SUPREME COURT OF PENNSYLVANIA

No. 10 MAP 2018

IN THE INTEREST OF: L.J.B., A MINOR,

APPEAL OF: A.A.R., NATURAL MOTHER

BRIEF OF *AMICI CURIAE* FREDERICK M. HENRETIG, M.D., HALLAM HURT, M.D., JUVENILE LAW CENTER, KIDSVOICE, PHILADELPHIA DEPARTMENT OF HUMAN SERVICES, AND SUPPORT CENTER FOR CHILD ADVOCATES

Appeal from the Order of The Superior Court of Pennsylvania dated December 27, 2017, at No. 884 MDA 2017, Vacating the Order Entered May 24, 2017, of the Clinton County Court of Common Pleas, Juvenile Division, at No. CP-18-DP-0000009-2017, and Remanding for Further Proceedings

---

Katharyn I. Christian McGee
(PA Bar No. 312347)
DUANE MORRIS LLP
30 South Seventeenth Street
Philadelphia, PA 19103
(215) 979-1000
Counsel for Amici Curiae

OF COUNSEL:
Frank P. Cervone
(PA Bar No. 37338)
SUPPORT CENTER FOR
CHILD ADVOCATES
1617 John F. Kennedy Boulevard
Suite 1200
Philadelphia, PA 19103
(267) 546-9202

Marcel Pratt, City Solicitor
(PA Bar No. 307483)
CITY OF PHILADELPHIA
LAW DEPARTMENT
1515 Arch Street, 17th Floor
Philadelphia, PA 19102
(215) 683-5038
Counsel for Amicus Curiae the Philadelphia Department of Human Services

TABLE OF CONTENTS

Page

INTEREST OF AMICI CURIAE 1

ARGUMENT 5

I. A Civil Finding of Child Abuse for Substance Exposed Infants is not Necessary to Protect Children 5

A. Pennsylvania's Existing Referral Mechanism is Sufficient to Protect Substance Exposed Infants 5

B. Protective Custody under CPSL, the Juvenile Act, and Rules of Juvenile Court Procedure Effectively Ensure Children's Protection 7

II. Construing Prenatal Substance Exposure as Child Abuse Will Deter Prenatal Care for Children and Women 9

A. Prevailing Standard of Care Favors Treatment of Prenatal Substance Use; Threat of a Child Abuse Finding Will Discourage Prenatal Care 10

B. Prenatal Substance Exposure May Have No More Lasting Detrimental Effects Than Other, Lawful Actions 16

III. Interpreting Prenatal Substance Exposure as Child Abuse Imposes Restrictions That Will Harm a Child 20

A. A Finding of Child Abuse Will Impose Restrictions That May Last a Lifetime and Long Exceed the Addiction Itself 20

B. Subjective Selection Biases and Drug Testing Inaccuracies Will Result in Unlawful Discriminatory Practices that Disproportionately Harm Women of Color, as well as Poor and Rural Women 23

1. Subjective Selection Biases 23

2. Testing Inaccuracies 25

TABLE OF AUTHORITIES

Cases

Johnson v. State, 602 So. 2d 1288 (Fla. 1992) 12

In the Interest of L.B., 177 A.3d 308 (Pa. Super. 2017), *appeal granted*, 2018 Pa. LEXIS 1707 (Pa. Apr. 3, 2018) 14, 19

New Jersey Dept. of Children and Families, Div. of Youth and Family Services v. A.L., 59 A.3d 576 (N.J. 2013) 12

New Jersey Div. of Child Protection and Permanency v. Y.N., 104 A.3d 244 (N.J. 2014) 12

In re Valerie D., 613 A.2d 748 (Conn. 1992) 12

Statutes

23 Pa. Cons. Stat. § 6301, et seq. 1, 7

23 Pa. Cons. Stat. § 6303 21

23 Pa. Cons. Stat. § 6315(a)(2) 7

23 Pa. Cons. Stat. § 6315(a)(3) 7

23 Pa. Cons. Stat. § 6344 22

23 Pa. Cons. Stat. § 6344(d) 22

23 Pa. Cons. Stat. § 6386(a) 6

23 Pa. Cons. Stat. § 6386(a)(2) 14

23 Pa. Cons. Stat. § 6386(b), (c)(1)-(4) 6

23 Pa. Cons. Stat. § 6501, *et seq.* 7

42 Pa. Cons. Stat. § 6302 8

42 Pa. Cons. Stat. § 6324(3) 8

42 Pa. Cons. Stat. § 6341(c) 8

42 Pa. Cons. Stat. § 6351(a) 9

42 Pa. Cons. Stat. § 6351(b) 9

42 Pa. Cons. Stat. § 6351(b)(1)-(2) 9

42 U.S.C. § 5106a 5

55 Pa. Code §3490.33 21

55 Pa. Code § 3490.39 21

Cal. Penal Code § 11165.13 12

Pa. R. Juv. Ct. P. § 1202 8

Pa. R. Juv. Ct. P. § 1202(A)(2)(a) 8

Pa. R. Juv. Ct. P. § 1202(A)(2)(b) 8

Other Authorities

American Academy of Pediatrics, *A Public Health Response to Opioid Use in Pregnancy* (2017) 10

American College of Nurse Midwives, *Position Statement: Addiction in Pregnancy* (2013 11

The American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Committee Opinion No. 473, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (January 2011, reaffirmed 2014) 11

The American College of Obstetricians and Gynecologists, *Statement on Opioid Use During Pregnancy* (May 26, 2016), *available at* https://www.acog.org/About-ACOG/News-Room/Statements/2016/ACOG-Statement-on-Opioid-Use-During-Pregnancy 12-13

The American College of Obstetricians and Gynecologists, *Toolkit on State Legislation, Pregnant Women & Prescription Drug Abuse, Dependence and Addiction* ("ACOG Toolkit"), at 1 ..... *Passim*

American Medical Association, *Perinatal Addiction - Issues in Care and Prevention H-420.962* (2017) 10

American Public Health Association, *Policy Statement No. 9020: Illicit Drug Use by Pregnant Women* (1990) 11

Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in America* (2017) ..... *Passim*

Cara Angelotta, M.D. & Paul S. Appelbaum, M.D., *Criminal Charges for Child Harm from Substance Use in Pregnancy*, 45 J. Am. Acad. Psychiatry Law 193, 193 (2017) 11

Danielle Kurtzleben, *Data Show Racial Disparity in Crack Sentencing*, U.S. News & World Report, Aug. 3, 2010 24

Fred M. Henretig, et al., *Child Abuse by Poisoning*, *in* Child Abuse: Medical Diagnosis and Management 549-599 (F.M. Henretig, et al. eds., Amer. Acad. of Pediatr. 3rd ed. 2009) 25

Hallam Hurt and Laura M. Betancourt, *Effect of Socioeconomic Status Disparity on Child Language and Neural Outcome: How Early is Early?*, 79 Pediatr. Res. 1-28 (2016) 17

Hallam Hurt, et al., *Children With and Without Gestational Cocaine Exposure: A Neurocognitive Systems Analysis*, 31 Neurotoxicology and Teratology 334, 334-41 (2009) 17

Hallam Hurt, et al., *Children With In Utero Cocaine Exposure Do Not Differ From Control Subjects on Intelligence Testing*, 151 Arch. of Pediatr. and Adolescent Med., 1237, 1237-41 (1997) 17

Hallam Hurt et al., *Children With and Without Gestational Cocaine Exposure: A Neurocognitive Systems Analysis*, Neurotoxicology and Teratology, Nov.-Dec. 2009, at 335 16

Hallam Hurt, et al., *Inner-City Children Perform Poorly on Intelligence Testing Regardless of In Utero Cocaine Exposure*, 39 Pediatr. Res. (1996) 17

Hallam Hurt, et al., *Natal Status of Infants of Cocaine Users and Control Subjects: A Prospective Comparison*, 15 J. Perinatology 297, 297-304 (1995 17

Hallam Hurt, et al., *School Performance of Children with Gestational Cocaine Exposure*, 27 Neurotoxicology and Teratology 203, 203-11 (2005) 17

Hallam Hurt, M.D. and Laura M. Betancourt, Ph.D., *Turning 1 Year of Age in a Low Socioeconomic Environment: A Portrait of Disadvantage*, 38 J. Dev. Behav. Pediatr. 493, 493-500 17

Hallam Hurt, M.D., et al., *A Prospective Evaluation of Early Language Development in Children With In Utero Cocaine Exposure and in Control Subjects*, 130 J. Pediatr. 310, 310-12 (1997) 17

Hallam Hurt, M.D., et al., *Cocaine-exposed Children: Follow-up Through 30 Months*, 16 Dev. Behav. Pediatr. 29, 29-35 (1995) 17

Jay E. Mattingly et al., *Effects of Obstetric Analgesics and Anesthetics on the Neonate: A Review*, Pediatric Drugs, 2003, 5 (9), at 616 15

Katherine T. Wild, et al., *The Effect of Socioeconomic Status on the Language Outcome of Preterm Infants at Toddler Age*, 89 Early Hum. Dev. 743, 743-46 (2013).....17

Lewis S. Nelson, Opioids, *in* Goldfrank's Toxicologic Emergencies 492-509 (Robert S. Hoffman, et al. eds., 10th ed. 2015) 25-26

Malaika Babb et al., *Treating Pain During Pregnancy*, Canadian Family Physician, Vol. 56, (Jan. 2010), at 25–27 14

March of Dimes, *Fact Sheet: Policies and Programs to Address Drug-Exposed Newborns* (2014).....11

Mary Anne Armstrong et al., *Perinatal Substance Abuse Intervention in Obstetric Clinics Decreases Adverse Neonatal Outcomes*, Journal of Perinatology, 2003, Vol. 23, at 3, 7.....14

Medication-Assisted Treatment for Opioid Addiction During Pregnancy (2005), at 2, *available at* www.ncbi.nlm.nih.gov/books/NBK64148/ 13

National Perinatal Association, *Position Statement 2017: Perinatal Substance Use* (2017).....11

Neonatal Abstinence Syndrome Cara Angelotta, UpToDate, Wolters Kluwer (Jan. 2018), *available at* https://www.uptodate.com/contents/neonatal-abstinence-syndrome?search=neonatal%20abstinence%20syndrome&source=search_result&selectedTitle=1~18&usage_type=default&display_rank=1 13

Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids (2017) 11

U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration: Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (Treatment Improvement Protocol (TIP) Series, No. 43.), Chapter 13: Medication-Assisted Treatment for Opioid Addiction During Pregnancy (2005), at 2, *available at* www.ncbi.nlm.nih.gov/books/NBK64148/.....13

U.S. Department of Health of Human Services, Factsheet, *Pregnancy and Opioid Pain Medications*, *available at* https://www.cdc.gov/drugoverdose/pdf/pregnancy_opioid_pain_factsheet-a.pdf 14

INTEREST OF AMICI CURIAE

Amici curiae are child advocates, medical professionals, and toxicologists.[1] *Amici* submit this brief in support of Appellant to amplify the discussion concerning why prenatal substance exposure is not child abuse as defined by Pennsylvania's Child Protective Services Law ("CPSL"), 23 Pa. Cons. Stat. § 6301, et seq., is unnecessary to protect children under CPSL, and ultimately would harm children by contravening prevailing standards of care for treatment of prenatal substance exposure and imposing lasting limitations on children and children's families.

Frederick M. Henretig, M.D., is a Professor Emeritus of Pediatrics in Philadelphia with over 40 years of experience in academic pediatric emergency medicine and medical toxicology. Dr. Henretig helped found Philadelphia's regional poison control center in 1985 and served as medical director until 2005. His scholarly interests include many areas within pediatric emergency medicine, including toxicology and environmental health. He is a senior editor or co-author of five textbooks, and he has authored or co-authored 60 original articles and over 100 textbook chapters and review articles, chiefly focusing pediatric toxicology. Dr. Henretig served on the American College of Medical Toxicology's ("ACMT")

[1] This *amici curiae* brief was prepared *pro bono*; no *amici curiae* paid in whole or in part for the preparation of the brief.

Board of Directors and represented the American Board of Pediatrics on the Sub-Board of Medical Toxicology, chairing in 2000. He is a recipient of ACTM's Matthew J. Ellenhorn Award for "extraordinary contributions to the field of medical toxicology."

Hallam Hurt, M.D., is a Professor of Pediatrics in Philadelphia. For nearly a quarter of a century, funded primarily by the National Institute on Drug Abuse, Dr. Hurt investigated the effects of in utero cocaine exposure on infant, child, and young adult outcomes. She has numerous publications related to this endeavor. Dr. Hurt's research also explores the effects of poverty in healthy term gestation African American female babies of low and higher socio-economic status. Dr. Hurt also cares for infants in the intensive care nursery, and their families, evaluating developmental outcomes of high-risk infants and participating in programs promoting literacy and enriching family understanding of developmental outcomes of preterm infants.

Juvenile Law Center ("JLC") advocates for rights, dignity, equity, and opportunity for youth in the child welfare and justice systems through litigation, appellate advocacy, policy reform, public education, training, consulting, and strategic communications. Founded in 1975, JLC is the first non-profit public interest law firm for children in the country. JLC strives to ensure that laws, policies, and practices affecting youth advance racial and economic equity, are

rooted in research, consistent with children's unique developmental characteristics, and reflect international human rights values. Core to JLC's work is advocating for policies that keep young people with their families, or when that fails, that create permanent, supportive family-like connections for older youth.

Founded in 1908 as the Legal Aid Society of Pittsburgh, **KidsVoice** represents approximately 3,000 children each year in dependency cases, including termination of parental rights proceedings. Many children represented by KidsVoice are victims of physical or sexual abuse where the perpetrators are investigated under Pennsylvania's CPSL. A national leader in multi-disciplinary advocacy and representation, KidsVoice provides every child with an attorney and a social service professional – staff members with expertise in social work, mental health, education, child development, case management, or substance abuse services. KidsVoice was one of five lead partners on a five-year, $6 million federal Quality Improvement Center Project for legal representation of abused and neglected children funded by the Children's Bureau of the United States Department of Health and Human Services and awarded to the University of Michigan as the lead agency.

The **Philadelphia Department of Human Services (DHS)** is the county's child welfare agency. DHS' mission is to provide and promote child safety, permanency, and well-being for children and youth at risk of abuse, neglect, and

delinquency. DHS has three primary operating divisions: (i) Community-Based Prevention Services (offers services designed to divert children and families from the formal child welfare system, including Out-of-School Time ("OST"), in-home case management, domestic violence support services, truancy intervention services, housing support, and mentoring); (ii) Child Welfare Operations (administers a child abuse hotline 24 hours per day, 365 days per year to respond to allegations of child abuse or neglect, conducts investigations and assess families to determine services need, and manages placement of children based on the existence of safety threats); and (iii) Juvenile Justice Services Center (operates Philadelphia's secure detention facility for juveniles and supports an array of diversion programs to prevent youth from entering the juvenile justice system).

Support Center for Child Advocates ("Child Advocates") provides legal assistance and social service advocacy for abused and neglected children in Philadelphia, Pennsylvania. Child Advocates protects children by securing social services, finding alternative homes, and helping children testify in court. Respected for diligent and effective advocacy throughout more than 40 years, Child Advocates works to ensure safety, health, education, family permanency and access to justice for all children committed to their care. Systemically, Child Advocates promotes collaborative, multi-disciplinary casework, and solutions to recurrent problems.

ARGUMENT

Prenatal substance exposure is not child abuse as defined by Pennsylvania's CPSL and treating it as child abuse is unnecessary to protect Pennsylvanian children. This Court should vacate the Superior Court's Order holding that a mother's use of illegal drugs while pregnant may constitute child abuse under the CPSL and remand for further proceedings. Failure to do so ultimately would harm children by contravening prevailing standards of care for treatment of prenatal substance exposure and imposing lasting limitations on children and the children's family.

I. A Civil Finding of Child Abuse for Substance Exposed Infants is not Necessary to Protect Children

A. Pennsylvania's Existing Referral Mechanism is Sufficient to Protect Substance Exposed Infants

The safety of the child is paramount for all parties involved in the child welfare system. Construing prenatal substance exposure as child abuse is unnecessary to ensure children's safety, and ultimately, it may harm children. Pennsylvania's existing mechanisms sufficiently protect the safety of substance exposed infants and children.

The federal Child Abuse Prevention and Treatment Act ("CAPTA") requires states to adopt "policies and procedures . . . to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure" 42 U.S.C. § 5106a.

Pennsylvania's CPSL likewise requires healthcare providers "involved in the delivery or care of children under one year of age" (hereinafter "infants") who are born with or affected by "illegal substance abuse by the child's mother[,] . . . [w]ithdrawal symptoms resulting from prenatal drug exposure . . . [or a] Fetal Alcohol Spectrum Disorder" to immediately "report or cause a report to be made to the appropriate county [children and youth] agency." 23 Pa. Cons. Stat. § 6386(a). Upon receipt of a report, the CPSL also requires a county agency to: perform "a safety assessment or risk assessment, or both, for the child;" immediately ensure the child's safety and place the child in emergency protective custody, if required; physically see the child within 48 hours; contact the child's parents within 24 hours; and "[p]rovides or arrange reasonable services to ensure the child is provided with proper parental care, control and supervision" 23 Pa. Cons. Stat. § 6386(b), (c)(1)-(4).

Pennsylvania's system of risk assessment and care effectively protects substance-exposed infants. Newborns rarely are sent home with an active user of a controlled substance, and in-home children very likely will be removed from the care of parents who are known active drug users not engaged in treatment. Construing prenatal substance exposure as child abuse will not increase infants' safety or protection. On the contrary, such a punitive measure likely will cause serious harm to pregnant women and infants.

B. Protective Custody under CPSL, the Juvenile Act, and Rules of Juvenile Court Procedure Effectively Ensure Children's Protection

Pennsylvania additionally has sufficient, existing legal mechanisms to protect children from inadequate parents. Pennsylvania's CPSL, Juvenile Act, 42 Pa. Cons. Stat. § 6301, *et seq.*, and Rules of Juvenile Court Procedure all include provisions for taking children into protective custody when necessary.

Under Pennsylvania's CPSL, a child may be taken into protective custody by a physician examining or treating the child, the director of a hospital or medical institution where the child is being treated, or a person designated by the director "if protective custody is immediately necessary to protect the child" 23 Pa. Cons. Stat. § 6315(a)(2). The physician, director, or designee of a hospital also may take a child into protective custody if the child is a newborn pursuant to the Newborn Protection Act (Chapter 65), 23 Pa. Cons. Stat. § 6501, *et seq*. 23 Pa. Cons. Stat. § 6315(a)(3). The child may be held in protective custody up to 24 hours, after which time the appropriate county Children and Youth ("C&Y") Agency must obtain a court order permitting the child to be held in custody for a longer period. *Id*. at § 315(b).

Further, a police officer or juvenile probation officer, pursuant to the Juvenile Act and the Rules of Juvenile Court Procedure, also has authority to take a child into protective custody for 24 hours without a court order "if there are

reasonable grounds to believe that the child is suffering from illness or injury or is in imminent danger from his [or her] surroundings, and that his [or her] removal is necessary."

42 Pa. Cons. Stat. § 6324(3); Pa. R. Juv. Ct. P. § 1202. A police officer, juvenile probation officer, or county C&Y agency also may obtain a protective custody order to remove a child from his or her home if the court determines that "remaining in the home is contrary to the welfare and the best interests of the child." Pa. R. Juv. Ct. P. § 1202(A)(2)(a). Following a court order, the county agency may take the child into protective custody in order to protect the child from abuse. Pa. R. Juv. Ct. P. § 1202(A)(2)(b).

The Juvenile Act provides the well-known legal mechanism for removing children from inadequate parents when a court determines this is necessary. The Commonwealth considers a child to be dependent if the child "is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his [or her] physical, mental, or emotional health, or morals." 42 Pa. Cons. Stat. § 6302. An adjudicatory hearing is held to determine whether there is clear and convincing evidence for the court to make a finding of dependency. 42 Pa. Cons. Stat. § 6341(c).[2] For a child adjudicated dependent, the

[2] In the instant case, L.B. was found dependent and taken into protective custody; these determinations were not appealed.

court holds a disposition hearing through which the court may permit the child to *inter alia* remain with his or her parents, guardian, or other custodian; transfer temporary legal custody to an individual or public or private agency; or transfer permanent legal custody to an individual found to be qualified to receive and care for the child. 42 Pa. Cons. Stat. § 6351(a). The legal standard governing the removal of a child from his or her parent's care is clear necessity; removal only may be ordered if the court determines alternatives to removal are unfeasible. 42 Pa. Cons. Stat. § 6351(b). Prior to any order or disposition removing a child from his or her home, a court must find "that continuation of the child in his [or her] home would be contrary to the welfare, safety or health of the child; and…whether reasonable efforts were made prior to the placement of the child to prevent or eliminate the need for removal of the child from his [or her] home, if the child has remained in his [or her] home pending such disposition[.]" 42 Pa. Cons. Stat. § 6351(b)(1)-(2). Pennsylvania's existing legal mechanisms effectively remove children from the care of inadequate parents, including active drug users when applicable; a further finding of civil child abuse for prenatal substance exposure is unnecessary.

II. Construing Prenatal Substance Exposure as Child Abuse Will Deter Prenatal Care for Children and Women

Public health disfavors construction of prenatal substance exposure as civil child abuse. Such a punitive approach (i) discourages necessary maternal and

prenatal care; (ii) ignores the effects of prenatal opioid exposure on infants and opens the door to over legislating the various decisions women make during pregnancies; and (iii) disproportionately harms women of color, poor women and rural women. Rather than promoting healthier children and pregnancies, construing prenatal substance exposure as child abuse will harm children and women.

A. Prevailing Standard of Care Favors Treatment of Prenatal Substance Use; Threat of a Child Abuse Finding Will Discourage Prenatal Care

Construing prenatal substance exposure as child abuse does not further neonatal or maternal health. As set forth more fully in Appellant's Brief, the prevailing standard of care recognized by every leading medical and public health organization is that prenatal substance exposure is a health concern "best addressed through education, prevention and community-based treatment, not through punitive drugs laws or criminal prosecution." The American College of Obstetricians and Gynecologists ("ACOG"), *Toolkit on State Legislation, Pregnant Women & Prescription Drug Abuse, Dependence and Addiction* ("ACOG Toolkit"), at 1.[3] "[T]he medical model of addiction views substance use disorders

[3] All leading medical and public health organizations in the United States oppose punitive responses to prenatal substance use, including American Academy of Pediatrics, *A Public Health Response to Opioid Use in Pregnancy* (2017)("punitive measures taken toward pregnant women are not in the best interest of the health of the mother-infant dyad[;]" they "are ineffective and may have detrimental effects on both maternal and child health."); American Medical Association, *Perinatal Addiction - Issues in Care and Prevention H-420.962* (2017)("[p]regnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are

as chronic, relapsing diseases, with substance abuse during pregnancy an unfortunate, but common occurrence. In the medical model, treatment not punishment, is the remedy to reduce consumption of substances during pregnancy." Cara Angelotta, M.D. & Paul S. Appelbaum, M.D., *Criminal Charges for Child Harm from Substance Use in Pregnancy*, 45 J. Am. Acad. Psychiatry Law 193, 193 (2017).

---

necessary to support rehabilitation . . . . Transplacental drug transfer should not be subject to criminal sanctions or civil liability"); American Society of Addiction Medicine, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (2017)("[s]tate and local governments should avoid any measures defining alcohol or other drug use during pregnancy as 'child abuse or maltreatment,' and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care services for these women"); National Perinatal Association, *Position Statement 2017: Perinatal Substance Use* (2017)("[t]reating [perinatal substance use] as . . . a deficiency in parenting that warrants child welfare intervention -- results in pregnant and parenting people avoiding prenatal and obstetric care and putting the health of themselves and their infants at increased risk"); ACOG, Committee on Health Care for Underserved Women, *Committee Opinion No. 473, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (January 2011, reaffirmed 2014)("[s]eeking obstetric–gynecologic care should not expose a woman to criminal *or civil penalties*, such as [*inter alia*] loss of custody of her children . . . . Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes.")(emphasis added); March of Dimes, *Fact Sheet: Policies and Programs to Address Drug-Exposed Newborns* (2014)("[MoD] opposes policies and programs that impose punitive measures on pregnant women who use or abuse drugs . . . . Pregnant women who are addicted to opioids often do not seek prenatal care until late in pregnancy because they are worried that they will be stigmatized or that their newborn will be taken away. [MoD] supports policy interventions that enable women to access services in order to promote a healthy pregnancy and build a healthy family"); American College of Nurse Midwives, *Position Statement: Addiction in Pregnancy* (2013)("ACNM supports a health care system in which women with substance addictions in pregnancy are treated with compassion, not punishment. Women should not be deterred from seeking care during pregnancy due to fear of prosecution"); and American Public Health Association, *Policy Statement No. 9020: Illicit Drug Use by Pregnant Women* (1990)("use of illicit drugs by pregnant women as a public health problem, and recommends that no punitive measures be taken against pregnant women who are users of illicit drugs when no other illegal acts, including drug-related offenses, have been committed").

Punitive laws do not work. Instead of promoting healthier pregnancies, such policies discourage women from seeking prenatal care and erode women's trust in healthcare providers, putting women and fetuses at risk. ACOG Toolkit, at 3; Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in America* (2017) ("AI Report"), at 9.[4] Moreover, removing a subsequently born child from a woman's care likely will not encourage treatment during future pregnancies; instead, lack of prenatal treatment likely will result.

Medically centered, collaborative approaches better serve the goals of maternal, fetal, and child health. Acknowledging that opioid use during pregnancy may put children at risk for neonatal abstinence syndrome ("NAS") or withdrawal, "evidence has shown that it does not lead to long-term complications." *ACOG Statement on Opioid Use During Pregnancy* (May 26, 2016), at 1, *available at* https://www.acog.org/About-ACOG/News-Room/Statements/2016/ACOG-

[4] Several other states have considered this issue and found against civil, punitive measures. *See e.g.*, *New Jersey Div. of Child Protection and Permanency v. Y.N.*, 104 A.3d 244, 246 (N.J. 2014) ("absent exceptional circumstances, a finding of abuse or neglect cannot be sustained based solely on a newborn's enduring methadone withdrawal following a mother's timely participation in a bona fide treatment program prescribed by a licensed healthcare professional to whom she has made full disclosure."); *New Jersey Dept. of Children and Families, Div. of Youth and Family Services v. A.L.*, 59 A.3d 576 (N.J. 2013) (drug use during pregnancy by itself does not establish child abuse or neglect); *In re Valerie D.*, 613 A.2d 748 (Conn. 1992) (prenatal cocaine use did not permit the state to terminate mother's parental rights); *Johnson v. State*, 602 So. 2d 1288, 1296 (Fla. 1992) ("by imposing criminal sanctions, women may turn away from seeking Prenatal care for fear of being discovered"). *See also* California's Child Abuse and Neglect Reporting Act, providing that an "indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child." Cal. Penal Code § 11165.13. But, "a positive toxicology screen at the time of delivery of an infant is not in and of itself a sufficient basis for reporting child abuse and neglect." *Id*.

Statement-on-Opioid-Use-During-Pregnancy.[5] ACOG, SAMHSA and other medical organizations further explain that while opioid withdrawal during pregnancy may be "associated with poor neonatal outcomes, including early preterm birth or fetal demise, and with higher relapse rates among women; robust evidence has demonstrated that maintenance therapy during pregnancy can improve outcomes." *Id.* Accordingly, medical professionals actually recommend pharmacotherapy treatment of opioid dependency – referred to varyingly as opioid substitution maintenance, opioid agonist therapy (OAT), or medication-assisted treatment (MAT) – for pregnant women using opioids to improve maternal and fetal outcomes. ACOG Toolkit, at 1. *See also* AI Report, at 31, 33.[6] MAT and similar therapies involve physician prescribed and supervised use of opioid-based medications to treat a woman's disease, and they have beneficial effects on infants, including lower use of assisted ventilation and reduced incidence of low birth

[5] Infants exposed to opioids in utero may experience withdrawal symptoms, commonly referred to as NAS, including *inter alia* irritability, sleep disturbances, feeding issues, gastrointestinal disturbances, seizures, low birth weight, and respiratory complications. *See* Lauren M. Jansson, M.D., *Neonatal Abstinence Syndrome* Cara Angelotta, UpToDate, Wolters Kluwer (Jan. 2018), *available at* https://www.uptodate.com/contents/neonatal-abstinence-syndrome?search=neonatal%20abstinence%20syndrome&source=search_result&selectedTitle=1~18&usage_type=default&display_rank=1.

[6] *See also* U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration: Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (Treatment Improvement Protocol (TIP) Series, No. 43.), Chapter 13: Medication-Assisted Treatment for Opioid Addiction During Pregnancy (2005), at 2, *available at* www.ncbi.nlm.nih.gov/books/NBK64148/ (since 1998, the National Institutes of Health consensus panel has "recommended methadone maintenance as the standard of care for pregnant women with opioid addiction").

weight and premature delivery. ACOG Toolkit, at 1; Mary Anne Armstrong et al., *Perinatal Substance Abuse Intervention in Obstetric Clinics Decreases Adverse Neonatal Outcomes*, Journal of Perinatology, 2003, Vol. 23, at 3, 7. In a 2017 report on the policing of pregnant women using drugs in the United States, Amnesty International found that such treatments play "an important role in attracting and retaining pregnant women in treatment and ensuring good contact with obstetric and community-based services including primary care." AI Report, at 33. Nevertheless, the Superior Court's Order contradicts this approach and muddies the proverbial water concerning when prenatal substance exposure would be considered child abuse.[7] Women battling their illnesses by engaging in physician supported opioid therapies could be liable for civil child abuse as opioids would still be found in the women's or infants' systems.

Likewise, opioid-based medications are common, if potentially problematic, pain medications used both illicitly and by prescription for moderate to severe pain during pregnancy and/or childbirth. Malaika Babb et al., *Treating Pain During Pregnancy*, Canadian Family Physician, Vol. 56, (Jan. 2010), at 25–27; and U.S.

[7] 23 Pa. Cons. Stat. § 6386(a)(2) exempts health care providers from mandatory reporting when an infants in utero exposure was "under the care of a prescribing medical professional" and "in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional." *Id*. Thus, a health care provider is not mandated to report a woman for prenatal exposure who engaged in MAT or other therapies. Yet, the Superior Court's Order broadly interprets the CPSL holding that a woman still could be liable for civil child abuse under the CPSL. *In the Interest of L.B.*, 177 A.3d 308, 309 (Pa. Super. 2017), *appeal granted*, 2018 Pa. LEXIS 1707 (Pa. Apr. 3, 2018)

Department of Health of Human Services, Factsheet, *Pregnancy and Opioid Pain Medications*, *available at* https://www.cdc.gov/drugoverdose/pdf/pregnancy_opioid_pain_factsheet-a.pdf. *See also* ACOG Toolkit, at 2 ("Short term use of opioids during pregnancy for episodic pain has not resulted in symptoms of neonatal abstinence syndrome."). When women receive opioids for pain management during labor, the drug often will cross the placental barrier in varying degrees to the baby. Jay E. Mattingly et al., *Effects of Obstetric Analgesics and Anesthetics on the Neonate: A Review*, Pediatric Drugs, 2003, 5 (9), at 616. While most anesthetic and analgesic agents in current use "are well tolerated by the fetus if judiciously administered[,]" they still will appear in a woman or infant's system and further confound the issue of testing inaccuracies. *Id*.[8]

"[W]hether or not a pregnant woman can stop her drug use, obtaining prenatal care, staying connected to the health care system, and being able to speak openly with a physician about drugs problems helps to improve birth outcomes." ACOG Toolkit, at 1. Defining prenatal substance exposure as child abuse under the CPSL would obviate the prevailing standard of care to treat prenatal substance

[8] "For labor analgesia, many options are available. Systemic administration of opioids and sedatives is one such option. Repeated maternal administration of opioids such as pethidine (meperidine) results in significant fetal exposure and neonatal respiratory depression. Patient-controlled analgesia with synthetic opioids such as fentanyl, alfentanil, and the new ultra-short-acting remifentanil may be used for labor analgesia in selected patients." *Id*.

exposure as a medical issue and may subject children and women to increased risks of medical harm.

B. Prenatal Substance Exposure May Have No More Lasting Detrimental Effects Than Other, Lawful Actions

Any study of prenatal substance exposure must acknowledge that an infant may experience pain and other symptoms of withdrawal that should be avoided at all costs.[9] However, evidence does not indicate opioid exposure itself as life threatening or causing permanent harm. "[T]here have been no reported long term effects of maternal opioid use on the developing child. Longitudinal studies over 5 to 10 years have shown that children who experienced NAS as infants do not exhibit signs of physical or cognitive impairment as they mature." ACOG Toolkit, at 2. *See also* AI Report, at 31.

Though relatively limited research to-date has focused on the effects of prenatal opioid exposure on a subsequent child, there is a wide body of clinical and research evidence that "findings once thought to be specific effects of gestational cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana and/or alcohol and the quality of the child's environment." Hallam Hurt et al., *Children With and Without Gestational Cocaine Exposure: A Neurocognitive Systems Analysis*, Neurotoxicology and Teratology, Nov.-Dec.

[9] *See supra* note 5.

2009, at 335. The ground-breaking work of Eileen Tyrala, M.D. – then at Einstein Hospital in Philadelphia – and Hallam Hurt, M.D. (one of the *amici* here) – of The Children's Hospital of Philadelphia – during the height of the "crack" epidemic investigated the effects of in utero cocaine exposure on infant, child, and young adult outcomes. In particular, Dr. Hurt's research showed that cocaine-exposed and non-exposed subjects, all from low socio-economic backgrounds, did not differ in developmental or cognitive outcome.[10] However, both groups performed poorly and below average on standardized testing. Dr. Hurt's conclusion: poverty is more injurious to children's outcomes than prenatal exposure to cocaine.[11] *Id.* Indeed,

[10] Hallam Hurt, M.D., et al., *Cocaine-exposed Children: Follow-up Through 30 Months*, 16 Dev. Behav. Pediatr. 29, 29-35 (1995); Hallam Hurt, et al., *Natal Status of Infants of Cocaine Users and Control Subjects: A Prospective Comparison*, 15 J. Perinatology 297, 297-304 (1995; Hallam Hurt, et al., *School Performance of Children with Gestational Cocaine Exposure*, 27 Neurotoxicology and Teratology 203, 203-11 (2005); Hallam Hurt, et al., *Children With In Utero Cocaine Exposure Do Not Differ From Control Subjects on Intelligence Testing*, 151 Arch. of Pediatr. and Adolescent Med., 1237, 1237-41 (1997); Hallam Hurt, M.D., et al., *A Prospective Evaluation of Early Language Development in Children With In Utero Cocaine Exposure and in Control Subjects*, 130 J. Pediatr. 310, 310-12 (1997); Hallam Hurt, et al., *Inner-City Children Perform Poorly on Intelligence Testing Regardless of In Utero Cocaine Exposure*, 39 Pediatr. Res. (1996); Hallam Hurt, et al., *Children With and Without Gestational Cocaine Exposure: A Neurocognitive Systems Analysis*, 31 Neurotoxicology and Teratology 334, 334-41 (2009); Hallam Hurt, M.D. and Laura M. Betancourt, Ph.D., *Turning 1 Year of Age in a Low Socioeconomic Environment: A Portrait of Disadvantage*, 38 J. Dev. Behav. Pediatr. 493, 493-500; Hallam Hurt and Laura M. Betancourt, *Effect of Socioeconomic Status Disparity on Child Language and Neural Outcome: How Early is Early?*, 79 Pediatr. Res. 1-28 (2016); Katherine T. Wild, et al., *The Effect of Socioeconomic Status on the Language Outcome of Preterm Infants at Toddler Age*, 89 Early Hum. Dev. 743, 743-46 (2013).

[11] Within the first two years of life, infants of lower socio-economic status show poorer cognitive and language performance than their counterparts. MRIs of infants have even shown the effects of poverty on brain scans within one month of age. *See generally supra* note 10. *See also* ACOG Toolkit, at 2; AI Report, at 22 (subsequent long-term studies of cocaine exposed infants found "cocaine exposure does not result in measurable differences in intelligence and other

medical professionals like the current furor surrounding prenatal opioid exposure to the misplaced fear surrounding the "crack baby" epidemic and caution against prematurely jumping to similar conclusions, which resulted in long-term harms.

Furthermore, Pennsylvania has declined to legislate lawful substances that a woman may choose to use during pregnancy, such as alcohol and tobacco, which are known to cause more pain and long-term harm to an infant. ACOG Toolkit, at 10. ("Decades of evidence have shown that alcohol and cigarettes – unlike opioids – cause long-term serious health consequences for mothers and infants, including prematurity. Smoking is the number one risk factor for delivering a baby prematurely.") An infant also can experience withdrawal from the broad class of anti-anxiety medications including barbituates, benzodiazames, and psychotropics. Use of these medications both on- and off-prescription occurs widely across the nation during pregnancy. Significantly, despite a higher likelihood of detrimental impact, there is little, if any, movement in the Commonwealth – nor anywhere else in the United States that *amici* could determine – to characterize in utero exposure to these substances and drugs as child abuse. Prenatal substance exposure and NAS have consequences that are not fully understood, but certainly not yet seen at the

outcomes[;]" developmental outcomes are tied to complex social environments in which people develop and poverty is a more powerful influence than exposure to cocaine).

magnitude that smoking and alcohol may impart upon the child, and the Commonwealth's legislature and courts have not recognized ingestion of these substances as civil child abuse.

Finally, as Judge Strassburger noted in his Superior Court concurring opinion and as Appellant discusses in her brief, construction of prenatal substance exposure as civil child abuse opens the door to statutory interpretations of other, lawful actions that also could "cause[ ], or create[ ] a reasonable likelihood of, bodily injury to a child after birth." *Interest of L.B.*, at 309. Public policy – as well as constitutional law – warn against the slippery slope of intruding upon the myriad decisions a pregnant woman makes

> that could be reasonably likely to result in bodily injury to her child after birth, which may vary depending on the advice of the particular practitioner she sees and cultural norms in the country where she resides. Should a woman engage in physical activity or restrict her activities? Should she eat a turkey sandwich, soft cheese, or sushi? Should she drink an occasional glass of wine? What about a daily cup of coffee? Should she continue to take prescribed medication even though there is a potential risk to the child? Should she travel to countries where the Zika virus is present? Should she obtain cancer treatment even though it could put her child at risk? Should she travel across the country to say goodbye to a dying family member late in her pregnancy? Is she a child abuser if her partner kicks or punches her in her abdomen during her pregnancy and she does not leave the relationship because she fears for her own life? . . . reasonable people may differ as to the proper standard of conduct.

Id. at 314.

Thus suggests the conundrum of the current case – what makes opioids different from smoking or other potentially harmful actions? Researchers and clinicians have identified many other environmental factors and conditions with potentially harmful effects on a developing fetus and/or infant, including polysubstance use, maternal stress, household environment such as chaos or violence, maternal IQ, maternal obesity and lead poisoning. No studies are large enough to control for every influence or condition that may have a lasting effect on the child, which leads to a question of causation – how to determine what factor caused a particular effect on a child – and a problem with disparate treatment of these several conditions. Construction of prenatal substance exposure as civil child abuse will not answer these questions or likely improve maternal and child health. Quite the opposite result likely will inure; constructing prenatal substance exposure as civil child abuse will increase women's distrust of healthcare professionals, potentially lead to less prenatal care, and potentially cause more harm to fetuses and children.

III. Interpreting Prenatal Substance Exposure as Child Abuse Imposes Restrictions That Will Harm a Child

A. A Finding of Child Abuse Will Impose Restrictions That May Last a Lifetime and Long Exceed the Addiction Itself

Upholding the Superior Court's Order that prenatal substance exposure constitutes child abuse to the subsequently born child likely will have the dual

effect of (i) causing child abuse investigators to "indicate" most, if not all, substance-exposed newborns, and (ii) occasion many additional findings of child abuse by Dependency Courts. The Superior Court's holding asks a Child Protective Services ("CPS") investigator to determine the intentionality of the mother – the intentional, knowing or reckless inquiry – at the moment of drug use. Beyond being an inappropriate decision for an investigator to make, such results would impose restrictions on a mother that may detrimentally impact her and a child, and may long exceed the period of addiction itself.

Reports of suspected child abuse are indicated by county C&Y Agency and Pennsylvania Department of Human Services ("PA-DHS") investigators based on substantial evidence. 23 Pa. Cons. Stat. § 6303. "Indicated" reports can be converted into "founded" reports following a judicial determination of child abuse, typically in a Dependency Court proceeding or pursuant to a criminal conviction for a crime related to a CPSL defined act of child abuse. *See id.* Upon a finding of child abuse, the party must register on the Statewide Central Register (colloquially known as "the Registry"). 55 Pa. Code §3490.33. The Registry provides a source of information for prospective employers. By regulation, PA-DHS must maintain founded and indicated reports on the Registry until the subject child is 23 years of age. 55 Pa. Code § 3490.39. For example, Pennsylvania law and regulations bar employment in most child-serving and health care fields for persons with a

founded case for five years, and many employers are reluctant to hire a person with an indicated case in these fields as well. *See* 23 Pa. Cons. Stat. § 6344. Child welfare agencies also use Registry information to screen prospective foster and adoptive parents. 23 Pa. Cons. Stat. § 6344(d).

Registry inclusion will adversely impact a mother's ability to maintain gainful employment and raise her child, which ultimately will adversely impact the child. As a child welfare system and child-centered community, we tolerate and even advance these barriers when needed for the safety and well-being of the child. But, should a woman in recovery from her addiction, with clean drug testing indicating she is no longer active in illicit drug use, be barred from parenting or employment? Should a mother who is using medically indicated pharmaceuticals that were inadequately detected or labeled during the CPS investigation be barred from employment? The arguments articulated by Appellant and other *amici curiae* concerning a mother's interests pertain similarly to the interests of a child, who will be well served by appropriate protective measures, but is poorly served by the Superior Court's Order and its effects.

B. Subjective Selection Biases and Drug Testing Inaccuracies Will Result in Unlawful Discriminatory Practices that Disproportionately Harm Women of Color, as well as Poor and Rural Women

1. Subjective Selection Biases

Drug testing policies generally dictate testing based upon discretionary risk factors that largely are applied selectively and subjectively, disproportionately harming women of color, poor women, and rural women. AI Report at 23-24. A 2007 study of over 8,000 women found "black women were 1.5 times more likely to be tested for illicit drugs than non-black women, despite similar rates of testing positive." *Id.* at 25. Similarly, a National Association of Pregnant Women study from 1973 to 2005 identified 413 arrests, detentions, or forced interventions on pregnant women concerning prenatal substance exposure. *Id.* at 23. Of these women, 71 percent qualified for indigent defense and 59 percent were women of color.[12] *Id*. Comprising only 52 percent of cases within the study, African-Americans were overrepresented. *Id.* These results are not new. The American Civil Liberties Union (ACLU) Reproductive Freedom Project documented prosecutions of women for prenatal substance exposure from 1990 to 1992; about 75 percent of the prosecutions were brought against women of color, even though approximately 75 percent of the United States' population was white. *Id.* at 22.

[12] Fifty-nine percent statistic was based on cases within the study where racial data was available. *Id*.

Another 1990 study similarly found that black women testing positive were 10 times more likely to be reported to child protective services than their counterparts. *Id.* at 25. Racial disparities in testing – even if based upon the unintentional implicit biases of well-intentioned healthcare professionals seeking to help – likely will lead women of color to more frequently be identified as using opioids or other substances while pregnant and be subjected to liability for civil child abuse. A similar differential pattern occurred in the disparate criminal prosecution and sentencing practices applied a decade ago to "crack" users (*i.e.*, by poor, predominantly minority populations) and powder cocaine users (*i.e.*, by wealthy white populations). Danielle Kurtzleben, *Data Show Racial Disparity in Crack Sentencing*, U.S. News & World Report, Aug. 3, 2010.

Poor and rural women also will be disproportionately impacted, especially those receiving care via Medicaid programs. *Id*. Drug treatment centers and programs, particularly those accepting – much less specializing in – treatment of pregnant women, generally are inaccessible to poor and rural women. *Id*. at 11, 30-31. Many treatment centers do not accept Medicaid and most private medical insurers does not include drug treatment, forcing women to pay out-of-pocket for care and unjustifiably harming poor women who may be willing, but unable to access treatment for drug addictions. *See id*. at 30 n.140 (*e.g.*, the annual cost for methadone treatment in the United States is $4,700; "[m]any women are simply are

unable to pay and left without treatment as a result"). Construing prenatal substance exposure as civil child abuse will result in unlawful, discriminatory practices disproportionately harming women of color as well as poor and rural women.

2. Testing Inaccuracies

The inherent inaccuracy of drug detection methods additionally will complicate investigative practices and compromise the results of drug testing of infants and mothers. Typical hospital routine drug screening tests can detect the naturally derived opiates codeine and morphine, and the morphine derivative, heroin. These routine drug screens today also can detect, with variable accuracy depending on dose, the common prescription opioids oxycodone (*e.g.*, in Percocet, OxyContin) and hydrocodone (in Vicodin). Of note, a positive drug screen result typically indicates only that an opioid is present; it does not distinguish amongst these agents. The screening test may miss oxycodone or hydrocodone in low concentrations, and it will not detect many commonly used (therapeutically and illicitly) opioids such as fentanyl and its derivatives, meperidine, oxymorphone and tramadol. Fred M. Henretig, et al., *Child Abuse by Poisoning*, *in* Child Abuse: Medical Diagnosis and Management 549-599 (F.M. Henretig, et al. eds., Amer. Acad. of Pediatr. 3rd ed. 2009). *See also* Lewis S. Nelson, Opioids, *in* Goldfrank's Toxicologic Emergencies 492-509 (Robert S. Hoffman, et al. eds., 10th ed. 2015).

Specific testing for these opioid drugs is complicated and requires more sophisticated levels of laboratory testing that is expensive, often requires send-out of specimens to reference laboratories, and may be unavailable in many community hospitals and other settings. *Id.* Lastly, while uncommon, a routine opioid screen may be positive if significant recent ingestion of poppy seeds has occurred, such as in muffins or bagels. While such false positive test results (that is, tests that incorrectly indicate drug use) may be uncommon in opioid testing, the failure of screening tests to detect some drugs may have a discriminatory effect. For example, if one class of users (*i.e.*, poor women) predominately use the easily-detectable street drug heroin, while another class of users (*i.e.*, women of higher socioeconomic status and ready access to physician prescribers) predominately use less-detectable prescription opioids such as oxycodone, hydrocodone, or suboxone, the former class will experience a higher rate of positive screens and a higher rate of indicated child abuse reports.

Thus, even in routine practice or in cases of mandatory drug testing for all women and infants, positive screening is a reliable confirmation of detectable opioids. But, distinguishing between heroin and commonly abused prescription opioids may require a much more sophisticated level of toxicology testing. With cost-prohibitive second-level testing needed – combined with a necessary

assessment of a woman's motivation for taking a drug – it is hard to imagine a drug testing rubric being administered routinely and well in all settings.

CONCLUSION

For the above-stated reasons, the *amici*, Dr. Frederick M. Henretig, Dr. Hallam Hurt, Juvenile Law Center, KidsVoice, Philadelphia Department of Human Services, and Support Center For Child Advocates, respectfully request this Court vacate the Order of the Superior Court holding that a mother's use of illegal drugs while pregnant may constitute child abuse under the CPSL and remand for further proceedings.

/s/ Katharyn I. Christian McGee
Katharyn I. Christian McGee
(PA Bar No. 312347)
DUANE MORRIS LLP
30 South Seventeenth Street
Philadelphia, PA 19103
(215) 979-1000

OF COUNSEL:

Frank P. Cervone
(PA Bar No. 37338)
SUPPORT CENTER FOR CHILD ADVOCATES
1617 John F. Kennedy Boulevard
Suite 1200
Philadelphia, PA 19103
(267) 546-9202

Counsel for Amici Curiae

Marcel Pratt, City Solicitor
(PA Bar No. 307483)
City of Philadelphia Law Department
1515 Arch Street, 17th Floor
Philadelphia, PA 19102
(215) 683-5038

Counsel for Amicus Curiae the Philadelphia Department of Human Services

Dated: May 3, 2018

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing Amicus Brief complies with Pa. R.A.P. 531 and 2135 in that the brief, exclusive of cover page, table of contents, table of authorities, Proof of Service and any addenda contains 6,719 words.

/s/Katharyn I. Christian McGee
Katharyn I. Christian McGee
(PA Bar No. 312347)
DUANE MORRIS LLP
30 South Seventeenth Street
Philadelphia, PA 19103
(215) 979-1000

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that on May 3, 2018, a true and correct copy of the foregoing Amicus Brief was served via electronic mail and United States mail, first class, postage prepaid, addressed:

David S. Cohen
3320 Market St., Suite 232
Philadelphia, PA 19104
(215) 571-4714
dsc39@drexel.edu
Counsel for Appellant

Amanda Beth Browning
Clinton County Children and Youth Social Services Agency
232 East Main Street
P.O. Box 787
Lock Haven, PA 17745
abrowning@clintoncountypa.com
Counsel for Appellee

C. Rocco Rosamilia
Rosamilia, Brungard & Rosamilia
241 West Main Street
Lock Haven, PA 17745
roccorosamilia@gmail.com
Guardian Ad Litem

Trisha Hoover Jasper
Protasio & Jasper PC
325 Market St.
Williamsport, PA 17701
Trisha@pj-law.org
Counsel for Father

/s/ Katharyn I. Christian McGee
Katharyn I. Christian McGee
(PA Bar No. 312347)
DUANE MORRIS LLP
30 South Seventeenth Street
Philadelphia, PA 19103
(215) 979-1000

Counsel for Amici Curiae