The Scholar: St. Mary's Law Review on Race and Social Justice

Volume 26 | Number 3 Article 2

9-15-2024

Prescribed Child Abuse? Using the Americans with Disabilities Act to Deconstruct Discrimination Against Medication for Opioid Use Disorder in Child Abuse & Neglect Proceedings

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Available at: https://commons.stmarytx.edu/thescholar/vol26/iss3/2

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PRESCRIBED CHILD ABUSE? USING THE AMERICANS WITH DISABILITIES ACT TO DECONSTRUCT DISCRIMINATION AGAINST MEDICATION FOR OPIOID USE DISORDER IN CHILD ABUSE & NEGLECT PROCEEDINGS

MAKENZIE STUARD*

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* The University of Texas at Austin School of Law, J.D., May 2024. The author wishes to thank Allison H. Benesch, Lia Sifuentes Davis, and David Knight, who encouraged the writing of this article and supported her through the extensive research. She would also like to thank all of those who have supported her disability rights work throughout law school, especially Hope Bauman, her co-president for Texas Law Disability and Neurodivergent Alliance (TLDNA), and the amazing editors of The Scholar: St. Mary's Law Review on Race and Social Justice.

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INTRODUCTION

"Once [a] mother is separated from her children, desperation sets in, even with the brightest and most determined of mothers," a father, Edwin Webbley, wrote in his daughter Megan Webbley's obituary, referencing the barriers his daughter encountered with their state's child welfare system.[1] Megan, like the parents of roughly three and a half million children per year, interacted with her state's version of Child Protective Services (CPS), resulting in the removal of her children from her custody.[2] Only

1. *See Obituary: Megan Angelina Webbley, 1988-2019,* SEVEN DAYS (Oct. 7, 2019, 6:00 AM), https://www.sevendaysvt.com/vermont/obituary-megan-angelina-webbley-1988-2019/Content?oid=28661339 [https://perma.cc/AA4D-XCKC] (describing the Department of Child and Family Services as "the punisher of addicted mothers, the separator of families and the arbiter of children's futures").

2. *See id.* (expressing disdain for the way child welfare agencies treat parents who relapse); *see also* Eli Hager, *CPS workers search millions of homes a year. A mom who resisted paid a price*, NBC NEWS (Oct. 13. 2022, 7:00 AM), https://www.nbcnews.com/news/us-news/child-abuse-welfare-home-searches-warrant-rcna50716 [https://perma.cc/G7WE-KWZ9] (describing the practices

53.4% of these types of separations result in reunification,[3] meaning parents like Megan face an arduous and emotionally destabilizing journey for a potential opportunity to regain custody of their children. Missing the opportunity by being unable to follow the necessary requirements for reunification may lead to permanent separation, resulting in life-long instability. Parents struggling with substance use disorder (SUD), like Megan, face even more difficulty.[4]

One-in-three children are placed in the foster care system because of allegations made regarding parental substance use.[5] However, simply commanding a parent with opioid use disorder (OUD) to "stop doing drugs" is as effective as telling someone with depression to stop feeling sad—it isn't that simple and it does not work.[6] Even though chronic drug use is a sign of a disability—which through its definition is generally indefinite or severe—not a lifestyle choice, substance use is too often treated as a character flaw or a daily choice to make "wrong" decisions.[7]

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of child welfare agencies as "coercive and manipulative"). The use of the word "CPS" throughout this piece means a state's agency designated to investigate child abuse and neglect complaints even though not all states use CPS as their acronym. This author also uses child welfare and child abuse and neglect interchangeably.

3. *See* Children's Bureau, *Child Welfare Outcomes Report Data*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://cwoutcomes.acf.hhs.gov/cwodatasite/ [https://perma.cc/KB6U-2564] (reporting that parents are only reunified with their children in slightly more than half of situations where a child is exiting the welfare system).

4. *See generally Obituary: Megan Angelina Webbley*, *supra* note 1 (challenging child welfare agencies to provide parents who use drugs with support and resources).

5. *See, e.g.*, Kristin Sepulveda & Sarah Catherine Williams, *One in Three Children Entered Foster Care in 2017 Because of Parental Drug Abuse*, CHILD TRENDS (Feb. 25, 2019), https://www.childtrends.org/blog/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse [https://perma.cc/34XY-JRJK] (highlighting the consistent increase of children entering state care due to parental drug abuse).

6. *Cf. Why are Drugs so Hard to Quit?*, NAT'L INST. ON DRUG ABUSE (Sept. 19, 2022), https://nida.nih.gov/videos/why-are-drugs-so-hard-to-quit [https://perma.cc/K9VG-J2RF] ("With repeated drug use, the brain may also build much stronger connections between drugs and cues associated with them—cues that may be difficult to avoid . . . repeated drug use can also weaken circuits in the brain that help people exercise self-control and tolerate stress.").

7. *See* Job Accommodation Network, *Temporary or Trial Accommodations*, https://askjan.org/topics/Temporary-Accommodations.cfm#:~:text=Temporary%20Impairments%20and%20Temporary%20Accommodations,does%20nno%20alone%20determine%20disability [https://perma.cc/U99T-F26P] (explaining that under federal law, a minor temporary condition is generally not considered a disability); Americans with Disabilities Act, 42 U.S.C. § 12102(1)(C) (1990) (describing a disability as one that is not temporary and minor); *compare* Nora Volkow, *Addiction Should Be Treated, Not Penalized*, NAT'L INST. ON DRUG ABUSE (May 7, 2021), https://nida.nih.gov/about-nida/noras-blog/2021/05/addiction-should-be-treated-

Many treatment programs and individuals who come into contact with those with OUD consider recovery to exclusively mean abstinence—thus perceiving substance use as repeated poor decision-making rather than a treatable disability.[8] This abstinence-only view misunderstands the effects of drug use on the body, the brain, and the person as a whole; in fact, OUD is defined as "a problematic pattern of opioid use leading to clinically significant impairment or distress."[9] Because brain chemistry is impacted by chronic drug use, whether prescribed or illicit, withdrawal symptoms resulting from quitting opioids can be excruciating and varied with symptoms including: (1) generalized pain, (2) diarrhea, (3) excessive sweating, (4) vomiting, (5) insomnia, (6) anxiety, (7) depression, (8) fatigue, (9) irritability, (10) increased likelihood of relapse, and (11) death.[10] Even if someone stops drug use temporarily, the brains of those with OUD may be unable to resist the urge to return to drug use years later; in essence, the cravings never fully go away and can impact one's day-to-day thought process and actions decades after the drug use ends.[11] Therefore, the treatments need to be long-term solutions, since experts recognize OUD as a lifelong disorder which can lead to an inability to fulfill basic obligations at school, work, and *in the home*.[12] Because OUD impacts one's ability to care for themselves, it follows that a mother with

not-penalized [https://perma.cc/E94T-M6AA] (describing addiction as a "treatable brain disorder" that "continues to be criminalized"); *with* U.S. DEP'T OF HEALTH & HUM. SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH V (2016), https://www.hhs.gov/sites/default/files/facing-addiction-in-america-surgeon-generals-report.pdf [https://perma.cc/4FL2-RFMC] (explaining that policies should reflect that addiction is a chronic illness comparable to diabetes so solutions should avoid perpetuating stigma).

8. *See* Catherine E. Paquette et al., *Expanding the Continuum of Substance Use Disorder Treatment: Nonabstinence Approaches*, 91 CLINICAL PSYCH. REV. 1, 12–13 (Nov. 26. 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8815796/pdf/nihms-1774219.pdf [https://perma.cc/A9GF-VKEJ] (questioning the effectiveness of imposing punitive measures on SUD patients who do not abstain from drug use).

9. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 541 (5th ed. 2013).

10. *See id.* at 541–46 (listing the diagnostic criteria for OUD).

11. *See Understanding Drug Use and Addiction Drug Facts*, NAT'L INST. ON DRUG ABUSE (June 2018), https://nida.nih.gov/publications/drugfacts/understanding-drug-use-addiction [https://perma.cc/LG4P-4VBB] (explaining how opioid use chemically alters the brain).

12. *See generally Mental Health and Substance Use Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/find-help/disorders [https://perma.cc/S2GN-V927] (last updated June 9, 2023) (linking substance abuse to mental disorders).

OUD will likely need support and an increased access to treatment options in order to consistently care for their children as they grow up.

The population of individuals with OUD is rapidly skyrocketing, and so too must our solutions to aid this community.[13] "In the year leading up to December 2020, over 92,000 people died by overdose—an almost 30 percent increase from the previous 12-month period."[14] In 2019 alone, more than nineteen million United States adults were living with a substance use disorder (SUD)—a rising number due in part, to the availability of cheaper alternatives, such as fentanyl.[15] To put it into perspective, one out of every ten individuals in the United States will develop some type of SUD during their lives.[16]

The issues presented by SUDs, specifically OUD, require a novel response.[17] The current responses from states misunderstand the nature of chronic drug use and often involve incarceration or termination of parental rights—sometimes contemporaneously.[18] Instead, states should look

13. *See* Meltem Odabas, *Concern About Drug Addiction Has Declined in U.S., Even in Areas Where Fatal Overdoses Have Risen the Most*, PEW RSCH. CTR. (May 31, 2022), https://www.pewresearch.org/short-reads/2022/05/31/concern-about-drug-addiction-has-declined-in-u-s-even-in-areas-where-fatal-overdoses-have-risen-the-most/ [https://perma.cc/R22D-CWEF] (explaining that rates of death due to overdose have increased across the United States).

14. LEGAL ACTION CTR., EMERGENCY: HOSPITALS ARE VIOLATING FEDERAL LAW BY DENYING REQUIRED CARE FOR SUBSTANCE USE DISORDERS IN EMERGENCY DEPARTMENTS 1 (2021), https://www.lac.org/assets/files/LAC-Report-Final-7.19.21.pdf [https://perma.cc/E4TN-UBBZ].

15. *See id*. at 8 (detailing how overdose death rates have hit record highs, with a 30% increase compared to years before the COVID-19 pandemic); *see also* Sally Friedman, *Press Release: New Project to Equitably Enforce Anti-Discrimination Protections and Promote Rights of People Who Use Drugs*, LEGAL ACTION CTR. (June 23, 2022), https://www.lac.org/news/new-project-to-equitably-enforce-anti-discrimination-protections-and-promote-rights-of-people-who-use-drugs [https://perma.cc/U3BG-3AQP] (claiming people who use drugs encounter discrimination across various aspects of their lives, including barriers when seeking treatment).

16. *See 10 Percent of US Adults Have Drug Use Disorder at Some Point in Their Lives*, NAT'L INST. ON HEALTH (Nov. 18, 2015), https://www.nih.gov/news-events/news-releases/10-percent-us-adults-have-drug-use-disorder-some-point-their-lives [https://perma.cc/P9V7-B7CE] (analyzing the survey findings on American adults unveiled a common occurrence of drug use disorder, often intertwining with various mental health conditions and frequently remaining unaddressed).

17. This Article focuses primarily on OUD as most of the caselaw, research, and treatments involve this type of SUD.

18. *See* LEGAL ACTION CTR., ABATEMENT REPORT FACT SHEET FOR CHAPTER 4: CARE FOR OPIOID USE DISORDER IN THE CRIMINAL JUSTICE SYSTEM 2 (2020), https://www.lac.org/assets/files/OpioidAbatementFactSheet-Chapter4-v1.pdf [https://perma.cc/9SR7-W4GQ] ("Over 30 percent of incarcerated individuals report suffering from serious withdrawal symptoms or an

at alternatives that have been shown to help individuals maintain long-term recovery and provide stability in their own lives and their respective family units. One productive first step is to expand access to treatment—beyond mere abstinence—for parents with OUD involved in the child welfare system.[19] Involuntary separation of a child and their parents because of parental opioid use is counterproductive since it has detrimental impacts on the parent's recovery and mental health.[20] Therefore, making it more unlikely that the child will be reunified with their parent(s). States need to acknowledge that children play a crucial role in a parent's recovery process, and removing children can strip parents of their primary motivation for seeking treatment in the first place.[21] Removals also affect the child's mental well-being and increase the risk that they, in turn, will cope with untreated mental health conditions through substance use.[22] This perpetuates a cycle of generational trauma, resulting in

inability to control their opioid use."); *see also* Jun Song Hong et al., *Termination of Parental Rights for Parents with Substance Use Disorder: For Whom and Then What?*, 29 SOC. WORK IN PUB. HEALTH 503, 504 (2014) (according to data from the U.S. Department of Health and Human Services, between 2002–2007, over 469,000 parents lost their custodial rights and many of those parents had some type of SUD).

19. *See* Berta K. Madras et al., *Improving Access to Evidence-Based Medical Treatment for Opioid Use Disorder: Strategies to Address Key Barriers Within the Treatment System*, NAT'L ACAD. OF MED. (Apr. 27, 2020), https://nam.edu/improving-access-to-evidence-based-medical-treatment-for-opioid-use-disorder-strategies-to-address-key-barriers-within-the-treatment-system/ [https://perma.cc/RL4X-E5MH] (emphasizing the need to remove barriers to addiction treatment and improve healthcare for those with OUD, since both barriers and poor or no healthcare results in higher rates of death).

20. *See generally* Allison D. Crawford et al., *Stigmatization of Pregnant Individuals with Opioid Use Disorder*, 3 WOMEN'S HEALTH REPS. 172, 175–76 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8896218/pdf/whr.2021.0112.pdf [https://perma.cc/327P-UL52] (asserting that in numerous cases, separation becomes necessary to ensure the safety of the child; however, pervasive stereotypes surrounding mothers with OUD as inherently unfit or criminal often prompt CPS, medical personnel, and judges to automatically perceive parental drug use as a risk to the child rather than considering the individual's parenting capabilities).

21. *See id*. at 175 (discussing how pregnant individuals using OUD are commonly concerned about potential CPS involvement, which they see as hindering their recovery efforts. Participants described how the constant fear of losing their child has resulted in relapses into opioid use.).

22. *See* Editorial Staff, *Children of Addicted Parents Guide: How to Deal with Addict Parents*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/rehab-guide/guide-for-children [https://perma.cc/QN3C-GXGM] (last updated Feb. 7, 2024) (stating that in households where one or more adults abuse alcohol or drugs, children are roughly twice as likely to develop addictive disorders themselves).

overwhelmed foster care systems, increased parental opioid use, and deaths by overdose.[23]

This Article proposes a solution to lower discrimination rates against parents with OUD and keep families together. Part I of this Article describes OUD and its treatment options and explores the systemic discrimination faced by those on the medication. Part II discusses the intersection between parents with OUD and the child welfare system. After the initiation of a child abuse and neglect proceeding, parents face numerous barriers that are counterproductive, result in relapse, and ultimately prevent the reunification of the family unit.[24] This Article focuses on parents seeking MOUD prescription as a treatment option or currently taking MOUD as prescribed. Part III describes how state entities and courts treat those on MOUD in a discriminatory manner. By deconstructing various written policies and erroneous assumptions about MOUD, parents with OUD will be more likely to reunify with their children or prevent the separation from occurring entirely. Part IV offers a solution.[25] By using the ADA, litigation can be utilized to attack the systemic denial of MOUD by state agencies and courts.[26] The ADA prohibits public entities from discriminating on the basis of disability.[27] When parents are denied an improvement period, criminalized because they test positive for prescribed MOUD, or told to taper off the medication before reunification

23. *See* Scott Simon, *The Foster Care System is Flooded with Children of The Opioid Epidemic*, NPR (Dec. 23, 2017, 8:11 AM), https://www.npr.org/2017/12/23/573021632/the-foster-care-system-is-flooded-with-children-of-the-opioid-epidemic [https://perma.cc/TP9M-FTZ5] (claiming thousands of children have been removed from the custody of parents or a parent because of parental drug use).

24. *See infra* Introduction; *see also, e.g.*, Shoshana Walter, *They Followed Doctors' Orders. Then Their Children Were Taken Away*, N.Y. TIMES MAG., https://www.nytimes.com/2023/06/29/magazine/pregnant-women-medication-suboxonbabies.html [https://perma.cc/9RFM-Q6PN] (last updated July 1, 2023) ("'It's like a sick game,' Caitlyn Carnahan, a mother in Oklahoma whose baby was taken for eight months in 2019, told me. 'They don't want you on illicit street drugs, so here, we're going to give you this medicine. But then if you take this medicine, we are going to punish you for it and ruin your family.'").

25. *See infra* II. Parents with OUD and their Interaction with the Child Welfare System.

26. *Cf.* Anne Kelsey, *The Power of the ADA to Challenge HIV Criminalization Laws*, CHLP (Apr. 13, 2021), https://www.hivlawandpolicy.org/news/power-ada-challenge-hiv-criminal-laws-2021 [https://perma.cc/49AP-KNET] (explaining how the ADA can be used to challenge laws that criminalize HIV and other infectious diseases).

27. *See* 42 U.S.C. §§ 12131–12134 (1990) (noting that disability spans across a variety of areas including employment, transportation, public accommodations, communications, and access to state and local government programs and services).

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can occur by the public entity against their doctor's medical opinion[28]—these policies are imposed based entirely on the individual's disability status. Legal advocates can use the ADA to break down written and unwritten policies to provide more opportunities for parents with OUD to reunify with their children or prevent the separation from occurring in the first place. Finally, this Article concludes with a call to use the ADA to protect both parents on MOUD and those considering trying it as a treatment option, as well as a request for state entities to rethink the way they address maternal drug use even when parents do not presently fall within the scope of the ADA.

I. MEDICATION FOR OPIOID USE DISORDER AND THE CHILD WELFARE SYSTEM'S NEGATIVE REACTION TO IT.

Effective treatment is critical to recovery.[29] Currently, the U.S. Food and Drug Administration has approved three types of medication for treating OUD (referred to hereinafter as MOUD)—methadone, buprenorphine, which includes brand names Subutex and Suboxone, and naltrexone.[30] Methadone and Suboxone alleviate physical dependency effects by targeting brain receptors activated by opioids without inducing euphoria.[31] Naltrexone, also known as Vivitrol, treats OUD by blocking the receptors typically activated by opioids, effectively preventing any rewarding effects.[32]

28. *See infra* III. For Parents Taking Medication for Opioid Use Disorder (MOUD), Parents Face Additional Barriers that are Counterproductive to Maintain Recovery.

29. *See Recovery is Possible: Treatment for Opioid Addiction*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/featured-topics/treatment-recovery.html [https://perma.cc/2JC5-9W88] (last updated Sept. 2, 2021) ("Preventing overdose death and finding treatment options are the first steps to recovery.").

30. *See generally* Jonathan Avery, *Naltrexone and Alcohol Use*, 179 AM. J. OF PSYCHIATRY 886 (2022) (investigating the effectiveness of various medications utilized in the treatment of alcohol use disorder).

31. *See* NAT'L INST. ON DRUG ABUSE, HOW DO MEDICATIONS TO TREAT OPIOID USE DISORDER WORK? (2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work [https://perma.cc/DZF5-4KYN] (asserting methadone and Suboxone's successful use for over four decades in treating OUD, it must be distributed exclusively through specialized opioid treatment programs).

32. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. ("SAMHSA"), *TREATMENT IMPROVEMENT PROTOCOL 63: MEDICATIONS FOR OPIOID USE DISORDER FOR HEALTHCARE AND ADDICTION PROFESSIONALS, POLICYMAKERS, PATIENTS, AND FAMILIES* 1–8 (2021), https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf [https://perma.cc/WLV9-

It is important for parents to have a choice between all three types of medication and complete abstinence because treatment has to be individualized to ensure long-term recovery.[33] Since MOUD minimizes cravings and withdrawal symptoms, when it works for patients, it can help them remain off illicit opioids and stabilize other parts of their lives, including their parenting obligations.[34] By not allowing parents with OUD access to MOUD as a treatment, child welfare agencies instead create long-term, negative consequences that are associated with parental rights terminations.[35] By conditioning reunification on parents discontinuing MOUD or imposing arbitrary time limits on allowable parental MOUD usage, the child welfare system effectively threatens the potential of a safe and supportive environment for the child.[36]

Despite reliable scientific evidence of MOUD's benefits, the system still routinely initiates child abuse and neglect proceedings centered on the parent's use of the treatment.[37] As a result from both inadequate treatment and their child's removal, parents—namely mothers—often relapse.[38] Unfortunately, for CPS and the courts, the relapse only confirms to them that the mother was unfit to parent from the start.[39]

BZG7] (describing a substance that targets opioid receptors in the central nervous system without causing the typical physiological effects of opioid agonists).

33. *See* Amy A Mericle et al., *Barriers to Implementing Individualized Substance Abuse Treatment: Qualitative Findings from the CASPAR Replication Studies,* 40 J DRUG ISSUES 819, 819–39 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3738209/ (detailing medication used to treat OUDs).

34. *See* SAMHSA, *supra* note 32, at 1–8 (listing therapeutic benefits of MOUD usage).

35. *See generally* NAT'L COUNCIL ON DISABILITY, ROCKING THE CRADLE: ENSURING THE RIGHTS OF PARENTS WITH DISABILITIES AND THEIR CHILDREN (2012), https://heller.brandeis.edu/parents-with-disabilities/pdfs/rocking-the-cradle.pdf [https://perma.cc/T8JU-BX7E] (stressing that the legal system lacks advocates prepared to assist patients).

36. *See* SAMHSA, *supra* note 32, at 2 (warning healthcare professionals about the need to educate both CPS and the patient about the ways to navigate parenthood while in treatment).

37. *See* Walter, *supra* note 24 (noting how many states focus solely on MOUD usage when investigating child abuse allegations).

38. *See id.* ("Women across the country have described being pressured, even ordered, by caseworkers and judges to get off their medications to resolve their child-welfare cases."). This pressure has resulted in numerous cases of relapse and then subsequent terminations of parental rights. *Id.*

39. *See id.* (describing a West Virginia judge who allowed the state to cut payment for the mother's Suboxone, resulting in relapse and the judge then terminating the mother's parental rights).

Consequently, parents with OUD, including those seeking MOUD treatment, face an elevated risk of parental termination.[40] Elizabeth Brico, a journalism fellow with Talk Poverty, wrote about her own experience with the child welfare system in Broward County, Florida, detailing the barriers many parents with OUD face.[41] As with so many others, her case began with an allegation of drug abuse.[42] In April of 2018, Brico's mother-in-law filed a report with the Broward County Sheriff's Child Protection Investigations Division, accusing her of using heroin.[43] The local sheriff's office initiated an investigation and promptly removed her children from the household.[44] Ms. Brico was then charged with neglect and posing an "imminent risk of serious harm" to her children.[45] Ms. Brico's history of methadone treatment and the birth of her oldest child while she was on methadone were used to justify the removal of her two younger daughters.[46] However, after a series of negative drug screens were completed and a determination by the sheriff's office that her children showed no signs of neglect, the same entity broadened—

40. *See id.* ("In some instances, women who refused to do so lost their parental rights. The pressure extends to women who have been in long-term recovery, who own homes, hold jobs and successfully parent other children.").

41. *See* Elizabeth Brico, *How Child Protection Services Can Trap the Parents They're Supposed to Help*, TALK POVERTY (July 16, 2019), https://talkpoverty.org/2019/07/16/child-protective-services-trap-parents/ [https://perma.cc/W5V8-DCZ8] (recounting her experience and discussing how the systemic stereotypes around MOUD persist in child protective services); *accord* Elizabeth Brico, *How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, THE APPEAL (Nov. 15, 2019), https://theappeal.org/how-child-services-punishes-mothers-with-substance-use-disorder-and-their-children/ [https://perma.cc/BX8B-GGYW] (expressing how an inexperienced Broward County employee contributed to her children being taken away).

42. *See* Brico, *supra* note 41 (adding that there was also an allegation of abandonment because she had left her kids with her in-laws for three days, but the Court's concern concentrated on her MOUD use); *see also How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 (narrating the beginning of her troubles as a user of MOUD and the discrimination she experienced at the hands of the child welfare system).

43. *See How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 (lamenting the breakdown of a familial relationship that ended up destroying her life as a mother).

44. *See id.* (defining the overreaction from Florida CPS regarding her involvement with substances).

45. *Id.* This petition for removal runs counter to the finding by the investigator that Brico's actions did not appear to put the children in any harm. *Id.*

46. *See id.* (explaining how the County determined that MOUD was not appropriate for a mother to use).

rather than closed—its investigation.[47] During the investigation, Ms. Brico's in-laws were granted physical custody while she was allowed only one supervised visit a week, which further destabilized her recovery.[48] An additional barrier to maintaining recovery existed. Because she was unable to qualify for Medicaid without custody of her daughters, she was also unable to seek immediate treatment for her PTSD or OUD.[49] Instead, she depended entirely on referrals, which consistently came after her hearings.[50] At the hearings, the Court marked her as noncompliant for failing to begin her services.[51] When referrals did come, they were abstinence-only providers, despite Ms. Brico's request for a MOUD referral.[52] Her request was continually ignored.[53] "Divorced from all [her] supports and motivations, and in a deep state of depression, [she] finally relapsed, as [she] had been accused of doing for the past six months."[54] Her evaluator demanded she immediately enter detox at an abstinence-

47. *See id.* (facing charges of "neglect and posing an imminent risk of serious harm" despite there being no finding of abuse or neglect).

48. Brico, supra note 41 (explaining how she was notified of the state petition to remove her children by a card that was left in her bedroom); *see also How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 (facing charges of "neglect and posing an imminent risk of serious harm" despite there being no finding of abuse or neglect).

49. *See* Brico, *supra* note 41 (noting her struggle to secure permanent housing); *see also How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 ("I was mandated to maintain stable housing and income, undergo a psychological evaluation, engage in trauma-informed individual counseling and substance use treatment, take parenting classes, and submit to random drug tests.").

50. *See* Brico, *supra* note 41 (stating that the referral came six months after the start of the case and three months after the trial); *see also How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 (revealing that a doctor obtained by her counsel stated the six-month waiting period for her referral "was 'well beyond the standard of care.'").

51. *See* Brico, *supra* note 41 (accentuating that this was done regardless of the inability to complete such tasks before the hearing); *see also How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 ("At no point did anyone question why strict compliance with these particular tasks would ensure safe parenting.").

52. *See* Brico, *supra* note 41 (saying that the treatment provider she was given was "an abstinence based-program that openly espoused punitive practices"); *see also How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 (evidencing that such programs remain the norm despite proof they are effective and some speculation of causing harm).

53. *See* Brico, *supra* note 41 (emphasizing how despite numerous requests, she was never provided with a methadone referral).

54. *Id.*

only facility despite her continued requests for a MOUD provider.[55] Towards the end of April 2019, realizing she was on her own, Ms. Brico proactively found a buprenorphine provider, but even then, the court advised her to use MOUD only *temporarily*.[56] Nevertheless, notwithstanding zero evidence of any maltreatment towards her kids, nor continued illicit substance use, Broward County terminated Ms. Brico's parental rights in 2020.[57]

Elizabeth Brico's story is not unique—mothers with OUD are disproportionately flagged by their state or county's version of CPS for abuse or neglect, often investigated *entirely* because of legally prescribed medication taken as prescribed.[58] While the American College of Obstetricians and Gynecologists recommends pregnant mothers with OUD take MOUD during pregnancy to help prevent relapse before, during, and after the birth of the child, almost half of all states have laws that say controlled substance use *of any kind* during pregnancy is child abuse under civil child-welfare law.[59] Furthermore, twenty-five states have mandatory reporting statutes requiring healthcare professionals to report suspected

55. *See id.* (clarifying that the detox referral was given "despite [her] not having a physical dependency").

56. *See id.* (showing that she enrolled immediately and won her court case to have it accepted despite pushback from the court); *see also How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 (explaining that this treatment "is most effective at preventing harm, relapse, and death"); *see also Buprenorphine*, SAMHSA, https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine [https://perma.cc/RNQ2-8TS] (last updated Mar. 28, 2024) (evidencing that buprenorphine "is safe and effective" when used properly).

57. *See* Elizabeth Brico, *"The Civil Death Penalty"—My Motherhood is Legally Terminated*, FILTER MAG. (July 13, 2020), https://filtermag.org/motherhood-legally-terminated/ [https://perma.cc/9E6T-VZD3] (revealing that the termination of "rights was not based on any actualized threats to [her] daughters' safety"); *see also Child Welfare: The Drug War Breaks Up Families*, UPROOTING THE DRUG WAR, https://uprootingthedrugwar.org/child-welfare/ [https://perma.cc/4TA6-JY9T] ("[T]he connection between drug use and supposed inability to care for children is not supposed by evidence.").

58. *See* Noah Addis, *Pregnant on Opiates: When Following Doctors' Order Breaks the Law*, NBC NEWS, https://www.nbcnews.com/news/us-news/pregnant-opiates-when-following-doctors-orders-breaks-law-n100781 [https://perma.cc/BA9B-YUWG] (last updated May 8, 2014, 3:42 AM) (emphasizing that women are stuck in a "Catch-22" because they often hear different things from health professionals and "law enforcement or child welfare agents").

59. *Cf. Committee Opinion: Opioid Use and Opioid Use Disorder in Pregnancy*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (2017), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy [https://perma.cc/NQS8-TYKJ] (providing that MOUD "in combination with prenatal care has been demonstrated to reduce the risk of obstetric complications").

prenatal drug use.[60] These reports trigger CPS to investigate, and if the mother tests positive for a controlled substance, subsequently removes the child upon delivery.[61] These laws, however, are generally vague and can be interpreted to include women taking *any* controlled substances that they are prescribed.[62] In eighteen states, drug use during pregnancy can also have criminal consequences centered on child abuse.[63] These broad statutes, in certain circumstances, allow discretionary reporting based on an individual looking suspicious, including those correctly following their doctors' recommendations.[64]

Although the Centers for Disease Control and Prevention (CDC) recommends MOUD throughout and after the pregnancy to improve both the infant's health outcomes and the mother's stability, using MOUD is not as simple as following science.[65] Depending on the state, the decision

60. *See* Laura J. Faherty, *Policies that Punish Pregnant Women for Substance Use Don't Help Mother or Baby*, RAND (Jan. 28, 2020), https://www.rand.org/pubs/commentary/2020/01/policies-that-punish-pregnant-women-for-substance-use.html [https://perma.cc/3W2K-BCCQ] ("[S]ince 2000, the number of states with policies that punish women for substance use during pregnancy has more than doubled.").

61. *See* Erin C. Work et al., *Prescribed and Penalized: The Detrimental Impact of Mandated Reporting for Prenatal Utilization of Medication for Opioid Use Disorder*, 27 MATERNAL & CHILD HEALTH J. 104, 110 (2023), https://pubmed.ncbi.nlm.nih.gov/37253899/ (describing the effects of mandatory CPS reporting on new mothers).

62. *See* Leticia Miranda et al., *How States Handle Drug Abuse During Pregnancy*, PROPUBLICA (Sept. 30, 2015), https://projects.propublica.org/graphics/maternity-drug-policies-by-state [https://perma.cc/5SD4-ZS6V] (providing the wording for individual states' mandatory reporting laws).

63. *Id.* (comparing states based on whether there are statues that make substance use during pregnancy a crime or whether there are other criminal consequences or grounds for prosecution).

64. *See* Erin C. Work et al., *supra* note 61 (discussing the perspective of pregnant women who experienced discrimination in addition to providing supportive alternatives to mandated reporting "such as parent-child home visiting, childcare, and maternal-infant mental health programs"); *see also* Kristin Jones, *States find a downside to mandatory reporting laws meant to protect children*, NPR (April 25, 2024, 7:00 AM), https://www.npr.org/sections/health-shots/2024/04/25/1247021109/states-find-a-downside-to-mandatory-reporting-laws-meant-to-protect-children:

Being reported to child protective services is becoming increasingly common. More than 1 in 3 children in the United States will be the subject of a child abuse and neglect investigation by the time they turn 18. . . .[P]arents or children with disabilities experience even more oversight. Research has found that, among these groups, parents are more likely to lose parental rights and children are more likely to wind up in foster care. In an overwhelming majority of investigations, no abuse or neglect is substantiated. . . .[F]amilies describe them as terrifying and isolating.

65. *Treatment for Opioid Use Disorder Before, During, and After Pregnancy*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/pregnancy/opioids/treatment.html [https://perma.cc/F2PP-LSK9]; *see also* Doris Titus-Glover et al., *Opioid Use Disorder in*

to take MOUD—even when prescribed by a licensed medical professional—may come with a dangerous and unnecessary choice. If a mother or her newborn tests positive for MOUD post-delivery, or her newborn experiences any withdrawal symptoms, it could lead to involvement from CPS, possible mandatory abstinence-based treatment, or prison time for the mother.[66] Mothers are then left with a difficult decision: Whether to continue taking the medication, which cuts cravings and prevents relapse but may subject her to child abuse proceedings, or to abstain from all substances and risk overdose and child endangerment if relapse occurs.[67] Mothers prescribed MOUD face stigma from the child welfare system,[68] placing them in a situation where they either risk overdose or having their parental rights terminated. When mothers choose to protect their lives by taking MOUD and maintain stability to raise their children, they are often punished.[69] States' words and conduct are sheer hypocrisy. This pattern of discrimination, based solely on obtaining treatment for OUD, is harmful because it perpetuates stereotypes that women with OUD are unfit to serve as parents and further punishes women for seeking access to medical care to maintain their recovery for their benefit as well as their kids.[70]

Pregnancy: Leveraging Provider Perceptions to Inform Comprehensive Treatment, 21 BMC HEALTH SERVS. RSCH. 1, 10 (2021) (concluding that a collaborative patient integrated approach to caring for pregnant women with OUD may be helpful in conjunction with leveraging medical professional perceptions and direct personal experiences); Jones, *supra* note 64 (Mandatory reporting laws "disproportionally harm families that are poor, Black, or Indigenous, or have members with disabilities.").

66. *See* Addis, *supra* note 58 (detailing that women who give birth to children diagnosed with Neonatal Abstinence Syndrome may face negative consequences such as child welfare participation, obligatory drug treatment, or even imprisonment due to the fact that using drugs during pregnancy is many times considered "child abuse").

67. *See id.* (identifying the dilemma between the drugs used by pregnant mothers leading to possible investigation or a potential miscarriage and highlighting the balancing interests of the mother between her own health and wellbeing and that of her child's).

68. *See id.* (expounding upon the misunderstandings that arise due to the prevalence of stigma and preconceived perceptions regarding MOUD use during pregnancy which may include CPS involvement).

69. *See id.* (quoting Susan Neshin, M.D., Medical Director of Jersey Shore Addiction Services: "[Maintenance] is the accepted standard of care," she said. "How can you then turn around and say she's committed child abuse?").

70. *See id.* (demonstrating that there are laws in place to identify babies who have been affected by the mother's use of drugs or exhibit withdrawal symptoms, which then flags CPS to ensure the wellbeing of the baby; but this is a slippery slope because if the mother has a OUD, she should be receiving medical treatment which the system may flag as an impairment in terms of parenting and lead to allegations of child abuse).

The Americans with Disabilities Act (ADA), enacted to eliminate discrimination on the basis of disability, provides a novel path to combat discrimination against mothers who use MOUD within the child welfare system.[71] In addition, federal law can be used to deconstruct biases that arise when women who use controlled substances while pregnant are prosecuted for their conduct. While the U.S. Health and Human Services and the U.S. Department of Justice acknowledge the application of the ADA to the actions of CPS, but the application of the law to civil child abuse and neglect proceedings remains limited.[72] There is no caselaw successfully applying the ADA to criminal child abuse prosecutions. Federal guidance, however, makes clear that the ADA applies to *all* services provided by child welfare agencies and to any courtroom proceedings.[73]

71. *See generally* 42 U.S.C. §§ 12131-12132; 28 C.F.R. § 35.104, 35.130(A); *see also* U.S. Dep't of Just., *The ADA and Opioid Use Disorder: Combating Discrimination Against People in Treatment or Recovery,* ADA.GOV (Apr. 5, 2022), https://www.ada.gov/resources/opioid-use-disorder/ [https://perma.cc/28NM-H969] (concluding that individuals with OUD who are not engaged in current illicit drug use are protected by the ADA. The ADA aims to make sure that disabled individuals receive the same opportunities and are not discriminated against due to their health condition or medical status.).

72. *See, e.g.*, Press Release, U.S. Dep't of Health & Hum. Servs., HHS OCR Secures Voluntary Resolution and Ensures Child Welfare Programs in the Oregon Department of Human Services Protect Parents with Disabilities from Discrimination (Dec. 4, 2019), https://www.einpresswire.com/article/503967242/hhs-ocr-secures-voluntary-resolution-and-ensures-child-welfare-programs-in-the-oregon-department-of-human-services-protect-parents-with-disabilities [https://perma.cc/9X2M-HDC3] ("The parents participated in services required by ODHS CWP to regain custody of their children, including psychological evaluations, parenting classes, and supervised visitation."); *see also* Press Release, U.S. Dep't of Just., Justice Department Finds that Pennsylvania Courts Discriminated Against People with Opioid Use Disorder (Feb. 7, 2022), https://www.justice.gov/opa/pr/justice-department-finds-pennsylvania-courts-discriminated-against-people-opioid-use-disorder [https://perma.cc/E294-DJ3T] ("The Justice Department identified three specific individuals with OUD who had been discriminated against by the Northumberland and Jefferson County Courts of Common Pleas."); *see also* Press Release, U.S. Dep't of Health & Hum. Servs, OCR Secures Agreement with West Virginia to Protect Persons in Recovery from Opioid Use Disorder from Discrimination on the Basis of Disability (May 13, 2020), https://www.hhs.gov/guidance/document/ocr-secures-agreement-west-virginia-protect-persons-recovery-opioid-use-disorder [https://perma.cc/S3CM-886Z] (quoting Assistant Secretary for Mental Health and Substance Use Elinore McCance-Katz, M.D., Ph.D.: "Successful treatment for opioid use disorder requires an individualized approach which includes FDA-approved and physician prescribed medication, as well as psychosocial and community recovery supports."); *see also* In re Hicks/Brown, 893 N.W.2d 637, 640–41 (Mich. 2017) (holding that state agencies have a duty under the ADA to reasonably accommodate a parent's disability before deciding to terminate parental rights).

73. *See* U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF JUST., PROTECTING THE RIGHTS OF PARENTS AND PROSPECTIVE PARENTS WITH DISABILITIES: TECHNICAL ASSISTANCE OF STATE AND LOCAL CHILD WELFARE AGENCIES AND COURTS UNDER TITLE II OF THE

It follows that both child abuse and neglect investigations, the proceedings, and the decision to reunify the parent and the child would fall within its scope. To prevent continued discrimination based on a parent's use of MOUD throughout the course of a child abuse and neglect case, the ADA is the answer.

II. PARENTS WITH OUD AND THEIR INTERACTION WITH THE CHILD WELFARE SYSTEM.

A. Scope of the Problem

An estimated 8.7 million children reside in homes where at least one parent has Opioid Use Disorder (OUD).[74] OUD is defined as recurrent drug use resulting in the failure to meet daily obligations and maintain personal health.[75] Researchers found that parents with OUD are more likely to live in low socioeconomic conditions, display negative parenting qualities, and "miss opportunities to foster healthy attachment" influencing their children's risk of anxiety, depression and disease.[76] Consequently, since 2000, the number of children placed in out-of-home care due to parental drug and alcohol use more than doubled, rising to 38.9%.[77]

AMERICANS WITH DISABILITIES ACT AND THE AMERICANS WITH DISABILITIES ACT AND SECTION 504 OF THE REHABILITATION ACT 2 (2015), https://www.hhs.gov/sites/default/files/disability.pdf [https://perma.cc/H94X-XSUZ] ("Discriminatory separation of parents from their children can result in long-term negative consequences to both parents and their children.").

74. *See* RACHEL N. LIPARI & STRUTHER L. VAN HORN, CHILDREN LIVING WITH PARENTS WHO HAVE A SUBSTANCE USE DISORDER (2017), https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html [https://perma.cc/4VC3-MEHE] (demonstrating with statistics the scope of the SUD issue in the United States).

75. *See id.* (finding that roughly one in thirty-five children had at least one parent who has an SUD).

76. *See* Marjo Flykt et al., *Maternal Representations, and Emotional Availability Among Drug-Abusing and Nonusing Mothers and their Infants*, 33 INFANT MENTAL HEALTH J. 123, 123–38 (2012) (acknowledging that infants of mothers who use drugs tend to display problematic interaction patterns in part because of deficient maternal interaction); *accord* Laura Lander et al., *The Impact of Substance Use Disorders on Families and Children; From Theory to Practice*, 28 SOC. WORK PUB. HEALTH 194, 195 (2013) (providing, for example, the attachment developed through eye contact, tone, rhythm of voice, and touch); *see also* LIPARI & VAN HORN, *supra* note 74 (recognizing that children with parents who have an SUD are more likely to engage in substance use themselves).

77. *See Child Welfare and Alcohol and Drug Use Statistics*, NAT'L CTR. ON SUBSTANCE ABUSE & CHILD WELFARE, https://ncsacw.acf.hhs.gov/research/child-welfare-and-treatment-statistics.aspx [https://perma.cc/D6LW-AJQ9] (identifying that half of the children under the age of one year that were removed from their homes had a parent with an SUD).

The COVID-19 pandemic will also likely lead to an increase in the number of parents with OUD because the amount of people who use drugs has increased by 22%.[78] Additionally, the pandemic increased socioeconomic stressors that negatively impact mental health conditions, as well as mental health conditions born out of isolation, both leading to increased opioid use as a coping mechanism.[79] Despite the rise in OUD worldwide, this likely does not signal a rise in substantiated abuse and neglect cases. Parents with OUD rarely intend to harm their children; rather, their focus can just be misplaced since their thoughts and energy are spent on removing their cravings, which can result in neglecting their children's needs.[80] Parents with OUD, who have formed a chemical dependency, may fail to consider the consequences of their choices.[81] These choices include, in part, disappearing for periods of time, leaving their child alone or with someone unable to meet the child's basic needs, and spending the household budget on removing cravings rather than on adequate food, housing, and healthcare.[82] Even when parents abstain from all illicit substances, the disorder itself has a chronic, relapsing nature.[83]

78. *See COVID Pandemic Fueling Major Increase in Drug Use Worldwide: UN Report*, UNITED NATIONS (June 24, 2021), https://news.un.org/en/story/2021/06/1094672 [https://perma.cc/74NH-Z9AR] (signaling that mental health conditions are on the rise and changes in drug use patterns during the pandemic have also contributed to an increase in SUDs).

79. *See id.* ("The COVID-19 crisis has pushed more than 100 million people into extreme poverty, and has greatly exacerbated unemployment and inequalities . . . These factors have the potential to spur a rise in [SUDs].").

80. *See* Jessica C. Smith et al., *Dynamics of Parental Opioid Use and Children's Health and Well-Being: An Integrative Systems Mapping Approach*, FRONT PSYCHOL. (Jun. 29, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8275850/ [https://perma.cc/KTE3-VLL3] (explaining how drug use can impact the parent-child relationship); *see also* Pew Trusts, *Barrier Limit Access to Medication for Opioid Use Disorder in Philadelphia* (Mar. 16, 2022), https://www.pewtrusts.org/en/research-and-analysis/reports/2022/03/barriers-limit-access-to-medication-for-opioid-use-disorder-in-philadelphia [https://perma.cc/2GXP-WSW5] (describing how those most in need of treatment often cannot find providers who will take them without insurance, are not able to consistently get transportation, have to take time off to get to appointments that they cannot afford to do, or face the most barriers to access treatment that could work for them). As substance use increases worldwide, the child welfare system needs to adapt to meet the needs of families of all socioeconomic statuses.

81. *See id.* (recognizing that often patients are off drugs because they don't have access easy access to drugs or because of external barriers like mandatory drug testing).

82. *See* LIPARI & VAN HORN, *supra* note 74 (finding that about seven million children under the age of seventeen years old lived in a two-parent household where at least one of which suffered from an SUD).

83. *See What is Drug Addiction?* NAT'L INST. ON DRUG ABUSE (July 2020), https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

As a result, instead of being offered additional support to ensure their recovery, parents with OUD are perceived as bad parents because they have used or currently use, despite the lack of a causal connection between substance use and adequate parenting.[84]

In an abuse and neglect case, the CPS investigator's opinion is the primary evidence used to determine child maltreatment, and the presence of substance use is strongly correlated with an investigator's assessment of harm to the child and increased likelihood of removal.[85] If more parents were in treatment for their substance use, one would assume, the number of child abuse investigations would decrease.[86] On the contrary, when more individuals access buprenorphine-based medication, CPS is *more* likely to put parents on MOUD through intrusive investigations.[87] These investigations occur despite the fact that OUD treatment decreases substantiated claims of child abuse or neglect.[88] Rather than expand access to MOUD, many states responded to the opioid epidemic by expanding civil definitions of child abuse and neglect to target parents using illicit substances, but the breadth also covered legally controlled substances.[89]

[https://perma.cc/DXL4-7BXC] (acknowledging that some biological factors such as genes, ethnicity, and gender may affect a person's risk of an SUD).

84. *See* Pamela Appea, *For Parents with Substance Use Disorder, Advocates Call For Resource and Support Instead of Family Separation*, PRISM (July 12, 2022), https://prismreports.org/2022/07/12/parents-substance-use-disorder-support-not-separation/ [https://perma.cc/UGT9-BXCL] ("[A] result of drug use, parents with substance use disorder can be labeled by child protective services as neglectful . . . [w]hen CPS intervenes and removes a child from the home, there can be long-lasting consequences for a caregiver's mental health, stability, housing options, employment and more, along with impacts on the children's mental health.").

85. *See* Lawrence M. Berger et al., *Caseworker-Perceived Caregiver Substance Abuse and Child Protective Services Outcomes*, 15 CHILD MALTREATMENT 199, 199–200 (2010); *see generally* Bryan G. Victor et al., *Domestic Violence, Parental Substance Misuse and The Decision to Substantiate Child Maltreatment*, 79 CHILD ABUSE & NEGLECT 31 (2018) (identifying the causal link between parental substance use and the child's removal).

86. *See generally* Lander et al., *supra* note 76 at 194 (explaining the positive impacts of treatment on the family and the parents' OUD).

87. Robin Ghertner & Mir M. Ali, *Treatment for Opioid Use Disorder May Reduce Substantiated Cases of Child Abuse and Neglect*, U.S. DEP'T OF HEALTH & HUM. SRVS. 1, 4, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/198071/Buprenorphine-Treatment-Child-Maltreatment-Cases.pdf [https://perma.cc/US4J-ZAQS].

88. *Id.*

89. *See* U.S. DEP'T OF HEALTH & HUM. SERVS., & CHILD.'S BUREAU, STATE STATUTES CURRENT THROUGH JULY 2019: PARENTAL SUBSTANCE USE AS CHILD ABUSE 3 (2020) https://www.childwelfare.gov/pubPDFs/parentalsubstanceuse.pdf [https://perma.cc/KB6U-2564] (explaining that California, Delaware, Florida, Iowa, Kentucky, Minnesota, New York, Oklahoma, Rhode Island, Tennessee, Texas, Vermont, and West Virginia use similar language).

For example, in thirteen states, the legislatures broadened child protection statutes to include the language: "using a controlled substance that impairs the caregiver's ability to adequately care for the child."[90] The vagueness of this portion of state statutes can too easily penalize parents taking prescribed medication.[91] This is because the determination of whether a child has been injured because of impaired parenting skills can too often cause an investigator to assume that substance use of any kind is equivalent to an injury to the child.[92] These erroneous misconceptions can lead to destabilizing referrals.[93] When judges dislike MOUD, they may feel the need to require more from parents on the medication, at which point such unnecessary child removals or parental terminations can occur.[94]

III. FOR PARENTS TAKING MEDICATION FOR OPIOID USE DISORDER (MOUD), PARENTS FACE ADDITIONAL BARRIERS THAT ARE COUNTERPRODUCTIVE TO MAINTAIN RECOVERY.

A. State Mandatory Reporting Laws Include Parents on MOUD Even Without Identified Protective Concerns.

State child abuse and neglect laws perpetuate unnecessary removals and stereotypes that parents on MOUD are unfit.[95] Currently, under

90. *See id.* (documenting the broad language certain states have employed in new statutes to signal a parent's inability to take care of their child).

91. *See, e.g.,* TEX. FAM. CODE ANN. § 261.101 (1)(I) (exemplifying the dangerous vagueness of the Texas statute, leading to parents losing their children based simply upon their "substance use").

92. *See id.* (illustrating how parental "substance use" as defined by the state statutes is considered a severe risk to a child's safety and well-being).

93. *See*, *e.g*., NY SOC. SERV. LAW § 371 (demonstrating a broad statute that produces such destabilizing ramifications on families).

94. *See generally* MINN. STAT. ANN. § 626.556 (f)(8) (codifying the vast amount of discretion judges have when evaluating a parent's ability to take care of their child that stems from the vagueness of the statute).

95. *Accord* MINN. STAT. ANN. § 626.556 (f)(8) (West 2013) (defining a form of neglect as chronic use of a controlled substance "that adversely affects the child's basic needs and safety"); PENN. CONS. STAT. Tit. 23, § 6303 ("Serious physical neglect" is anything that results in a failure to meet a child's basic needs); CALI WELF. & INST. CODE § 300 (explaining that neglect can occur when a child has suffered or faces a substantial risk based on the "failure or inability of the parent or guardian to. . .protect the child"); NY SOC. SERV. LAW § 371 (considering a child to be neglected if their health has been impaired or could be by a parent failing to exercise a minimum degree of

Massachusetts state law, healthcare reporters *must* report mothers for abuse and neglect if they give birth to a baby exposed to "addictive drugs."[96] Because of the vagueness of the term "addictive drugs," Methadone and Suboxone can become encompassed within the term and may be deemed by hospital workers to require mandatory reporting.[97] Once a mother is reported, they must undergo a post-delivery CPS evaluation.[98] Depending on CPS and the overseeing judge's opinions of MOUD, this may result in unnecessary removals and terminations.[99] Removing newborns from their mothers has detrimental consequences for both parties.[100] It is also counterproductive because the best treatment for Neonatal opioid withdrawal syndrome (NOWs), a temporary and expected result of MOUD withdrawal in newborns, is a mother's engagement with the infant through skin-to-skin holding and swaddling.[101] Removal is also dangerous for the mother, who has an increased likelihood of relapse if separated from her newborn; therefore, the best treatment for both the newborn with withdrawal symptoms and the mother with OUD is bonding with each other, which the act of removal completely ignores.[102]

care, while also including a broad discretionary provision that can include any parental acts deemed "serious. . .[and] requiring the aid of the court" by an observer).

96. *See* MASS. GEN. LAWS ANN. ch. 119 § 51(a) (2008) (requiring mandatory reporting if "physical dependence upon an addictive drug at birth, shall immediately communicate with the department orally and, within 48 hours, shall file a written report with the department detailing the suspected abuse or neglect . . . .").

97. *See* Caitlin White, *Mandatory Reporting Law is Harmful for Pregnant People with Substance Use Disorder*, HEALTHCITY (Jun. 29, 2021), https://healthcity.bmc.org/policy-and-industry/mandatory-reporting-law-harmful-pregnant-people-sud [https://perma.cc/W7YF-7HV8] (highlighting the groundless intrusiveness of the Massachusetts statute on parents with SUD).

98. *See* MASS. GEN. LAWS ANN. ch. 119 § 51(a) (2008) (demonstrating the kind of language in the Massachusetts code that produces such outcomes).

99. *See* Shoshana Walter & Melissa Lewis*, A Mother's Worst Nightmare*, REVEAL (June 29, 2023), https://revealnews.org/article/a-mothers-worst-nightmare-medication-assisted-treatment/ [https://perma.cc/EQ7Y-RSXL] (explaining the impossible decision women with OUD must make between giving up their treatment or risk giving up their child).

100. *See, e.g.*, *Treating Opioid Use Disorder During Pregnancy*, NAT'L INST. ON DRUG ABUSE (July 1, 2017), https://nida.nih.gov/publications/treating-opioid-use-disorder-during-pregnancy#ref. [https://perma.cc/7W5Q-E4AB] (correlating when a maternal drug use is considered child abuse or requires involuntary hospitalization it incentivizes women from seeking treatment).

101. *See id.* (outlining the benefits and consequences of breastfeeding among mothers with OUD and the positive impacts on newborns experiencing withdrawal).

102. *See* Marjukka Pajulo et al., *Substance-Abusing Mothers in Residential Treatment with their Babies: Importance of Pre- and Postnatal Maternal Reflective Functioning*, 33 INFANT MENTAL HEALTH J. 70 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3418818/ [https://perma.cc/YF75-EWSN] ("[S]trengthening maternal-fetal attachment can foster stronger

The inclusion of prescribed MOUD within state statutes also generates fear.[103] Mothers scared of losing custody of their children to CPS may decide to stop taking MOUD against physician advice or not seek it out at all.[104] A relapse—or continued illicit substance use—is harmful to the development of the fetus and can have long-term consequences after birth as opposed to medically supervised MOUD, which can improve outcomes.[105] If left untreated, pregnant women with OUD face increased risks of preterm birth defects, impaired fetal growth, and even the death of their fetus.[106] On the other hand, babies born from mothers who used MOUD during pregnancy risk the possibility of only mild withdrawal symptoms, if any, which are both treatable and temporary.[107]

Despite the medical benefits of MOUD for both the child and the mother, states are not in the business of supporting MOUD-based recovery.[108] Currently, thirty-three states have mandatory reporting statutes, some of which also subject mothers to criminal proceedings or civil

motivation in the mother to become and remain abstinent drug use, take better care of her own health, and make changes in her own social relationships and life circumstances for the sake of her baby.").

103. *See, e.g.*, Walter & Lewis, *supra* note 99 (illustrating the stories of women who have to battle between treatment for their SUDs and maintaining custody of their children).

104. *See id.* (highlighting that when maternal drug use is considered child neglect or requires involuntary hospitalization it disincentivizes women from seeking treatment).

105. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., PUB. NO. 18-5054, CLINICAL GUIDANCE FOR TREATING PREGNANT WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS 2, 17 (2018) ("Women with OUD and their infants face critical barriers to optimal care such as legal consequences . . . these legal consequences may drive women away from available care, seeking care or continuing to engage in care thereby potentially leading to worse outcomes for both the fetus and mother.").

106. *See, e.g.*, *id.* (describing the types of barriers that exist for pregnant women with OUD and the consequences to their fetus of their choice to refuse treatment or withdraw from treatment).

107. *See* CLINICAL GUIDANCE FOR TREATING PREGNANT WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS, *supra* note 105, at 84 (emphasizing the importance of education for pregnant women and how to treat their child who is potentially born with mild withdrawal symptoms); *see also* O. Fajemirokun-Odudey et al., *Pregnancy Outcome in Women Who Use Opiates*, 126 EURO. J. OF OBSTETRICS & GYNECOLOGY AND REPROD. BIOLOGY 170, 170–72 (2006) (summarizing that babies who were born with heroin in their system spent more time in the hospital and had higher rates of neonatal death than babies born on methadone).

108. *See* Sara Novak, *Draconian Laws Deter Pregnant Women from Treating Drug Abuse*, SCI. AM. (June 15, 2023), https://www.scientificamerican.com/article/draconian-laws-deter-pregnant-women-from-treating-drug-abuse/ [https://perma.cc/6AM7-QPXK] (requiring health care professionals to report prenatal substance use and imposing other punitive measures on parental substance use deters addiction treatment).

commitment.[109] Though many states do provide exceptions for prescribed medications, mothers still fear public judgment or the mere possibility of CPS involvement and may choose not to disclose their use of MOUD pre-delivery.[110] This does not mean, however, that CPS involvement in those cases is not ever warranted.[111] Instead, the existence of MOUD should enlighten CPS's approach to questioning; parents should be approached not with accusatory statements, but with understanding and pride for choosing to seek treatment to begin with, and asked whether they would like any post-delivery support to maintain their recovery.[112] If there are no protective concerns besides the use of MOUD for a history of opioid addiction, the case should not proceed.[113]

B. Bias-Facing Parents Undergoing MOUD Treatment is Imbedded in the Child Welfare System and Results in Unfair and Counterproductive Treatment.

When parents with OUD enter child abuse and neglect proceedings, they are thrown into a fast-paced, demanding system, equipped only

109. *E.g.,* BUREAU OF JUSTICE ASSISTANCE, SUBSTANCE USE AND PREGNANCY—PART 1: CURRENT STATE POLICIES ON MANDATORY REPORTING OF SUBSTANCE USE DURING PREGNANCY AND THEIR IMPLICATIONS 1–4 (2023) https://www.cossup.org/Content/Documents/Articles/RTI_Substance_Use_and_Pregnancy_Part_1.pdf [https://perma.cc/K443-QJL3] (differentiating between some states that require reporting of suspected drug use and other states that require reporting and testing for drugs if use is suspected).

110. *Contra* ARIZ. REV. STAT. ANN. § 13-3620 (2019) ("A health care professional who . . . after a routine newborn physical assessment of a newborn infant's health status or following notification of positive toxicology screens of a newborn infant, reasonably believes that the newborn infant may be affected by the presence of alcohol or a drug shall immediately report this information . . . .").

111. *See* LAURA RADEL ET AL., OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER IN THE CHILD WELFARE CONTEXT: CHALLENGES AND OPPORTUNITIES 4–5 (2018), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//185086/MATChildWelfare.pdf [https://perma.cc/223D-8HWK] (acknowledging that even though MOUD is the gold standard of care for pregnant women, the use of it may trigger a CPS report by the hospital where the mother delivered).

112. *See id.* at 8–9 (detailing the reasons why MOUD for opioid misuse is not always understood by important stakeholders and suggesting how to overcome that educational barrier).

113. *See id.* (citing to a Kentucky program in which clients who received MOUD were at a higher rate of being able to retain custody of their children than those who did not receive assistance).

with—what is often—ineffective counsel.[114] These parents are expected to strictly adhere to the child welfare system's view of abstinence-only recovery, leaving no time for setbacks or the difficulties that may arise through the process.[115] Despite MOUD's benefits, courts and caseworkers alike view MOUD negatively and often make decisions based on personally held stereotypes about the medication.[116] For example, some judges predicate their rulings against reunification on the existence of a parent's Suboxone prescription, using it as evidence that drug use remains current and has not been resolved.[117] In *In re B.H.*, the Court opined that the choice to continue taking the medication alone was evidence that the parents "don't want to do what is in the child's best interest as to drug use and lifestyle."[118] The same is true when a child is born with withdrawal symptoms from MOUD.[119] Courts and CPS caseworkers use the withdrawal symptoms as evidence that the mother caused harm to her child and should know that she needs to take steps to come

114. *See generally* Theresa Glennon, *Walking with Them: Advocating for Parents with Mental Illness in the Child Welfare System*, 12 TEMP. POL. & CIV. RTS. L. REV. 273, 281 (2003) (illustrating the fast pace of the judicial process once parents sign voluntary placement agreements).

115. *See* RADEL ET AL., *supra* note 111, at 15 (emphasizing the benefit of more flexible timelines for patient treatment and recovery as treatment "does not always follow fixed steps or timeframes").

116. *See* In re B.S., No. 15-0184, 2015 WL 5125420, at *3 (W.Va. 2015) (refuting petitioner's allegations that if he had been allowed to use Suboxone, he could have corrected his drug addiction and that the petitioner's "long-term reliance on Suboxone [was] a problem"); *see also* In re J.C., 232 W.Va 81, 86 (W.Va. 2013) (agreeing with the circuit court that the very fact Suboxone was prescribed during pregnancy is evidence that petitioner has not resolved her drug issues since the prior termination proceeding); In re K.A., No. 2008CA00067, 2009 WL 1486627, at *2–3 (Ohio Ct. App. 2009) (reviewing the lower court's decision and agreeing with the lower court that the appellee using Suboxone without a prescription was concerning). This Article does not argue that taking Suboxone without a prescription or taking it for another purpose that is not OUD is not a legitimate concern. The focus of this Article is on barriers that prevent access to MOUD in the first place, which may lead to someone self-medicating or relapsing.

117. *Compare* In re B.S., 2015 WL 5125420, at *3 (noting that the petitioner could not prove the Suboxone could "correct his drug addiction in any foreseeable time."), *with* In re J.C., 232 W.Va at 86 (detailing one mother's history of taking Suboxone and testing negative on subsequent drug treatment despite not going through substance abuse treatment), *and* In re K.A., 2009 WL 1486627, at *3 (relaying a caseworkers concern of a parents use of Suboxone without a prescription. The court ultimately decided that the parents' environment for their children was unsafe.).

118. *See* In re B.H.-1, No. 18-0174, 2018 WL 2928162, at 2 (W.Va 2018) (agreeing with the circuit court's opinion that the parents "don't want to do what is in the child's best interest" when the parents continued taking Suboxone).

119. *See id.* (opining that the newborn's withdrawal symptoms should be a sign to the mother of the need to taper off of MOUD).

off the medication completely so as not to cause further harm; when the mother refuses or fails to taper off, she is punished.[120] According to Elizabeth Brico, CPS also focuses on a parent's history of drug use, even if that history never resulted in child abuse or neglect proceedings to justify emergency removals.[121] Feeling discouraged from intrusive CPS investigations or involuntary removals that are out of their control, mothers with OUD may cease to interact with their newborns altogether, harming both mother and child.[122] Without support and the added barrier of stigma, a parent's disengagement may cause them to miss visitations, which may be used as evidence in favor of parental termination in court.[123]

Even though MOUD is well-studied, most child welfare stakeholders struggle to reconcile their personal stigmas and limited understanding of the medication with fact-based research and understanding.[124] This view that MOUD is just substituting one drug for another endures, but it is scientifically inaccurate and can undermine the effective use of MOUD.[125] But, many child welfare stakeholders echo this opinion, with courts imposing blanket bans on MOUD use, thus negatively affecting all

120. *See id.* ("[D]espite the fact that the [mother's] use of Suboxone caused the child severe withdrawal symptoms after his birth, [the mother] did not take steps to cease the use of this substance.").

121. *See id*. (recognizing that once child neglect is assumed, parents seeking a remedy encounter "unsympathetic judges who work against parents"); *see also How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 (describing how CPS workers focus on parents past drug use to conduct invasive investigations even when current drug tests come back negative for all illicit substances).

122. *See* Crawford et al., *supra* note 20 (identifying a study which found that parents or pregnant individuals were given the negative labels of being a "bad parent" because of the stigma surrounding MOUD).

123. *See id.* (encouraging compassion and empathy for pregnant and parenting individuals regarding substance use to encourage repairing parental bonds rather than replacing them).

124. *See* SAMHSA, *supra* note 32, at 2 (recognizing that clients taking MOUD may face challenges like stigma because some groups do not consider people taking MOUD to be "clean and sober"); *see also* RADEL ET AL., *supra* note 111, at 2 (acknowledging a challenge of MOUD is that treatment and recovery efforts are not linear and child welfare stakeholders struggle to understand that).

125. *See* SAMHSA, *supra* note 32, at 2 (suggesting that people who discontinue OUD after only a short time generally return to drug use and offers "maintenance treatment" as an alternative); *see also* RADEL ET AL., *supra* note 111, at 2 ("Those who stay in treatment often abstain longer from illicit opioid use and show increasing clinical stability.").

child welfare-involved parents with OUD.[126] Addiction treatment is not a one-size-fits-all approach and must be tailored to address the unique needs of each patient.[127] MOUD may not be the optimal choice in some situations, yet state employees often presume to know what's best for individuals with OUD.[128] Once an individual achieves stability through MOUD, they can focus on other areas of improvement, such as securing or maintaining employment and engaging in counseling for co-occurring psychiatric conditions.[129] When MOUD proves effective, individuals are able to abstain from illicit substances and are more likely to fulfill their basic obligations compared to those undergoing services without medication.[130] As some individuals require lifetime MOUD use, the Substance Abuse and Mental Health Services Administration strongly discourages "arbitrary time limits on the duration of treatment with [MOUD]."[131] Regardless, child welfare professionals and courts continue to impose strict timelines for MOUD usage, and require detox if use extends "too long."[132]

To the child welfare system, recovery means abstaining completely from all substances, even when it runs counter to the goal of creating a

126. *Compare* Debra C. Weiss, *Judges, Drug Court Officials Targeted by Pharmaceutical Company Regarding its Anti-opioid Medication,* ABA J. (Aug. 3, 2017, 10:25 AM), https://www.abajournal.com/news/article/pharmaceutical_company_pitches_its_anti_opioid_medication_to_drug_court_jud [https://perma.cc/WVJ6-H9P8] (explaining how some drug courts in the United States allow patients to use only Vivitrol to fight opioid addiction), *with* Justice Department Finds that Pennsylvania Courts Discriminated Against People with Opioid Use Disorder, *supra* note 72 (emphasizing that individuals with OUD need support and often face discrimination "rooted in stereotypes and myths rather than in science").

127. *See* Weiss, *supra* note 126 ("Alkermes CEO Richard Pops told ProPublica that he does not support drug courts requiring Vivitrol shots, and it's not the appropriate drug for every patient.").

128. *See id.* (relaying that the drug is pushed by "sheriffs, police chiefs and charismatic judges who took it upon themselves to see if they could drive better outcomes").

129. *See* Timothy J. Wiegand, *The New Kid on the Block—Incorporating Buprenorphine into Medical Toxicology Practice*, 12 J. MED. TOXICOLOGY 64 (2016) ("[P]atients stabilized on buprenorphine have increased employment, enhanced engagement with social services, and better overall health and well-being.").

130. *See* SAMHSA, *supra* note 32, at 61 (highlighting how taking buprenorphine, methadone, or naltrexone can effectively suppress a patient's illicit opioid use).

131. *See id.* at 38 (emphasizing that "patients can take medication for [MOUD] on a short-term or long-term basis" but if MOUD medication is discontinued, they "generally return to illicit opioid use").

132. *See* RADEL ET AL., *supra* note 111, at 15 (noting that judges may deny reunification if parents remain on MOUD "without a clear road map to recovery and reunification").

safe and stable home.[133] In *Interest of L.L.*, the Pennsylvania Supreme Court upheld a parental termination after reviewing the record of the lower court.[134] The judge from the lower court wrote:

> [T]he continued use of Suboxone for over five years is a *crutch* for treating Mother's opioid addiction, rather than treating the cause and ending an addiction. Counseling and tapering off of Suboxone is what [the Monroe County Children and Youth Services' caseworker] was looking for; otherwise, there is a concern that a missed dose, or some other circumstance, could lead to a relapse of opioid use . . . the [the Monroe County Children and Youth Services' caseworker]'s goal is to eliminate her dependence on something in order to lessen her chance of a relapse.[135]

The CPS caseworker, the lower court judge, and the appeals court judge all perpetuated a problematic stereotype of Suboxone and other types of MOUD: that those on them are not in active recovery.[136] In contrast, the National Institute of Drug Abuse views recovery more fluidly as the process by which individuals with SUD regain social function, improve health, and lead lives where the desire for illicit substances is not at the forefront.[137] Expectations that an individual should taper off of MOUD are counterproductive and dangerous even when signs of other substance misuse are present.[138] Researchers found that using illicit

133. *See* In re B.S., No. 15-0184, 2015 WL 5125420, at *3–4 (W.Va. 2015) (reasoning that parental rights could be terminated if there would be a "long-term reliance on Suboxone"); *see also* In re J.C., 232 W.Va 81, 86 (W.Va. 2013) (holding that prescription of Suboxone evidenced that the petitioner "has not resolved her drug issues since the prior termination proceeding"); *see also* In re K.A., No. 2008CA00067, 2009 WL 1486627, at *2–3 (Ohio Ct. App. 2009) (highlighting that a mother's usage of self-prescribed Suboxone was concerning); *see also* RADEL ET AL., *supra* note 111, at 15 ("Medication-assisted treatment is not always well understood by child welfare stakeholders, which can limit parents' recovery options and lower the likelihood of family reunification.").

134. *See* Interest of L.L., 260 A.3d 151, at *13 (Pa. Super. Ct. 2021) (mem. op.) (reasoning that termination of parental rights of a parent on MOUD would "best serve [the child's] developmental, physical, and emotional needs and welfare").

135. *Id.* at 9.

136. *See id.* (showing concern towards the mother's "continued choice of this treatment for an opioid addiction without actually addressing her dependence on drugs").

137. *See Effective Treatments for Opioid Addiction*, NAT'L INST. ON DRUG ABUSE (Nov. 2016), https://nida.nih.gov/publications/effective-treatments-opioid-addiction [https://perma.cc/9UFU-DQWL] ("[P]atients treated with medication were more likely to remain in therapy compared to patients receiving treatment that did not include medication.").

138. *See* SAMHSA, *supra* note 32, at 61 ("[F]orcing a patient to taper off of medication for nonmedical reasons or because of ongoing substance misuse is generally inappropriate.").

substances or buying non-prescribed MOUD is an indicator that individuals are trying to seek treatment to avoid symptoms of withdrawal.[139] Cravings may result simply because the dosage is not high enough.[140] However, courts tend to use positive tests for buprenorphine and illicit substances as a sign that parents are failing in recovery or point to a dosage over 16 mg as a sign that the person is addicted to this substance; other stakeholders may determine that some dosages are simply too high even though they must be individualized to meet the patient's needs.[141] Even if parents are compliant with all services, they may still be told they are not eligible for reunification based on MOUD use—barrier after barrier, those on MOUD are given every reason to give up.[142] These requirements are inconsistent with how MOUD is meant to be used and generally go against medical advice.[143] Courts and other child welfare stakeholders are not medical practitioners and should not act as such.

139. *See* Jennifer J. Carroll et al., *The More Things Change: Buprenorphine/Naloxone Diversion Continues While Treatment Remains Inaccessible*, 12 J. ADDICTION MED. 459, 462 (2018) (describing a study where "84% of opioid injectors who reporting diverted buprenorphine/naloxone use claimed to have sought the diverted medication for self-treatment purposes")

140. *See* Carroll, *supra* note 139 (addressing the results of self-medication when treating an opioid addiction compared to when accessed through medical grade dosages); *see also* Lucinda A. Grande et al., *Evidence on Buprenorphine Dose Limits: A Review*, 17 J ADDICT MED. 509, 509–16 (Jun. 16, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10547105/ (explaining that it "is important to establish a dose that meets each patient's treatment needs," however, patients face dose limits and other barriers that force them to lower their dose which may not meet the individual's need).

141. *See id*. at 460 (referencing the removal of children by social services if the parents are found to be on medications); s*ee also* LEGAL ACTION CTR., MEDICATION FOR OPIOID USE DISORDER MYTHS & FACTS, 1–3 (2021), https://www.lac.org/assets/files/Myth-Fact-for-MAT.pdf [https://perma.cc/9RJ5-QP8K] (highlighting stigmas and realities regarding buprenorphine use).

142. *See generally* Complaint at 5–9, United States v. Unified Judicial Sys, of Pa., (E.D. Pa. 2022) (No. 22-cv-00709) (depicting examples of individuals legally affected by MOUD treatment); *see also* U.S. Dep't of Health & Hum. Servs., *supra* note 72 (denying a kinship placement of children to a couple, despite a favorable home rating, because of the man's rehabilitative use of MOUD).

143. *See Effective Treatments for Opioid Addiction*, *supra* note 137 (noting the medical purpose of MAT treatment); *see also* Justice Department Finds that Pennsylvania Courts Discriminated Against People with Opioid Use Disorder, *supra* note 72 (highlighting individuals who have suffered at the hands of MAT treatment stigmas).

1. The Problematic Reliance on an "Abstinence Only" View.

As discussed above, state child welfare systems continue to distrust MOUD despite its effectiveness.[144] This abstinence-only view has resulted in an exploding foster care system.[145] In 2016 alone, 92,107 children were removed from their homes due to one or both of their parents' substance abuse.[146] Only half of all children removed to foster care during this period returned to their original homes.[147] Child removal does not just hurt the child; it also causes a host of negative health consequences for the parents, including suicidality, depression, anxiety, post-traumatic stress disorder, and premature mortality.[148] In fact, removal of children from the home makes it 15% more likely that their mother will increase opioid usage and get further away from recovery.[149] In order to even be considered for reunification, child welfare agencies and other stakeholders require increased surveillance of parents with OUD and impose other types of rigid requirements, despite evidence that such stringent requirements do not result in a transition out of problematic drug use.[150] Additionally, stringent requirements that are not made on a parent-to-parent basis can be counterproductive for those who lack community support and socioeconomic means.[151] Visitation, for instance, may be impossible even when granted because of a lack of transportation or

144. *See* In re B.S., No. 15-0184, 2015 WL 5125420, at *2 (W.Va. 2015) (opining that Suboxone is not a long-term solution).

145. *See* Simon, *supra* note 23 (emphasizing the overwhelming increase to the U.S. foster care system due to America's opioid crisis).

146. *See* Aukje Lamonica & Miriam Boeri, *Stories of Loss: Separation of Children and Mothers Who Use Opioids*, 15 J ETHNOGR. QUAL. RES. 1, 3 (2020) (noting 2016 statistics regarding children being removed due to parental drug use).

147. *See id.* (referencing 2016 removal statistics regarding the frequency of children removed from homes as a result of parental drug use).

148. *See* LISA SANGOI, MOVEMENT FOR FAMILY POWER "WHATEVER THEY DO, I'M HER COMFORT, I'M HER PROTECTOR." HOW THE FOSTER SYSTEM HAS BECOME GROUND ZERO FOR THE U.S. DRUG WAR 36 (2020) (listing the negative consequences that parents whose children have been removed are enduring).

149. *See* ANGELA MORELAND ET AL., CHILD YOUTH SERV. REV., TYPES OF CHILD MISTREATMENT AND CHILD WELFARE INVOLVEMENT AMONG OPIOID-USING MOTHERS INVOLVED IN SUBSTANCE USE TREATMENT 4 (2021) (noting the increasing opioid use for child-welfare mothers).

150. *See* Lamonica & Boeri, *supra* note 146, at 20 (highlighting that current CPS surveillance of child-welfare mothers is not effective).

151. *See id.* at 11 (emphasizing that mothers with little social support tend to downward spiral in CPS cases).

other logistical barriers.[152] With or without employment, low socioeconomic parents often lack the necessary resources to enter treatment and maintain it.[153] Rather than being provided with individually focused treatment services or flexible timelines for finding MOUD providers, women who relapse are susceptible to being labeled as "child abusers" or "non-compliant with services" without any discussion about why they were unable to meet the requirements imposed upon them.[154] Consequently, parents with OUD are separated from their children for longer, have slower reunification processes, and have increased CPS presence after reunification.[155]

Even though MOUD has been shown to improve child welfare outcomes, state child welfare systems continue to require total sobriety within unachievable timeframes.[156] A Kentucky study found that parents on MOUD are 120% more likely to maintain child custody compared to parents who did not receive MOUD.[157] Even in the program within the study, only 10% of clients were taking MOUD, a factor believed to be largely due to stigma against the medication, and the belief that individuals on MOUD are replacing one addiction for another.[158] This misunderstanding results in an unending cycle of relapse, removal, and eventually termination making it even less likely that child-welfare involved parents will stick with MOUD.[159] Consequently, though 90% of those with OUD could benefit from MOUD, a treatment gap persists, and many child welfare stakeholders disapprove of MOUD.[160] As a result, the

152. *See id.* at 12 (explaining some of the basic obstacles child-welfare mothers must endure).

153. *See id.* (noting the major obstacle in child-welfare parents' rehabilitation–starting and finishing treatment).

154. *See id.* (acknowledging state and local government's trend away from professional recommendations to avoid defining substance abuse by pregnant women as child abuse or maltreatment).

155. *See* Hall et al., *Medication-Assisted Treatment Improves Child Permanency Outcomes for Opioid-Using Families in the Child Welfare System*, J. SUBST. ABUSE TREAT. 1 (2016) (comparing the reunification rate between parents with SUDs and their children).

156. *See id.* (identifying the statistically significant positive correlation between families receiving medically assisted treatment and their likelihood of retaining custody of their children).

157. *See id.* (quantifying the increase of parents on MOUD maintaining child custody).

158. *See id.* (interpreting the small sample size of clients on MOUD to be the result of an established stigmatization against medicine).

159. *See id*. at 8–11 (clarifying the misconstruing of MOUD for OUD among parents).

160. *See* Press Release, NYU Langone Health, Almost 90 Percent of People with Opioid Use Disorder Not Receiving Medication (Aug. 4, 2022), https://nyulangone.org/news/almost-90-

presumption that any kind of substance use is grounds for parental termination results in cataclysmic effects on the next generation; it does not need to be this way.[161]

2. Judge's Opinions—Made Through Either Overt Statements or Additional Requirements Placed Only on Parents in MOUD Treatment—can Prevent Reunification Even if the Parent is no Longer Using Illicit Substances.

The question of reunification is left to the judge.[162] Unfortunately, judges do not view MOUD uniformly, which can result in different outcomes for parents.[163] Even when a judge does not completely oppose its use, the preference for abstinence—no substances at all—over MOUD use may still create a stigma that impacts key decisions at each stage in a parent's abuse and neglect proceeding.[164] Reunification, for instance, can be and has been denied because the parent remains on the medication.[165]

Some courts have imposed a durational requirement on MOUD use and require a parent to stop taking MOUD before they will be considered fit for reunification.[166] This view that MOUD is only a short-term solution unnecessarily increases the time the child is removed from the household and is not backed by science.[167] *In re. M.M*, highlights the negative

percent-people-opioid-use-disorder-not-receiving-lifesaving-medication [https://perma.cc/HLN2-92UK] (reporting that the vast majority of people with OUD are not receiving any type of MOUD).

161. *Cf.* Roxy Todd, *Inside West Virginia's Overwhelmed Foster Care System*, MARKETPLACE (Oct. 9, 2019), https://www.marketplace.org/2019/10/09/inside-west-virginias-overwhelmed-foster-care-system/ [https://perma.cc/34B4-2EBV] (illustrating the strain placed on West Virginia's foster care system due to the opioid addiction plaguing America).

162. *See* Peter Slevin, *Judges Describe Agonizing Decisions*, WASH. POST (Jan. 16, 2000), https://www.washingtonpost.com/archive/local/2000/01/16/judges-describe-agonizing-decisions/a5aa2020-a241-44a6-9af0-bd66c196231a [https://perma.cc/Y6UT-DB5J] (analogizing the decision of judges as similar to 'playing God').

163. *See* Barbara Andraka-Christou et al., *Criminal Problem-Solving and Civil Dependency Court Policies Regarding Medications for Opioid Use Disorder*, 43 SUBSTANCE ABUSE 425, 431 (2021) (emphasizing how the variability in court MOUD policies manifests in case-by-case decisions made by judges).

164. *Cf.* In re B.S., No. 15-0184, 2015 WL 5125420, at *6 (W.Va. 2015) (agreeing with a lower court's denial of reunification).

165. *See id.* (denying reunification for a mother on appeal).

166. *See* RADEL ET AL., *supra* note 111, at 8 (referring to the professional misunderstanding of medication-assisted treatment for OUD).

167. *See* Walter, *supra* note 24 ("Congress said their intent was to flag parents addicted to opioids and connect them to services and treatment. But the law didn't spell out how states should do that or that efforts should be made to keep families together."); *see* Amy A Mericle et al.,

impact MOUD bias can have on the parent-child relationship and the problematic use of judicial power to make medical decisions.[168] The West Virginia Supreme Court reviewed a parental termination of the lower court on an abuse of discretion standard.[169] The lower court judge was very open about his views of MOUD, stating, "I always have a problem with people being on Suboxone to begin with, and that's my position."[170] The state's supreme court expanded on the lower court's view:

> Suboxone was not introduced to, in my opinion, to be a long-term treatment type situation for [people]. You know, it is hard for me to sit up here and order the Department to make them give her a special medical card for Suboxone when she has been using Suboxone for five years. Mr. Easton . . . I am not unsympathetic to her situation. I mean, she's addicted to Suboxone now. That's the problem. But it's not because of the Department. She was addicted to Suboxone before this case ever got started it sounds like.[171]

The West Virginia Supreme Court reversed the lower court's decision to terminate the Petitioner's parental rights on two grounds.[172] First, Petitioner was not given any notice or opportunity to taper off MOUD and could not afford to pay for treatment, resulting in her relapse.[173] Second, the circuit court abused its discretion by refusing Petitioner's special

Barriers to Implementing Individualized Substance Abuse Treatment: Qualitative Findings from the CASPAR Replication Studies, 40 J DRUG ISSUES 819, 819–39 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3738209/ (depending on the patient's needs, MOUD treatment may range from short-term to lifelong).

168. *See* In re. M.M., 244 W.Va. 316, 329 (W.Va. 2020) ("According to the record, the petitioner was granted supervised visitation with her children twice a week for two hours a day. It is unclear from the record whether the visitation arrangements included all of her children."); *see also* LEGAL ACTION CTR., *supra* note 141, at 3 ("Just as judges . . . would not decide that a person should treat their diabetes through exercise and diet alone and instruct them to stop taking insulin, these same actors are not trained to make medical decisions with respect to MOUD.").

169. *See* In re. M.M., 244 W.Va. 316, 324 (W.Va. 2020) (evaluating the circuit court's factual decisions regarding the completion of an improvement period for abuse of discretion).

170. *See id.* at 321 (recognizing the circuit judge's predisposition to parents on Suboxone).

171. *See id*. at 321–22 (expanding upon the circuit judge's opinions regarding addiction and Suboxone).

172. *See id.* at 328–29 (remanding the case to the circuit court).

173. *See id.* at 325 (finding that the circuit court "abused its discretion when determining that the petitioner failed to satisfy the conditions of her improvement period").

medical card, which she used to pay for MOUD.[174] In reversing the decision, the court did not address the blatant discrimination of the lower court.[175] Instead, the court reinforced the idea that MOUD was a temporary solution.[176] When the case began, Petitioner's consistent access to MOUD allowed her to maintain her recovery from illicit substances, but by the time this decision was made and because of the prolonged lack of access to MOUD, she was testing positive for methamphetamine, amphetamine, and buprenorphine.[177] The stigma around MOUD does not just appear in this one judicial decision; the stigma radiates through every decision made by these courts when parents use MOUD or choose not to use MOUD because of fear of negative consequences.[178] The issue in this case—and many others—was that a mother lost her parental rights after she relapsed and could not regain her stability because she was denied legal access to the treatment that had worked—MOUD, and eventually she sought out illicit MOUD in an attempt to self-medicate, which was only seen as further evidence of her failure to maintain recovery.[179] It can be reasonably inferred that her relapse occurred from the denial of legally prescribed MOUD.[180] By focusing *only* on whether the parental termination was appropriate at the time of the parental termination, the Court missed an important opportunity to make a ruling regarding MOUD use.[181] At the time of appeal, the Petitioner no longer qualified under the ADA, as it has been interpreted, because she was currently

174. *See id.* (noting that West Virginia Code instructs courts to terminate parental rights "upon finding that there is no reasonable likelihood that the conditions of neglect or abuse can be substantially corrected in the near future").

175. *See id.* at 328 (evading the circuit court's discriminatory approach).

176. *See* In re. M.M., 244 W.Va. at 321 (reinforcing the stigma that MOUD cannot be a permanent aid).

177. *See id.* at 320–21 (noting that "on April 4, she potentially tested positive for methamphetamine . . . . According to the transcript of a subsequent hearing, the April 4 test result was later deemed to be a false positive").

178. *See id.* at 328 (citing the West Virginia Code without stipulating any deviations from negative stigmas).

179. *See id.* at 320 (recognizing that orders from the West Virginia Department of Health and Human Resources had a material impact on Petitioner's recovery).

180. *See id.* (detailing that her relapse occurred after her car broke down, leaving her unable to travel to the medication-assisted treatment center).

181. *See* In re. M.M., 244 W.Va. 319 (describing the impact of MOUD on the potential for termination of parental rights).

using illicit substances.[182] Had the court taken a broader approach to her case by looking at every decision made by the judge in denying her reunification earlier before ever getting to the parental termination question, the court would have found that MOUD or assumptions about those who are on MOUD were the reason for her getting to the parental termination stage to begin with.[183] The barriers put up by the court and the other stakeholders in her case ultimately caused her to relapse.[184] Stigma does not just affect an individual court's decision; rather, it exists within the child welfare system and within every decision along the way—no matter how insubstantial some decisions may look at first glance—in states with high populations of individuals with SUDs.[185]

Though child welfare cases are often complex and involve a myriad of other factors, the focus should be on whether the decision to deny reunification or even to maintain the case, to begin with, is rooted in stigma based on a petitioner's legal use of MOUD.[186] Discriminatory policies could include: refusing to allow people to stay on MOUD, denying improvement periods because of continued MOUD use; setting arbitrary timetables for tapering; requiring additional services for those on MOUD; having different policies for those on MOUD versus other types of prescriptions; or refusing to allow a child to remain in a home where someone is on MOUD.[187]

182. *See* U.S. Dep't of Just., *supra* note 71, at 2 (concluding that an "individual in treatment or recovery from opioid use disorder . . . unless currently engaged in illegal drug use[,]" does not have a disability under the ADA).

183. *See* In re. M.M., 244 W.Va. at 320 (2020) ("She was previously attending that treatment with a medical card . . . [a]nd when the children were removed from her care as part of this abuse and neglect case, she did lose eligibility.").

184. *See generally id.* (insinuating the court was at fault for inadequately looking at the factors in the case).

185. *See id.* at 326 ("We are also troubled by the apparent bias against [MOUD] that was evident during the circuit court hearings.").

186. *See id.* at 320 (recognizing that the petitioner here was able to eventually receive her treatment with a medical card and maintain recovery).

187. *See* U.S. Dep't of Health & Hum. Servs., *supra* note 72 (denying kinship placement of children to an uncle because he was on legally prescribed Suboxone was a violation of Title II of the Americans with Disabilities Act); *see also* Press Release, U.S Dep't of Just., Justice Department Secures Agreement with Pennsylvania Courts to Resolve Lawsuit Concerning Discrimination Against People with Opioid Use Disorder (Feb. 1, 2024), https://www.justice.gov/opa/pr/justice-department-secures-agreement-pennsylvania-courts-resolve-lawsuit-concerning [https://perma.cc/V4GV-PA3H] ("[T]hose affected by [the Unified Judiciary System of Pennsylvania's] court policies were put through an agonizing choice: take their medication and face incarceration or termination from their treatment court program or forgo their medication and suffer

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The child welfare system represents itself as wanting children to have safe, permanent homes, but overt discrimination prevents homes from becoming or staying safe and permanent.[188] However, the resistance by some to see OUD as a medical condition is hurting children and the mothers who want to raise them.[189] Reforms to policies banning MOUD, or preventing participation by those taking MOUD, have so far come exclusively through litigation and settlements.[190] Though effective, they had minimal effect on uprooting state-sanctioned bias throughout the state's agencies and courts.[191] As a result, existing laws and the broad discretion left to those involved in the child welfare system perpetuate stereotypes—and relapses—that tear families apart, all under the guise of legality.[192]

Even when West Virginia passed legislation to ensure families did not remain separated because of parental MOUD use, its child welfare system continued justifying removals by pointing to other arbitrary concerns

painful withdrawal symptoms while risking relapse, overdose and death. . .through the enforcement of their discriminatory policies.").

188. *Accord* In re. M.M., 244 W.Va. at 326 (highlighting the hypocrisy in the system).

189. *E.g.*, *id*. at 319 (showcasing, generally, a court which did not recognize OUD as a medical condition and further harming children).

190. *See* Press Release, U.S. Att'y's Off. Dist. of Mass., Massachusetts General Hospital Enters Agreement with U.S. Attorney's Office to Better Ensure Equal Access for Individuals with Disabilities (Aug. 7, 2020), https://www.justice.gov/usao-ma/pr/massachusetts-general-hospital-enters-agreement-us-attorney-s-office-better-ensure-equal [https://perma.cc/P9FK-9SNG] (resolving allegations that a hospital denied a patient a lung transplant because he was being treated with MOUD), ; *see also* Settlement Agreement at 1, U.S. v. Charlwell Operating, LLC, U.S. Attorney's Off. Dist. of Mass. (May 10, 2018) (resolving allegations that a skilled nursing facility denied a patient who was being treated with MOUD); *see also* Press Release, Volvo Group North America To Pay $70,000 To Settle EEOC Disability Discrimination Suit (Jan. 19, 2018), https://www.eeoc.gov/newsroom/volvo-group-north-america-pay-70000-settle-eeoc-disability-discrimination-suit [https://perma.cc/ZU92-UMAR] (resolving allegations that an employer refused to hire someone on MOUD).

191. *E.g.*, Walter, *supra* note 24 (explaining the continued removals, separations, and terminations that result from MOUD discrimination).

192. *See* Lisa Clemans-Cope et al., *Opioid and Substance Use Disorder and Receipt of Treatment Among Parents Living With Children in the United States, 2015–2017*, ANIMAL FAM. MED. (May 2019) ("Addressing [barriers to MOUD] could increase the share of parents with OUD and other SUDs who are receiving [MOUD], which in turn could improve the health and functioning of parents and their children, protect child welfare, and preserve or reunify families."); *see also* DELEENA PATTON ET AL., WASH. STATE DEP'T OF SOC. & HEALTH SERV., SUBSTANCE USE DISORDER TREATMENT PENETRATION AMONG CHILDREN WELFARE-INVOLVED CAREGIVERS 1 (2020) (showing that coordinating referrals for caregivers with OUD to MOUD can shorten time in out-of-home placements for children and benefit the caregivers in reaching recovery).

arising entirely because of MOUD.[193] In *In re M.M.*, the West Virginia Department of Health and Human Resources (DHHR) instituted a policy against people leaving the state to access MOUD and asked parents not to enter a MOUD program if they were not part of one already.[194] During the improvement period, DHHR and other child welfare team members took it upon themselves to determine whether the petitioner in that case needed to be tapered off MOUD entirely by meeting with her medical provider.[195] Attempting to influence a patient's treatment steps far outside the scope of DHHR and the court's role.[196] Another issue is that the language of West Virginia's statute also allows the child welfare system to broadly interpret what "fulfilling treatment obligations" means, which based on current caselaw, will likely continue to mean imposing expectations on parents with OUD that would not be imposed on other parents who did not have OUD.[197] Further, it allows DHHR and other members of the child welfare system to dictate parent's medical care even when medical providers are in opposition of those demands.[198] When medical professionals or parents involved in the child welfare system do not meet these arbitrary demands, the court can then point to a relapse, going out of state for prescription even when there are no available options in a parent's home state, failing to enter abstinence-only detox facilities where MOUD is not provided even when alternatives are requested, failing to complete services in a timely manner even when referrals to MOUD providers have not been given as requested, or other events as the reason for the termination.[199] The termination is then not solely based on MOUD

193. *See* W. VA. CODE § 49-4-604(f) (2020) (preventing courts from terminating parental rights on the basis of participation in a medication-assisted treatment program).

194. *See* In re. M.M., 244 W.Va. 319, 320 (2020) (explaining the terms for participation in a MOUD program).

195. *See id.* at 329 ("During the improvement period, the petitioner and MDT should consult with the petitioner's MAT provider to determine whether she should be titrated completely off the MAT medication or whether a maintenance dose is required.").

196. *See generally* Alan A. Stone, *Judges as Medical Decision Makers: Is the Cure Worse than the Disease?*, CLEV. ST. L. REV. 579 (1984) (discussing the weaknesses of having judges make medical decisions).

197. *See* In re. M.M., 244 W.Va. at 321 (discussing termination of parental rights due to participation in a MOUD despite the West Virginia statute).

198. *See* Walter & Lewis, *supra* note 99 ("Women across the country have described being pressured, even ordered, by caseworkers and judges to get off their medications to resolve their child welfare cases.").

199. *See generally* In re. M.M., 244 W.Va. at 328 (2020) (describing a case where termination of parental rights was appropriate according to the court).

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participation, but rather, on the inability to complete services because of the barriers to accessing MOUD.[200] Legislation, though helpful, does not remove the overt discrimination that persists within this system of state government.[201]

IV. APPLYING THE AMERICANS WITH DISABILITIES ACT (ADA) TO CHILD ABUSE AND NEGLECT PROCEEDINGS TO PREVENT PARENT-CHILD SEPARATION AND AVOID A PARENT'S RELAPSE.

The ADA provides two useful paths forward. First, an individual taking MOUD can raise the ADA throughout child abuse and neglect proceedings to prevent agency staff from "basing assessments, services, or decisions on assumptions, generalizations, or stereotypes about disability," and allow for an individualized assessment instead.[202] Under the theory of *Hicks/Brown* discussed below, once the child welfare system—including the courts—is aware of a disability, they must uphold an "affirmative duty to make reasonable efforts at reunification" through overt acts in providing accommodations to preserve family relationships.[203] For those with OUD, adapting treatment services can help place the parent with OUD on equal footing as those without disabilities; some ideas include increasing time to get access to MOUD, not requiring full detox if the parent is lawfully taking MOUD, delaying hearings until a parent has secured a MOUD provider, or allowing a child to stay in the home unless there are imminent threats (not rooted in bias about MOUD) to the safety of the child.[204] Second, large pattern and practice cases can be brought against child welfare agencies and the state judicial systems to ensure compliance with the ADA as it pertains to MOUD.[205] Though

200. *See generally* Walter & Lewis, *supra* note 99 (providing a case of a mother whose parental rights were terminated due to relapse after the state cut off her access to treatment).

201. *See id.* ("'I always have a problem with people being on Suboxone to begin with, and that's my position,' the judge said during one hearing.").

202. *See* U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF JUST., *supra* note 73 (providing steps for child welfare agencies to ensure ADA compliance).

203. *See* In re Hicks/Brown, 893 N.W.2d 637, 639 (Mich. 2017) (explaining that once the Department was aware of the disability it could not take a passive approach).

204. *See generally* U.S. EQUAL EMP. OPPORTUNITY COMM'N, TECHNICAL ASSISTANCE MANUAL ON THE EMPLOYMENT PROVISIONS (TITLE I) OF THE AMERICANS WITH DISABILITIES ACT (1992) (explaining the principles and goals of reasonable accommodations).

205. *See* U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF JUST., *supra* note 73 (enforcing compliance to protect individuals with disabilities from discrimination).

cases in which judges have been sued based on individual disability-discriminatory decisions have been largely unsuccessful, dicta suggests that plaintiffs may state a claim against a state court system by showing discrimination against people with disabilities exists within the judiciary's operations.[206] In fact, this legal argument was used by the U.S. Department of Justice in their lawsuit against the United Judicial System of Pennsylvania (UJS); their argument alleged that UJS, through the actions of their individual courts, violated Title II of the ADA by prohibiting those under the judiciary's supervision from using MOUD, or imposing barriers to try to deter the use of MOUD in the first place, without providing the individualized assessments required by the ADA.[207] Liability under the ADA offers a path to deconstruct state action that punishes individuals seeking medical treatment and provides everyone an equal opportunity to complete child abuse and neglect proceedings with reunification or—better yet—avoid the process altogether.[208]

A. Title II of the ADA Applies to Child Welfare Agencies and Courts.

The ADA was enacted in 1990 to provide civil rights protections to people with disabilities.[209] Under Title II of the ADA, persons with disabilities are guaranteed equal opportunity in the "services, programs, or activities of a [non-federal] public entity" and are prevented from being "subjected to discrimination by any such entity."[210] It follows that all state and local government activities are within the law's coverage,

206. *See generally* Prakel v. State of Indiana, No. 4:12-cv-45-SEB-WGH, 2013 WL 3287691, at 1, 4 (S.D. Ind. June 28, 2013) (proving that although cases against judges for discrimination are typically unsuccessful, there remains a form of relief for plaintiffs).

207. *E.g.*, Complaint at 1, United States v. Unified Judicial Sys, of Pa., (ED. Pa. 2022) (No. 22-cv-00709) (arguing that United Judicial System of Pennsylvania discriminated against individuals with OUD by prohibiting the use of helpful medications for those participating in its programs).

208. *See generally* U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF JUST., *supra* note 73 (supporting the purpose of holding state actors liable for the blatant use of discrimination and giving individuals a form of relief).

209. *See* 42 U.S.C.A. § 12101(b)(1)–(4) (2018) ("It is the purpose of this chapter—to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities . . . . ").

210. *See* 42 U.S.C. § 12132 (2018) (protecting individuals with disabilities in a similar manner as the Fourteenth Amendment of the United States Constitution).

including activities of the legislative and judicial branches.[211] Under the ADA, public entities may not treat persons with disabilities based on "generalizations or stereotypes," and instead, must individually assess each person using "facts and objective evidence."[212] "Disability" is interpreted broadly to include anyone whose "physical or mental impairment [ ] substantially limits one or more major life activities," has a history of such impairment, or is perceived by others to have one.[213]

To effectuate the purposes of the ADA, disability is broadly construed and exists even when medication or other mitigating measures are used to prevent the full effects of their disability.[214] A refusal to allow access to medically necessary treatment without an individualized assessment and against medical opinion to treat one's disability can give rise to a violation of the ADA.[215] Public entities are required to make reasonable modifications to their written or unwritten policies, practices, and procedures to ensure people with disabilities are not denied participation or the benefit of any aspect of the public entities' activities.[216] Despite the ADA's usefulness, it is rarely ever applied to parents with disabilities in child abuse and neglect proceedings.[217]

211. *See* 28 C.F.R. Pt. 35, App. B (2011) ("The scope of [T]itle II's coverage of public entities is comparable to the coverage of Federal Executive agencies . . . but includes activities of the legislative and judicial branches of State and local governments.").

212. *See* U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF JUST., *supra* note 73 (reiterating that under the ADA, public entities may not use individual's disabilities as a means of discrimination).

213. *See* 42 U.S.C. § 12102(1)(A) (defining what it means to qualify as having a disability under the ADA).

214. *See* 42 U.S.C. § 12102(4)(A), (E)(i)(I) (providing that even if an individual is prescribed anti-epilepsy medication and as a result has no seizures, this does not remove the existence of a legal disability).

215. *See* Pesce v. Coppinger, 355 F. Supp. 3d 38, 45 (D. Mass. 2018) (overcoming the defendant's diversion and safety concerns, to hold that denying MOUD without an individual assessment and contrary to medical opinion to plaintiff while once in jail was a violation of the ADA); *see also* Smith v. Aroostock Cty., 376 F. Supp. 3d 149, 160 (D. Me. 2019) (holding that denying MOUD to an incarcerated person is likely in violation of the ADA); *see also* Finnigan v. Mendrick, No. 21-CV-341, 2021 WL 736228, at 8 (N.D. Ill. Feb. 24, 2021) (inviting the plaintiff to refile if denied methadone by defendants).

216. *See* U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF JUST., *supra* note 73 (emphasizing the reasonable modifications needed to be in accordance with the ADA).

217. *See* Press Release, U.S. Dep't of Just., Justice Department Reaches Landmark Agreement with Massachusetts Department of Children and Families to Address Discrimination Against Parents with Disabilities (Nov. 19, 2020), https://www.justice.gov/opa/pr/justice-department-reaches-landmark-agreement-massachusetts-department-children-and-families

Regardless of the lack of enforcement in this arena, child welfare agencies and the state judicial system are subject to the ADA.[218] The Supreme Court of Michigan in *In re Hicks/Brown* recognized that Michigan's Department of Health and Human Services (MDHHS), in addition to its affirmative duty under state law "to make reasonable efforts to reunify a family before seeking termination of parental rights," also had obligations under the ADA to reasonably modify services or programs offered to parents with disabilities if they are aware of a disability.[219] In that case, MDHHS knew the parent had an intellectual disability and knew she had requested access to a mental health agency on five separate occasions to participate in her other services.[220] Medical professionals within MDHHS even provided the recommendations that the parent could benefit from individually tailoring her services.[221] Nonetheless, the service provider was denied her requested service, which led to an unsuccessful completion of her other services.[222] The circuit court refused to consider the failure to reasonably accommodate her under the ADA and terminated her parental rights.[223] The Supreme Court of Michigan vacated the termination order and concluded MDHHS did not use reasonable efforts under state law because it did not modify the services to accommodate the parent's disability (which must be an affirmative action)—implying reasonable efforts at reunification did not exist when the ADA was violated.[224] Taking this logic a step forward, even if state law does not require a child welfare agency to use reasonable efforts to reunify in specific circumstances, such as a case where there is a prior termination,

[https://perma.cc/HR2G-ZYXL] (applying the ADA to child welfare decisions to seek termination of parental rights, and the focus is on CPS and not the state court systems).

218. *See id.* (emphasizing that ADA is strictly enforced when it comes to children).

219. *See* In re Hicks/Brown, 893 N.W.2d 637, 639 (Mich. 2017) (affirming the department's duty to families); *see also* Robertson v. Las Animas Co. Sheriff's Dep't, 500 F.3d 1185, 1196 (10th Cir. 2007) (explaining that the public entity must have knowledge of the disability, whether by assumption or informed by the individual).

220. *See In re Hicks/Brown*, 893 N.W.2d at 639 (recounting the facts of the case).

221. *Contra id.* at 642 ("Despite the recommendations of the Department's medical professionals that Brown could benefit from services tailored to her disability . . . the circuit court nonetheless concluded that the Department had made reasonable efforts at reunification and terminated Brown's parental rights.").

222. *See id.* (alluding that the circuit court reached an incorrect decision).

223. *See id.* (emphasizing the circuit court's error in its application of ADA obligations).

224. *See id.* (vacating the termination order predicated on an incomplete analysis on if reasonable efforts were made).

states would still have to abide by the ADA in any services they do provide or determinations they do make.[225] Parents with disabilities do not get a pass in the determination of fitness, but they do require meaningful and equal access to services similar to those interacting with the child welfare system who do not have a disability.[226]

There is a dire need for the ADA, given the short timeline of child abuse and neglect proceedings and CPS's tendency to remove children of parents with disabilities from their homes.[227] However, parents often raise the ADA as a last-ditch effort to prevent termination on appeal.[228] At this point, courts often point to other areas of concern, even if many of the identified issues would have been prevented by policy or practice modification.[229] When a parent seeks a remedy in a separate action post-parental rights termination, such injunctive relief does not include getting their children back; often, by the time the ADA lawsuit is over, it is too late.[230] A request for accommodations under the ADA should be raised early by the parent's counsel rather than as a last-effort defense.[231] Counsel should consistently put pressure on the court and CPS to not engage in disability discrimination and write detailed requests for accommodations upon the existence of policies targeting people with disabilities or practices that make it more difficult for those with disabilities to access treatment.[232] On appellate review, these unaddressed requests show that the parent received inadequate services and may not actually be unfit.[233]

225. *See* U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF JUST., *supra* note 73 (outlining the basic requirements that states need to follow under ADA).

226. *See id.* (contouring the boundaries of ADA regulation for parents with disabilities).

227. *Accord* In re. A.W., 2019 WL 2452784, at 6–7 (W.Va. App. 2019) (attempting to raise an ADA claim on appeal).

228. *See, e.g.*, *id.* at 6 (refusing to consider whether Petitioner had been denied an accommodation under the ADA).

229. *See, e.g.*, *id.* at 7 (refusing to allow reunification because the parent would not taper off of Suboxone).

230. *See* Dave Shade, *Empowerment for the Pursuit of Happiness: Parents with Disabilities and the Americans with Disabilities Act*, 16 LAW & INFQ. 153, 214 (1998) ("No ADA remedy can restore the family . . . .").

231. *See* In re Hicks/Brown, 893 N.W2d 637, 642 (2017) (describing parent counsel's request for more individualized assistance to accommodate the parent's intellectual disability).

232. *See id.* at 640 (referencing Title II of the ADA requiring that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services . . . . ").

233. *See, e.g.*, *id.* at 642 (holding that the lower court's termination of parental rights was premature because no accommodation was granted despite notice of one being needed).

It follows that by documenting accommodation requests, reviewing courts could see whether the services provided are appropriate for the individual parent to meet their parenting goals and safety plan; if a parent with disabilities is consistently barred from accessing appropriate services for reunification, then it undermines the state's case for permanent child separation.[234] The ADA can quite literally be the difference between being subjected to the civil death penalty or not.[235] With over thirty percent of child abuse and neglect court cases—and even more in states with a higher prevalence of the opioid crisis—involving parents with one or more disabilities, it is important that we rethink how parents with OUD are treated and how we ensure parents and their children are not destabilized by temporary or permanent separation.[236]

B. The ADA Requires Parents with OUD in Abuse and Neglect Proceedings be Reasonably Accommodated and Policies be Modified.

The ADA's antidiscrimination protections extend to parents with OUD who are in MOUD treatment.[237] OUD is a type of drug addiction and

234. *See* Dale Margolin Cecka, *No Chance to Prove Themselves: The Rights of Mentally Disabled Parents Under the Americans with Disabilities Act and State Law*, 15 VA. J. SOC. POL'Y & L. 112, 121–22 (2007) (noting that the ADA may apply to parental termination proceedings upon the court's review of the adequacy of services provided).

235. *See CPS Removes 10,000 Fewer Children Per Year Than in 2017, How the Legislature Protected Children by Reigning in Texas' Child Protection Agency*, FAM. FREEDOM PROJECT, https://familyfreedomproject.org/cps-removes-10000-fewer-children/#:~:text=In%20civil%20law%2C%20termination%20of,death%20before%20losing%20their%20child [https://perma.cc/NUD3-7R2F] (describing parental termination as the civil death penalty).

236. *See* Philip A. Swain & Nadine Cameron, '*Good Enough Parenting': Parental Disability and Child Protection*, 18 DISABILITY & SOC'Y 165, 169 (2003) (opining how rethinking the system can, in the long run, support parents in reconnecting and establishing parenthood with their child); *see also* Elizabeth Lightfoot & Sharyn DeZelar, *The Experiences and Outcomes of Children in Foster Care who Were Removed Because of a Parental Disability*, 62 CHILD. & YOUTH SERVS. REV. 22, 26 (2016) (estimating nineteen percent of the children in foster care were removed due in part to a parent's disability); *see also* Matt Harvey, *Drug Crisis, pandemic fueling surge in West Virginia's abuse-and-neglect cases*, WVNEWS (Aug. 1, 2021), https://www.wvnews.com/news/wvnews/drug-crisis-pandemic-fueling-surge-in-west-virginias-abuse-and-neglect-cases/article_a2e1d104-eee2-11eb-b48b-27b2c8ded99f.html [https://perma.cc/5EZ9-MXVZ] (estimating ninety-five abuse and neglect cases per county in West Virginia due mainly to substance use and the effects of the COVID-19 pandemic).

237. *See generally* U.S. Dep't of Just., *supra* note 71 (including all those in recovery for OUD not currently using illicit substances, as falling within the scope of the ADA).

falls squarely within the four corners of the ADA, as it substantially limits one or more major life functions.[238] These major life functions may vary, but can include failing to meet basic obligations, or having a substantial limitation when it comes to "caring for oneself [or others], learning, concentrating, thinking, communicating, working, or the operation of major bodily functions, including neurological and brain functions."[239] Further, the ADA also covers individuals in recovery because they would be limited if not for the treatment or services they receive to support their recovery.[240] The application of the ADA to improve access to MOUD has been taken up by disability rights advocates and the courts; when state government entities impose blanket denials on MOUD use or demand those on MOUD—who use the medication under the supervision of a licensed health care professional and takes the medication as prescribed—to meet additional requirements that are not required of those on other medications can be an ADA violation.[241] This is because MOUD is one of three medications used to treat OUD.[242]

238. *See* 29 C.F.R. § 1630.2 (2024) (stating the qualifications of someone with a "disability" under this federal regulation); *see also* 42 U.S.C. § 12102 (stating the relevant statutory qualifications for "major life activities").

239. *See* 29 C.F.R. § 1630.2 (2024) (stating the qualifications of someone with a "disability" under this federal regulation); *see also* 42 U.S.C. § 12102 (stating the relevant statutory qualifications for "major life activities").

240. *See The ADA, Addiction, Recovery, and Employment*, NAT'L NETWORK (2024), https://adata.org/factsheet/ada-addiction-recovery-and-employment#:~:text=Use%20of%20Drugs-,The%20ADA%20protects%20a%20person%20in%20recovery%20who%20is%20no,such%20as%20opioids%20or%20morphine [https://perma.cc/J45G-U34N] ("The ADA protects a person in recovery who is no longer currently engaging in the illegal use of drugs and who can show that they meet the definition of disability.").

241. *See* Pesce v. Coppinger, 355 F. Supp. 3d 35, 45 (D. Mass. 2018) (recognizing the defendant's denial of the plaintiff's use of methadone, under their current policy, would be an ADA violation because methadone treatment for the plaintiff is necessary to avoid "severe physical and mental illness, relapse into opioid addiction, and death" and forces painful withdrawal; all of which run counter to the opinion of the plaintiff's treating physician); *see also* 42 U.S.C. § 12210(d) ("The term 'illegal use of drugs' means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act."); *see also* 28 C.F.R. § 35.104, 36.104 (2024) ("The term illegal use of drugs does not include the use of drug[s] taken under supervision by a licensed health care professional . . . . ").

242. *See* HEALTH RESS. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., CARING FOR WOMEN WITH OPIOID USE DISORDER: A TOOLKIT FOR ORGANIZATION LEADERS AND PROVIDERS 13 (2020), https://www.hrsa.gov/sites/default/files/hrsa/owh/caring-women-opioid-disorder.pdf [https://perma.cc/47FY-UVP8] ("Medication treatment can restore balance to the brain systems affected by addiction, relieve physical cravings for the substance, and return body

There is one exception to OUD coverage under the ADA: " . . . [C]urrent illegal use of drugs . . . . "[243] "[C]urrent illegal use of drugs" means if the individual in question uses illicit substances recent enough to ". . . justify a reasonable belief that a person's drug use is current, or that continuing use is a real and ongoing problem," then they do not qualify as having a disability under the ADA[244] Hence, it would not be an ADA violation to dismiss someone from employment who does not provide a prescription for MOUD but tests positive for buprenorphine.[245] But more questions arise. What if the policy or practice itself led to the current use of illegal drugs? That question is complicated, and the courts have not yet provided an answer. A court's analysis should be based on the legality of the policy/practice itself to effectuate the purposes of the ADA in rooting out discrimination.[246] The Court should look at where the individual would be but-for the policy/practice, or more specifically, the stigma. The policy or practice should still be interpreted as discriminatory, even if some of those harmed currently use illicit substances because they relapsed after barriers made it harder to receive MOUD.[247] To hold otherwise would obliterate the ADA's protection of those with a "drug addiction" and reinforce efforts to obliterate individuals' access to non-abstinence OUD treatment when it may be the only form of recovery that

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functions to normal."); *see* SAMHSA, *supra* note 32, at 1–3 ("Ongoing outpatient medication treatment for OUD is linked to better retention and outcomes than treatment without medication.").

243. *See* U.S. Dep't of Just., *supra* note 71, at 3 (noting the single exception to OUD coverage); *see also* 42 U.S.C. § 12210(a) (codifying the exception and prohibiting coverage when an individual engages in current illegal drug use).

244. *See* U.S. Dep't of Just., *supra* note 71, at 3 (clarifying the criteria to determine which individuals are currently using illegal drugs); *see also* 28 C.F.R. § 35.104(4) (2016) (explicating that if drug use is recent enough, the user may not be covered under the ADA, but that there is an exception to the current illicit drug use exception which is that a drug rehabilitation program may not deny participation because of current illegal drug use); *but see* Collings v. Longview Fibre Co., 516 U.S. 1048, 833 (1996) (holding that "current" drug use was not limited to the use of drugs on the particular day in question, instead it extended to days or weeks after the last use, even if they have entered or completed drug rehabilitation programs). The exact length of time that someone is "currently using" remains up unclear. *See id.*

245. *See* U.S. Dep't of Just., *supra* note 71, at 3 (suggesting that if a volunteer were to test positive for opioids and does not have a valid prescription, they may be dismissed).

246. *See* Joshua D. Blecher-Cohen, *Disability Law and HIV Criminalization*, 130 YALE L. J. 1560, 1583 (2021) (providing examples of where a court's analysis was policy focused and concerned the policy's discriminatory effect).

247. *See id.* (finding that "[u]nder the 'comprehensive view of . . . discrimination advanced in the ADA' that the Supreme Court has recognized, these facts" can create a "presumptive claim of discrimination . . . even without comparator evidence.").

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prevents illicit drug use.[248] Think about it this way: If someone has a seizure because the law prohibits them from using an anti-epilepsy medication, then under the current OUD/current use exception reasoning, then they no longer have a disability granting them status as a "qualified individual" under the ADA, and this can result in a lawsuit's dismissal before the policy is ever reviewed by the court. It is a dangerous and backward interpretation. Instead, the interpretation should be based on where the plaintiff or complainant was when they were impacted by the policy or practice, not where they may be days or months after they are forced to stop taking MOUD. If an individual is currently using drugs, even after successfully participating in MOUD treatment, they should still be able to seek injunctive relief. Policies and practices banning or making it difficult to receive MOUD single out people with OUD for adverse treatment without thought to whether they were using illicit substances at the time or not.

Title II of the ADA supersedes state laws conflicting with its antidiscrimination provision even when a state can demonstrate the regulation of certain activities is within its police powers.[249] This means that state law can be unenforceable if it "facially discriminates against [people with disabilities]."[250] Even if facially neutral, state law or other state agency policies may still need to be modified if adverse treatment exists:

> To state a claim, a plaintiff must:
> i. Be excluded from participation in a public entity's services, programs or activities or be otherwise discriminated against by a public entity ("adverse treatment");
> ii. Suffer such exclusion or discrimination due to their disability ("causality"); and

248. *E.g.*, In re B.S., 2015 WL 5125420, at 3–4 (W.Va. 2015) (rejecting the petitioner's allegation that his drug addiction could be resolved with Suboxone, by stating that the record did not show that Suboxone could correct his drug addiction in any foreseeable time); *see also* 28 C.F.R. § 35.108(b)(1) (including "drug addiction" within physical or mental impairment).

249. *See* Mary Joe C. N.Y. State & Local Ret. Sys., 707 F.3d 144, 163–64 (2d Cir. 2013) (rejecting an interpretation of a state statute that runs counter to the ADA's remedial purpose and that the ADA preempts inconsistent state law when appropriate and necessary to effectuate a reasonable accommodation under Title II); *see also* Barber v. Colorado Dep't of Revenue, 562 F.3d 1222, 1232–33 (10th Cir. 2009) (deciding that there was no conflict with the ADA and state law, but advised that defendants would not be able to violate the ADA under the guise of state law).

250. *See* Hargrave v. Vermont, 340 F.3d 27, 30 (2d Cir. 2003) (holding a state law that allowed healthcare professionals to override power-of-attorney designations by people with mental disabilities was facially discriminatory and therefore unenforceable).

iii. Be a qualified individual with a disability within the meaning of the statute ("qualified individual").[251]

The second half of the "adverse treatment" clause most aptly applies to individuals with MOUD involved in child abuse and neglect proceedings.[252] These individuals are not excluded from the activity, but rather, evidence suggests those with OUD are more likely to be involved in these proceedings.[253] It is one of the main reasons people with MOUD do not seek this treatment despite its known benefits.[254] State actors use the child welfare system to target individuals with OUD taking MOUD by imposing additional requirements only on them and doing so under the guise of creating a safe environment for the child.[255]

251. *See* Blecher-Cohen, *supra* note 246, at 1582 (citing Nat'l Fed'n of the Blind v. Lamone, 813 F.3d 494, 503 (4th Cir. 2016)) (relying on 42 U.S.C. § 12132 to describe the arguments ADA litigants can bring against discriminatory state laws); *see also* U.S. Dep't of Just., *supra* note 71, at 1 ("The ADA is a federal law that gives civil rights protections to individual with disabilities in many areas of life. The ADA guarantees that people with disabilities have the same opportunities as everyone else to enjoy employment opportunities, participate in state and local government programs, and purchase goods and services.")

252. *See, e.g.*, Blecher-Cohen, *supra* note 246, at 1582 (explaining how the second provision for adverse treatment is essentially a "catch-all" clause extending to antidiscrimination mandates for a much wider range of actions).

253. Daniel Max Crowley, *Considering the Child Welfare System Burden from Opioid Misuse: Research Priorities for Estimating Public Costs*, 25 AM J MANAG CARE (July 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7895335/#:~:text=Although%20federal%20data%20on%20the,care%20entry%20and%20poor%20foster ("Although federal data on the specific association between opioid misuse and CWS involvement are limited, ample evidence highlights the role of parental substance misuse as a significant contributing factor to the increased rates of child abuse and neglect. . . ."); *Cf.* Blecher-Cohen, *supra* note 246, at 1576–77 (describing how HIV criminalization laws reinforces stigma, perpetuates stereotypes, and results in those with HIV coming in contact more often with abusive government action).

254. *See Barriers Limit Access to Medication for Opioid Use Disorder in Philadelphia*, PEW CHARITABLE TR. (Mar. 16, 2022), https://www.pewtrusts.org/en/research-and-analysis/reports/2022/03/barriers-limit-access-to-medication-for-opioid-use-disorder-in-philadelphia#:~:text=University%20of%20Washington.-,The%20stigma%20toward%20OUD%20and%20MOUD%E2%80%94and%20treatment%20hesitancy,OUD%20reluctant%20to%20seek%20treatment [https://perma.cc/TCM3-ZSD9] (addressing the stigma that surrounds individuals who use MOUD, as there can be negative attitudes by health care providers who see treatment as just another drug).

255. *See* Blecher-Cohen, *supra* note 246, at 1564 (applying a similar analysis to HIV criminalization laws).

The ADA prevents policies and practices that are merely a façade to impose generalized stereotypes to protect those with disabilities.[256] This includes decisions to terminate parental rights that are not based on independent protective concerns.[257] These cases are more difficult because policies and practices may result in an individual being excluded from the protection of the statute; a case against the judiciary, CPS, the state itself, or a singular qualified individual with a disability could prevent harm to those who already relapsed through ongoing revisions to current policies, practices, and trainings for key decision-makers.[258] Any policies and practices containing harsher penalties for taking MOUD, as opposed to other medications, would cause parents with MOUD that are involved with the child welfare system to be "subject to discrimination" through affirmative enforcement of those policies/practices.[259] Both increase the likelihood of parental termination while decreasing opportunities to exit the program through reunification and case dismissal.[260]

In cases where CPS or family courts imposed arbitrary requirements or blanket bans of MOUD, without regard to individual assessment, causality is clear.[261] The adverse treatment need only be "by reason of [their] disability."[262] Exclusions or denials of MOUD participants or those interested in accessing MOUD may require a more substantive inquiry, especially if there are no explicit written policies barring the use of the

256. *Cf.* Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 598–600 (1999) (demonstrating that the Court opined that government polices "perpetuate unwarranted assumptions" about people with disabilities are cognizable as discrimination under the ADA, in other words, state-sanctioned stigma is a violation).

257. *E.g.*, In re Hicks/Brown, 893 N.W.2d 637, 640 (Mich. 2017) (holding that state agencies have a "duty under the ADA to reasonably accommodate a [parent's] disability before terminating parental rights").

258. *See* U.S. Dep't of Just., *supra* note 71, at 14 (citing to 42 U.S.C. § 12210(a)—the current illicit drug exception).

259. *See* Doe v. Cnty. Of Centre, 242 F.3d 437,448–49 (3d Cir. 2001) (labeling the County's blanket policy as discriminatory because it treated the Does differentially during the foster parent application process solely based on their son's HIV status and therefore violated the ADA); *see also* Complaint Unified Judicial Sys. Of Pa*.*, *supra* note 142, at 11 (alleging an ADA violation exists, in part due to an individual on MOUD who was not allowed to graduate and was subjected to additional medical detoxes and treatments that other participants were not required to do).

260. *See* Walter, *supra* note 24 (attributing a mother's relapse to court-imposed barriers, resulting in parental termination).

261. *See generally* Blecher-Cohen, *supra* note 246, at 1564 (describing the causality between having HIV and then, due to the disability, being subjected to penalties).

262. *See* 42 U.S.C. § 12132 (setting forth protections for people with disabilities).

medication.[263] Upon close review of state entities' actions and the reasons for those actions, discriminatory impact can be found in the arbitrary requirements imposed on those using MOUD: These can include (1) prohibiting an improvement period until the parent has tapered completely off of MOUD; (2) allowing MOUD only during pregnancy; (3) recommending parental termination because of inability to taper off MOUD; (4) barring MOUD from being retrieved legally out-of-state; or (5) barring those not on MOUD from starting the medication.[264] All raise a presumption of discrimination because these requirements are imposed only on people currently taking MOUD or requesting MOUD as an alternative to abstinence-based treatment or are simply instituted as a result of MOUD use.[265] These policies rely on stereotypical assumptions about those on MOUD and the medication itself, such as that the use of MOUD is just "replacing one substance for another."[266] These assumptions generalize the public entities' approach to MOUD, and public entities can then fail to perform an individual assessment and deference to the treating medical professional as required by the ADA.[267] Blanket application of these requirements to those with OUD requesting MOUD access has an underlying discriminatory basis and acts as an intentional barrier to inclusion.[268]

In child abuse and neglect proceedings, these "requirements" are often pretexts for a discriminatory motive to prevent reunification and increase termination based on subjective feelings about MOUD rather than

263. *Cf.* Paula A. Braveman et al., *Systemic and Structural Racism: Definitions, Examples, Health Damages, and Approaches to Dismantling*, 41 HEALTH AFFS. 171, 171 (2022) ("[S]ystemic and structural racism are forms of racism that are pervasively and deeply embedded in systems, laws, written or unwritten policies, and entrenched practices and beliefs that produce, condone, and perpetuate widespread unfair treatment and oppression of people of color with adverse health consequences."); *see* Pesce v. Coppinger, 355 F. Supp. 3d 35, 47 (D. Mass. 2018) (detailing how certain treatment programs impact MOUD users).

264. *See id.* at 42 (exploring treatment options for opioid use disorder in a correctional facility).

265. *But see* MEDICATION FOR OPIOID USE DISORDER MYTHS & FACTS, LEGAL ACTION CTR. 1, 1 (June 2021) (providing facts to dispel harmful myths surrounding MOUD).

266. *See id.* at 1–2 (describing how MOUD stereotypes impact perception.)

267. *See id. (*"[U]sing [MOUD] as a crutch rather than go through real recovery.")

268. *See id.* (presenting evidence that contradicts claims that "[c]ourts are in a better position than doctors to decide appropriate OUD treatment").

medical or actual safety considerations.[269] When a family court orders or attempts to discourage those with OUD from taking MOUD, more than one individual is harmed because it will impact anyone asking for, using, or considering MOUD-based treatment.[270] These general policies are implemented solely because of how individuals choose to treat their drug addiction.[271] They also perpetuate stereotypes about MOUD and discourage individuals from discussing the treatment option with a physician.[272] In short, the policies do exactly what the child welfare system holds itself out as attempting to prevent—harm to families.[273]

The causality requirement also exists in states that criminalize or automatically trigger child abuse and neglect proceedings when a newborn or post-partum mother tests positive for prescribed or illicit controlled substances.[274] States provide two justifications for these statutes: (1) a means to protect the health of babies; and (2) a way to deter parents from engaging in conduct harmful to the health of the mother and child.[275] In states where criminal or civil statutes include legally prescribed controlled substances, the law's breadth prescribes harsh penalties to mothers taking or considering MOUD.[276] These harsh penalties further discourage mothers who are not using MOUD from seeking treatment that could prevent illicit drug use.[277] Though no empirical data has been collected on the

269. *See* Pesce v. Coppinger, 355 F.Supp.3d 35, 46 (D. Mass. 2018) (arguing that medical decisions that rest on stereotypes, rather than on an individualized inquiry, may be considered discriminatory).

270. *See* LIPARI & VAN HORN, *supra* note 74 (highlighting how "[c]hildren having a parent with an SUD are at risk of experiencing direct effects, such as parental abuse or neglect").

271. *See id.* (providing analytical data on households with children ages seventeen and younger that have a parent with an SUD).

272. *See generally* Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 599–600 (1999) (advocating for disability rights in a segregated environment).

273. *See* '*How the Legislature Protected Children by Reigning in Texas' Child Protection Agency*, FAM. FREEDOM PROJECT, *supra* note 235 ("When CPS does remove a child from their home, they are mandated by law to seek reunification of the child with their family as their number one goal.").

274. *See* Mass. Gen. Laws Ann. 119 § 51(a) (Mandating that if a child is suspected to be dependent on a drug when born, the professional report the case to CPS).

275. *See generally* SAMSHA, TREATMENT IMPROVEMENT PROTOCOL (TIP) SERIES, LEGAL RESPONSIBILITIES AND RECOURSE CH. 6 (36th ed. 2000) (discussing statutes across several states that are designed to protect children's health and safety, as well as punish the drug users).

276. *See* Walter, *supra* note 24 (describing parent's hesitation to seek prescribed MOUD out of fear of losing parental rights or harming the child).

277. *See id.* (stating that reporting is mandatory when there is "reason to believe" abuse or neglect exists with no exception for prescribed medications).

correlation of child abuse and neglect proceedings and MOUD usage during pregnancy, CPS has been known to use a past child or a current newborn born on MOUD as justification to open an investigation and remove a child.[278] Essentially, a disability and subsequent treatment for OUD is used to initiate child abuse and neglect proceedings.[279] Punishing drug use—whether prescribed or not—perpetuates the stigma that those with OUD are "bad parents" and, in doing so, deters parents from seeking MOUD.[280] Criminalization of MOUD allows negative stereotypes, such as viewing mothers with OUD as "criminals," to continue even when they seek treatment.[281] The adverse effects of these laws are illustrated in a study of the forty-three states that implemented punitive measures for mothers who drink while pregnant.[282] The study found that pregnant women drinking was more prevalent in states implementing punitive measures than in states that do not.[283] Punitive measures scare mothers away from prenatal care and treatment for their substance use out of fear of being reported to CPS or a criminal prosecutor.[284] Without any

278. *How Child Services Punishes Mothers with Substance Use Disorder—and their Children*, *supra* note 41 (explaining the effects of prior involuntary terminations and current children born with any type of opioid in their system).

279. *See id.* (laying out how CPS used her previous treatment to set a trial).

280. *See Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, (Dec. 2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period#:~:text=The%20American%20College%20of%20Obstetricians,be%20harmful%20to%20their%20pregnancy [https://perma.cc/47A8-X4YB] (discussing how pregnant people with substance use disorder do not seek treatment because of social stigma, and fear the health care system because health care professionals are mandated reporters).

281. *See* Hicks v. State, 153 So.3d 54, 66 (Al. Crim. App. 2011) (finding that women using illicit substances during pregnancy is criminal child abuse under chemical endangerment statutes).

282. *See generally* Sarah C.M. Roberts et al., *State Policies Targeting Alcohol Use Disorder Pregnancy and Alcohol Use among Pregnant Women 1985–2016: Evidence from the Behavioral Risk Factor Surveillance System*, 29 WOMEN'S HEALTH ISSUES 213 (May–Jun. 2019) (conducting a study on the outcome of policies that impact mothers using illicit substances during their pregnancy).

283. *See id.* (Most policies targeting alcohol use during pregnancy do not appear to be associated with less alcohol consumption during pregnancy).

284. *See, e.g.*, Aaron E. Carroll, *Why Warning Pregnant Women Not to Drink Can Backfire*, N.Y. TIMES (Aug. 19, 2019), https://www.nytimes.com/2019/08/19/upshot/pregnancy-alcohol-warnings-backfire.html [https://perma.cc/9CQG-82CU] ("Qualitative research finds that pregnant women who use drugs avoid prenatal care out of fear that, if their providers find out about their drug use, they will be reported to child protective services and lose their children.").

treatment, hormones combined with fear can exacerbate alcohol use.[285] Punishing a mother for alcohol use places the child in more danger by increasing their risk of developmental disabilities, birth defects, and death because mothers will be deterred from seeking any treatment.[286] Mothers who are incarcerated or civilly committed because of substance use cannot seek out treatment, which makes long-term recovery even more unlikely and uncontrolled substance use more probable.[287]

Out of all the parents taking prescriptions during pregnancy, only MOUD is both heavily stigmatized and a controlled substance, thus resulting in more stigma for those who are on the medication.[288] Often, there is no individualized assessment of whether child abuse or neglect is actually taking place when CPS responds to a positive test; it is assumed based on the presence of a controlled substance alone.[289] Additionally, there is often not an adequate assessment of whether there is sufficient harm to a third party.[290] CPS also fails to recognize that before MOUD is prescribed during pregnancy, medical professionals have already inquired into the possibility of harm from MOUD and found it to be the best treatment option for the safety of both the mother and child.[291] More specifically, medical professionals weigh the cost of temporary effects on a child born with MOUD in their system against the benefit of preventing permanent harm that illicit substances can cause to both the mother and

285. *See, e.g.*, *id.* (discussing how child neglect policies lead women to avoid medical care and continue drinking).

286. *See id.* (explaining the unintended externalities for the babies of pregnant women for punished for consuming alcohol).

287. *See* Christine E. Grella et al., *A Scoping Review of Barriers and Facilitators to Implementation of Medications for Treatment of Opioid Use Disorder within the Criminal Justice System*, INTER. J. DRUG POL'Y 1, 2 (2020) (compiling research that indicates women in the justice system have a lack of access to drug recovery care).

288. *Cf.* T.E.P. v. Leavitt, 840 F. Supp. 110, 111 (D. Utah 1993) (invalidating Utah's prior ban on marriage for people with HIV/AIDS for violating the Americans with Disabilities Act and enjoining enforcement).

289. *See* Walter, *supra* note 24 (documenting instances of mothers losing access to their children due to positive test results).

290. *See generally id.* (outlining the steps taken in removal of an infant from its mother immediately following only one positive drug test, despite the drug being medicinal and not for recreational use).

291. *See id.* (highlighting the refusal of CPS to refer to hospital records and medical professional testimony to the contrary when removing an infant for a mother's alleged drug use).

child.[292] The general consensus among medical professionals is that MOUD use during pregnancy is correlated to better maternal and neonatal outcomes.[293] But CPS too often removes newborns because they are perceived as being in danger based on the positive drug test alone, without an individualized assessment of objective facts, including the "severity of the risk to the child, and the probability that the potential injury to the child will actually occur[.]"[294] If a CPS investigation was opened without any other protective concerns, following a referral for either past MOUD use or current MOUD use, an ADA violation arguably exists.[295] This is because the investigation is opened entirely because of a plaintiff's disability or history of a disability.[296] If removals on these grounds are occurring extensively throughout the state, it may establish a pattern and practice of discrimination.[297] Therefore, state agencies and the judiciary would be required under the ADA to close investigations and dismiss the case if no other concerns except those stemming from the use of prescribed MOUD exist.[298]

To proactively address liability concerns, caseworkers and courts should identify barriers to accessing MOUD in their communities and establish supports like family treatment courts to improve access for those

292. *See, e.g.*, *id.* (balancing the negative impacts of parental separation and short-term exposure to MOUD in newborns).

293. *See* Titus-Glover et al., *supra* note 65, at 1 ("Medications for opioid use disorder (MOUD) are recommended . . . for comprehensive treatment of maternal opioid use disorder.").

294. *See The Americans with Disabilities Act: Title II Technical Assistance Manuel*, U.S. DEP'T JUST., https://www.ada.gov/taman2.html [https://perma.cc/V468-5FN5] (explaining the standards of review in cases for those with disabilities).

295. *See* 29 C.F.R. § 1630.2(r), app. at 356 (1999) (outlining the requirements for what constitutes a direct threat of harm); *see also* EEOC TECHNICAL ASSISTANCE MANUAL ON THE ADA 8.7 ("An employer cannot prove a high probability of substantial harm simply by referring to statistics indicating the likelihood that addicts or alcoholics in general have a specific probability of suffering a relapse.").

296. *E.g.,* EEOC TECHNICAL ASSISTANCE MANUAL ON THE ADA 8.7 (explaining the regulation that prevent employers from instigating investigations based on disability claims alone).

297. *See* Justice Department Finds that Pennsylvania Courts Discriminated Against People with Opioid Use Disorder, *supra* note 72 (highlighting alleged discrimination against those with OUD across the states' treatment courts).

298. *Cf.* Statement of Interest at 4, A.V. through Hanson. v. Douglas Cnty. Sch. Dist. RE-1, 586 F. Supp. 3d 1053 (D. Colo. 2022) (No. 21-cv-00704-WJM-SKC) (explaining that the defendants are responsible for ensuring that their policies do not discriminate against individuals with documented disabilities). *Cf.* Justice Department Reaches Landmark Agreement with Massachusetts Department of Children and Families to Address Discrimination Against Parents with Disabilities, *supra* note 217 (opening a case on the basis of a parent's intellectual disability).

currently using these medications and those who could benefit from them.[299] Courts, acknowledging barriers to MOUD in advance, can also use more flexible timelines because patients on MOUD rarely follow a linear path to recovery.[300] A public entity should not base its actions on stereotypes and should accommodate those with disabilities through affirmative acts throughout the child welfare process.[301] Additionally, by applying the findings of the alcohol use study, the promotion of MOUD use rather than the penalization of its use could reduce the number of babies born exposed to illicit substances, premature birth, and parental overdoses.[302] Mothers would also benefit because it would also begin to remove the fear parents may have about discussing OUD treatment with their physicians or other confidants.[303] As a result, families in which one or more parents have OUD would have a higher chance of staying together because MOUD would be more likely to be seen as an accessible and life-saving option rather than a risk.[304]

C. Defenses States Could Raise for an ADA Claim or Lawsuit.

State actors within the child welfare system might invoke a defense of direct threat, fundamental alteration, or undue burden to oppose a request for treating OUD with MOUD.[305]

1. Direct Threat

Direct threat assessments must be individualized and based on objective facts, and if a threat can be eliminated by providing a reasonable

299. *See* RADEL ET AL., *supra* note 111, at 9 (explaining that family treatment courts provide an opportunity to incorporate MOUD and therapy to those with OUD).

300. *See id.* at 8–9 (identifying individuals with opioid use disorder are prone to having additional substance use disorders and concurrent mental health conditions).

301. *See* 28 C.F.R. § 35.130(h) (2016) (stating that public entities can enforce valid safety requirements essential for safe functioning).

302. *See generally* Roberts et al., *supra* note 282, at 218 (comparing punitive environments to supportive environments among pregnant women).

303. *See id.* (emphasizing that in states where priority treatment is enforced, pregnant women might be more inclined to accurately report their alcohol consumption).

304. *See id.* (discussing that evidence has found that treatment is more likely to lead to successful family reunification).

305. *Cf.* RADEL ET AL., *supra* note 111, at 5 (identifying key reasons for treatment shortages).

accommodation, then the agency is required to provide it.[306] In many cases, concerns that a parent may relapse, or a parent who does relapse after tapering down, can be alleviated by the provision of MOUD.[307] States actually create health risks and safety concerns by barring access to necessary medication or forcing parents to taper off all substances on an arbitrary timetable.[308] One court explicitly rejected generalized fears of MOUD being sold on the streets or not used as prescribed as insufficient to override the actual threat an individual will face by not having access to it.[309] To be denied MOUD, a state must determine that the individual in question "poses a direct threat to the health or safety of others [and this determination] may not be based on generalizations or stereotypes about the effects of a particular disability."[310] However, arbitrary barriers to MOUD and blanket MOUD bans are in place based on misconceptions individuals have about the medication, not because they actually cause a threat—in fact, if MOUD works, then access can resolve the threat.[311] MOUD usage is too often erroneously framed as a moral failing, even though MOUD can actually help eliminate illicit substance use and help parent's work on stability in other parts of their life.[312] The

306. *See The Americans with Disabilities Act: Title II Technical Assistance Manual*, *supra* note 294 (explaining direct threat); *see also* Justice Department Reaches Landmark Agreement with Massachusetts Department of Children and Families to Address Discrimination Against Parents with Disabilities, *supra* note 217 ("DCF will not base decisions about removal of a child on stereotypes or generalizations about persons with disabilities.").

307. *See Treatment Before, During, and After Pregnancy*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Nov. 15, 2022), https://www.cdc.gov/pregnancy/opioids/treatment.html [https://perma.cc/4CJ3-ESPT] ("A safety plan for the mother and family needs to be in place before slowly stopping MOUD, so that plans are in place if opioid relapse occurs.").

308. *See generally* White, *supra* note 97 (dispelling negative beliefs about MOUD treatments for pregnant people).

309. *See, e.g.*, Pesce v. Coppinger, 355 F. Supp. 3d 35, 44–48 (D. Mass. 2018) (rejecting the defendants' proposed treatment plan, stating that it would be "ineffective at treating Pesce's disorder and that could potentially place Pesce at a high risk of relapse and overdose upon release").

310. *See* 42 U.S.C. § 12111 (2018) ("The term 'direct threat' means a significant risk to the health or safety of others that cannot be eliminated by a reasonable accommodation."); *see also The Americans with Disabilities Act: Title II Technical Assistance Manual*, *supra* note 294 (explaining the individual assessments used to determine whether a direct threat exists).

311. *See* CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 307 (providing clinical guidance for pregnant people with OUD).

312. *Cf.* Tatyana Roberts et al., *Opioid Use Disorder and Treatment Among Pregnant and Postpartum Medicaid Enrollees*, KFF (Sept. 19, 2023), https://www.kff.org/medicaid/issue-brief/opioid-use-disorder-and-treatment-among-pregnant-and-postpartum-medicaid-enrollees/ [https://perma.cc/X7CX-84RM] (discussing punitive state laws that contribute to lower OUD treatment).

same is true for state statutes criminalizing controlled substance use.[313] The majority of these statutes do not inquire about substantial third-party harm, and instead, apply punishment regardless; thereby, these decisions are based on generalizations rather than objective facts.[314] By denying or punishing MOUD usage without individual threat assessments, states actually perpetuate the unsafe and "neglectful" conditions the child welfare system is designed to prevent.[315]

2. *Fundamental Alteration and Undue Burden*

The ADA's implementation of regulations also includes a fundamental alteration and an undue burden defense.[316] However, MOUD access without interference from state actors would not "fundamentally alter the nature of the service, program, or activity" in child abuse and neglect proceedings.[317] Merely relaxing time constraints to access services or referring child welfare-involved parents to medical treatment outside of the abstinence-only providers normally used by CPS does not change the structure or nature of the program.[318] A defense of this nature would rest on the assumption that MOUD is not true recovery, so abstinence is necessary, which is facially discriminatory.[319] The undue burden defense,

313. *See* BRIAN STAUFFER, EVERY 25 SECONDS: THE HUMAN TOLL OF CRIMINALIZING DRUG USE IN THE UNITED STATES 20 (Human Rights Watch 2016), https://www.hrw.org/report/2016/10/12/every-25-seconds/human-toll-criminalizing-drug-use-united-states [https://perma.cc/W3HS-R4KN] (penalizing behavior irrespective to harm is an "unjustifiable infringement of individuals' autonomy and right to privacy").

314. *See id.* (explaining that this penalizing pattern is seen throughout the nation); *see also* Pesce v. Coppinger, 355 F. Supp. 3d 35, 44–48 (D. Mass. 2018) (rejecting defendants fear of diversion in part because the individual danger of painful withdrawal symptoms, relapse, and death are actual and foreseeable. There was no evidence of diversion in this case).

315. *Cf. id.* (commenting on a current Massachusetts law that requires healthcare providers to report "suspected abuse or neglect" when a person gives birth to a baby who was exposed to substances used in the treatment of OUD).

316. 28 C.F.R. § 35.130.

317. *See* 28 C.F.R. § 35.130(b)(7)(i) (regulating public entities to avoid discrimination based on disability status).

318. *See* Joshua B. Kay, *The Americans with Disabilities Act: Legal and Practical Applications in Child Protection Proceedings,* 46 CAP. UNIV. L. REV. 783, 811 (2018) (arguing for the flexibility courts need to use to ensure parents are being accommodated for their intellectual disabilities and that services should not be denied because they are thought to be futile).

319. *See* MX Group, Inc. v. City of Covington, 293 F.3d 326, 345 (6th Cir. 2002) (opining that when a policy is facially discriminatory, "it makes little sense . . . to require . . . an accommodation, when the only accommodation fundamental change to the ordinance, could not be considered reasonable").

on the other hand, allows entities to decline accommodations that would "result . . . in undue financial and administrative burdens."[320] MOUD provision would actually limit the expenses incurred by the state because of child removals, court proceedings, foster care services, and termination of parental rights.[321] By finally having some control over their disability, parents would have greater opportunities to gain stable employment and housing and focus on meeting the needs of their children, which would prevent reoccurring child abuse and neglect proceedings.[322] In fact, allowing all parents with OUD to attempt MOUD if interested, even if it takes longer to get them access to providers and stability, would decrease the long-term administrative and financial costs incurred from the long-term placement of removed children.[323] States need to start thinking about how best to keep families together. ADA litigation—even if there are some losses—will have a positive effect on system-wide reform as more people become aware of MOUD and its potential benefits, and it becomes more available for those with OUD. Currently, the media is enflamed by the negative effects of the opioid crisis, but there is little discussion about how states impede access to medication that may help sustain people's recovery.[324] Litigation will start to force system-wide changes in how CPS approaches and courts consider involuntary removals, reunifications, and parental terminations, as well as increase discussion around MOUD access more generally.[325]

320. *See* 28 C.F.R. § 35.150(a)(3) (prohibiting usage of excessive financial or administrative burdens).

321. *See* Shade, *supra* note 230, at 207 (illustrating the unfair consequences applied to those who abuse opioids).

322. *See Treatment for Opioid Use Disorder May Reduce Substantiated Cases of Child Abuse and Neglect*, U.S. DEP'T OF HEALTH & HUM. SERVS, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/198071/Buprenorphine-Treatment-Child-Maltreatment-Cases.pdf [https://perma.cc/4LXD-5HSF] (expressing confidence that greater access and lesser stigma surrounding MOUD would encourage parents to seek treatment).

323. *See Overdose Deaths and Jail Incarceration*, VERA, https://www.vera.org/publications/overdose-deaths-and-jail-incarceration/national-trends-and-racial-disparities [https://perma.cc/V6JR-CRAX] (increasing MOUD and investing more in treatment facilities would decrease jail admissions and overdose death).

324. *See generally* Simon, *supra* note 23 (expressing concern for the effects of media sensationalism on opioid treatment).

325. *See id.* (exploring the positive impact litigation could have on improving access for those with SUDs).

CONCLUSION

The effects of the opioid crisis are ravaging the United States' child welfare system.[326] The state's current response using punitive measures and parental terminations under the façade of deterrence is not working; instead, it is generating a cycle of persons with disabilities who are too scared to seek a treatment that may work for them.[327] Treatment could reduce substantiated maltreatment claims and keep families together.[328] As a result, parents with OUD are being incarcerated, their parental rights are being terminated, and punishments are being doled out—all resulting in families being torn apart.[329] In response, parents too often turn back to illicit drug use.[330] Thus, the cycle continues and will continue until there is a change.[331]

The ADA provides a way to potentially decrease both the number of children entering foster care and parental overdoses.[332] By challenging discriminatory policies against parents with OUD under the ADA, child welfare systems will be forced to revise their policies, reexamine how they treat those with OUD, and open avenues for alternative treatment.[333]

326. *See id.* (connecting the opioid crisis to an increase of child welfare actions from the states).

327. *See* Crawford et al., *supra* note 20 (exploring the generational consequences of criminalizing OUD).

328. *See* Kay, *supra* note 318, at 818 (explaining that "[p]arents with disabilities are disproportionately represented in the child protection system, and once involved in the system, they are more likely than other parents to suffer termination of their parental rights.")

329. *See* Walter, *supra* note 24 (detailing the experiences of parents with OUD dealing with child services and having their children taken away).

330. *See* Lynda Russell et al., *Gender, Addiction, and Removal of Children Into Care,* 13 FRONTIERS IN PSYCH. 1–2, 6 (2022) ("[R]eporting increased rates of suicide attempts and self-harm, relapse or increase in drug and alcohol use is common following removal. Parents also reported experiencing strong negative emotions including anger, agitation, anxiety and sadness.").

331. *See id.* (discussing how "the removal of children is having a serious effect on parents, which may in turn further exacerbate their addiction and further affect children who may return to their care").

332. *See* U.S. Dep't of Just., *supra* note 71 (describing how OUD is classified as a disability under the ADA).

333. *See* U.S. Dep't of Just., *Rights of Parents with Disabilities*, ADA.GOV, https://www.ada.gov/topics/parental-rights/# [https://perma.cc/D6NC-KYYZ] (stating that "[c]hild welfare agencies and courts need to make sure that they provide their services in ways that do not discriminate against parents with disabilities. Importantly, an agency or court may not rely on stereotypes about individuals with disabilities. And, in many instances, they must make reasonable changes to the way they usually do things so that people with disabilities can fully participate.").

The need for the ADA is urgent. Once the parental relationship is terminated, options are almost nonexistent to regain custody.[334] With the explosion of substance use and overdoses combined with deteriorating state foster systems, the prevention of illicit drug use by parents should be the aim of the child welfare system going forward rather than separating families because of prescribed substance use.[335] This means looking at all the options for treatment. Parents going through child abuse and neglect proceedings, which are already destabilizing and fast-paced, should not be faced with generalized stereotypes based only on their disability. Instead, they need to be given the tools to be successful in their recovery. The child welfare system needs to recognize that success means more than abstinence-based treatment—it could, depending on the parent, mean recovery through MOUD.

334. *Cf.* TEX. DEP'T. OF FAM. AND PROTECTIVE SERVICES, CHILD PROTECTIVE SERVICES HANDBOOK 18–19, https://www.dfps.texas.gov/handbooks/cps/files/CPS_pg_5560.asp [https://perma.cc/ETN2-LPM4] (detailing the method of reinstating parental rights in the State of Texas).

335. *See* Simon, *supra* note 23 (demonstrating how state foster systems are being detrimentally impacted by the increase substance abuse).