IN THE COMMONWEALTH COURT OF PENNSYLVANIA

ALLEGHENY REPRODUCTIVE HEALTH CENTER, et al.,	:	
Petitioners,	:	
v.	:	**Affidavit of Sarah C. Noble, D.O.**
PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES, et al.,	:	
Respondents.	:	

DECLARATION OF SARAH C. NOBLE

I, Sarah C. Noble, make this declaration:

1. I am a board-certified psychiatrist in Pennsylvania specializing in women's mental and behavioral health. My particular expertise is in the intersection of psychiatry and obstetrics.

2. I am aware that Pennsylvania's Medicaid program, Medical Assistance, provides health care coverage for low-income Pennsylvanians. I am also aware that Medical Assistance does not cover abortion procedures unless the pregnancy is caused by rape or incest, or where the abortion is necessary to avert the death of the pregnant woman.

3. For many women, the perinatal period (the period during pregnancy and for one year following delivery) is a time of vulnerability to mental illness.

Indeed, pregnancy can destabilize a woman's mental health in several ways, by (1) exacerbating the symptoms or prompting a recurrence of a pre-existing mental health disorder; (2) sparking a new mental illness; (3) presenting a barrier to effective treatment for a mental health or substance use disorder; or (4) causing emotional distress that compromises a woman's ability to cope with life. Low socioeconomic status has repeatedly been identified as a risk factor for certain mental illnesses during pregnancy.[1] There is no clinical justification for denying Medical Assistance coverage to women who seek an abortion in order to protect their mental health and well-being.

4. In addition, by limiting poor women's options to address unwanted pregnancy Medical Assistance is in turn putting the lives of both these women and their fetuses at risk. Unwanted and unintended pregnancy has been associated with an increased risk of interpersonal violence.[2] This is particularly true for women who are on Medicaid; according to one study they were 2.5 times more likely to experience abuse before and during pregnancy.[3] It is hypothesized that pregnancy

[1] *See* Alessandra Biaggi et al. "Identifying the Women At Risk of Antenatal Anxiety and Depression: A Systematic Review." *J. Affective Disorders* 62,64, (2016): 191 (citing C.A. Lancaster et al. "Risk Factors for Depressive Symptoms During Pregnancy: A Systematic Review." *Am. J. Obset. & Gynecol*. 5, 14 (2010): 202).

[2] Gibson J, et al. "The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature." *Stud Family Planning* 39, 2 (2008): 28.

[3] Goodwin M, et al. "Pregnancy Intendedness and Physical Abuse Around the Time of Pregnancy: Findings from the Pregnancy Risk Assessment Monitoring System, 1996-1997." *Maternal & Child Health J.* 4, 2 (2000): 89.

coercion and/or birth control sabotage are critical mechanisms underlying unintended pregnancy, and are either precursors to physical abuse or part of the overall control the abuser has on the woman.[4]

5. Based on my clinical experience and familiarity with the literature on mental health and pregnancy, I believe that the Medical Assistance abortion exclusion, which denies coverage to countless women, harms the mental health of pregnant, low-income Pennsylvanians.

I. BACKGROUND AND QUALIFICATIONS

A. *Education and Training*

6. I received my Doctor of Osteopathic Medicine degree from the Philadelphia College of Osteopathic Medicine in 2007. In 2011, I completed the Albert Einstein Medical Center Psychiatry Residency Training Program, during which time I served as the Chief of Medical Student Education.

7. Since 2011, I have worked as an attending psychiatrist at Albert Einstein Medical Center, and I currently serve on the Medical Staff Board and am Medical Director of the Outpatient Clinic. I have served on several academic committees at Albert Einstein Medical Center, including its Psychiatric Education Committee, its Medical Education Committee, and its Curriculum Committee. I

[4] Miller E, et al. "Pregnancy Coercion, Intimate Partner Violence and Unintended Pregnancy." *Contraception* 8, 14 (2010): 321.

also helped to develop Albert Einstein Medical Center's Women's Behavioral Health Program.

8. I have served on several professional committees related to women's mental health, including the Association of Gay and Lesbian Psychiatrists' Women's Committee and Program Committee, and the Pennsylvania Psychiatric Association's State Hospital Committee. I am also a frequent lecturer on perinatal mental health screening and treatment and have conducted research and published on numerous issues relating to mental health during pregnancy.

9. Throughout this affidavit, I refer to patients I have treated. I have changed their names and do not use any personally identifying information. These patient examples are used to provide real-world illustrations of the information contained within this affidavit and each is representative of other patients I have treated.

B. ***Clinical Practice***

10. The overwhelming majority of my patients—several hundred each year—are in the perinatal period. I see patients during and after their pregnancies at the request of the obstetrics and pediatric departments. I will often follow my patients for months or years as they work through the developmental milestone of motherhood. Together, we make difficult decisions about whether to start medications during pregnancy that might affect their fetus. Sometimes we are also

struggling to determine the right path for a woman to take around the topic of an abortion. At other times we are processing grief around the loss of a wanted child. This is difficult and rewarding work because I get to walk with women through an amazing and challenging time in their lives and see the different ways in which they handle unforeseen and unexpected events in life.

11. For example, one woman, Samantha, who was 18 when I met her, had just given birth to her son. Since then, I've seen her get her GED, start working, have a second unintended pregnancy, and then lose her mom to an overdose. She continues to move forward and parent with grace despite all of her challenges.

12. On the other hand, Stephani is illustrative of many of the women I have treated. She came to me 6 months after the birth of her son because she was tearful and isolating herself. She reported that initially the father of the baby had been excited about her pregnancy, but around the second trimester he had told her he didn't think he could support a baby. She felt trapped at that point knowing that it was too late to get an abortion. She felt alone because her own mother was in active addiction so was no help in this new role as a parent. She was struggling to connect to the baby because of her severe postpartum depression.

13. A majority of the women I treat in the perinatal period are low-income and receive medical assistance.

14. I submit this declaration as an expert in the interaction between pregnancy and mental health. This expertise extends to the circumstances in which a woman may seek an abortion in order to protect her mental health and the well-being of her family. My curriculum vitae, which sets forth my experience and credentials in greater detail and contains a full list of my qualifications, is attached as Exhibit A to this declaration. All of my opinions in this declaration are stated to a reasonable degree of professional certainty.

II. Pregnancy and Mental Health

A. *The Impact of Pregnancy on Mental Health*

15. A significant number of women will experience a mood disorder (such as depression or bipolar disorder), an anxiety disorder (such as generalized anxiety disorder or panic disorder), obsessive-compulsive disorder (OCD), or a trauma-related disorder (such as post-traumatic stress disorder (PTSD)) during the perinatal period. For example, the data suggest that up to 14.5 percent of pregnant women experience a new episode of major or minor depression during pregnancy.[5]

16. Indeed, statistics on the prevalence of mental health disorders among pregnant women are likely under-representative, as many women will never seek treatment either because they assume their symptoms are normal, because of the

[5] Gaynes Bradley N, et al. "Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes." *Agency for Healthcare Res. and Quality: Evid. Rep./Tech. Assessment* 1, 4 (2005): 119.

stigma surrounding mental illness, or because of time or financial limitations.[6] The data for our hospital suggest that the numbers are more likely around one in four women who meet the qualifications for depression or anxiety at some point during their perinatal period.

17. Pregnancy can destabilize a woman's mental health in several ways. *First*, for a woman with a pre-existing mental health disorder, pregnancy can exacerbate existing symptoms or cause a recurrence (that is, a relapse) in a woman who had been successfully regulating her condition prior to pregnancy. These types of changes may be due to the hormonal fluctuation associated with pregnancy, stress and lifestyle changes, a modification of an established medication regimen as a result of the pregnancy, or a combination of any of the above. For example, Tiffany was a young woman who came to me after the birth of her second child. She had stopped her antidepressants when she found out she was pregnant, and at the same time had to stop therapy because of insurance changes. Relationship problems as well as past trauma complicated Tiffany's perinatal depression creating a relapse of symptoms.

18. Recurrence during pregnancy is particularly common among women with bipolar disorder. Approximately 60 to 70 percent of women with bipolar

[6] *Id.* at 1 ("Perinatal depression . . . often goes unrecognized because many of the discomforts of pregnancy and the puerperium are similar to symptoms of depression.").

disorder will experience an episode during pregnancy and/or the postpartum period.[7] For example, Misty is a young woman who had completed college and was doing well in her career when she became pregnant. She had a difficult delivery and was in the ICU with pregnancy complications. Subsequent to that she began to see me for severe anxiety and mood swings. It took a year for her bipolar disorder to get controlled during which time her career fell apart as well as her relationship with her child's father.

19. It is difficult to predict how long it will take a woman to recover from a recurrence of any mental health disorder as her prognosis will depend in part on whether she is receiving appropriate treatment. Most medications take four to six weeks to reach maximum efficacy, and if a woman does not immediately seek treatment, or if she is initially not treated appropriately, it may take many months beyond that. Therapy and lifestyle changes, which are often also necessary for a full recovery, may take even longer to implement effectively. Often recovery is complicated by the normal challenges of the postpartum period such as sleep deprivation and social isolation.

20. Moreover, for many women, the ramifications of a relapse extend well beyond the episode itself. People who can maintain stability have better overall

[7] Mittal L, et al. "Bipolar Disorder in Pregnancy and Breast Feeding: a Practical Guide for the General Psychiatrist." *Psychiatric Annals* 45, 8 (2015): 411, 412.

prognoses than people who relapse and remit, as each episode of a psychotic or mood disorder increases the likelihood of a subsequent episode.

21. *Second*, pregnancy can destabilize a woman's mental health with a new-onset mental illness during pregnancy. Charlene came to me during her second pregnancy with extreme panic attacks, which were new for her. She was finding herself unable to care for her 10-year-old son, manage the household or get to work or school. We acknowledged the many balls she was juggling in addition to the pregnancy and agreed to start sertraline, an anxiety medication, and psychotherapy.

22. *Third*, I have treated many women suffering from postpartum mental illness. Indeed, postpartum depression occurs in nearly 15 percent of women within the first three months after pregnancy,[8] and a woman who experiences postpartum depression is at greater risk of experiencing it again after a subsequent pregnancy. One of my first patients was Rachel. She brought her infant son to our appointment, but to my dismay she had his car seat turned away from her and didn't pick him up at all during the session. One of the most common symptoms of postpartum depression is a mother's inability to bond with her infant. One of the most striking studies to explain this is one in which depressed and non-depressed mothers were exposed to their own infant's cry, another infant's cry, and

[8] Gaynes et al., *supra* note 5, at 4.

a control sound while being monitored in an fMRI (fMRI is a powerful study tool to see which parts of the brain are active at any given time). Non-depressed mothers showed significantly greater activation towards their own infant's cry than other infant or control sound. Depressed mothers showed no difference in their brain scans for all three sounds.[9] Thus for depressed mothers their infant's cry is essentially registering the same as a simple tone and has lost the evolutionary pull to grab the mother's emotional heart strings.

23. Postpartum psychosis, while rare, is a subset of postpartum illness that is considered a psychiatric emergency.[10] Women experiencing postpartum psychosis may lose touch with reality, becoming delusional and sometimes homicidal, and recovery is often slow. While it is unclear precisely what causes postpartum psychosis, hormonal fluctuation has been shown to be a factor,[11] and psychosocial changes, such as sleep deprivation, likely also play a role.[12] Women

[9] Laurent H, et al. "A Cry in the Dark: Depressed Mothers Show Reduced Neural Activation to Their Own Infant's Cry." *Social Cognitive Affective Neuroscience* 7 ,2 (2012): 130.

[10] *See, e.g.*, Mittal et al., *supra* note 7, at 412.

[11] Payne JL, et al. "Reproductive cycle-associated mood symptoms in women with major depression and bipolar disorder." *J. Affective Disorders* 99 (2007): 221, 222.

[12] *Id*. at 227; *see also* Payne JL, et al. "A Reproductive Subtype of Depression: Conceptualizing Models and Moving Toward Etiology." *Harv. Rev. Psychiatry* 17 (2009): 72, 72 (citing Sharma V & Mazmanian D. "Sleep Loss and Postpartum Psychosis." *Bipolar Disorders* 5 (Apr. 2003): 98, 98-105).

with bipolar disorder are at particular risk for postpartum psychosis.[13] And women who have previously experienced an episode of postpartum psychosis are at an extremely high risk of recurrence—between 30 and 50 percent with each subsequent delivery.[14]

24. *Fourth*, pregnancy can cause sadness, anxiety, and/or compulsions during the perinatal period that can compromise a woman's mental health and well-being, impair her functioning, and require treatment, even if her symptoms do not meet the criteria for a formal diagnosis. This is particularly likely where there are other psychosocial risk factors at play, such as poverty or abuse, where the woman does not have a romantic partner or family support, and/or where the pregnancy is medically high-risk. Robin is a mom who I often reference as an example of having the disabling "scary thoughts" that can occur during the postpartum period. She refused to bathe her son and instead had her mother do so after having visions that she was drowning her infant. Robin had minimal support from the baby's father.

25. Numerous studies have identified having a "low income" as a risk factor for mental illness.[15] Women of low socioeconomic status are at even greater

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[13] Mittal et al., *supra* note 7, at 412.

[14] *Id.*; *see also* Jones I, et al. "Bipolar Disorder, Affective Psychosis, and Schizophrenia in Pregnancy and the Post-Partum Period." *Lancet* 384 (2014): 1789, 1791.

[15] Biaggi et al., *supra* note 1, at 71.

risk of mental illness due to increased stressors such as financial stress, lack of education, and a lack of support from a partner, family, and friends.[16] There are also more complicated factors related to the fact that women of low socioeconomic status are more likely to have experienced increased exposure to adverse events when they were children. We know that early exposure to adverse events like abuse, drug using or incarcerated parents, or parents with severe mental illness can lead to increased risk of both physical and mental health problems during adulthood.[17] Subsequent studies have shown the unfortunate link between adverse child events and low socioeconomic status that can create a never ending cycle of poor mental and physical health for our patients.[18] Research shows that these stressors can lead to adverse health outcomes both directly (by producing physiologic disruptions or biological memories that undermine the development of the body's stress response systems and affect the developing brain) and indirectly (by contributing to the adoption of risky behaviors, such as smoking);[19] clinical

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[16] Goyal D, et al. "How much does low socioeconomic status increase the risk of prenatal and postpartum depressive symptoms in first-time mothers?" *Women's Health Issues* 20, 2 (2010): 100.

[17] Felitti V, et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults." *Am. J. Prev. Med.* 14, 4 (1998): 245.

[18] Halfon N, et al. "Income Inequality and the Differential Effect of Adverse Childhood Experiences in US Children." *Academic Pediatrics* 17, 7S (2017): S72.

[19] *See, e.g.*, Shonkoff JP, et al. "Technical Report: The Lifelong Effects of Early Childhood Adversity and Toxic Stress," *Am. Acad. of Pediatrics*, 129(1) (Jan. 2012): e232, e235,

experience bears this out. In addition, these stressors can make it difficult for women to engage in critical health care and self-care, which in turn exacerbates their mental health symptoms.

26. Many of my patients come to me saying that they want to be better mothers than their own mothers were. Many have been exposed to sexual trauma at the hands of a family member or close family friend. Many have been left to raise themselves or even their siblings by parents who were using drugs or were struggling with mental illness. But these young women have limited financial and emotional resources to change their trajectory. Natalie is a young woman who I have treated for many years since the birth of her second daughter. She is now pregnant with her fourth child. Natalie's goal has always been to parent differently than her own mother who left her six children to be raised by a grandmother. But Natalie struggles with severe depression and often cannot get out of bed for days. She is on social security disability and her electricity and gas get turned off a couple of times a year due to budget constraints. The father of her children helps at times, but he can be emotionally violent towards her, so she is ambivalent about having him in the home. Like many women of low socioeconomic status, Natalie experienced early childhood trauma that put her at risk for depression. She also

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e237–38, e243; Smith MV, et al. "Early Childhood Adversity and Pregnancy Outcomes." *Maternal & Child Health J*. 20 (2016): 790, 790–91, 793–95.

has financial stress, minimal education, and lacks support from a partner, family, and friends which have increased her risk of depression. Like many women on medical assistance, Natalie was exposed to adverse childhood events and also has current risk factors that that put her at risk for perinatal mental health problems.

B. *Medications and Pregnancy*

27. Pregnant women who regulate a mental health disorder with medication often face a difficult and complicated choice. On the one hand, psychiatric illness itself is associated with negative outcomes for both the woman and the embryo or fetus she is carrying,[20] and there may be only one type of medication that effectively manages a woman's condition, allowing her to function to her fullest potential and avoid the dangerous behaviors associated with some mental illnesses. On the other hand, some medications pose a significant teratogenic risk (i.e., they may interfere with the development of an embryo or fetus) and are therefore contraindicated for pregnant women. In other words, a pregnant woman taking certain medications must choose among three options: (1) continue the medication and risk harm to the embryo or fetus; (2) discontinue the

[20] *See, e.g.*, Mittal et al., *supra* note 7, at 412 ("Women with bipolar disorder who do not receive treatment are at higher risk of delivering infants who are small for gestational age or microcephalic. Women with bipolar disorder, whether treated or not, are more likely to smoke, be overweight, and abuse substances. Additionally, they are more likely to have cesarean delivery, instrumental delivery, and preterm delivery when compared to those without bipolar disorder." (citation omitted)).

medication and risk harm to herself, and thus also to the embryo or fetus she is carrying; or (3) terminate the pregnancy.

28. The classic example of a teratogenic medication is valproate, an anti-convulsant used to treat bipolar disorder. Gestational exposure to valproate carries a risk of neural tube defects, craniofacial and cardiac defects, lower IQ, and autism spectrum disorder, among other outcomes.[21] Ironically, valproate also decreases the efficacy of contraception, and thus increases the likelihood of an unintended pregnancy. For all of these reasons, I avoid recommending valproate to women of reproductive age, pregnant or not. Nevertheless, because it is a very effective mood stabilizer—and because there are varying levels of awareness, even among psychiatrists, about its teratogenic risks—some women of childbearing age do still rely on it.

29. There are significant gaps in our collective knowledge of the teratogenic risks of medications used to regulate mental health disorders, which further complicates the issue. This is unavoidable in light of the ethical limitations on studying pregnant women: while the gold standard of research is a randomized, controlled, double-blind study comparing outcomes between a group given a treatment and a group given a placebo, pregnant women cannot ethically be

[21] *See, e.g.*, Mittal et al., *supra* note 7, at 413.

included in such studies. Observational and retrospective studies, two alternative research models, are simply not as reliable.

30. The paucity of clear data on the risks that many of these medications pose to fetal development, as well as on the relative risks that untreated or under-treated mental illness poses to fetal development, makes the decision of whether to take a particular medication during pregnancy all the more complicated and personal. For instance, a recent study that was widely reported on in the mainstream media found that second- or third-trimester maternal use of selective serotonin reuptake inhibitors (SSRI's) used to treat depression was associated with a diagnosis of autism spectrum disorder (ASD) in children.[22] However, there is no consensus on the mechanism underlying this association: do antidepressants increase the risk of ASD, or is the underlying depression the key factor and antidepressant use merely a proxy for severity of illness? Because of these confounding elements, researchers generally agree that leaving maternal depression untreated or undertreated is not necessarily the safer option.[23] Given

[22] Boukhris T, et al. "Antidepressant Use During Pregnancy and the Risk of Autism Spectrum Disorder in Children." *JAMA Pediatrics* 170 (2016): 117.

[23] *See* Clements CC, et al. "Prenatal Antidepressant Exposure is Associated with Risk for Attention-Deficit Hyperactivity Disorder But Not Autism Spectrum Disorder in a Large Health System." *Molecular Psychiatry* 20 (2015): 727, 731–35; Rai D, et al. "Parental Depression, Maternal Antidepressant Use During Pregnancy, and Risk of Autism Spectrum Disorders: Population Based Case-Control Study." *BMJ* 346 (2013): 1, 5.

that there are few easy answers in this area of medicine, every woman should have the opportunity to make the decision she feels is right for her circumstances.

31. Even among medications that have been relatively closely studied, such as the mood stabilizers I described above, a woman cannot avoid risk by simply switching to a different medication. This is so for several reasons. *First*, if the new medication is less effective, or if there is a period of under-treatment during the transition, the woman may experience a recurrence of the illness which itself poses a serious risk to the fetus. In the case of a woman with bipolar disorder, this could manifest itself in behaviors like reckless driving, prolonged lack of sleep, drug and alcohol usage, and risky sexual practices—all of which carry unique risks to the fetus. *Second*, the alternative medication may carry its own teratogenic risks. For instance, a woman with bipolar disorder who switches from valproate to lithium during pregnancy will reduce the risk of fetal neural tube defects associated with valproate, but increase the risk of fetal cardiac defects associated with lithium. In the case of a woman with severe depression, transitioning from one antidepressant to another simply because the latter might have more safety data means that the fetus has now been exposed to two different medications, and the mother has a period of being under-treated and is now at risk for relapse of her depression.

32. To make matters even more difficult, many health care providers are ill-informed about the existing data regarding the risks of these medications, as well as the relative risks of discontinuing or switching medications abruptly during pregnancy. I have had a number of patients referred to me by their obstetrician because their usual psychiatrist either told them to stop their psychiatric medication during pregnancy or told them they did not feel comfortable prescribing it until the woman delivered. This is particularly concerning in the case of women with schizophrenia or bipolar illness which, as explained above, are likely to recur during or after pregnancy. This can potentially lead to situations like that of Tammy, a woman who had just delivered and only a few hours later began to see things in her room that were not there. She had stopped her haloperidol during her pregnancy, and her psychosis returned immediately following delivery. Sadly, she had to be hospitalized on the psychiatric unit before she could go home with her baby. Had she continued her medication through the pregnancy that might have been avoided.

33. Lastly, although we have complicated and often contradictory data on the risk of medications during pregnancy, we have very clear information on the effects of postpartum depression on the developing child. Multiple studies have shown that maternal postpartum depression causes an increased risk of behavioral problems in their offspring. This can manifest in internalizing or externalizing

behaviors in adolescents, negative mood states and behavioral inhibition or behavioral disinhibition, respectively.[24] Maternal depression has also been linked to decreased growth of preschool and school-aged children. It is unclear whether this poor growth is due to malnutrition or increased cortisol levels (an indicator of stress) in the children.[25]

C. *Substance Use Disorders and Pregnancy*

34. According to the 2013 National Survey on Drug Use and Health, 5.4 percent of pregnant women ages 15 to 44 years report current (past 30 days) use of illicit drugs.[26] 9.4 percent of pregnant women report current alcohol use, and 15.4 percent report current cigarette use.[27] "Substance use disorders [SUDs] remain some of the most commonly missed and undertreated diagnoses among pregnant women, and those with SUDs are less likely to receive prenatal care than their pregnant peers who do not use substances, often due to fear of legal repercussions."[28]

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[24] Gjerde L, et al. "Maternal Perinatal and Concurrent Depressive Symptoms and Child Behavior Problems: A Sibling Comparison Study." *J Child Psychiatry and Psychology*, 58, 7 (2017): 283.

[25] Surkan P, et al. "Impact of Maternal Depressive Symptoms on Growth of Preschool and School-Age Children." *Pediatrics* 130, 4 (2012): 853.

[26] Substance Abuse & Mental Health Servs. Admin., "Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings," at 26-27 (Sept. 2014).

[27] *Id.* at 40, 51.

[28] McLafferty L, et al. "Guidelines for the Management of Pregnant Women with Substance Use Disorders." *Psychosomatics* 1, 3 (2016); *see also* Schempf AH. "Drug Use and

35. Substance use disorders pose serious health risks to both a pregnant woman and the embryo or fetus she is carrying.[29] These risks are often heightened where a woman struggles with multiple forms of substance abuse—for example, an addiction to both cigarettes and cocaine[30]—as is often the case. In addition to the direct harms that SUDs pose for embryonic and fetal development,[31] women with SUDs are often less likely to meet other basic needs, such as nutrition, that are important for their own health and for a healthy pregnancy.[32] A recent report from the Pennsylvania Health Care Cost Containment Council reports that substance use was present in one of 25 maternity stays in 2016-2017 and that 82% of the maternal stays involving opioid use were Medicaid participants.[33] Pregnant women often struggle to find treatment for their SUD because they are usually

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Limited Prenatal Care: An Examination of Responsible Barriers." *Am. J. Obstetrics & Gynecology* (Apr. 2009): 412.e1, 412.e3.

[29] McLafferty et al., *supra* note 28, at 4-5.

[30] *See id.* at 6, 12.

[31] *Id.*

[32] *Id.* at 10.

[33] "Maternal Hospital Stays Involving Substance Use and Opioids," PA Healthcare Cost Containment Council, at 1, 2 (Dec. 2018), http://www.phc4.org/reports/researchbriefs/opioids/121118/docs/researchbrief_opioids121118.pdf.

required to attend specialty programs that might not be easy to access or fit around childcare or work responsibilities.[34]

36. There are high rates of co-morbidity of SUDs and mood disorders. In other words, a woman who suffers from a mood disorder is more likely to also have an SUD, and vice versa.[35] Krystal is a woman who came to me for assistance during her fourth pregnancy. The pregnancy was unwanted but she felt morally obligated to carry it to term. Unfortunately, the father of the fetus had no interest in participating. The combination of ambivalence about the pregnancy as well as depression led Krystal to relapse, and she began to smoke Wet (a combination of marijuana and PCP). Claire is another woman who was referred to me for severe anxiety during pregnancy. She had several significant traumas in her history as well as many current stressors in her life. Soon after the delivery of her son she relapsed on drugs and was in and out of rehabs for about a year.

III. Abortion Care May Be Necessary for a Woman's Mental Health and Well-Being

37. There is no clinical justification for denying Medical Assistance coverage to a woman who decides to have an abortion in order to protect her

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[34] Von Nostrand E, et al. "Changing the Culture: Pregnant Women Impacted by the Opioid Crisis." Univ. of Pittsburgh (2017), http://cphp.pitt.edu/images/HPM_2133_White_Paper-final.pdf.

[35] *E.g.*, McLafferty et al., *supra* note 28, at 6; Substance Abuse & Mental Health Servs. Admin., "Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health," at 32-35 (Sept. 2015).

mental health and well-being. Moreover, a woman who is delayed in or prevented from obtaining a desired abortion (because of cost or otherwise) will likely experience psychological and emotional distress as a result, regardless of whether she has a history of mental illness. This is particularly so for a woman who decides to end her pregnancy after learning that the fetus has a developmental malformation or is at high risk of developing a debilitating condition, but the woman is delayed in or prevented from obtaining the abortion she seeks. In this situation the woman is usually struggling with the grief of losing a child that she wanted but now is not able to carry to term. I remember very clearly meeting with Anna who had just had her 3D ultrasound. She told me that she could not get the look on the doctor's face out of her mind because as soon as she saw it she knew something was wrong with her baby. Her child's craniofacial bones were not developing appropriately and he would not be able to breathe once he was born, so she would have to terminate. Thankfully, she had significant family support to get her through the grieving process.

38. Having an unplanned or unwanted pregnancy is widely recognized as a risk factor for the development of a mood disorder or symptoms of a mood disorder.[36] For some women who are feeling extreme distress around an unplanned pregnancy, having an abortion can alleviate those symptoms.

[36] *See* Biaggi et al., *supra* note 1, at 68.

39. Lauren was one such woman. She was working full time, attending school, and raising her two children when she found out she was pregnant. The father of her children had just gone to jail for a marijuana charge, and it was unclear when he would return. She and I spent a considerable amount of time weighing the risk of her recurrent postpartum anxiety as well as the financial and emotional burden a third child would place on her small family. She eventually decided that having a third child would prevent her from moving forward in her career and providing the kind of life she wanted for her children, such as music lessons and extracurricular sports. Thankfully, she was able to mobilize the funds to obtain her abortion and we averted a potential mental health crisis.

40. I have also seen first-hand that cost can prevent a woman from obtaining an abortion she would choose to have if she could afford to. Robin was a young mom who was emblematic of the women on Medical Assistance who are at risk because they are unable to obtain elective abortions. She already had three children and was living paycheck to paycheck. The father of her first two children had been murdered. The father of her youngest child and her current pregnancy was "in and out." She had hoped to get an abortion as she knew that she would be unable to take care of another child, but she was not able to afford the cost. Instead, she was referred to me in the last trimester of her pregnancy with severe depression. I treated her through her postpartum period as she struggled to care for

her four children as well as her ill mother with limited funds. Her depression did not resolve due to these ongoing external stressors.

41. Whether to continue a pregnancy is a profoundly personal decision, particularly for women grappling with the complicated challenges and choices I've described above. Indeed, women with identical diagnoses but different life circumstances may make entirely different decisions about whether and how to move forward with their pregnancy and with their mental health treatment. For instance, a patient who has severe bipolar disorder, but a trusted psychiatrist and OB-GYN, a supportive family, and/or financial security, may feel comfortable pursuing and continuing a pregnancy as long as she is fully informed about the various risks and plans her treatment carefully. But another patient with equally serious bipolar disorder may conclude that the risk of destabilizing her mental health is too high, particularly if, like a significant percentage of my patients, she is unexpectedly pregnant, financially insecure, without a supportive partner, and/or experiencing violence in the home.

42. Having the ability to end a pregnancy for mental health reasons significantly impacts women's lives, not only psychologically but also economically. Mental health and substance abuse symptoms are often expensive—both expensive to treat and expensive in terms of lost earning potential—and each episode heightens the cost of the illness and makes it more and more difficult for a

woman to function in society. In my experience, a woman cannot maximize her potential for economic independence and personal development unless she has information about, and access to, a range of options for negotiating her mental health and wellness during pregnancy, including abortion.

43. Not only does this difficult decision affect the woman making it, but it can also affect any children she might have. The existing children of a woman who is denied an abortion for an unwanted pregnancy will be affected through what has been termed the "resource dilution model." This exemplifies what I have seen in my patients: that a parent's time, money, and energy are finite, and adding another child at the wrong time will dilute those resources for the other children.[37] When studied, the children of women who are denied an abortion were found to be 4 percentage points lower on milestones achieved, three times more likely to live in a household receiving WIC or TANF, and more likely to live in a household in which the mother reported not having enough money to pay for food, housing, and transportation.[38] Simone came to me after the birth of her third child. She worked full-time but, due to childcare constraints, she worked nights. This meant that she would only sleep about 2-3 hours a day when her infant would sleep and her two older boys were at school. She made sure her children were fed and clothed, but

[37] Greene Foster D, et al. "Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children." *J. Pediatrics* 5 (2018): 5.

[38] *Id.* at 3.

due to lack of sleep, severe depression, and limited social supports, she had little else to provide for her children. She was particularly resentful of her oldest child who was intelligent and inquisitive and required more emotional energy from her than she could spare.

44. In sum, it is critical that a pregnant woman, whether she is a risk for a new-onset mental health condition, has a pre-existing condition, is struggling with a SUD, or is simply trying to manage the well-being of herself and her family be given all of the information about the risks of her illness, the risks of potential treatments, and the balance between the two. She then must be allowed to make and effectuate an informed decision about how best to manage her mental health, including whether to continue or end the pregnancy. It is my expert opinion that the Medical Assistance abortion exclusion denies women coverage for abortion procedures with no clinical justification and at the expense of women's mental health and well-being as well as that of her children.

I make this declaration subject to the penalties of 18 Pa. C. S. § 4904 (unsworn falsification to authorities).

Dated this 10 of January, 2019.

Sarah C. Noble, D.O.