**SB 216**
**Opponent Testimony**

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Dear Chairman Manning, Vice-Chair McColley, Ranking Member Thomas, and members of the Senate Judiciary Committee, thank you for the opportunity to offer opponent testimony for SB 216.

I am a student, working towards a Master of Science in Public Health in the department of Health Policy at Johns Hopkins Bloomberg School of Public Health. I have lived in Ohio the entirety of my life before departing for graduate school, and I am a registered voter in the state of Ohio. I attended the Ohio State University where I earned a BS in neuroscience and worked towards credits for a Chemical Dependency Counselor Assistant's license. I also worked as a research assistant with STEPP, a prenatal clinic that treated pregnant people with opioid use disorder. After graduating, I was a counselor at Community Medical Services, where I was the designated counselor for pregnant clients. All of these experiences contributed my decision to pursue graduate education so that I could be an advocate for science and public health in policy, which is the role I hope to play in this testimony. I am deeply disturbed by the tragedy of infant Dylan's death. However, due to numerous concerning pieces of this legislation, I do not think SB 216 is the solution to this tragedy. This bill is not going to accomplish the goal of reducing substance exposure during pregnancy, and in fact could do harm to the very cause it hopes to change. I strongly oppose this bill and will use this written testimony to share my perspective and the evidence against this policy.

During my time at Community Medical Services, I often worked with pregnant clients who delayed seeking treatment in pregnancy because of fears of judgement, legal issues, and child services involvement if they sought care. Leading medical experts, including the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, agree that criminalizing pregnant people with substance use disorder is ineffective and can be harmful to both the pregnant person and their infant.[1,2] Creating more punitive consequences for the health issue of substance use disorder will cause people to be even more scared of seeking treatment, which should be the primary goal for anyone looking to minimize harm of substance use in pregnancy. This fear could also drive pregnant people to delay prenatal care, which will likely lead to a higher rate of preventable complications and even maternal mortality.[3] As Ohio works

to address the need for supporting pregnant people, children, and families impacted by substance use, punitive policies are not the answer.

Stigma is a massive driver of delaying medical care among pregnant people who use substances, which in the end harms both the pregnant person and the fetus. Classifying substance use during pregnancy as abuse will exponentially drive more stigma, which will likely lead to less engagement in treatment and thus poorer health outcomes.[4] Additionally, the literature shows that states with punitive policies for substance use in pregnancy have less people engaged in the best treatment for OUD in pregnancy, medications like methadone and buprenorphine, and have worse Neonatal Abstinence Syndrome (NAS), also referred to as neonatal opioid withdrawal syndromes (NOWS), outcomes.[5,6,7] States that have these policies in place have also been tied to higher rates of low birthweight and preterm births, which ultimately leads to excessive costs to the state.[8] A better path forward for Ohio to decrease the harm substance use during pregnancy may cause is to pass supportive and compassionate policies so that pregnant people feel safe and supported in accessing health services that will improve their wellness and the outcomes of their pregnancy. The literature clearly indicates this is a more favorable approach.[7,9,10]

One of the most beautiful things I witnessed as a counselor was the dedication parents had to accessing needed treatments and supports for themselves in order to parent their children. In this vein, a piece of this legislation particularly concerning to me is the requirement that the court prohibit "any contact between the child's parent and the child". This takes away the huge motivating factor that regular visits with their children can be for parents and the benefit for young children to stay connected to their parents. I worry that this portion of this policy will make it even harder for parents to be motivated in finding recovery and will drastically reduce reunification rates. Additionally, the mandated 6-month removal period is an incredibly long time for a positive substance screen alone. this is particularly concerning for infants experiencing Neonatal Abstinence Syndrome (NAS) as studies have shown that first-line interventions include close physical contact with the parent and breastfeeding, and these alone can minimize the severity of NAS, often eliminating the need for pharmacological intervention.[10,9] With the specifications in this bill, this evidence-based intervention would be impossible. There are also studies that find an association between early mother-child separation and poor behavioral outcomes for the child.[11] Separating an infant and its parent should be the absolute last resort, not the first measure a policy takes.

Additionally, the requirement that the parent complete an inpatient rehabilitation program is problematic. Inpatient rehabilitation can take a long period of time to get into, and require a person to depart from their family, jobs, etc. for a significant period of time. The most evidence-based form of treatment for opioid use disorder is medication for opioid use disorder (MOUD). However, many inpatient rehabilitation facilities in Ohio do not provide MOUD, which I know from my time as a counselor with clients treated with methadone. This forces people into a form

of treatment that potentially either does not allow them to continue their medication if they are previously established in this treatment or does not allow them to start the most effective treatment available—and one recommended by the National Academy of Science Engineering and Medicine, the American Society of Addiction Medicine, the American College of Obstetrics and Gynecology, and the World Health organization, among others. I would like to be clear that I believe everyone's choice in their substance use treatment is their own, however requiring someone to participate in a form of care that may not offer the most evidence-based treatment is not a sound public health approach and will likely have significant ramifications in the form of less treatment success, higher overdoses, and ultimately less reunification.

After years of working with the evidence and the people themselves, I have deep concerns that this bill will cause significant harm to both pregnant people and their infants. I too want to limit harms that can be caused by substance use in pregnancy, which is what this legislation is trying to do, but classifying a pregnant person as a child abuser and applying the punitive measures this bill proposes will not accomplish that goal. Thank you for your time in reviewing my testimony, and for thinking critically about this matter. I absolutely welcome any questions you may have.

Sincerely,

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