Test and Consequence: Health Professional Complicity and Alternatives to Family Separation

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Medical Director, Friends Research Institute
Substance Use Warmline Clinician, UCSF

No Disclosures

Objectives:

Understand professional society recommendations for substance use assessment at time of birth

Identify racial inequities along the child welfare pipeline

Name an alternative to reflex child welfare report for substance exposure

Assumptions

Addiction is a chronic condition, treatment works, and recovery happens all the time

Child abuse (physical, sexual, emotional) is real, rare, and within health professional responsibility to assess and respond

Substance exposure is not in-and-of-itself child abuse

From the Comprehensive Child Development Act to CAPTA (Child Abuse Prevention Treatment Act):

- 1971 – Nixon vetoes the bipartisan Comprehensive Child Development Act

- 1974 – CAPTA enacted: consecrates the child welfare system in federal law, one of the largest open ended entitlement programs for low-income children

"All the News That's Fit to Print"

The New York Times

LATE CITY EDITION

Weather: Cloudy and mild with rain likely today, tonight, tomorrow. Temp. range: today 49-59; Thursday 40-49. Full U.S. report on Page 86.

VOL. CXXI .. No. 41,593 — © 1971 The New York Times Company — NEW YORK, FRIDAY, DECEMBER 10, 1971 — 15 CENTS

PRESIDENT VETOES CHILD CARE PLAN AS IRRESPONSIBLE

He Terms Bill Unworkable and Voices Fear It Would Weaken Role of Family

CONGRESS FIGHT VOWED

But Overriding of Nixon's Step Is Doubted—Javits May Seek Compromise

By JACK ROSENTHAL
Special to The New York Times

WASHINGTON, Dec. 9—In a stinging message, President Nixon vetoed today a Congressionally initiated bill to establish a national system of comprehensive child development and day care.

The proposal, he said, was

Pay Board Approves Rise Of 46% Over 42 Months

Railroad Signalmen's Contract Backed—Big Part Now in Effect, and Officials Say Exception to Rule Is Justified

By WALTER RUGABER
Special to The New York Times

WASHINGTON, Dec. 9—The Pay Board approved today a contract under which the railroad signalmen would receive wage increases far exceeding its general standard of 5.5 per cent annually.

The agreement calls for rises of about 46 per cent over 42 months beginning in January, 1970. Its precise impact during Phase Two of the economic stabilization program was not entirely clear.

Text of Pay Board statement appears on Page 27.

Pay Board officials said that under the Government's guidelines there was ample justification for an exception in the

gress, the Pay Board said, and raises of 2.6 per cent last January and 2.9 per cent last April were recommended by a Presidential emergency board.

The board approved another step, calling for 5 per cent more pay last Oct. 1. All these amounts are included in a contract signed by the union, with about 10,000 members, and the railroads on Nov. 16—after the 90-day freeze had ended.

It is therefore considered as a "new" contract and subject to the guidelines, the board ruled. But sources said the signalmen were clearly entitled to a "catch up" with the economy and increases comparable to those won by the other rail-

LINDSAY IMPOSES CONTRACT CURBS ON CONSTRUCTION

Awards Halted Until March as City Nears Exhaustion of Borrowing Capacity

By MARTIN TOLCHIN

Mayor Lindsay imposed what he termed a "partial moratorium" on the awarding of new construction contracts yesterday as the City Planning Commission proposed a $2.3-billion capital budget for 1972-73.

"Only the most urgent and fully ready new projects will be allowed to start construction during the moratorium," Mr. Lindsay said in a letter to the seven commissioners. "In addition, 41 projects on which construction contracts have already been awarded will be allowed to proceed."

The moratorium—until March

INDIA REPORTS FOE IN ROUT IN EAST AS ENCIRCLEMENT OF DACCA GAINS; BOMBS RAZE AN ORPHANAGE THERE

PAKISTAN REPLIES

Insists Force Holds On in East and Denies Loss of Big Cities

By SYDNEY H. SCHANBERG
Special to The New York Times

CALCUTTA, India, Dec. 9—The commander of India's eastern forces said tonight that the retreat of the Pakistanis in East Pakistan had become a rout as Indian troops continued to push the foe into an ever-

Mandated Reporting: The Early Evidence

- The act was “creating a system of reporting, sanctioned and encouraged by the law, which could invade and harm the lives of parents and children as easily as help them.”
- But in place of undoing or rethinking – penalties for non-compliance were enacted

Reporting Child Abuse and Neglect:
Guidelines for Legislation

Alan Sussman
Director, Model Child Abuse Reporting Law Project

Stephan J. Cohen
Associate Director, Model Child Abuse Reporting Law Project

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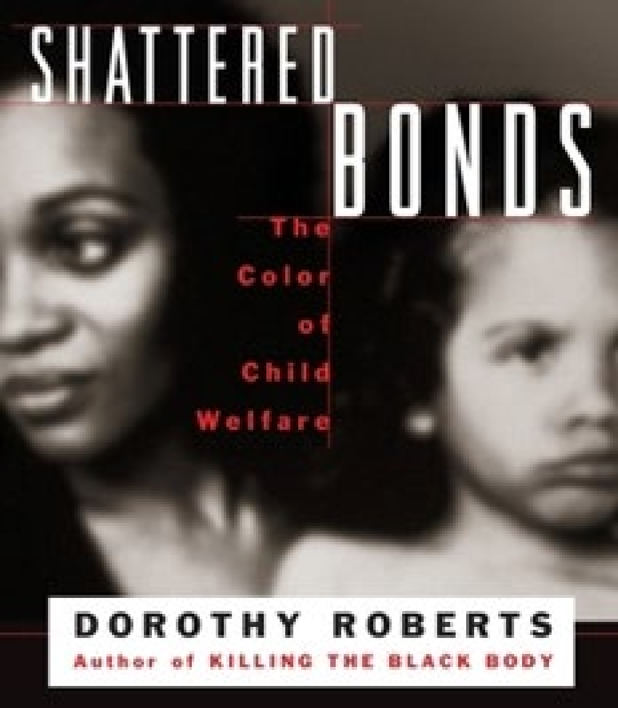
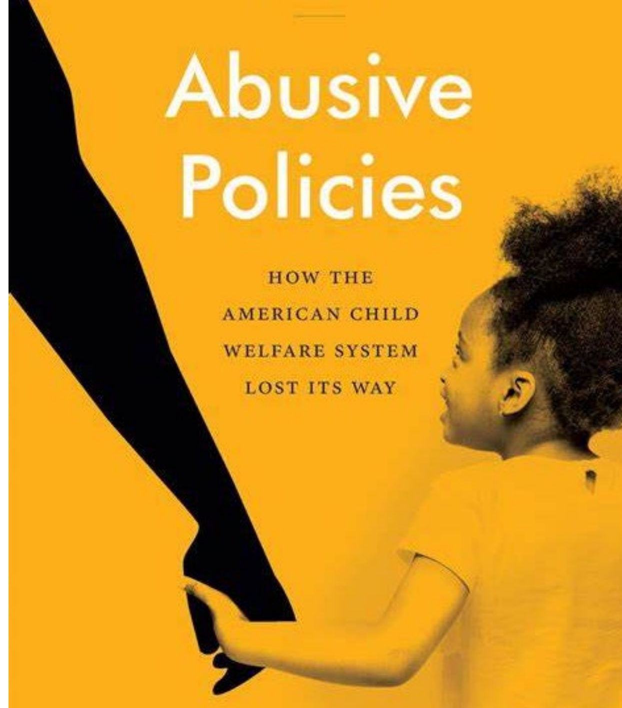
CENTRAL MISSOURI STATE UNIVERSITY
Warrensburg





RESEARCH ■ VULNERABLE POPULATIONS

Prenatal care among mothers involved with child protection services in Manitoba: a retrospective cohort study

Elizabeth Wall-Wieler PhD, Kathleen Kenny MHSc, Janelle Lee BSc, Kellie Thiessen RM RN, Margaret Morris MD MEd, Leslie L. Roos PhD

■ Cite as: *CMAJ* 2019 February 25;191:E209-15. doi: 10.1503/cmaj.181002

Universal Mandatory Reporting Policies and the Odds of Identifying Child Physical Abuse

Grace W. K. Ho, PhD, RN, Deborah A. Gross, DNSc, RN, and Amie Bettencourt, PhD

(*Am J Public Health.* 2017;107:709–716. doi:10.2105/AJPH.2017.303667)

Getting Eyes in the Home: Child Protective Services Investigations and State Surveillance of Family Life

Kelley Fong

American Sociological Review 2020

Article

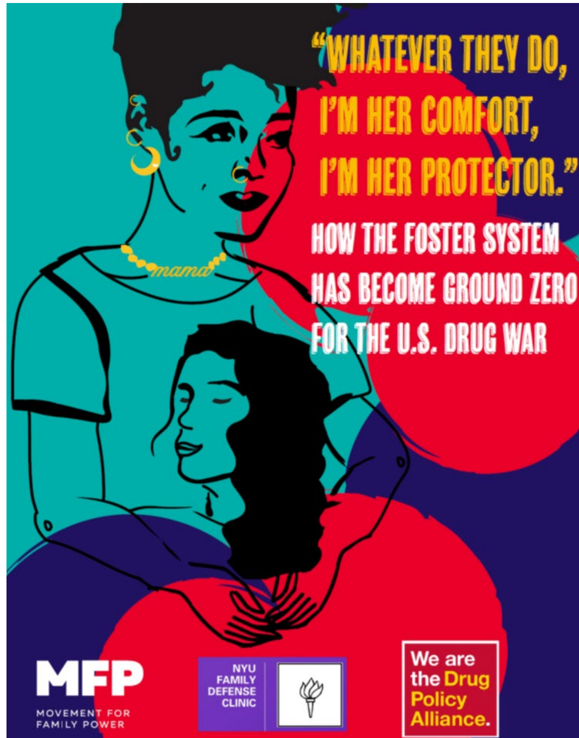
State Child Welfare Policies and the Measurement of Child Maltreatment in the United States

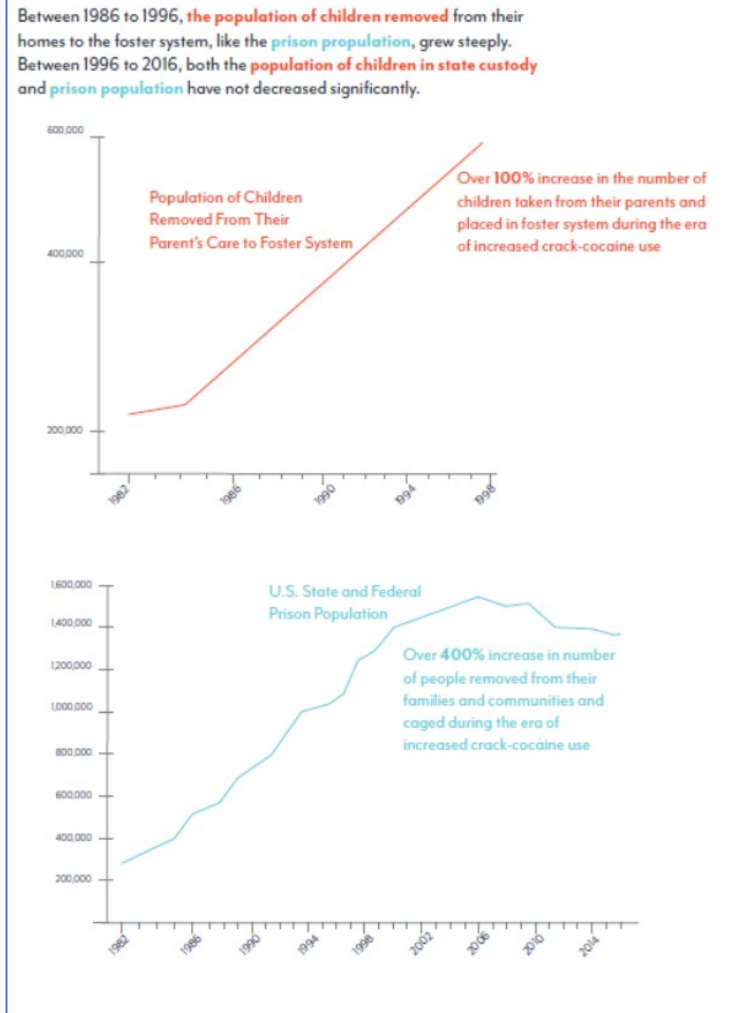
Elizabeth Day[1], Laura Tach[1], and Brittany Mihalec-Adkins[2]

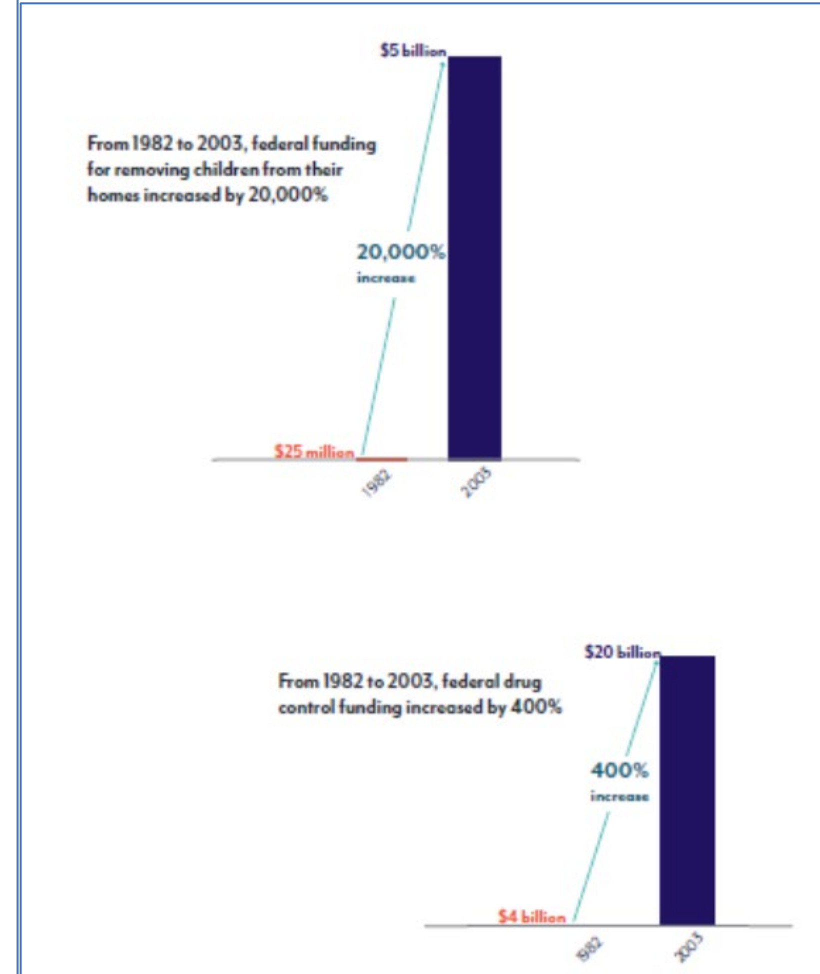
Child Maltreatment 2022, Vol. 27(3) 411–422

Mandatory Reporting Makes Families Less Safe

Family Policing and Mass Incarceration: Parallel Growth







Medicine and Abolition

AMA Journal of Ethics®
March 2022, Volume 24, Number 3: E188-193

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Alignment of Abolition Medicine With Reproductive Justice

Crystal M. Hayes, PhD, MSW and Anu Manchikanti Gomez, PhD

Abstract
Abolition medicine and reproductive justice are synergistic approaches that advance a radical vision of a racially just world. Abolition medicine and reproductive justice push medical and carceral systems towards a focus on the structural factors that impede safe and dignified parenting and childrearing, bodily autonomy, and sexual and reproductive health. Persons experiencing incarceration are stripped of authority over their health decisions, bodily autonomy, and freedom, with major implications for their well-being, sexuality, and reproduction. Black and Brown individuals and communities, who are disproportionately affected by mass incarceration and health disparities, are most in need of abolitionist reproductive justice. This article urges abolitionist clinicians to interrogate the health care sector's relationships with carceral systems and reproductive oppression.

The art of medicine
Abolition medicine

Who do you serve, who do you protect? Doctors and nurses are not soldiers. Antibiotics are not bombs, hospitals are not the front lines, hard-working medical trainees are not "gunners", and neither disease nor patients are "the enemy". Militarised language valorises aggression and violence in medical training and the clinical encounter while obfuscating the loyalties of health workers who serve and protect individuals and communities in need.

Narrative medicine, and the broader health humanities, is committed to honouring the stories shared between providers and patients, as well as understanding the structural narratives that contextualise experiences of health and illness. Narrative medicine teaches us that stories matter, particularly at moments of crisis, trauma, and upheaval. Language affects the way that policies, actions, and attitudes are shaped towards justice or injustice. Who tells a story? Who benefits from that story? Whose voice is heard and whose silenced? Who is framed as heroic and who villainous? All of these questions drive socially just narrative work.

the streets to support their communities, some parts of the state moved from lionising its health personnel to injuring or arresting them along with other protesters, and even destroying their medical tents. Police SWAT teams swooped down on many US cities and the difference between real and metaphorical soldiers became startlingly clear: the militarised police and National Guard resembled an army, while health workers were stuck with persisting shortages of PPE and, in our view, a meaningless metaphor of heroism.

Who do you serve, who do you protect? This question, taken from the title of a 2016 volume on police brutality and visions for community safety, is one that demands answering by health professionals more urgently now than ever. Not only who do health personnel, as individuals, serve and protect, but who do our hospitals, clinics, universities, and other institutions serve and protect? And, more importantly, who should we serve and protect?

The gaping health disparities exposed by COVID-19 are consequences of a long history of structural racism

VIEWPOINT

Should I Call Child Protection?–Guidelines for Clinicians

Mical Raz, MD, PhD
University of Rochester and University of Rochester Medical Center, Rochester, New York.

Josh Gupta-Kagan, JD
Columbia Law School, New York, New York.

Andrea G. Asnes, MD, MSW
Yale School of Medicine, New Haven, Connecticut.

Child protection investigations are a commonplace occurrence for US children and their families. At current levels of risk, a third of all children and more than half of Black children can expect to experience such an investigation before turning 18 years old.[1] While the risk of child protective services (CPS) investigations varies widely across states, significantly greater risk for Black children is a constant.[2] In addition, large and longstanding disparities in reports to CPS by socioeconomic class, race, and disability status raise significant concerns about equity and justice. Black children are more likely to be investigated and removed from their homes, and, once removed, spend longer time in substitute care; they are less likely to be reunited with their families and experience termination of parental rights at rates higher than White families.[3] Parents with disabilities and parents of children with disabilities are also disproportionately represented among families investigated by CPS. As other studies have identified, physicians and medical professionals contribute to these disparities in reporting.

Pediatric clinicians can narrow the front door to the child protection system by preventing unnecessary reports that can detrimentally impact child and family

2. CPS Reports Usually Do Not Lead to Supports for Struggling Families

CPS reports are not effective tools for providing help to families in need. In reality, a majority of investigations conclude without the provision of new services. Clinicians who make CPS reports out of sincere concern that families lack necessary resources may not realize that these reports will lead to a stressful and expensive investigation, and the family may be no better off at its conclusion. Clinicians worried about families lacking resources should first be knowledgeable of and rely on local resources such as food pantries and housing assistance programs or be prepared to refer to social workers or other professionals who might have this expertise.

3. If You Suspect Physical Abuse but Are Not Sure, CPS Likely Does Not Have the Clinical Expertise to Assess

Pediatric clinicians concerned that a child's injury may be due to physical abuse face real diagnostic dilemmas. But CPS will not likely resolve these dilemmas. CPS relies on the evaluation of medical professionals to assess whether child abuse has occurred. As other scholars have noted, a medical professional who is unsure about the likelihood of maltreatment may refer to CPS,

The art of medicine
Abolitionist child protection

Further reading

Beland LP, Huh J, Kim D. The effect of Affordable Care Act Medicaid expansions on foster care admissions. *Health Econ* 2021; 30: 2943-51

Berthold O, Clemens V, Levi BH, Jarczok M, Fegert JM, Jud A. Survey on reporting of child abuse by pediatricians: intrapersonal inconsistencies influence reporting behavior more than legislation. *Int J Environ Res Public Health* 2022; **19**: 15568

As paediatricians, our job is to protect children's health, safety, and wellbeing. This is particularly true for paediatricians involved with child protection, whose professional responsibility it is to identify, treat, and report situations of child maltreatment and abuse. Calls for the abolishment of the child welfare system may feel antithetical to this ethical and professional responsibility towards the wellbeing of children. Yet as legal scholar Dorothy Roberts has suggested in her description of the child protection system in the USA, "It's essential to see Child Protective Services as part of a long-standing agenda by a white, settler-colonial, and enslaving state to oppress Black and Native communities, to control

and narrative humility, have made clear that the role of practitioner bias is a formidable one. For years, in the USA and across the world, data have indicated disproportionalities and disparities in the field of child welfare, based on race, ethnicity, and other identities. Indigenous children in Australia, Black and minority ethnic children in England, Māori children in New Zealand, and First Nations children in Canada are disproportionately represented in the child welfare system. But what are those of us whose livelihoods, professional identities, and ethical cores are wrapped up in this admittedly flawed system to do? Does an abolitionist perspective suggest we sidestep the ethical responsibilities of our professions?

Drugs were not a Category of Mandatory Reporting: Until "Crack Baby" Panic

The New York Times

FRIDAY, MAY 25, 1990

Crack Babies Turn 5, and Schools Brace

By SUSAN CHIRA

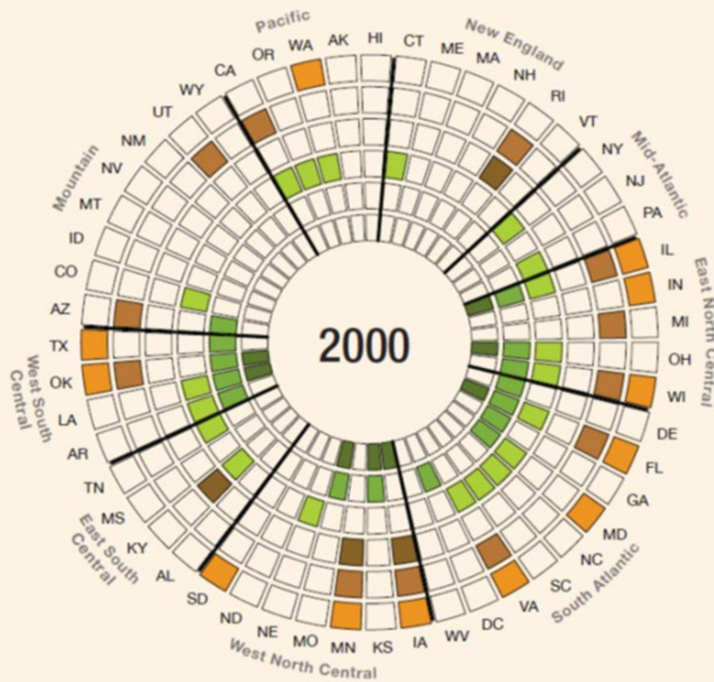
Children of Crack
Are the Schools Ready?
A special report.

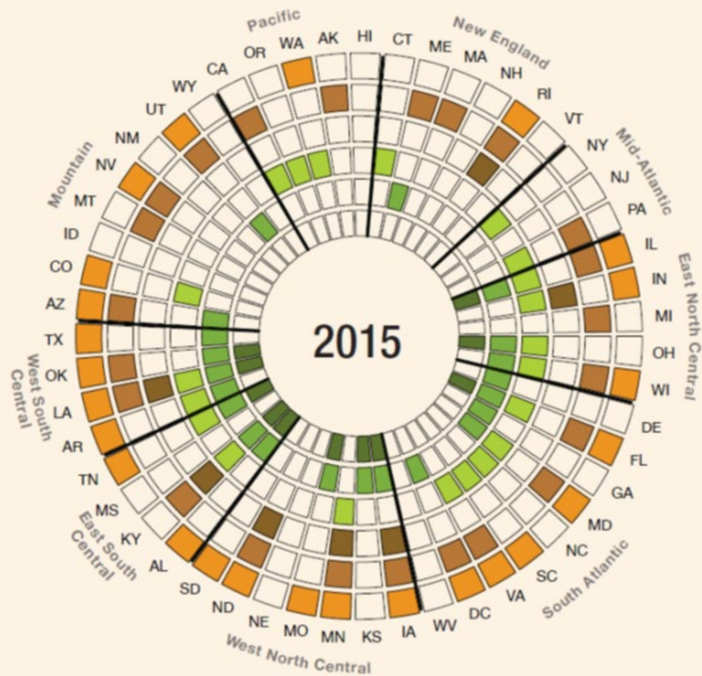
Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

LAST WEEK in this city, Greater Southeast Community Hospital released a 7-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: "Because [the mother] demanded that the baby be released."

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep, and trained her in CPR. But on the very first night, the mother went out drinking and left the child at a friend's house—without the monitor. Within seven hours, the baby was dead. Like Dooney Waters, the 6-year-old living in his mother's drug den, whose shocking story was reported in The Washington Post last week, this child was all but abandoned by the authorities.

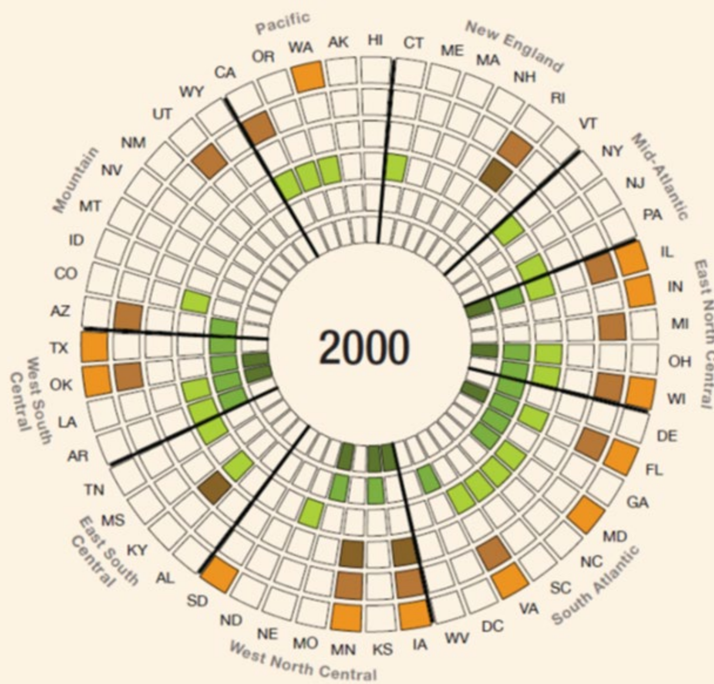


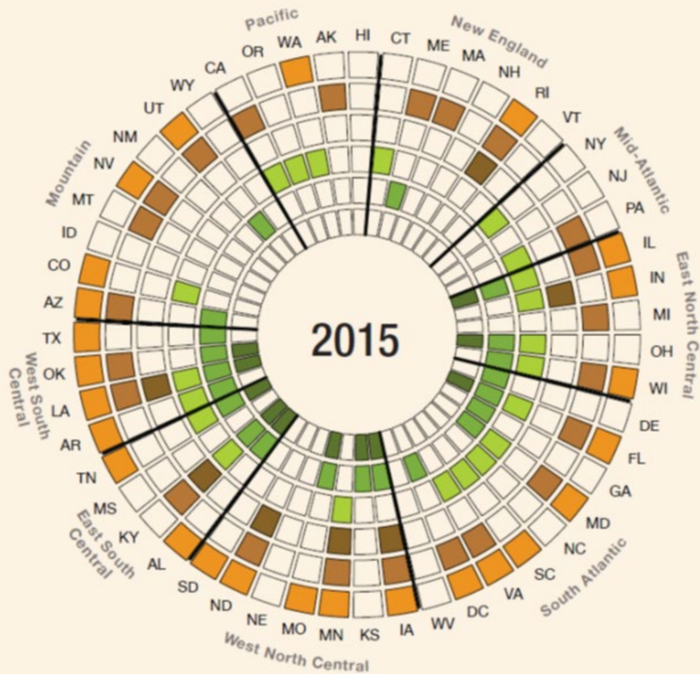


State Policies on Substance Use in Pregnancy

- 25 states and DC consider substance use during pregnancy to be child abuse
- 5 consider it grounds for civil commitment
- 26 states and DC require health care professionals to report suspected prenatal drug use
- 2 states require drug testing of pregnant and birthing patients in certain circumstances (MN, ND)
- 4 states mandate drug testing of newborns in certain circumstances (LA, MN, ND, WI)

1. Guttmacher, July 1, 2023 https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy
2. If When How September, 2024 https://ifwhenhow.org/resources/prenatal-drug-exposure-capta/





Drug Policy is becoming less Punitive But Punitive Policies Related to Substance Use in Pregnancy have Proliferated

Due to increasingly reproductive health policies at the state level

1. Roberts, et al., *Forty years of state alcohol and pregnancy policies in the USA: best practices for public Health or efforts to restrict Women's reproductive rights?* Alcohol and Alcoholism, 2017
2. Paltrow, *The war on drugs and the war on abortion: Some initial thoughts on the connections, intersections and effects.* Reproductive Health Matters, 2002

Mandatory Reporting Does Not Improve Population Health Outcomes

Punitive Policies Associated with:

- No Improvement in Birth Outcomes
- Increased Odds of Neonatal Abstinence Syndrome
- Increased Odds of Low Birth Weight
- Increased Odds of Preterm Delivery
- Decreased Odds of any Prenatal Care
- Decreased Odds of APGAR 7+

FAHERTY, ET AL., *ASSOCIATION BETWEEN PUNITIVE POLICIES AND NEONATAL ABSTINENCE SYNDROME AMONG MEDICAID-INSURED INFANTS IN COMPLEX POLICY ENVIRONMENTS.* ADDICTION, 2022

THOMAS, ET AL., *DRUG USE DURING PREGNANCY POLICIES IN THE UNITED STATES FROM 1970 TO 2016.* CONTEMPORARY DRUG PROBLEMS, 2018

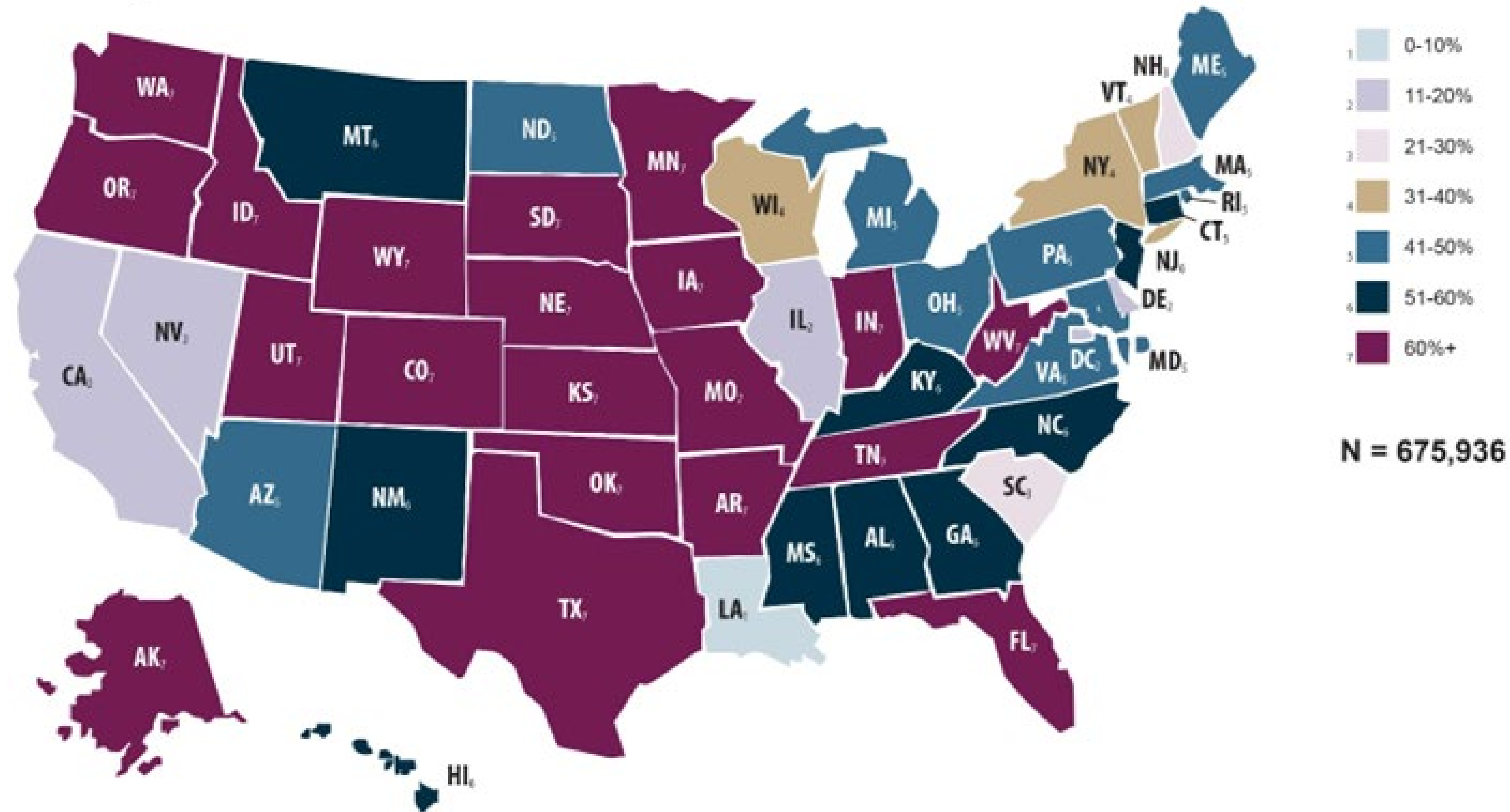
CARROLL, *THE HARMS OF PUNISHING SUBSTANCE USE DURING PREGNANCY.* IJDP, 2021

ROBERTS, ET AL., *FORTY YEARS OF STATE ALCOHOL AND PREGNANCY POLICIES IN THE USA: BEST PRACTICES FOR PUBLIC HEALTH OR EFFORTS TO RESTRICT WOMEN'S REPRODUCTIVE RIGHTS?* ALCOHOL AND ALCOHOLISM, 2017

Percent of Children Removed with Parental Alcohol or Drug Abuse as an Identified Condition of Removal by Age, 2019

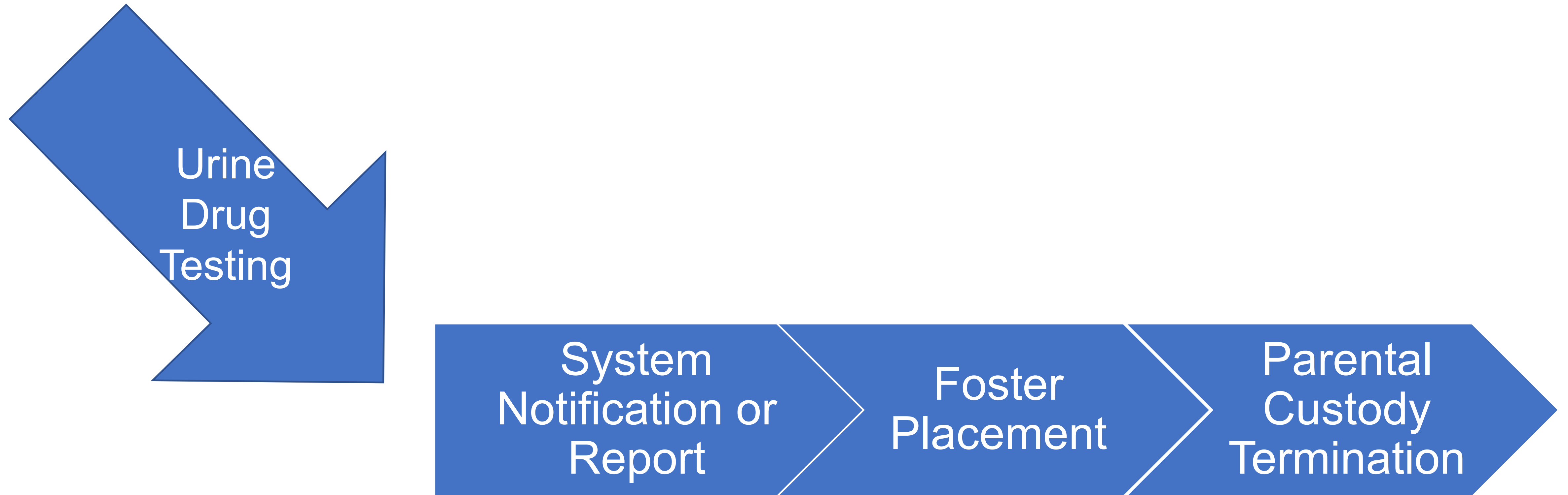
Under Age 1

National Average 50.7%



HRW, 2022, www.hrw.org/report/2022/11/17/if-i-wasnt-poor-i-wouldnt-be-unfit/family-separation-crisis-us-child-welfare

The Child Welfare System Pipeline
(simplified)



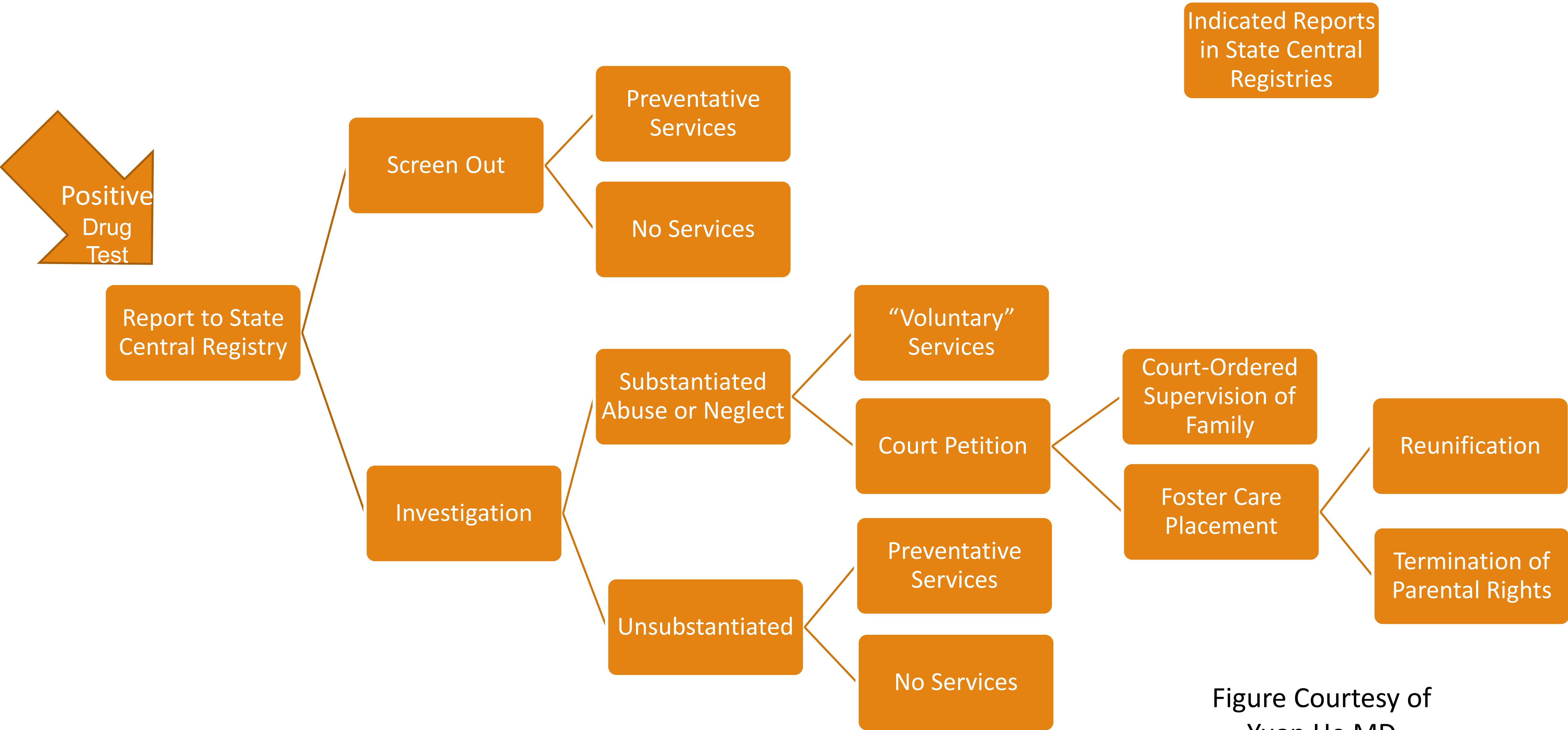


Figure Courtesy of Yuan He MD

Mandatory Reporting for Substance Exposure Corrupts Care

False "Administrative Urgency"

Offsets responsibility of care from health to surveillance systems

Misalignment with recovery (or collapse of recovery into abstinence)

Overuse and misuse of drug testing at birth

What is the Clinical Utility of Routine Drug Testing during the Birthing Hospitalization?

Assessment: Screening versus Testing

Medical versus “Moral”

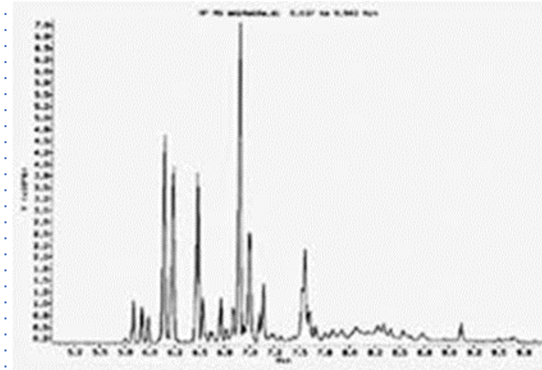
What is a Drug Test?

Presumptive

- Point-of-care
- Elisa
- Rapid and Cheap
- Results Binary

Definitive

- Gas Chromatography / Mass Spectrometry
- Costly and Timely
- Results specific and quantified



Presumptive Drug Tests: Poor Quality Information

TABLE 3. **Summary of Agents Contributing to Positive Results by Immunoassay**[a]

Substance tested via immunoassay	Potential agents causing false-positive result
Alcohol[20]	Short-chain alcohols (eg, isopropyl alcohol)
Amphetamines[21-40]	Amantadine
	Benzphetamine
	Bupropion
	Chlorpromazine
	Clobenzorex[b]
	l-Deprenyl[c]
	Desipramine
	Dextroamphetamine
	Ephedrine
	Fenproporex[b]
	Isometheptene
	Isoxsuprine
	Labetalol
	MDMA
	Methamphetamine
	l-Methamphetamine (Vick's inhaler)[d]
	Methylphenidate
	Phentermine
	Phenylephrine
	Phenylpropanolamine
	Promethazine
	Pseudoephedrine
	Ranitidine
	Ritodrine
	Selegiline
	Thioridazine
	Trazodone
	Trimethobenzamide
	Trimipramine
Benzodiazepines[16,41,42]	Oxaprozin
	Sertraline
Cannabinoids[1,8,43-48]	Dronabinol
	Efavirenz
	Hemp-containing foods
	NSAIDs
	Proton pump inhibitors
	Tolmetin
Cocaine[49-51]	Coca leaf tea
	Topical anesthetics containing cocaine
Opioids, opiates, and heroin[8,14,52-63]	Dextromethorphan
	Diphenhydramine[e]
	Heroin
	Opiates (codeine, hydromorphone, hydrocodone, morphine)
	Poppy seeds
	Quinine
	Quinolones
	Rifampin
	Verapamil and metabolites[e]
Phencyclidine[8,52,64-70]	Dextromethorphan
	Diphenhydramine[e]
	Doxylamine
	Ibuprofen
	Imipramine
	Ketamine
	Meperidine
	Mesoridazine
	Thioridazine
	Tramadol
	Venlafaxine, O-desmethylvenlafaxine
Tricyclic antidepressants[71-81]	Carbamazepine[f]
	Cyclobenzaprine
	Cyproheptadine[f]
	Diphenhydramine[f]
	Hydroxyzine[f]
	Quetiapine

TABLE 2. **Length of Time Drugs of Abuse Can Be Detected in Urine**

Drug	Time
Alcohol	7-12 h
Amphetamine	48 h
Methamphetamine	48 h
Barbiturate	
Short-acting (eg, pentobarbital)	24 h
Long-acting (eg, phenobarbital)	3 wk
Benzodiazepine	
Short-acting (eg, lorazepam)	3 d
Long-acting (eg, diazepam)	30 d
Cocaine metabolites	2-4 d
Marijuana	
Single use	3 d
Moderate use (4 times/wk)	5-7 d
Daily use	10-15 d
Long-term heavy smoker	>30 d
Opioids	
Codeine	48 h
Heroin (morphine)	48 h
Hydromorphone	2-4 d
Methadone	3 d
Morphine	48-72 h
Oxycodone	2-4 d
Propoxyphene	6-48 h
Phencyclidine	8 d

Data from references 7 through 12.

Moeller KE, Mayo Clinic Proc, 2008

False Positive, True Positive, and the Potential for Misinterpretation

BREASTFEEDING MEDICINE
Volume 11, Number 1, 2016
© Mary Ann Liebert, Inc.
DOI: 10.1089/bfm.2015.0173

Correspondence

Maternal Epidural Fentanyl Administered for Labor Analgesia Is Found in Neonatal Urine 24 Hours After Birth

Albert Moore, Aly el-Bahrawy, Roupen Hatzakorzian, and William Li-Pi-Shan

Dear Editor:

FENTANYL IS AN OPIOID MEDICATION that is given epidurally for labor analgesia. Although fentanyl is commonly used, there are reports of it interfering with breastfeeding success.[1] We could find no information on whether fentanyl would be found in a neonate more than 24 hours after delivery and so decided to present this case.

The patient gave consent, and the research ethics board gave approval for this study. A 34-year-old, 39-week gravida 1 para 0 woman presented in spontaneous labor. She was 162 cm tall, weighed 75 kg, was healthy, took no medication other than prenatal vitamins, and had enjoyed an uneventful pregnancy. She requested and received an epidural at 4:45 h the day of her admission. The epidural catheter placement was uncomplicated, and adequate analgesia was provided using a pump that infused 0.06% bupivacaine with 2 μg/mL fentanyl at 10 mL/hour with a patient-controlled 5-mL demand bolus and a lockout time of 10 minutes. Throughout her labor the patient received six extra boluses of this solution.

A 3,780-g baby boy was born at 14:08 h, with Apgar scores of 9 and 9 at 1 and 5 minutes, respectively, and an umbilical artery pH of 7.19. The epidural pump was stopped soon after birth, with the patient receiving 140 mL of the epidural solution (280 μg of fentanyl over 11 hours = 25 μg/hour). The patient recovered and was discharged to the postpartum ward where she was assessed by us the next day. At that time she had used no medications for pain.

The baby-dependent items on the LATCH score were assessed, and the latching ability and audible swallowing were rated at 2 (normal). Urine samples were collected from the mother at 14:00 h. At the same time, a clean sponge was placed in a new diaper, which provided a neonatal urine sample that was collected at 17:00 h. The samples were sent to a toxicology laboratory, where it was determined that the maternal urinary fentanyl level was 2.0 ng/mL, whereas the neonatal level was 2.4 ng/mL.

Although it is known that epidurally administered fentanyl crosses the placenta, it is thought that this leads to clinically unimportant levels in the neonate.[2] The measured half-life of fentanyl administered intravenously to infants 1 day or less of age is highly variable and ranges from 75 to 441 minutes,[3] making the duration it would remain in the neonate unclear. Our case demonstrates that fentanyl can persist in the neonate for at least 24 hours after delivery, at amounts that may have clinical effects. The minimum effective analgesic level of fentanyl in plasma for adults is 0.63 ng/mL.[4] Although the corresponding level is unknown in neonates, a level of 1.1 ng/mL has necessitated prolonged intubation in neonates.[3] The urinary concentration seems to have some correlation with fentanyl dosage and levels.[5]

Although fentanyl is transferred in breastmilk, it is virtually undetectable in colostrum 10 hours after it has been given maternally.[6] In addition, fentanyl's limited oral bioavailability makes us believe the majority of neonatal fentanyl was from placental transfer and not through breastmilk. Although our LATCH score was reported as normal, more subtle markers of breastfeeding difficulty may have been found if we had assessed the Widstrom stages of neonatal breastfeeding,[7] or more severe problems may have occurred if the patient had required higher fentanyl doses. Adequate initiation is essential for the continued success of breastfeeding, and it is possible that the presence of neonatal fentanyl could interfere in the important first days of life.

In conclusion, we provide evidence that fentanyl administered through an epidural for less than 12 hours will remain in the mother and neonate, even 24 hours after cessation of the epidural infusion. The clinical implications of this should be further investigated.

References

1. Beilin Y, Bodian CA, Weiser J, et al. Effect of labor epidural analgesia with and without fentanyl on infant breast-feeding: A prospective, randomized, double-blind study. *Anesthesiology* 2005;103:1211–1217.
2. Gambling DR, Huber CJ, Berkowitz J, et al. Patient-controlled epidural analgesia in labour: Varying bolus dose and lockout interval. *Can J Anaesth* 1993;40:211–217.
3. Koehntop DE, Rodman JH, Brundage DM, et al. Pharmacokinetics of fentanyl in neonates. *Anesth Analg* 1986;65:227–232.
4. Gourlay GK, Kowalski SR, Plummer JL, et al. Fentanyl blood concentration-analgesic response relationship in the treatment of postoperative pain. *Anesth Analg* 1988;67:329–337.
5. Van Nimmen NF, Poels KL, Menten JJ, et al. Fentanyl transdermal absorption linked to pharmacokinetic characteristics in

Department of Anesthesia, Royal Victoria Hospital, Montreal, Quebec, Canada.

ELSEVIER
American Journal of Obstetrics and Gynecology
Available online 23 November 2022
In Press, Corrected Proof What's this?

Original Research
Obstetrics

Fentanyl in the labor epidural impacts the results of intrapartum and postpartum maternal and neonatal toxicology tests

Molly R. Siegel MD [a], Grace K. Mahowald MD, PhD [b], Sacha N. Uljon MD, PhD [b], Kaitlyn James PhD [a], Lisa Leffert MD [c], Mackenzie W. Sullivan MD [a], Susan J. Hernandez CNM [a], Jessica R. Gray MD [d], Davida M. Schiff MD [e], Sarah N. Bernstein MD [a]

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Background

A positive urine fentanyl toxicology test may have considerable consequences for peripartum individuals, yet the extent to which fentanyl administration in a labor epidural may lead to such a positive test is poorly characterized.

ARTICLE

Rates of Fentanyl Positivity in Neonatal Urine Following Maternal Analgesia During Labor and Delivery

Natasha Novikov,[a,b] Stacy E.F. Melanson,[a,b] Jaime R. Ransohoff,[a,c] and Athena K. Petrides[a,b,*]

Background: Fentanyl is commonly given as an analgesic during labor and delivery. The extent of transplacental drug transfer and fetal exposure is not well studied. We analyzed the relationship between neonatal urine fentanyl results and various peripartum factors.

Methods: A total of 96 neonates with urine toxicology screening between January 2017 and September 2018 were included in the study. Medical record review was used to obtain maternal, neonatal, and anesthesia parameters. A subset of 9 specimens were further tested for levels of fentanyl and norfentanyl by liquid chromatography-tandem mass spectrometry.

Results: In 29% ($n = 24$) of cases associated with fentanyl-containing labor analgesia, neonatal toxicology screens were positive for the presence of fentanyl. Positive test results strongly correlated with the cumulative dose and duration of labor analgesia ($P < 0.001$). The odds of positive neonatal fentanyl screen results increased 4-fold for every 5 hours of maternal exposure to labor analgesia. Importantly, however, neonatal outcomes for infants with positive and negative urine fentanyl screens were the same.

Conclusions: Our study establishes that maternal fentanyl analgesia is strongly associated with positive neonatal urine fentanyl screens and suggests that more judicious use of these laboratory tests may be warranted.

IMPACT STATEMENT

The information presented in this manuscript informs practitioners on the strong correlation between cumulative fentanyl dosage and a positive neonatal fentanyl screen. This manuscript also highlights the low impact of apparent transplacental fentanyl transfer on short-term neonatal outcomes. This information will benefit practitioners, their patients, and their patients' offspring through informed use and interpretation of laboratory tests.

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Drug Tests: Poor Quality Information that is Misinterpreted

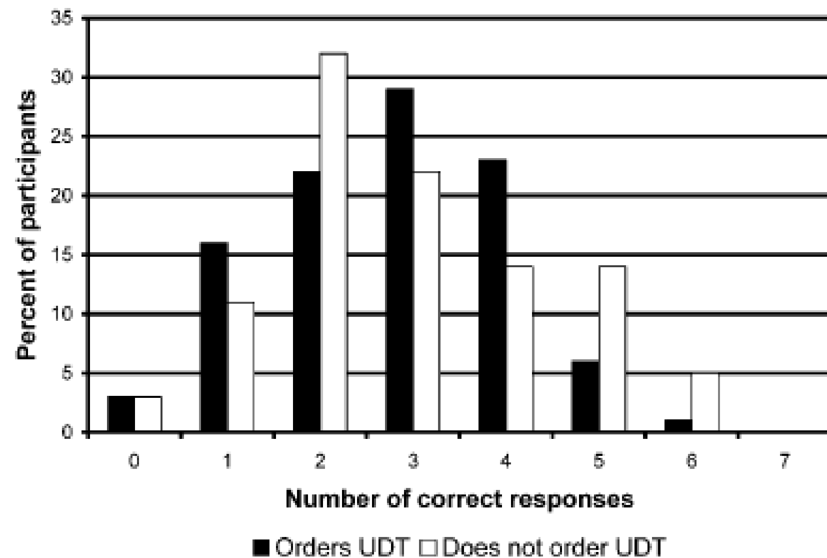

Figure 2.

APPENDIX. URINE DRUG TESTING (UDT) QUESTIONNAIRE: KNOWLEDGE QUESTIONS*

1. In a patient prescribed Tylenol #3 (codeine and acetaminophen), one would reasonably expect which of the following to be detected in the urine:
   - a. codeine
   - b. dihydrocodeine
   - c. morphine
   - d. all of the above
   - **e. a and c only**

2. In a patient prescribed MS Contin (morphine), one would reasonably expect which of the following to be detected in the urine:
   - a. codeine
   - b. dihydrocodeine
   - **c. morphine**
   - d. all of the above
   - e. a and c only

3. In a patient using heroin, one would be likely to detect which of the following in the urine:
   - a. heroin
   - b. hydromorphone
   - **c. morphine**
   - d. all of the above
   - e. a and c only

4. A patient on OxyContin (oxycodone) therapy is administered a random urine drug test. He notifies you that he ate a large lemon poppy seed muffin for breakfast. What substances might reasonably be detected in the urine?
   - a. oxycodone
   - b. codeine
   - c. morphine
   - **d. all of the above**
   - e. a and c only

5. A patient on chronic opioid therapy tests positive for cannabis on a random urine drug screen. She explains that her husband sometimes smokes pot in their bedroom. Is this a plausible explanation for the test findings?
   - a. yes
   - **b. no**

6. Which of the following are plausible explanations for a negative urine opiate drug screen in a patient on chronic opioid therapy:
   - a. Patient ran out of opioid early and has not used any in a few days.
   - b. Patient is a "fast metabolizer."
   - c. Drug screen does not detect that particular opioid.
   - **d. a, b, and c**
   - e. a and c only

7. A patient on chronic Dilaudid (hydromorphone) therapy tests negative for opioids on a urine drug screen. The patient claims to be using the medicine as prescribed. The most appropriate next step would be to:
   - **a. subject this urine to a different type of test**
   - b. readminister a urine drug screen at the next visit
   - c. taper and discontinue opioid therapy
   - d. refer the patient to a detoxification/rehabilitation program
   - e. notify law enforcement

* Correct responses are bolded.

Drug Testing NOT required in CAPTA and NOT criteria for reporting

Screening vs. Testing Professional Society Recommendations

Universal Screening:

Recommended (ACOG, ASAM, SMFM, AAP, SAMHSA, CDC)

- Voluntary (ACOG, SAMHSA, CDC)

Testing:

Drug Test NOT an Assessment of Addiction
Positive Drug Test NOT sign of health or ill health
Positive Drug Test NOT evidence of harm
Positive Drug Test NOT criteria for discharge
(ACOG, ASAM, SAMHSA, CDC, AAP)

ASAM: Definitive testing required "when the results of inform decisions with major clinical or non-clinical implications for the patient"

- Consent required (ACOG, ASAM, SMFM, SAMHSA)

Drug Tests: Overused and Misinterpreted

"Equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons' engagement with healthcare services."

American Society of Addiction Medicine Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People, 10, 2022

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Prenatal Drug Exposure: CAPTA Reporting Requirements for Medical Professionals

February 29, 2024
By If/When/How

Health care providers are often unsure of state and federal requirements for drug testing pregnant and birthing people and their newborns, and hospital policies around drug tests are typically more stringent than the law requires. As a result, pregnant people and new parents face state violence and criminalization

Michigan[67]

- A drug test on a pregnant or birthing person is **NOT** required by law.
  - If screening indicates the need for a drug test, providers should ask for and get informed consent prior to drug testing a pregnant or birthing person.
- A drug test on a newborn is **NOT** required by law.
- If a newborn is drug tested and the result includes “any amount of alcohol, a controlled substance, or a metabolite of a controlled substance,” a health care provider must report the positive test unless it is the result of medical treatment for the newborn or birthing parent.[68]
  - A report is **NOT** required for prescribed opioid use disorder treatment, such as methadone or buprenorphine.
  - A report is **NOT** required for prescription cannabis.
- If a mandated reporter does not test a newborn, a report is required **only if** the health care provider “**knows**, or from the child's symptoms has **reasonable cause to suspect** “the newborn has “any amount of alcohol, a controlled substance, or a metabolite of a controlled substance.”[69]
  - A report is **NOT** required for prescribed opioid use disorder treatment such as methadone or buprenorphine.
  - A report is **NOT** required for prescription cannabis.

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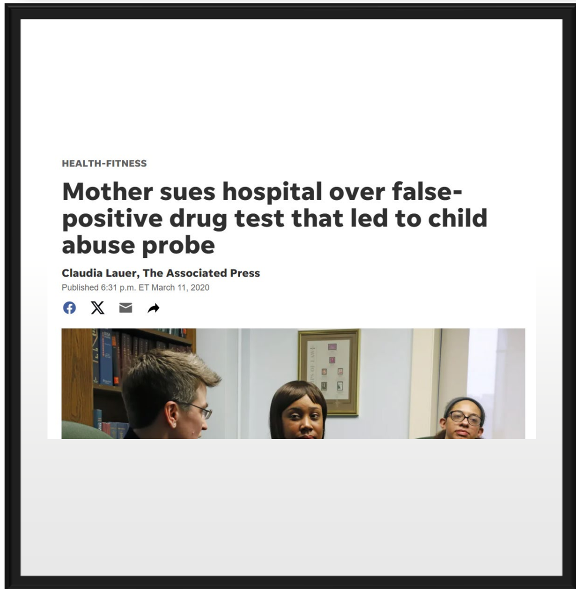
U.S. | Pregnancy Hospitals Drug Testing In-Depth

How Hospitals Are Secretly Drug Testing Pregnant Women

Published May 10, 2023 at 5:00 AM EDT | Updated May 10, 2023 at 9:07 AM EDT

The Maternal Mortality Crisis Could Worsen In These Seven States



HEALTH-FITNESS

Mother sues hospital over false-positive drug test that led to child abuse probe

Claudia Lauer, The Associated Press

Published 6:31 p.m. ET March 11, 2020

The Marshall Project Nonprofit journalism about criminal justice SEARCH ABOUT NEWSLETTERS DONATE

FILED 6:00 a.m. EST
02.14.2024

FEATURE

Medical Marijuana Is Legal, But Oklahoma Is Charging Women for Using It While Pregnant

Courts are set to decide if using the drug during pregnancy is a crime, even as a growing number of women in the state face prosecution.

The Washington Post
Democracy Dies in Darkness

This article was published more than **2 years ago**

LIFESTYLE Food Home & Garden Well+Being Inspired Life Parenting

A false positive on a drug test upended these mothers' lives

13 min

(iStock/Washington Post illustration)

By Anne Branigin

July 2, 2022 at 11:00 a.m. EDT

“Test and Report”

“The laws, regulations, and policies that require health care practitioners and human service workers to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement.”

ACOG, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period: Statement of Policy*, 11, 2020

“Test and Report” -- Provider Culpability

- Most child welfare reports (<1yr) are from medical professionals during birthing hospitalization
- Health Professional Reporting increased 400% in past decade
- Driven by (misuse of) urine drug testing
- Compounds racial inequities

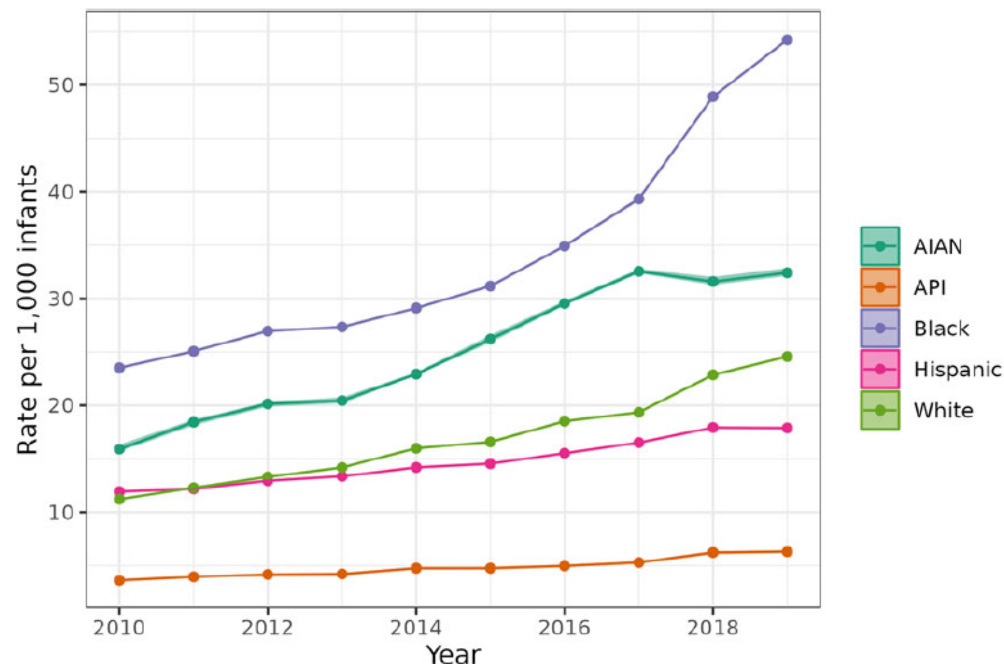


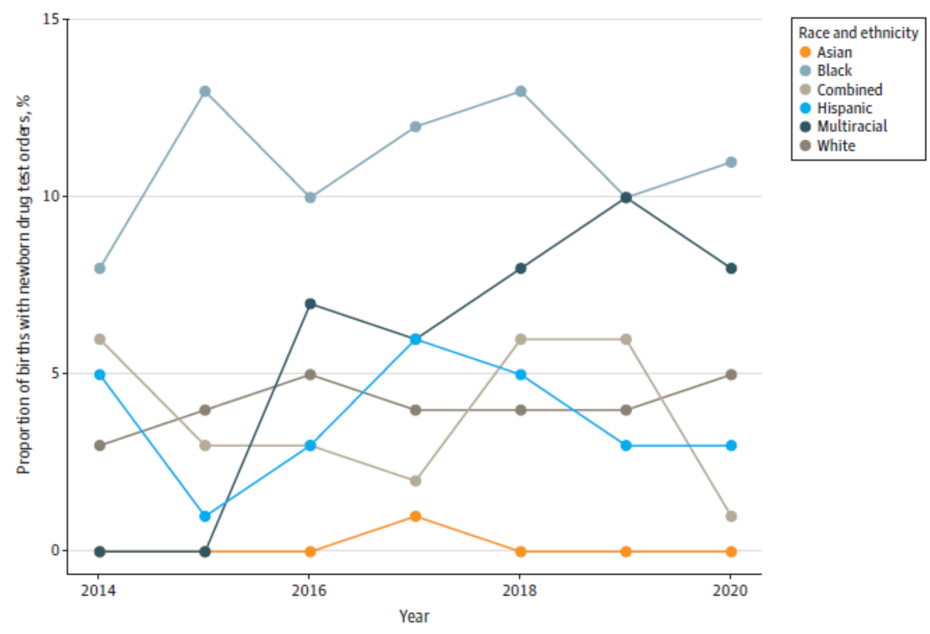
FIG. 2. U.S. child welfare investigations of infants (age <1 year) initiated following a medical professional report, 2010–2019 by child race/ethnicity. *Intervals* indicate uncertainty from missing race/ethnicity data.

Health Equity V7.1, 2023 https://www.liebertpub.com/doi/10.1089/heq.2023.0136

HHS 2020 https://www.childwelfare.gov/pubs/factsheets/cpswork/

AAP 2015 https://pediatrics.aappublications.org/content/135/5/948

Figure 1. Newborn Drug Testing Incidence Over Time, by Birthing Parent Race and Ethnicity



Newborn drug testing incidence was significantly higher for Black newborns compared with White and Asian newborns in all years, newborns in the combined group (those self-reporting as American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and other race) for all years except 2014 and 2019, and Hispanic newborns in all years except 2014. Testing prevalence was significantly higher for White newborns compared with Asian newborns in all years, the combined group in 2020, multiracial newborns in 2014 and 2015, and Hispanic newborns in 2015. Multiracial includes patients self-reporting as 2 or more race options. Hispanic includes patients self-reporting as Hispanic ethnicity, regardless of race selection.

JAMA Network Open. 2023;6(3):e232058. doi:10.1001/jamanetworkopen.2023.2058 March 8, 2023 6/12

American Journal of Obstetrics & Gynecology
AJOG MFM
Maternal-Fetal Medicine

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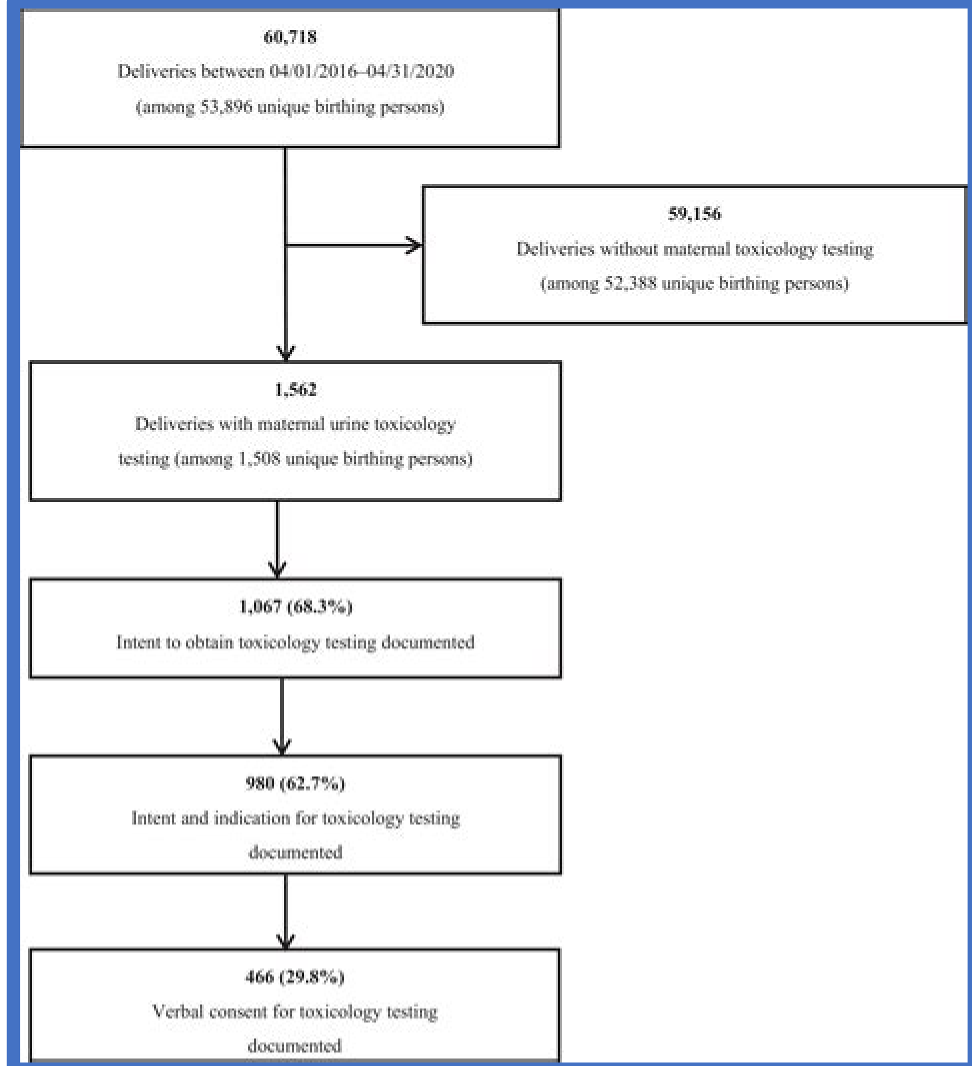
ORIGINAL RESEARCH | VOLUME 4, ISSUE 4, 100621, JULY 2022 Download Full Issue

Informed consent is poorly documented when obtaining toxicology testing at delivery in a Massachusetts cohort

Kathleen J. Koenigs, MD • Joseph H. Chou, MD, PhD • Samuel Cohen, MD • ... Joseph Distefano, BS • Sarah N. Bernstein, MD • Davida M. Schiff, MD, MSc • Show all authors



Racial Inequities in Drug Testing and Selection Bias in Child Welfare Reporting

1202 THE NEW ENGLAND JOURNAL OF MEDICINE April 26, 1990

SPECIAL ARTICLE

THE PREVALENCE OF ILLICIT-DRUG OR ALCOHOL USE DURING PREGNANCY AND DISCREPANCIES IN MANDATORY REPORTING IN PINELLAS COUNTY, FLORIDA

IRA J. CHASNOFF, M.D., HARVEY J. LANDRESS, A.C.S.W., AND MARK E. BARRETT, PH.D.

Abstract Florida is one of several states that have sought to protect newborns by requiring that mothers known to have used alcohol or illicit drugs during pregnancy be reported to health authorities. To estimate the prevalence of substance abuse by pregnant women, we collected urine samples from all pregnant women who enrolled for prenatal care at any of the five public health clinics in Pinellas County, Florida (n = 380), or at any of 12 private obstetrical offices in the county (n = 335); each center was studied for a one-month period during the first half of 1989. Toxicologic screening for alcohol, opiates, cocaine and its metabolites, and cannabinoids was performed blindly with the use of an enzyme-multiplied immunoassay technique; all positive results were confirmed.

Among the 715 pregnant women we screened, the overall prevalence of a positive result on the toxicologic tests of urine was 14.8 percent; there was little difference in prevalence between the women seen at the public clinics (16.3 percent) and those seen at the private offices (13.1 percent). The frequency of a positive result was also similar among white women (15.4 percent) and black women (14.1 percent). Black women more frequently had evidence of cocaine use (7.5 percent vs. 1.8 percent for white women), whereas white women more frequently had evidence of the use of cannabinoids (14.4 percent vs. 6.0 percent for black women).

During the six-month period in which we collected the urine samples, 133 women in Pinellas County were reported to health authorities after delivery for substance abuse during pregnancy. Despite the similar rates of substance abuse among black and white women in our study, black women were reported at approximately 10 times the rate for white women (P<0.0001), and poor women were more likely than others to be reported.

We conclude that the use of illicit drugs is common among pregnant women regardless of race and socioeconomic status. If legally mandated reporting is to be free of racial or economic bias, it must be based on objective medical criteria. (N Engl J Med 1990; 322:1202-6.)

Journal of Behavioral Health Services & Research, 2011. © 2011 National Council for Community Behavioral Healthcare. DOI 10.1007/s11414-011-9247-x

Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting

Sarah C. M. Roberts, DrPH
Amani Nuru-Jeter, PhD, MPH

	Chasnoff (1990)	Roberts (2011)
Positive Urine Drug Test		
Black Women	14.1%	14%
White Women	15.4%	14%
Child Welfare Report		
Black Women	10.7%	13.5%
White Women	1.1%	7.6%

Racial Inequities in Family Separation

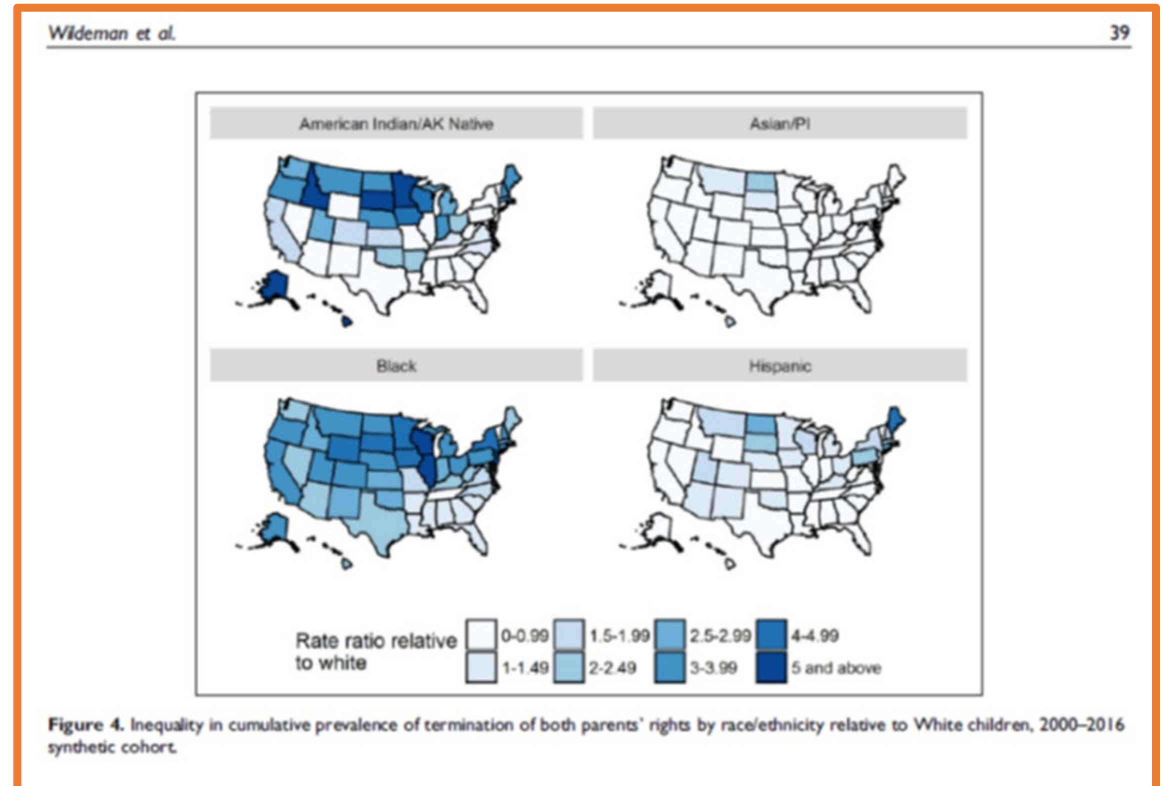


Figure 4. Inequality in cumulative prevalence of termination of both parents' rights by race/ethnicity relative to White children, 2000–2016 synthetic cohort.

MFP 2020
Wildeman C, 2020 *Child Maltreatment*

APRIL 30, 2021

A Proclamation on National Foster Care Month, 2021

Every child deserves to grow up in a supportive, loving home where they can thrive and prosper. During those

As we work to address immediate needs, we must be clear about long-standing challenges in child welfare and commit to advancing child and family well-being in every way we can. Our children, birth parents, and resource and kin families deserve nothing less. So this National Foster Care Month, we also recognize the histories of injustice in our Nation's foster care system. Throughout our history and persisting today, too many communities of color, especially Black and Native American communities, have been treated unequally and often unfairly by the child welfare system. Black and Native American children are far more likely than white children to be removed from their homes, even when the circumstances surrounding the removal are similar. Once removed, Black and Native American children stay in care longer and are less likely to either reunite with their birth parents or be adopted. Too many children are removed from loving homes because poverty is often conflated with neglect, and the enduring effects of systemic racism and economic barriers mean that families of color are disproportionately affected by this as well. Children with disabilities are over-represented among youth in care and may be inappropriately placed in group settings instead of provided the individualized support they need. Children in foster care — particularly youth of color and LGBTQ+ children who are already subject to disproportionate rates of school discipline and criminalization — are also at an increased risk of becoming involved in the juvenile justice system. And for LGBTQ+ foster youth, foster care systems are not always equipped to safely meet their needs.

The United Nations Committee on the Elimination of Racial Discrimination (CERD)

A POWERFUL & EMOTIONAL DAY. It was such a BLESSING to be given the opportunity to speak about what's happening to BLACK & Brown bodies in AMERIKKKA-Asking for the support of outside forces 2 hold the US accountable 4 the atrocities they're committing in the name of help & safety.

MUST WATCH: Powerful testimony by @JMacForFamilies @UNGeneva #CERD #NGO briefing this morning 🔥✊🏽 #ZeroDiscrimination #BlackFamiliesMatter

2:11

7:26 AM · Aug 9, 2022

RACIAL (IN)JUSTICE IN THE U.S. CHILD WELFARE SYSTEM

Response to the Combined Tenth to Twelfth Periodic Reports of the United States to the Committee on the Elimination of All Forms of Racial Discrimination

July 2022

ENDORSED BY THE FOLLOWING ORGANIZATIONS: Center for Family Representation; Community Legal Services of Philadelphia; Culture Creations, Inc.; Disability and Civil Rights Clinic, Brooklyn Law School; East Bay Family Defenders; Families Together in New York State; Family Defense Consulting; JMacForFamilies; Lawyers for Children; Louisiana Elite Advocacy Force; MJCF Coalition; National Association of Counsel for Children; National Center for Youth Law; NYU School of Law Family Defense Clinic; Parent Legislative Action Network; Partners for Our Children, Seattle, WA; Sayra and Neil Meyerhoff Center for Families, Children and the Courts, The University of Baltimore School of Law; The Bronx Defenders; The National Juvenile Justice Network; upEND Movement; Village Arms LLC

ENDORSED BY THE FOLLOWING INDIVIDUALS: Alejandra Londono Gomez (Policy Analyst & Former Child Welfare Worker); Angela Olivia Burton (Attorney); Bobbi Taylor (Lived Experience Engagement Consultant); Dorothy E. Roberts (George A. Weiss University Professor of Africana Studies, Law & Sociology, University of Pennsylvania); Heather Imperiale (Mother, Activist); Honorable Bryanne Hamill; Whitney Bunts (Policy Analyst)

PREPARED BY:
Children's Rights
Columbia Law School Human Rights Institute

Why Do Health Professionals Report?

Motivation for Report:

1. Connection to Services & Resources

“The goal is to get mom help, right? We’re not calling the police. We’re not trying to have her arrested. We are trying to bring the resources to bear that would allow her to get the help she needs so that she gets reunited with her child in a safe way.”

“They can help that mom with transportation, with housing, and with food, and with stuff that I just can't do. So, it's not - and sometimes moms will get into that and realize, "Oh, my god. They're helping me with this. This is not what I expected." So, it's good.”

“Health care provider decision-making around prenatal substance use reporting” *DAD* 2022 Roberts SCM et al

Does Child Welfare Actually Provide or Connect to Services?

Are mandated services logistically feasible or culturally relevant?

Is surveillance necessary for provision of services?

Why can't the healthcare system provide (linkage to) services?

“Better Safe Than Sorry”? Child Welfare Report and Consequence for Drug Exposure

20% children experience abuse or neglect in out-of-home placement

Mental health and somatic conditions greater among children in foster care compared to general population

Toxic stress: The physiologic result of physical of dangerous, recurrent, or prolonged experience of trauma caused by the initiation of the stress response without the protective existence of a compassionate adult

Non-death Loss and Grief in Foster Care

Dorsey S, *Journal of Child & Family Studies*, 2012; Jonkowski MK, *Child Maltreatment*, 2019
Forkey HC, *J of Child & Family Studies*, 2016; Mitchell MB, *Child Adolesc Soc Work J*, 2018

Why Do Health Professionals Report?

Motivation for Report:

2. Fear of Consequences to Infant of no Report

"The big thing that kept crossing my mind as I thought about not reporting was just what if something were to happen to this baby related to unsafe living situation or this patient feeling too overwhelmed to kind of keep up with the tasks of parenting. And that fear was kind of the risk that was a big motivating factor."

"The risks of not reporting are danger to the child. The child could be in a lot of danger. The child could die."

Child Maltreatment 2020

U.S. Department of Health & Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

Child Fatalities due to Maltreatment are Tragic and Rare

1713 fatalities in 2020 (rate 2/100,000)

Each Death is Preventable

But there is no evidence that removing children for substance exposure protects them from fatality due to maltreatment

Does Child Welfare Prevent Harm to Infants Prenatally Exposed to Substances?

What are the risks of separation versus risks of child remaining with their family?

Substance Use in Pregnancy and Subsequent Child Maltreatment: Where is the Evidence?

- Substance-exposed infants have increased likelihood of child welfare involvement
- No strong evidence of substantiated maltreatment
- Overall literature is of poor methodological quality

Review Article

Child Maltreatment
1-26
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Prenatal Substance Exposure and Child Maltreatment: A Systematic Review

Anna E. Austin[1,2], Caitlin Gest[1], Alexandra Atkeson[1], Molly C. Berkoff[3], Henry T. Puls[4], and Meghan E. Shanahan[1,2]

Abstract

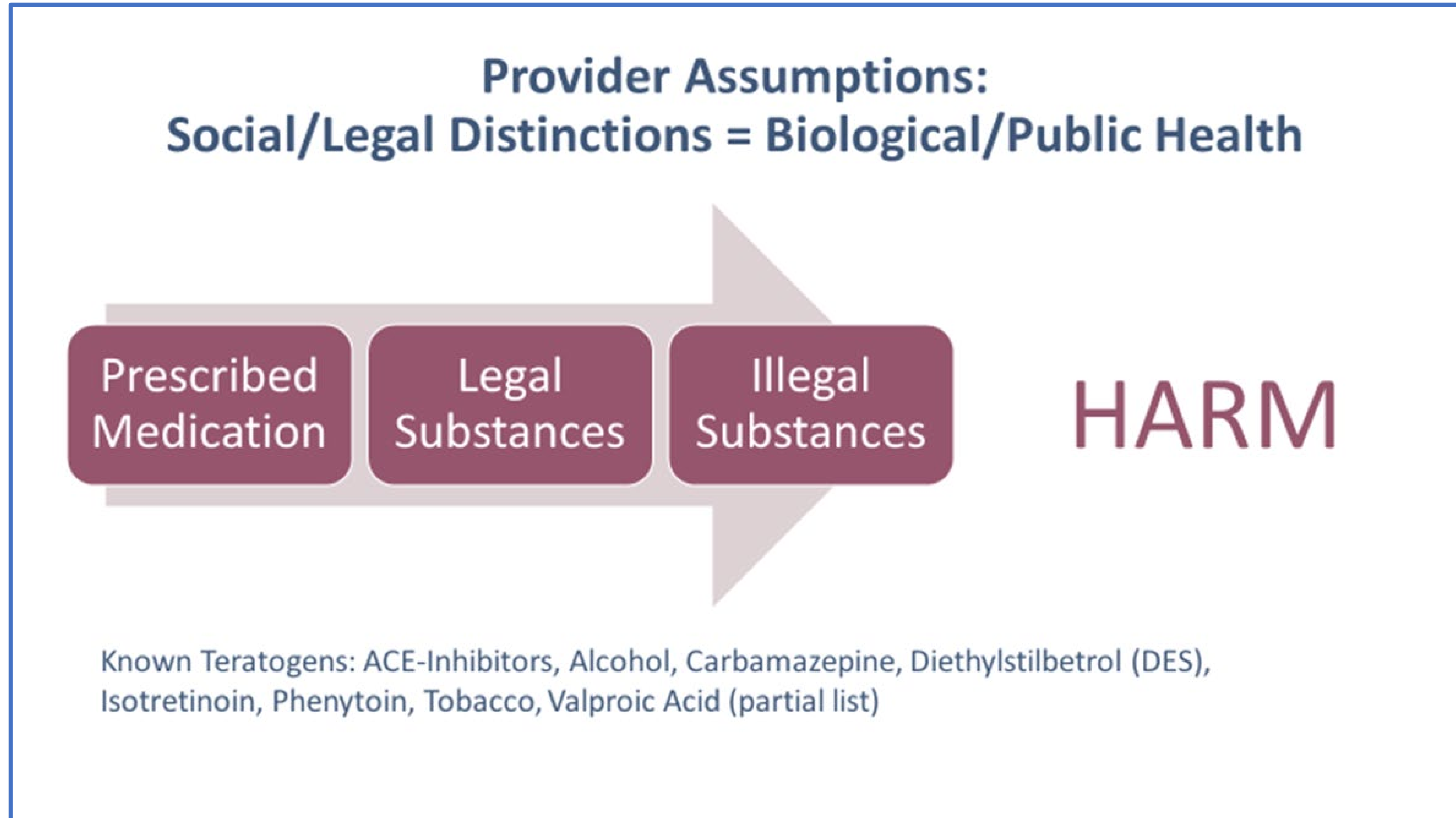
State and federal policies regarding substance use in pregnancy, specifically whether a notification to child protective services is required, continue to evolve. To inform practice, policy, and future research, we sought to synthesize and critically evaluate the existing literature regarding the association of prenatal substance exposure with child maltreatment. We conducted a comprehensive electronic search of PubMed, Web of Science, PsycInfo, CHINAL, Social Work Abstracts, Sociological Abstracts, and Social Services Abstracts. We identified 30 studies that examined the association of exposure to any/multiple substances, cocaine, alcohol, opioids, marijuana, and amphetamine/methamphetamine with child maltreatment. Overall, results indicated that substance exposed infants have an increased likelihood of child protective services involvement, maternal self-reported risk of maltreatment behaviors, hospitalizations and clinic visits for suspected maltreatment, and adolescent retrospective self-report of maltreatment compared to unexposed infants. While study results suggest an association of prenatal substance exposure with child maltreatment, there are several methodological considerations that have implications for results and interpretation, including definitions of prenatal substance exposure and maltreatment, study populations used, and potential unmeasured confounding. As each may bias study results, careful interpretation and further research are warranted to appropriately inform programs and policy.

Keywords

child maltreatment, infants, substance abuse

The Internalization of Drug Policy

The fetus does not know if the exposure is prescribed, used as directed or misused, legal or illegal, natural or synthetic



Exposure (birth)

Measurement (school)

GAP

GAP:

Parenting Competence
Parent Health
Early Child Development
Environmental Toxins
Social Safety Net
Resilience
Nutrition
Violence

Social Development

Brain Development

Measurement and Context

Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 85, No. 6
doi:10.1007/s11524-008-9315-6
© 2008 The New York Academy of Medicine

Illicit Drug Use and Adverse Birth Outcomes: Is It Drugs or Context?

Ashley H. Schempf and Donna M. Strobino

ABSTRACT *Prenatal drug use is commonly associated with adverse birth outcomes, yet no studies have controlled for a comprehensive set of associated social, psychosocial, behavioral, and biomedical risk factors. We examined the degree to which adverse birth outcomes associated with drug use are due to the drugs versus surrounding factors. Data are from a clinical sample of low-income women who delivered at Johns Hopkins Hospital between 1995 and 1996 (n=808). Use of marijuana, cocaine, and opiates was determined by self-report, medical record, and urine toxicology screens at delivery. Information on various social, psychosocial, behavioral, and biomedical risk factors was gathered from a postpartum interview or the medical record. Multivariable regression models of birth outcomes (continuous birth weight and low birth weight ([LBW] <2,500 g)) were used to assess the effect of drug use independent of associated factors. In unadjusted results, all types of drug use were related to birth weight decrements and increased odds of LBW. However, only the effect of cocaine on continuous birth weight remained significant after adjusting for all associated factors (−142 g, p=0.05). No drug was significantly related to LBW in fully adjusted models. About 70% of the unadjusted effect of cocaine use on continuous birth weight was explained by surrounding psychosocial and behavioral factors, particularly smoking and stress. Most of the unadjusted effects of opiate use were explained by smoking and lack of early prenatal care. Thus, prevention efforts that aim to improve newborn health must also address the surrounding context in which drug use frequently occurs.*

KEYWORDS *Illicit drugs, Psychosocial factors, Pregnancy, Birth weight, Low birth weight*

TABLE 3 Linear regression results of birth weight and drug use

	Marijuana coefficient (95%CI)	Cocaine coefficient (95%CI)	Opiates coefficient (95%CI)	Heavy smoking 10+ cigarettes per day coefficient (95%CI)	Heavy drinking daily/weekly coefficient (95%CI)
Unadjusted	−250.0 (−384.0, −116.0)***	−475.1 (−584.6, −367.7)***	−462.3 (−582.0, −342.5)***	−543.8 (−674.3, −413.3)***	−438.3 (−629.1, −247.5)***
Adjusted for other drug use	−0.2 (−140.6, 140.2)	−219.7 (−369.4, −70.0)**	−165.1 (−324.6, −5.5)*	−307.7 (−470.1, −145.3)***	−120.5 (−319.8, 78.8)
Social factors	12.7 (−127.6, 152.9)	−225.0 (−377.4, −72.8)*	−170.2 (−330.3, −10.1)*	−278.8 (−445.1, −112.6)**	−83.7 (−284.6, 117.1)
Social and psychosocial factors	7.7 (−131.5, 146.9)	−187.2 (−339.0, −35.5)*	−162.1 (−321.0, −3.1)*	−232.2 (−398.2, −66.2)**	−68.1 (−267.7, 131.5)
Social, psychosocial, and behavioral factors	10.1 (−128.2, 148.5)	−171.3 (−322.5, −20.1)*	−129.9 (−289.2, 29.5)	−225.9 (−391.0, −60.8)**	−46.3 (−245.3, 152.6)
Social, psychosocial, behavioral, and biomedical factors	−24.6 (−155.8, 106.5)	−142.0 (−285.8, 1.8)	−85.6 (−237.7, 66.4)	−158.2 (−315.9, −0.5)*	−30.6 (−219.4, 158.2)

Social factors include maternal age, money for necessities, and housing. Psychosocial factors include stress and pregnancy locus of control. Behavioral factors include early prenatal care. Biomedical factors include hypertensive disorders, other medical risk factors, prepregnancy weight, and net weight gain.

*$p<0.05$; **$p<0.01$; ***$p<0.001$

Intrauterine Exposure and the Care-Giving Environment

Children With In Utero Cocaine Exposure Do Not Differ From Control Subjects on Intelligence Testing

Hallam Hurt, MD; Elsa Malmud, PhD; Laura Betancourt; Leonard E. Braitman, PhD;
Nancy L. Brodsky, PhD; Joan Giannetta

Inner-city Achievers

Who Are They?

Hallam Hurt, MD; Elsa Malmud, PhD; Leonard E. Braitman, PhD; Laura M. Betancourt, BA;
Nancy L. Brodsky, PhD; Joan M. Giannetta, BA

Table 5. Home Observation for Measurement of the Environment*

Measurement	IQ≥90 (n=24)	IQ<90 (n=104)	*P* Value
Learning Stimulation	9 (5-11)	7 (1-11)	<.001
Language Stimulation	7 (6-7)	7 (4-7)	.03
Physical Environment	6 (5-7)	6 (0-7)	.25
Warmth and Affection	6 (2-7)	5 (0-7)	.01
Academic Stimulation	5 (4-5)	5 (1-5)	.006
Modeling	4 (2-5)	4 (0-5)	.05
Variety in Experience	8 (6-9)	7 (4-9)	<.001
Acceptance	4 (3-4)	4 (0-4)	.06
Total	48.5 (40-53)	43 (20-53)	<.001

**Values are expressed as median (range). See Caldwell and Bradley for more information on HOME.[10]*

Healthcare is not Safe, Especially for Pregnant People who use Drugs; Discrimination is a Patient Safety Issue

A drug test is not a parenting test.

Take action: bit.ly/IC-Toolkit

We must **dismantle and divest** from systems that unfairly target and criminalize Black and Brown pregnant and parenting people. **We have the power to build better.**

MFP
MOVEMENT FOR FAMILY POWER

We are the Drug Policy Alliance.

The Bronx Defenders
Redefining public defense

Don’t Report

Hit the “Pause” Button; Take a Time-Out

DRUG USE DURING PREGNANCY AND THE HEALTH PROFESSIONAL’S ROLE IN REDUCING HARM

Supports Before Reports.
A Drug Test is Not A Parenting Test.

How might a report to child welfare impact the birthing person? Their family? Their existing children? Their legal status? Their health? Their recovery? Their community?

1 CONNECTION

- Does this person/family trust me?
- Do I trust them?
- Why/why not?
- How can I build trust?

2 SUPPORT

- How can I connect this person to culturally and linguistically effective and needed resources?
- What are the alternatives for resources beyond my reliance on child welfare?
- Is this the person connected to community-based resources that are not tied to state intervention? (list examples?)

3 POVERTY

- Are the issues this person/family is facing related to living in poverty?
- If so, are there community-based resources they can utilize instead of reporting them to the state and potentially creating harm/family separation?

4 HEALTH

- Is urine drug testing necessary for this person’s medical care?
- How does a the drug test inform or improve clinical care?

5 CONTEXT/STORY

- Do I need to learn more about this person, their family, and their support system?
- What support systems exist for this person/family?
- Have I asked them this directly?

6 EQUITY

- What harms might befall a child whose parent is reported to child welfare?
- How do those harms differ if child is Black? American Indian? Has parents with insecure legal status?
- Would I report a person of my race and ethnicity who is experiencing these issues to child welfare?

Drug Use During Pregnancy

Supports Before Reports

The Health Professional’s Role in Reducing Harm

As providers, we know that sometimes **our interventions, policies, and practices can cause harm.**

There are limits to what a urine drug test can tell us. It doesn’t tell us if someone has a substance use disorder - and the results are **seldom clinically useful.**

A drug test is not a parenting test.

While we’d like to think that a report to child welfare agencies will lead to better resources and support, evidence shows us that **it is more likely that it will lead to increased surveillance and family separation instead.**

If our goal is to support babies and empower families, we need to find alternatives to punitive systems.

We need:

- genuine connections with families based in trust and transparency
- to collaborate with our patients and clients in creating their care plans
- to ask parents about their preferences, priorities, and unmet needs
- community-based resources and supports outside of child welfare systems
- to understand the unintended consequences of making a report
- to appreciate the inherent inequities in how systems treat poor, Black, and Brown families

A drug test is NOT a parenting test.

De-Implementation: Hospital Policy and State Legislation

- Change hospital drug testing and reporting policies and procedures
- Involve people w living experience in the process
- Change state law

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Hennepin County Attorney > News > Hennepin County Attorney Mary Moriarty ends criminalization of pregnancy

Hennepin County Attorney Mary Moriarty ends criminalization of pregnancy

Hennepin County Attorney Mary Moriarty today announced a new policy that would end the criminalization of pregnancy for people struggling with substance use.

CHILDREN'S RIGHTS

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MANDATED SUPPORTER, NOT MANDATED REPORTER

Home / News & Voices / Mandated Supporter, not Mandated Reporter

By Alexandria Ware | February 9, 2023

- "Mandatory Supports Not Mandatory Reports" Coined by Joyce McMillan JMAC
- Partner with preventive legal advocacy organizations to provide legal assistance for people involved
- Partner with impacted peoples – Parent Advocate
- Miranda Rights for patients

Carceral Complicity

State Violence,

Iatrogenic Injustice ,

and

Decriminalization

Stopping Criminalization at the Bedside

Wendy A. Bach[1]
and Mishka Terplan[2]

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Keywords: Reproductive Health, Pregnancy, Criminalization, Health Privacy, Mandatory Reporting

Abstract: Low-income women and, disproportionately low-income women of color seeking reproductive and pregnancy care are increasingly subject to what this article terms carceral care – care compromised by its' proximity to punishment systems. This article identifies the legal and health care practice mechanisms leading to carceral care and proposes solutions designed to stop criminalization at the bedside.

Between 2014 and 2016, Tennessee prosecuted over 120 women for fetal assault, a crime defined as the in-utero transmission of narcotics.[1] Over 90% of the Tennessee criminal court charging documents included information obtained in the health care setting.[2] The negative effects of these disclosures on patient trust and patient care are clear. As one effected woman reported, "when I was pregnant, I was scared to death to have that open relationship with my doctor because the laws in effect prevented ... it from being a care issue. It became a law, a liability issue. I was freaking terrified."[3] The very real possibility of prosecution forced her to engage in what Fong has called "selective visibility,"[4] weighing the legal risk of disclosing potentially medically relevant information against any possible risk to their health of non-disclosure.

This is not new. Subordinated communities have long experienced the effects of racialized and gendered drug and reproductive health policies and reproductive control. Neoliberal policies have further weakened the social contract, weaponized access to remaining public services, and contributed to hyper-regulation[5] and criminalization. Agencies that purport to support (as well as those that police and prosecute) have both long surveilled and intervened in poor families.[6] Health professionals, reflecting their normative and privileged social status, have historically over-reported patients in their care to surveillance and policing agencies. This information sharing is complex and often far exceeds what is required by law. And community members have responded tactically, seeking both to benefit from the help that agencies

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Introduction

Lisa Sangoi

The child welfare and foster system (foster system) [8] holds perhaps the greatest power a state can exercise over its people: the power to forcibly take children away from parents and permanently sever parent- child relationships.

Begin by Decriminalizing Healthcare

- Institutions concerned with the promotion of public health possess a duty of justice: Decriminalize Health Care

- Child Welfare Reporting for substance use is discriminatory, discretionary, and shifts locus of care from clinical expertise to administrative and policing authorities

- Recognize that clinical care and research are both embedded in structures of oppression: Center on the people we serve, focus on empowerment, and partner with them to develop truly supportive services

PUNISHMENT, TREATMENT, EMPOWERMENT: THREE APPROACHES TO POLICY FOR PREGNANT ADDICTS

IRIS MARION YOUNG

In this paper I bring some issues and concepts of feminist ethics, postmodernism, and critical theory to reflect on an important women's issue–policy approaches to pregnant women who are habitual drug users. Many people, including many law enforcement officials, child protection agents, and legislators, think that women who use drugs during pregnancy should be punished for the harm or risks of harm they bring to their babies. I analyze this punishment approach and argue that the situation of pregnant addicts does not satisfy the conditions usually articulated by philosophers to justify punishment. A punishment approach, moreover, may have sexist and racist implications and ultimately operates more to maintain a social distinction between insiders and deviants than to protect children.

Most of those who criticize a punishment approach to policy for pregnant addicts call for meaningful treatment programs as an alternative. I interpret this treatment approach as a version of a feminist ethic of care. For the most part, theorizing about the ethics of care has remained at the level of ontology and epistemology, with little discussion of how the ethics of care interprets concrete moral issues differently from more traditional approaches to ethics. By conceptualizing a treatment approach to pregnant addicts as justified by an ethics of care, I propose to understand this ethics of care as a moral framework for social policy.

Although I agree with a treatment approach to policy for pregnant addicts, from a feminist point of view there are reasons to be suspicious of many aspects of typical drug treatment. Relying on Michel Foucault's notions of disciplinary power and the operation of "confessional" discourse in therapy, I argue that treatment often operates to adjust women to dominant gender, race, and class structures and depoliticizes and indi-

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Addiction and Pregnancy: Environment of Mutual Mistrust

Provider

Mistrust emerges from prejudice

Acting on mistrust is form of epistemic injustice

Consequences of misplaced trust are minor

Patient

Mistrust justified due to historical trauma and current experiences of discrimination

Consequences of misplaced trust are severe

Power Differential

Responsibility for overcoming mistrust rests with providers

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