4) (abuse and neglect can be established if a child "is in imminent danger of becoming impaired as the result of the failure of his parent . . . to exercise a minimum degree of care"). Instead, DYFS argued, and the lower courts accepted, that the risk of harm to A.D. from A.L.'s drug use "can be plainly seen by simply imagining what would have happened in this case." (Appellant's Pet. Cert. 11.) But questions that are scientific in nature may not properly be left to the imagination, and DYFS failed to offer any peer-reviewed social science research to the effect that A.L.'s drug use during pregnancy created a likelihood that she would abuse or otherwise harm her child. Nor did DYFS present even a single witness who could testify that A.L. was currently using drugs, currently had a drug dependency problem, or that she had a drug problem that was causing her to be unable to parent safely; nor was even a single witness called who had ever observed A.L. with her children.

There is no question that it is a common assumption that a pregnant woman or parent who uses an illegal drug or who is dependent on such drugs is more likely to abuse or neglect her or his child than one who does not.[48] There is, however, little peer-reviewed evidence meeting minimum requirements for scientific rigor, such as having well-matched control groups and defining key terms such as "substance abuse" or "neglect," to support this assumption.[49] At the same time there is a growing

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[48] This assumption is reinforced by media coverage regarding pregnant women and drug use, which frequently presents biased and unsupported claims that such women are bad mothers. *See* Kristen W. Springer, *The Race and Class Privilege of Motherhood: The New York Times Presentations of Pregnant Drug-Using Women*, 25 *Sociological Forum* 476, 489 (2010) ("In short, crack-using pregnant women were significantly more likely to be presented as bad mothers and blamed for societal problems, despite the fact that alcohol and tobacco are more detrimental for fetuses. These finding indicate that something other than concern for children' s welfare is driving the media presentation of pregnant drug use."), attached hereto at B-39.

[49] 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 publicized finding, that children whose 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. But not only did this survey fail to qualify as reliable scientific evidence, the report itself 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

body of peer-reviewed, evidence-based research to the contrary.[50] For example a study of Australian women in treatment for opiate 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."[51] The authors suggested that "[a] focus on substance use may, in practice, obscure these other factors, [including a greater number of children, mental health problems, and less social support,]

"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. *See also* David J. Hanson, *The Center on Addiction and Substance Abuse: A Center for Alcohol Statistics Abuse?*, http://alcoholfacts.org/CASAAlcoholStatisticsAbuse.html (challenging the quality and value of research from the Center and noting its refusal to submit its work to peer review).

[50] *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), attached hereto at B-40; Margaret H. Kearney *et al.*, *Mothering on Crack Cocaine: A Grounded Theory Analysis*, 38 *Soc. Sci. & Med.* 351, 355 (1994), attached hereto at B-41.

[51] Stephanie Taplin & Richard P. Mattick, Nat'l Drug & Alcohol Research Ctr. (Univ. New S. Wales, Sydney), Technical Rep. No. 320, *Child Protection and Mothers in Substance Abuse Treatment* 9 (2011), *available at* http://www.idpc.net/sites/default/files/library/child-protection-and-mothers-in-substance-abuse-treatment-tech-report-320.pdf.

which can be ameliorated."[52] 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.[53] 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."[54]

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."[55] For these reasons the National Council of Juvenile and Family Court Judges concluded that "[j]uvenile and family court proceedings are not

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[52] *Id.* at 72.

[53] Brenda D. Smith & Mark F. Testa, *The Risk of Subsequent Maltreatment Allegations in Families with Substance-Exposed Infants*, 26 *Child Abuse & Neglect* 97 (2002), attached hereto at B-42.

[54] *Id.* at 110. The authors also hypothesized that having a child welfare allegation based on drug use during pregnancy might expose "parents to additional surveillance or additional risk aversion on the part of decision-makers" which in turn could affect the likelihood of receiving subsequent additional allegations. *Id.* at 111.

[55] 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), attached hereto at B-43.

necessary, and probably not desirable in most situations involving substance-exposed infants."[56]

Despite widespread and commonly held beliefs about drug use and parenting, courts are obligated, especially where such fundamental rights as those here at issue are concerned, to base decisions on facts -- not on imagination, conjecture, or presumption. Because no evidence, much less scientifically valid evidence, was submitted in this case to support DYFS's claim that A.L.'s drug use while pregnant caused harm to her child or threatened future harm, the lower courts erred in finding that DYFS had established abuse or neglect, and their decision should be reversed.

III. 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(C)(4)(B) PROPOSED BY DYFS AND ACCEPTED BY THE COURTS BELOW.

As Appellant argues in her briefing, the Appellate Division erred as a matter of statutory construction in expanding the scope of *N.J.S.A.* 9:6-8.21 to treat a fetus as a "child," thus subjecting A.L. to intrusive child welfare investigations and a finding of abuse solely on the basis of drug use that took place prior to A.D.'s birth, without any allegations -- let alone

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[56] National Council of Juvenile and Family Court Judges, Permanency Planning for Children Project, *Protocol for Making Reasonable Efforts to Preserve Families in Drug-Related Dependency Cases* 17 (1992), attached hereto at B-44.

proof -- of harm after birth. (*See* Pet. Cert. 8-11.)[57] In so expanding *N.J.S.A.* 9:6-8.21, the Appellate Division relied upon scientifically unsupported assumptions about how best to further New Jersey's interest in child health and in its public policy of "combat[ing] the dangerous effects of narcotics," *A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490, at *14, and overlooked evidence of the harmful impact its interpretation would have on the health and well-being of women and children in New Jersey, particularly in low-income communities and communities of color.[58]

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[57] The plain text of *N.J.S.A.* 9:6-8.21(c)(4)(b) makes reference only to a "parent or guardian" and her or his child; it says nothing about "pregnant women" or their "fetuses." *See N.J.S.A.* 9:6-8.21(c)(4)(b). Thus, to apply the abuse and neglect law to pregnant women and their fetuses would be to expand the statute way beyond its intended reach. *See Giardina v. Bennett*, 111 *N.J.* 412, 420-21 (1988) (concluding that New Jersey's Wrongful Death Act, *N.J.S.A.* 2A:31-1, did not apply to a stillborn). Indeed, in *N.J. Div. of Youth & Family Services v. L.V.*, 382 *N.J. Super.* 582 (Ch. Div. 2005), the court held that *N.J.S.A.* 9:6-8.21(c) "clearly does not expressly include a fetus in its definition of a child," and that to punish a woman in the absence of harm to the child once born would "be an unauthorized punishment for her past transgressions against the child *in utero* or *in esse*." *Id.* at 590 (internal quotation marks omitted). Although the Appellate Division argued that *L.V.* is distinguishable because it involved a pregnant woman's refusal of prescribed medication, the court in *L.V.* did not rely on this distinction, instead squarely holding that "the protections afforded by the Act are limited to the child's situation after his or her birth and not while a fetus." *Id.*

[58] *Amici* also notes that were this Court to adopt the Appellate Division's construction, it would implicate significant constitutional concerns regarding, *inter alia*, a woman's right to privacy, equal protection of the laws, and the right to medical decision-making, implicating both her right to life and

A. Evidence-Based Research Does Not Support the Claim that Threats, Including Threats of Loss of Custody, Further State Interests in Child Health and in Combating Use of Illegal Drugs.

Without reference to any scientific evidence, the Appellate Division asserted that its expansion of *N.J.S.A.* 9:6-8.21 would further state interests in child safety and state policy regarding drug use.[59] *A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490, at *14-15. The longstanding consensus among leading medical and

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health during pregnancy. *See Planned Parenthood of Cent. New Jersey v. Farmer*, 165 *N.J.* 609, 631-32 (2000); *see also Roe v. Wade*, 410 *U.S.* 113, 152-53 (1973); *Griswold v. Connecticut*, 381 *U.S.* 479, 484-86 (1965). This Court's jurisprudence countenances against a statutory construction that raises constitutional concerns. As this Court stated in *Whirlpool Properties, Inc. v. Director, Division of Taxation*: "[W]hen a statute's constitutionality is drawn into question or placed in serious doubt, this Court should ascertain whether a construction of the statute is possible that avoids the constitutional problem." 208 *N.J.* 141, 172 (2011) (citing *State v. Miller*, 170 *N.J.* 417, 433 (2002)).

[59] *Amici* note that while the Appellate Division cited a state policy of protecting children through the criminal law from the "dangerous effects of narcotics" and the "perils of drug trafficking," *A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490, at *14-15, New Jersey also has laws addressing drug issues that favor a harm reduction, public health approach, rather than a punitive one. Indeed, this harm reduction response underlies the passage, on December 18th, 2006, of the "Blood-borne Disease Harm Reduction Act," which allowed up to six cities to establish syringe access programs. *N.J.S.A.* 26:5C-26 *et seq.* More recently, on Dec. 5, 2011 the Legislature passed Senate Bill 958/Assembly Bill 1088, which permits limited pharmacy sales of syringes and needles without a prescription. S.B. 958, 214th Leg. (N.J. 2010-2011); A.B. 1088, 214th Leg. (N.J. 2010-2011). This legislation is currently awaiting Governor Christie's signature.

public health organizations, however, is directly to the contrary.

Comprehensive, early, and high-quality prenatal care is one of the most effective weapons against pregnancy complications and infant mortality, especially for women experiencing a drug dependency problem.[60] The fear of the loss of custody of a child, by contrast, has been identified in peer-reviewed, published research and numerous government reports as a barrier to care for pregnant drug users.[61]

Specifically, over the course of nearly three decades, every leading medical organization, governmental body, and appellate court to have considered the question has concluded that responding to issues of drug use and pregnancy through punitive measures is likely to produce even worse outcomes for

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[60] *See* P. Moran *et al.*, *Substance Misuse During Pregnancy: Its Effects and Treatment*, 20 *Fetal & Maternal Med. Rev.* 1 (2009), attached hereto at B-45; Andrew Racine *et al.*, *The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City*, 270 *JAMA* 1581, 1585-86 (1993) (finding that pregnant women who use cocaine but who have at least four prenatal visits significantly reduce their chances of delivering low birth weight babies), attached hereto at B-46.

[61] *See, e.g.*, Sarah C.M. Roberts & Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, 15 *J. Maternal & Child Health* 333 (2010), attached hereto at B-47; 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), attached hereto at B-48; Marilyn L. Poland *et al.*, *Punishing Pregnant Drug Users: Enhancing the Flight from Care*, 31 *Drug & Alcohol Dependence* 199 (1993), attached hereto at B-49.

children. Fear of punishment operates as a deterrent to pursuing drug treatment, prenatal care, and labor and delivery care, and discourages the disclosure of critical medical information to health professionals -- all with potentially devastating results.[62]

1. Threats of Child Custody Loss Undermine Maternal, Fetal, and Child Health by Deterring Pregnant Women from Seeking Beneficial Services and Healthcare.

Numerous studies have found that pregnant women are deterred from seeking prenatal care and drug treatment if doing so will raise the possibility or increase the likelihood that they will lose custody of a child.[63] According to a report published by the National Center on Substance Abuse and Child Welfare:

> One key reason for this 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

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[62] Eminent medical organizations, including the American Medical Association, have uniformly condemned punitive approaches to the problem of drug use during pregnancy. *E.g.*, AMA Bd. of Trustees, *Legal Intervention During Pregnancy*, 264 *JAMA* 2663, 2670 (1990) ("Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate."), attached hereto at B-50.

[63] *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), attached hereto at B-51; Roberts & Pies, *supra* note 61; Roberts & Nuru-Jeter, *supra* note 61.

done to ensure that the physician's office is seen as a safe and supportive resource to all pregnant women.[64]

Another federal report found that fear of losing children to the child welfare system was a 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."[65] Numerous additional studies of drug-dependent pregnant women have likewise found that fear of child welfare interventions and the loss of custody of their children are significant factors that deter women from seeking health care and disclosing drug use.[66]

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[64] 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 B.M. Lester *et al.*, *Substance Use During Pregnancy: Time for Policy to Catch up With Research*, 1 *Harm Reduction J.* 1477 (2004)), *available at* http://www.ncsacw.samhsa.gov/files/SAFERR.pdf.

[65] 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.

[66] *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), attached hereto at B-52; Jessup *et al.*, *supra* note 63; Poland *et al.*, *supra* note 61; Roberts & Pies, *supra* note 61; Roberts &

Indeed, the harm resulting from mothers' fear of being reported to child welfare authorities and potentially losing child custody is so apparent that the American College of Obstetricians and Gynecologists ("the College") Committee on Health Care for Underserved Women has called upon doctors to take action to change policies that require mandatory reporting of pregnant drug-using women to child welfare authorities, and that lead to punitive interventions, including loss of child custody.[67] The College wrote:

> use of the legal system to address perinatal alcohol and substance abuse is inappropriate. . . . In states that mandate reporting [to civil child welfare authorities], policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions.[68]

Nuru-Jeter, *supra* note 61; 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."), attached hereto at B-53; *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.").

[67] Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, *Committee Opinion 473, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, 117 *Obstetrics & Gynecology* 200 (2011), attached hereto at B-54.

[68] *Id.* at 201.

The College committee explained that punitive approaches, including the loss of child custody, wrongly treat addiction as a moral failing. Instead, "[a]ddiction is a chronic, relapsing biological and behavioral disorder with genetic components. . . . subject to medical and behavioral management in the same fashion as hypertension and diabetes."[69]

Beyond deterring women from seeking care altogether, the ruling below is also likely to undermine the provider/patient relationship for those women who do seek care. A relationship of trust is critical for effective medical care because "[t]he promise of confidentiality encourages patients to disclose sensitive subjects to a physician."[70]

Indeed, the facts of this case as described in the Appellate Division's opinion are consistent with these findings. Faced with the threat of the removal of her child, A.L. did not, apparently, confide in a trusted health care provider, but rather appears to have denied drug use altogether, thus impeding rather than furthering any treatment A.L. might have needed or wanted. *A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490 at *2-3. This response will, tragically, become more rather than less common

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[69] *Id.* at 200.

[70] Robert Arnold *et al.*, *Medical Ethics and Doctor/Patient Communication,* in *The Medical Interview: Clinical Care, Education and Research* 363, 365 (Mack Lipkin, Jr. *et al.* eds., 1995), attached hereto at B-55.

should the Appellate Division's decision be permitted to stand. It should not.

2. Threats Do Not Work as a Mechanism to Address Drug Dependency Problems.

The Appellate Division also overlooked the broad consensus in the medical community that threats do not work as a mechanism to reduce drug use for individuals suffering from addiction. The medical profession has long acknowledged that drug dependence and addiction, as opposed to mere drug use, has biological and genetic dimensions and cannot often be overcome without treatment.[71] Addiction is marked by "compulsions not capable of management without outside help." *Robinson v. California*, 370 *U.S.* 660, 671 (1962) (Douglas, *J.*, concurring). For this reason, the vast majority of drug dependent people cannot simply decide to refrain from drug use or achieve long-term abstinence without appropriate treatment and support.

Given the compulsive nature of drug dependency, warnings or threats are unlikely to deter drug use among pregnant women. In fact, contrary to the commonly-held belief that punishment of drug-using parents will help children by motivating parents to

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[71] Am. Psychiatric Ass'n., *The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* Ch. 4 (4th ed. 1994) (distinguishing between use, dependency, and addiction), attached hereto at B-56; American Medical Association, *Proceedings of the House of Delegates: 137th Annual Meeting, Board of Trustees Report NNN* 236, 241, 247 (June 26-30, 1988), attached hereto at B-57.

seek help, 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.[72]

Research also finds that treatment outcomes are greatly improved when a woman retains custody of her children during treatment (known as "family treatment"). According to one

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[72] *See* Ondersma *et al.*, *supra* note 66, at 99-100 (noting that removal of an infant "can result in extreme distress to parents," and "is often overwhelming for others who have little ability to respond adaptively to emotional upheaval" and may lead some parents "to simply give up"); Ellen M. Weber, *Child Welfare Interventions for Drug-Dependent Pregnant Women: Limitations of a Non-Public Health Response*, 75 *UMKC L. Rev.* 789, 831 (2007). Likewise, many common assumptions about the nature and value of mandated services have been questioned in the peer reviewed social science literature. *See* Philip H. Jos *et al.*, *The Charleston Policy on Cocaine Use During Pregnancy: A Cautionary Tale*, 23 *J.L. Med & Ethics* 120, 123 (1995) (noting that treatment ordered through judicial systems lack the hallmarks of quality medical services, such as the guarantee of doctor-patient confidentiality, considered essential to the therapeutic relationship), attached hereto at B-58. Thus, being a drug-dependant woman involved in a child welfare proceeding carries with it significant stigma, Weber, *supra*, at 831, which in turn "leads down a pathway. . . to diminished health outcomes." Comm. on Crossing the Quality Chasm, Inst. of Med., *Improving the Quality of Health Care for Mental and Substance-Use Conditions* 81 (2006), *available at* http://iom.edu/Reports/2005/Improving-the-Quality-of-Health-Care-for-Mental-and-Substance-Use-Conditions-Quality-Chasm-Series.aspx. According to one study, "[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." 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), attached hereto at B-59.

study, almost 60% of women who retained custody of their infants completed treatment successfully, compared with only 32% of women who lost custody.[73] 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 a low 17% completion rate.[74]

Children also reap the benefit of an intact family. One University of Florida study compared outcomes in cocaine-exposed newborns who were placed in foster care to outcomes for those who were able to stay with their addicted mothers. After six months of placement with either foster care or their own mothers, the babies were tested using measures of infant development including rolling over, sitting up, and reaching out: the children placed with their birth mothers did better.[75]

Allowing the lower court decisions to stand would, then, place New Jersey law directly at odds with prevailing medical

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[73] Robert H. Nishimoto & Amelia C. Roberts, *Coercion and Drug Treatment for Postpartum Women*, 27 *Am. J. Drug & Alcohol Abuse* 161, 170 (2001), attached hereto at B-60.

[74] H. Westley Clark, *Residential Substance Abuse Treatment for Pregnant and Postpartum Women and Their Children: Treatment and Policy Implications*, 80 *Child Welfare* 179, 189 (2001), attached hereto at B-61.

[75] 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), attached hereto at B-62.

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 and reaffirm that child custody determinations be based on reliable scientific evidence, rather than on unsubstantiated misconceptions.

B. The Expansion of *N.J.S.A.* 9:6-8.21(c)(4)(b) Proposed by DYFS and Accepted by the Courts Below Would Dramatically Expand DYFS's Jurisdiction Over Pregnant Women and Families.

In discussing its expansion of *N.J.S.A.* 9:6-8.21(c)(4)(b), the Appellate Division suggested that the expanded application of New Jersey's abuse and neglect law would be limited to cases in which a woman consumes illegal drugs during her pregnancy. *A.L.*, 2011 *N.J. Super. Unpub. LEXIS* 1490, at *14. Nothing in the broadly-worded text of the statute, however, limits its application to drug use in particular, or to unlawful activities in general. The Appellate Division's decision thus opens the door to a dramatic and legislatively unauthorized expansion of the state's power to investigate and intrude upon pregnant women and their families.

Because, as discussed *supra* Part II.A, numerous behaviors, conditions, and external factors may affect pregnancy outcomes, the Appellate Division's ruling opens the door to abuse and

neglect claims for a wide array of legal and illegal activities undertaken during pregnancy. Numerous courts addressing this issue in related contexts have repeatedly come to this same conclusion. *See, e.g., Kilmon v. State*, 905 *A.*2d 306, 311-12 (Md. 2006) (refusing to recognize a misdemeanor of "reckless endangerment" 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); *Cochran v. Commonwealth*, 315 *S.W.*3d 325, 328 (Ky. 2010) (ruling that Kentucky's child endangerment law did not apply to a woman who tested positive for cocaine during pregnancy and discussing the many actions and inactions that may affect pregnancy outcomes); *Reinesto v. State*, 894 *P.*2d 733,

736-37 (Ariz. Ct. App. 1995) (recognizing that "[m]any types of prenatal conduct can harm a fetus" and concluding that "[a]llowing the state to define the crime of child abuse according to the health or condition of the newborn child would subject many mothers to criminal liability for engaging in all sorts of legal or illegal activities during pregnancy").

As these cases recognize, if this Court is willing to entertain the Appellate Division's dramatic expansion of *N.J.S.A.* 9:6-8.21(c)(4)(b), then smoking, failing to eat properly, failing to lose or gain the sufficient amount of weight, failing to get sufficient exercise (or, for that matter, exercising too much), and continuing to work in a stressful job could also be potential grounds for a neglect finding.

Nor is the potential for DYFS to further expand its jurisdiction remote. DYFS has, in fact, previously used other constitutionally impermissible criteria to allege abuse and neglect, such as informed refusal of medication intended to prevent maternal-child HIV transmission, *see L.V.*, 382 *N.J. Super.* at 590-91, refusal to pre-authorize cesarean surgery, *see N.J. Div. of Youth & Family Servs. v. V.M.*, 408 *N.J. Super.* 222, 249 (App. Div. 2009) (Carchman, *J.*, concurring), and most recently, receipt of legally prescribed, federally-recommended methadone to manage opiate addiction, *see N.J. Div. of Youth & Family Servs. v. A.J.*, No. FN 07-364-10, slip op. at 22 n.8

(N.J. Super. Ct. Fam. Div. Essex County Feb. 22, 2011) (decision under consideration for publication in which trial court ruled in favor of the defendant mother, who used methadone during pregnancy, noting the "value and necessity of expert testimony on methadone maintenance as the preferred treatment for pregnant women"), attached hereto at B-63.[76]

While these cases each present a different factual scenario, they all attempt to treat what a pregnant woman does,

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[76] Other recent cases that have come before the Appellate Division demonstrate the importance of a careful examination of scientific evidence. While several cases have resulted in holdings that children were abused or neglected based upon symptoms of withdrawal at birth, as a consequence, at least in part, of their mothers' need for methadone during their pregnancies, prescribed or otherwise, *N.J. Div. of Youth & Family Servs. v. N.P.*, 2009 *N.J. Super. Unpub. LEXIS* 578 (App. Div. Mar. 25, 2009), attached hereto at B-64, *N.J. Div. of Youth & Family Servs. v. E.C.*, 2008 *N.J. Super. Unpub. LEXIS* 2783 (App. Div. Apr. 28, 2008), attached hereto at B-65, *N.J. Div. of Youth & Family Servs. v. S.S.*, 2006 *N.J. Super. Unpub. LEXIS* 1177 (App. Div. Aug. 8, 2006), attached hereto at B-66, none of these cases were decided with the benefit of medical experts qualified to testify regarding opiate addiction in pregnant women, its treatment with methadone, and its potential side-effects on neonates. When, on the other hand, a trial court had the opportunity to hear the testimony of medical experts on the advisability and necessity of methadone treatment of pregnant women, notwithstanding the potential for Neonatal Abstinence symptoms at birth, that court ruled in favor of the defendant mother. *A.J.*, No. FN 07-364-10, slip op. at 22. *Amici* recognize that these cases do not constitute binding precedent under *R.* 1:36-3, but wish to call them to the Court's attention as "secondary research," *Nat'l Union Fire Ins. Co. of Pittsburgh v. Jeffers*, 381 *N.J. Super.* 13, 18 (App. Div. 2005), exemplifying the importance of expert and scientific evidence. Pursuant to *R.* 1:36-3, copies of all of the above cases and all contrary unpublished opinions known to counsel have been included in the appendix and served upon all parties.

does not do, or experiences during her pregnancy as a basis for treating her as an abusive or neglectful parent under the state's child welfare laws. This is not and cannot be the law, and this Court should reject the lower courts' extraordinary expansion of DYFS's power.

C. The Proposed Expansion of *N.J.S.A.* 9:6-8.21(c)(4)(b) Would Disparately Harm Low-Income Communities and Communities of Color.

Indeed, the lower courts' expansion of *N.J.S.A.* 9:6-8.21(c)(4)(b) is particularly troubling because it increases the potential for discriminatory application of the child welfare laws, and risks the unnecessary separation of children from poor and of color parents. Social science and medical research reveals a disturbing prevalence of race and class disproportionality 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. 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."[77] Among other things, it found (1) that most research studies suggest that race alone or race interacting with other factors is strongly related to the rate of child welfare investigations; (2) that 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) that child maltreatment is reported more often for low-income than middle- and upper-income families with similar presenting circumstances; and (4) that hospitals overreport abuse and neglect among African Americans and underreport maltreatment among whites.[78]

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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[77] 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.

[78] *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"), attached hereto at B-67.

for drugs than children of other races,[79] despite the lack of any evidence based research supporting race or any other factor as a basis for screening some women and not others.[80] 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.[81] Thus, the harmful effects of the proposed expansion

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[79] *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), attached hereto at B-68; 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.

[80] *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.), attached hereto at B-69.

[81] *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. Obstetrics & Gynecology* 469.e1 (2009) (African American women suffer

of *N.J.S.A.* 9:6-8.21(c)(4)(b) -- including discouraging women from seeking prenatal care and putting pregnant women at risk of state intervention for any activity associated with a heightened risk of harm to newborns -- 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." *See N.J. Div. 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 expansion of *N.J.S.A.* 9:6-8.21(c)(4)(b) to treat a fetus as a "child," as proposed by DYFS and the lower courts in this case, will further burden already vulnerable communities, and is likely to exacerbate existing biases in how abuse and neglect claims are

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disproportionate rates of many adverse pregnancy consequences, including stillbirths, ectopic pregnancies, infant mortality, premature labor, and low birth-weight babies), attached hereto at B-70; Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* 172 (1997), attached hereto at B-71.

reported and pursued. For this reason as well, the lower courts' decision should be reversed.

IV. IF THIS COURT REQUIRES FURTHER ELUCIDATION OF THE SCIENTIFIC PRINCIPLES THAT SHOULD GOVERN THIS INQUIRY, IT SHOULD APPOINT A SPECIAL MASTER.

The New Jersey Legislature has chosen not to enact a law that treats evidence of drug use by a pregnant woman as child abuse or neglect. As Appellant argues, the Court should not, then, accept the State's invitation to radically expand the reach of the law, in violation of the Legislature's intent. (*See* Appellant's Pet. Cert. 8-11.) If the Court determines, however, that Title 9 might, as a matter of law, extend to the use of a drug by a pregnant woman and that the scientific research regarding prenatal exposure to cocaine and related issues requires further exploration by the Court, then it should consider the pertinent science in a proceeding where the parties 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 State v. Harvey*, 151 *N.J.* 117, 167 (1997) ("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.[82] 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 valuable assistance.[83]

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.* at 54, and to review the science underlying the legal standard for the admissibility of eyewitness testimony in *State v. Henderson*, 208 *N.J.* at 208. In *State v. Moore*, 188 *N.J.* at 191, the Court remanded 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 questions, and directed that plenary hearings be held to

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[82] Margaret G. Farrell, *The Function and Legitimacy of Special Masters*, 2 *Wid. L. Symp. J.* 235, 253 n.76 (1997).

[83] Margaret G. Farrell, *Coping with Scientific Evidence: The Use of Special Masters*, 43 *Emory L.J.* 927, 929-30 (1994).

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 prenatal exposure to cocaine and the relationship between 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 prenatal exposure to cocaine, or that expanding Title 9 is consistent with the state's interest in promoting the health and well-being of pregnant women, mothers, and children.

CONCLUSION

For the reasons set forth above, *amici curiae* Experts and Advocates in Maternal and Fetal Health, Child Welfare, Public Health and Drug Treatment respectfully request that the Court reverse the decision of the Appellate Division.

Respectfully submitted,

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Dated: January 9, 2012

APPENDIX A

Statement of Interest of Amici Curiae

Amicus Curiae American Academy of Addiction Psychiatry is an international professional membership organization made up of practicing psychiatrists, university faculty, medical students and other related professionals. Founded in 1985, it currently represents approximately 1,000 members in the United States and around the world. AAAP is devoted to promoting access to continuing education for addiction professionals, disseminating new information in the field of addiction psychiatry, and encouraging research on the etiology, prevention, identification, and treatment of addictions. AAAP opposes the prosecution of pregnant women based on the belief that punitive measures will undermine prenatal care, discourage many women from seeking substance abuse treatment, and damage the medical provider-patient relationship that is founded on principles of confidentiality.

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 54,000 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 1,874 members who provide healthcare to the women of New Jersey.

Amicus Curiae American Society of Addiction Medicine is a nationwide organization of more than 3600 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 "child abuse," and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health services.

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 National Council on Alcoholism and Drug Dependence-NJ ("NCADD-NJ") works 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 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 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 our members and through on-line venues, and quality

handouts and seeks to help its patient-members fulfill all of their reproductive and parenting needs.

Amicus Curiae Addiction Science Research and Education Center is an organization dedicated to encourage addiction research and educate the public and treatment professionals about the latest science of drug abuse and chemical dependence.

Amicus Curiae American Association of Birth Centers ("AABC") is a national non-profit multi-disciplinary organization that represents the interests of women and families in advocating for improved access to birthing services. AABC promotes the rights of women and their families in all communities to birth their children in an environment which is safe, sensitive, cost-effective, and requires minimal intervention — a right that includes informed consent and refusal of medical services.

Amicus Curiae American Civil Liberties Union ("ACLU") is a nationwide, non-partisan organization of more than 500,000 members dedicated to preserving the principles of liberty and equality embodied in the Constitution and this nation's civil rights laws. Through its Reproductive Freedom Project, the ACLU has long fought to ensure that women, including pregnant women, are accorded equal treatment under the law.

Amicus Curiae American Civil Liberties Union - New Jersey is a private non-profit, non-partisan membership organization dedicated to the principle of individual liberty embodied in the Constitution. Founded in 1960, the ACLU-NJ has nearly 15,000 members in the State of New Jersey. The ACLU-NJ has participated in numerous cases raising important issues pertaining to parental rights and reproductive rights. *See, e.g., Acuna v. Turkish*, 192 *N.J.* 399 (2007) (opposing lawsuit against doctor for failing to inform pregnant woman that an abortion "would kill . . . an actual existing human being"); *Sojourner v. New Jersey Dep't of Human Services*, 177 *N.J.* 318 (2003) (challenging constitutionality of family cap on welfare benefits, which denied an increase in the cash benefit upon the birth of an additional child); *Moriarity v. Bradt*, 174 *N.J.* 189 (2001) (challenging grandparent visitation statute as violating parental rights); *Planned Parenthood v. Farmer*, 165 *N.J.* 609 (2000) (striking down Parental Notification for Abortion Act as violating State Constitution's equal protection provisions).

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 prosecution, conviction, and incarceration 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 Baron Edmond de Rothschild Chemical Dependency Institute of the Beth Israel Medical Center (International Center for Advancement of Addiction Treatment) ("the Institute") comprises the addiction treatment advocacy efforts and the related research activities of Beth Israel Medical Center, which has been in the forefront of addiction treatment for almost 45 years, and currently serves some 13,000 individuals with substance misuse problems annually. The Institute's highly respected research staff has published scores of seminal findings in peer-reviewed professional journals. Institute staff members are active participants in international conferences and have played a very strong advocacy role, in America and abroad, for humane policy reform and expansion as well as enhancement of treatment services. The Institute brings its expertise to this Court to explain that punitive government interventions will only deter pregnant substance abusers from obtaining prenatal care and drug treatment and undermine health outcomes for mother and child.

Amicus Curiae Black Women's Health Imperative is dedicated to promoting optimum health and wellness for Black women.

Amicus Curiae Center for Children of Incarcerated Parents ("CCIP") was founded in 1989 to prevent intergenerational crime and incarceration. CCIP produces high quality documentation on and the development of model services for children of criminal offenders and their families. CCIP offers educational curricula that includes: parent education for prisoners; parent empowerment; parent education for substance-dependent parents in treatment; parent education for elementary school children; family life education; health education for incarcerated mothers; women's issues; the effects of trauma and violence on children; mentor training; and parent advocacy for prisoners. In addition, CCIP provides therapeutic services for children,

children's caregivers, and teachers, as well as a range of family reunification services.

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. To ensure 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 parents and professionals seeking reform of 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 child welfare systems. A significant percentage of CWOP members are mothers in recovery. A large part of CWOP's work involves debunking prevailing stereotypes about child welfare-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, ultimately protecting children by helping and strengthening their families and communities.

Amicus Curiae Children's Justice Foundation is a nonprofit civil rights organization devoted to protecting the civil rights of families and foster children, particularly African American children who, neither abused nor neglected, are court ordered into foster care without a legal basis or a trial, in direct violation of state and federal laws.

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 Harm Reduction Coalition 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. We recognize that the structures of social inequality impact the lives and options of affected communities differently, and work to uphold every individual's right to health and well-being, as well as in their competence to protect themselves, their loved ones, and their communities. Since its inception in 1994, HRC advances harm reduction philosophy, practice and public policy by prioritizing areas where structural inequalities and social injustice magnify drug-related harm. HRC operates five core programs: 1) technical assistance, training, and capacity building on expanding syringe access, overdose prevention and education, hepatitis C prevention and treatment, and HIV prevention in communities of color; 2) policy analysis and advocacy on drug user health issues in local, regional, and national arenas; 3) publications, reports, and topical materials; 4) national and regional conferences, community forums, and coalitions; 5) and extensive education/training on harm reduction principles and practice through the Training Institute.

Amicus Curiae Harm Reduction International is a leading non-governmental organization working to promote and expand support for harm reduction work worldwide. We work to reduce the negative health, social and human rights impact of drug use and drug policy - such as the increased vulnerability to HIV and hepatitis infection among people who inject drugs - by promoting evidence based public health policies and practices, and human rights based approaches to drug policy. We are an influential global source of research, policy/legal analysis and advocacy on drug use, health and human rights issues. This includes research and analysis on policies relating to women who use drugs in the contest of public health, sending, prisons and the rights of the child. The organization is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

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 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 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 Doctors for Healthy Drug Policies ("IDHP") is an organization of medical doctors from 49 countries devoted to increasing the participation of medical doctors in drug policy reform. Drug policies effect the health of us all, but

especially people who use drugs and those who are living with HIV and chronic pain. There is a gap between evidence based practice and drug policy in many countries and IDHP aims to influence changes in drug policies and practices to promote harm reduction and create healthy drug policies internationally.

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. We have done a tremendous amount of policy advocacy work to expand treatment opportunities for people with alcohol and drug problems and to oppose legislation and other measures that employ a punitive approach, rather than a public health approach, to addiction. We have also represented individuals and 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 National Advocates for Pregnant Women ("NAPW") is a non-profit organization dedicated to ensuring the human and civil rights, health, and dignity of pregnant and parenting women, while protecting children from counterproductive and misguided state policies. NAPW advocates for reproductive and family justice, including the right to carry a pregnancy to term, access to culturally appropriate and evidence based medical care, and the rights of parents and children to family integrity undisrupted by inappropriate state action. NAPW joins this case as amicus because of the harm to parents, children and family life if child custody decisions are made without regard to reliable evidence based in science and medicine in the guise of protecting children.

Amicus Curiae National Association of Nurse Practitioners in Women's Health (NPWH) was founded in 1980 with the mission to assure the provision of quality health care to women of all ages by nurse practitioners. NPWH defines quality health care to be inclusive of an individual's physical, emotional, and spiritual needs and recognizes and respects women as decision-makers for their health care. NPWH's mission includes protecting and promoting a woman's right to make her own choices regarding her health within the context of her personal, religious, cultural, and family beliefs. NPWH works with a wide range of individuals and groups within nursing, medicine, the health care industry, and the women's health community and is a trusted source of

information on nurse practitioner education, practice, and women's health issues.

Amicus Curiae National Coalition for Child Protection Reform ("NCCPR") is an organization of professionals, drawn from the fields of law, academia, psychology and journalism, who are dedicated to improving child welfare systems through public education and advocacy. NCCPR, a tax-exempt non-profit organization founded at a 1991 meeting at Harvard Law School, is incorporated in Massachusetts and headquartered in Alexandria, Virginia. NCCPR devotes much of its attention to public education concerning widespread public misconceptions about the child protective system and its impact on the children it is intended to serve. Lawyer members of NCCPR also individually have litigated numerous precedential cases involving child protection policies and proceedings. NCCPR is concerned that, contrary to promoting the interests of vulnerable newborn children, a policy which calls for the arrest of those children's mothers based upon urine or blood toxicology screens, or methadone treatment causes children to suffer unnecessary psychological harm and trauma from being separated from their mothers. NCCPR is also concerned that such a separation interferes with the children's constitutionally protected liberty interest in their relationship with their mothers.

Amicus Curiae National Latina Institute for Reproductive Health ("NLIRH") is the only national non-profit organization working to promote reproductive health and justice for a growing and diverse population of Latinas. The communities we represent face numerous barriers in accessing necessary healthcare: cost, language access, cultural competency, discrimination, and immigration status have all perpetuated health disparities between Latinas and the population at-large. Criminalizing a pregnant woman's behavior or struggle with substance use does not improve health outcomes for women and their children, but it does create additional obstacles to care. The chilling effects of criminalization are likely to reduce a woman's willingness to seek prenatal and maternity care, as well as treatment for substance use. Health care providers should not act as agents of immigration authorities or police by sharing information about a patient's medical condition or immigration status. These practices are used to funnel pregnant women and new mothers into the immigration and criminal justice systems. NLIRH believes that the purpose of healthcare is, and should remain, improving health outcomes, not enforcing drug policy or immigration laws.

Amicus Curiae National Organization for Women (NOW) of New Jersey, Morris County works to eliminate discrimination, harassment, violence against women and advocates for women's equality, including their reproductive freedom.

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. We are 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 our belief that the government has an obligation to safeguard the health of all people; that we value women's descriptions of their own experiences and believe health policy should reflect the diversity of those experiences; and that we believe 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 New Jersey State Affiliate of the National Organization for Women ("NOW-NJ") is a statewide women's rights organization consisting of 10,000 women and men members, activists, and allies. Incorporated in 1975, NOW-NJ has 13 chapters throughout the state, each autonomous and self-governed, on campuses and in the local community. NOW-NJ is a completely volunteer organization, whose mission is to take action to bring women into full participation in American society now, exercising all privileges and responsibilities thereof in truly equal partnership with men. This purpose includes, but is not limited to, equal rights and responsibilities in all aspects of citizenship, public service, employment, education, and family life, and it includes freedom from discrimination because of race, ethnic origin, age, marital status, sexual orientation, gender identity, or parenthood. NOW-NJ is the state the National Organization for Women ("NOW"). NOW is the largest, most comprehensive women's advocacy group in the United States. NOW has 500,000 contributing members and 550 chapters in all 50 states and the District of Columbia. The National Organization for Women Foundation, created in 1986, is

a 501(c)(3) organization affiliated with NOW that is devoted to furthering women's rights through education and litigation. Since its inception, NOW Foundation's goal has been to achieve equal rights for all women and to assure that women and girls have access to a full range of reproductive health care services and that their fundamental human right of bodily autonomy is protected, among other objectives.

Amicus Curiae Physicians and Lawyers for National Drug Policy ("PLNDP") is a non-partisan group of the nation's leading physicians and attorneys, whose goal is to promote and support public policy and treatment options that are scientifically-based, evidence-driven, and cost-effective. The initiative, funded by the JEHT and Robert Wood Johnson, and building on the earlier work of Physician Leadership on National Drug Policy, is organized around the belief that effective policies for alcohol and other drugs must be grounded in data, not politics. PLNDP will advocate for evidence-based policy decisions and will encourage local innovation by establishing stable professional partnerships in every state and by supporting community coalitions. For the first time, physicians and lawyers, often viewed as squaring off in policy debates, have joined forces to make a concerted effort to move the national conversation beyond the often misleading and polarizing policy debates of the past.

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 M. Douglas Anglin, PhD, was the Founding Director of the UCLA Drug Abuse Research Center (1984-1997) and was an Associate Director of the Integrated Substance Abuse Programs (ISAP) from 1998 to 2010. He is currently a Senior Advisor in the Department of Psychiatry and Biobehavioral

Sciences. Dr. Anglin has been conducting research on substance abuse epidemiology, etiology, treatment evaluation, and social policy since 1972. He has been Principal Investigator on more than 25 federally funded research studies and on numerous state- and foundation-supported projects. He has been the author or co-author of more than 225 published articles. Dr. Anglin has served as an advisor to many national treatment evaluation studies, including the Drug Abuse Treatment Outcome Study and the Federal Bureau of Prisons Drug Programs Evaluation Project. He has also served as consultant to the following agencies: National Institute on Drug Abuse, Office of National Drug Control Policy, Center for Substance Abuse Treatment, National Academy of Sciences Institute of Medicine, National Institute of Justice, California Youth Authority and Departments of Alcohol and Drug Programs and Corrections, and Los Angeles County Alcohol and Drug Program Administration.

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 Day, MD, 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 NIH 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 Deborah A. Frank, MD, is a Professor of Pediatrics at Boston University School of Medicine. Dr. Frank is also an Assistant Professor of Social and Behavioral Sciences at the Boston University School of Public Health. 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. 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. She has published widely on these topics, including numerous articles concerning prenatal cocaine 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 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 the case.

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 Terratology 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 of Psychology in both the Departments of Psychiatry and Psychology at Columbia University, and Director of the Residential Studies and Methamphetamine Research Laboratories 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 or co-author of dozens of peer-reviewed scientific articles in the area of neuropsychopharmacology, co-author of the textbook Drugs, Society, and Human Behavior, and a member of an NIH review group. Dr. Hart was recently elected to Fellow status by the American Psychological Association (Division 28) for his outstanding contribution to the field of psychology, specifically psychopharmacology and substance abuse. In addition to his substantial research responsibilities, Dr. Hart teaches

undergraduate and graduate courses and was recently awarded Columbia University's highest teaching award.

Amicus Curiae Stephen R. Kandall, MD, is a pediatrician who has cared for over a thousand babies exposed to drugs. He is retired chief of neonatology at Beth Israel Medical Center in New york and has written a book, Substance and Shadow: Women and Addiction, published by Harvard University Press outlining the horrors of prosecuting women who need drug treatment.

Amicus Curiae Barry M. Lester, Ph.D., 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 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, 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 criminal prosecutions, of pregnant women with drug abuse problems will harm both maternal and child health.

Amicus Curiae Robert G. Newman, MD, MPH, was until January, 2001, President and CEO of Continuum Health Partners, Inc., a $2.2 billion hospital network in New York City. Prior to the creation of Continuum in 1997 he was CEO of the Beth Israel Health Care System for 20 years. He is now President Emeritus of Continuum and 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 mid-'70s treated over 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 phsychologist 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 of Wayne State. His primary interest is in brief computer delivered motivational interventiosn 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, is a professor at Northwestern with a joint appointment as a faculty fellow at the Institute for Policy Research. She is a frequent speaker and prolific scholar on issues related to race, gender, and the law

and has published more than 75 articles and essays in books and scholarly journals, including Harvard Law Review, Yale Law Journal, and Stanford Law Review, authored 2 award-winning books, and co-edited 5 casebooks and anthologies. Her latest book, Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-first Century, was published in July 2011. Her other books and articles include *Shattered Bonds: The Color of Child Welfare* (Basic Books/Civitas, 2001; paperback, 2002); *Killing the Black Body: Race, Reproduction, and The Meaning of Liberty* (Random House/Pantheon, 1997; Vintage paperback, 1999); "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and The Right of Privacy," 104 Harvard Law Review 1419 (1991). Roberts received fellowships and grants from the National Science Foundation, Robert Wood Johnson Foundation, Searle Fund, Hastings Center, Fulbright Scholars Program, Harvard University Program in Ethics and the Professions, and Stanford Center for Comparative Studies in Race and Ethnicity, and as a visiting professor was the recipient of the Outstanding First-Year Course Professor Award for 1997-98. She serves as Chair of the Board of Directors of the Black Women's Health Imperative and is currently conducting research on the effects of child welfare agency involvement in African-American neighborhoods and on race-based biotechnologies.

Amicus Curiae Lynn Singer, PhD, serves as the Case Western University's Deputy Provost and Vice President for Academic Affairs. She currently is Principal Investigator of IDEAL, Institutions Developing Excellence in Academic Leadership, a three-year NSF funded program to develop emerging leaders among faculty at Case Western Reserve University and five public universities to foster equity and inclusion. Prior to this, she was Principal Investigator of an NSF ADVANCE Institutional Transformation Award of $3.5 million to enhance the careers of women faculty in science and engineering. As Professor of Environmental Health Sciences, Pediatrics and Psychiatry, Dr. Singer has directed numerous large federally and privately funded research programs, including a 19-year study of high risk preterm infants, and longitudinal studies of drug-exposed infants in Cleveland and London. She has edited two books, *Psychosocial Assessment of Adolescents*, and *Biobehavioral Assessment of Infants*, and has authored more than 125 articles in the medical and psychological literature. Dr. Singer has participated in numerous NIH and other federal review committees and currently serves on the Governing Council of the Neurobehavioral Teratology Society and the NIH Center for Scientific Review Committee on Child Psychopathology and Development. She has also served on local community boards

including the Achievement Center Medical Professional Advisory Board, the Cleveland PlayHouse Board and the Bellefaire-JCB Strategic Planning Committee. In 1997, the CWRU School of Medicine named her a "Million Dollar Professor" an achievement attained annually until she became a full-time administrator in 2006, and for which in 2003, she received a special U.S. Congressional recognition. In 2009, she received the Cleveland Human Rights Campaign Leadership Award as well as the American Council on Education-Ohio Women's Network Award for Excellence in Leadership in Higher Education. Dr. Singer's prior experience included work as a Special Education teacher for emotionally disturbed children at Bellefaire School, directing the Department of Psychological Services at Health Hill Hospital, and directing Pediatric Psychology and the Medical-Behavioral Center at Rainbow Babies' and Children's (RB&C) Hospital. At RB&C and Metro Health Center, she also co-directed the Center for Advancement of Mothers and Children, a special clinic for drug-using women and their children.

Amicus Curiae Linda L.M. Worley, MD, PLLC, 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). She directs the campus side Student Mental Health Program, the College of Medicine Faculty Wellness Program and is the consulting psychiatrist to the ANGELS program in the department of Obstetrics and Gynecology. Dr. Worley is a board certified Psychiatrist with sub-specialization in Psychosomatic Medicine. Dr. Worley was recruited to join the UAMS Department of Psychiatry Faculty in 1992. She received the American Psychiatric Association Gold Award for directing a model program for the nation for addiction treatment for women with their children.

Amicus Curiae Trecia Wouldes, PhD, is a developmental psychologist and Senior Lecturer in the Department of Psychological Medicine in the Faculty of Medical and Health Sciences at the University of Auckland. She is also a member of the Executive Board of the Werry Centre for Child and Adolescent Mental Health. The focus of her teaching and research is the health, mental health and development of children exposed to biological and/or psychological insults that occur prenatally or during early childhood. She is currently the Director of the Auckland, New Zealand site of the 5-site Infant Development Environment And Lifestyle (IDEAL) study investigating the developmental outcomes of children born to mothers who use methamphetamine during their pregnancy. Through her research, Dr. Wouldes has developed a special interest in the provision of

early, evicence-based interventions for infants, toddlers and pre-school children.

Amicus Curiae Tricia E. Wright, MD, MS, is an assistant professor of Obstetrics, Gynecology and Women's Health at the University of Hawaii John A. Burns School of Medicine and founder, former medical director, and now Women's Health Liaison of the PATH Clinic, an outreach clinic of Waikiki Health Center, Which provides prenatal, postpartum and family planning to women with a history of substance use disorders. She is board certified in both OB/Gyn and Addiction Medicine and a Fellow of the American College of Obstetricians and Gynecology. She specializes in taking care of pregnant women with substance use disorders and psychiatric illness. She won funding approval in 2006 from the Hawaii legislature to start the first perinatal clinic for women with substance use issues in the state. Her research interests include substance use disorders among pregnant women, including barriers to family planning, best practices for treatment, and the effects of methamphetamine and tobacco on the placenta.