What the New Task Force on Prenatal Alcohol and Drug Use Will Mean for Women and Children

A new state task force on prenatal Substance Use Disorder (SUD) will likely consider whether to end mandated reporting of SUD to child protection, both prenatally and at birth.

Medical associations' policy positions uniformly state that mandated reporting of prenatal SUD inhibits women from seeking medical care. While the research isn't as clear-cut as they say, creative outreach efforts to engage high-risk women in prenatal care is probably the best current option for protecting children.

Other legislative proposals would severely limit mandated reporting of newborns who are withdrawing from drugs or alcohol. We don't support this. Instead, we recommend intensive, non-voluntary services first to begin addressing the serious consequences of prenatal alcohol abuse. Also, as this study shows, while the research is less definitive on prenatal drug use, it isn't clearly harmless, and may also cause developmental damage.

Podcast on prenatal SUD

There has been a push to change statutes regarding mandated reporting of substance abuse during pregnancy, and at the time of birth. The outcome this year was that a bill was passed, HF 2095 SF 2543, to establish a task force that will look at this issue.

We should note first that we have concerns about the membership on this task force. It does not include any child advocates or advocates for children with Fetal Alcohol Syndrome Disorders. So we will be watching the process to ensure that ample opportunity is made available for public input and that that input is considered seriously. Adding people to the task force may not be an option because membership is spelled out in detail in the statute.

Prior to the task force bill being introduced, a different bill was proposed that would place a number of obstacles in the way of primary care providers reporting substance abuse both prenatally and perinatally. That bill has been withdrawn in favor of the task force, but is worth noting because it could be reintroduced next year if the task force doesn't include the provisions that the authors want.

I want to note that I am consciously using the term "substance abuse" at points where it is appropriate, even though the favored term of art currently is Substance Use Disorder, or SUD. I am concerned that only using the term SUD may suggest that people are only victims of excessive drug use, when in fact people often have some level of agency. For example they can choose to get prenatal care or not, they can choose to get treatment for their addiction or not. My experience doing direct work with street youth is that almost everyone has some agency, some ability to take steps, however small, that will make them more independent.

That bill strikes language that gives infant withdrawal symptoms, known as Neonatal Abstinence Syndrome, or NAS, as a reason for a report to child protection.

It changes the process from reporting to 'notification'. While anyone can 'notify' child protection of a substance abuse issue, only a physician, Nurse Practitioner, or Physician's Assistant is authorized to claim harm to a newborn child's health, safety, or development. Others who are currently required to report such as RNs may 'notify' but not claim harm. We don't know for sure what is the intent of this change but it appears to leave child protection with fewer grounds for intervening.

Regarding newborns, the legislation requires there to be other reasons to report child maltreatment other than "just" positive toxicology tests, medical delays, or Fetal Alcohol Spectrum Disorders. All of these seem reason enough to me to get some oversight of helpless newborn, who would be sent home to a precarious situation.

Similarly, toxicology reports for both infant and mother can only be for the purposes of medical treatment, not for reporting of child maltreatment. And, before a woman receives a toxicology screen or allows one for the newborn she must give both written and oral informed consent.

We would have serious concerns about these proposals being included in the recommendations from the task force, or reintroduced as legislation in the 2024 session.

The purpose of these restrictions appears to be to make it more difficult to get mothers and newborns in the child protection system. But this may be an exercise in futility. SUD is usually one of a number of issues that occur together and contribute to child neglect. As a result, according to a study by Prindle, Hammond, and Putnam-Hornstein entitled "Prenatal substance exposure diagnosed at birth and infant involvement with child protective services", and there is a link to it in the script for this blog, 61% of children born with NAS end up in the child protection system within a year anyway, and 29% have an out of home placement. Instead of trying to keep women from getting involved with child protection, when that is almost certain to happen anyway, activists for women and child advocates would be better off working together to make sure that intensive services are available starting in the hospital to women who are struggling with these issues. These could include timely outpatient treatment, an early learning scholarship for high quality childcare, and enrollment in an intensive home visiting program that includes social services support and parenting skills training.

As mentioned in the blog, virtually all of the associations representing different physician specialties as well as nurses believe strongly that requiring medical personnel to report prenatal drug abuse is counterproductive in that it keeps women from getting prenatal care. These include the American Nurses Association, the American College of Gynecologists and Obstetricians, and the American Academy of Family Practice Physicians.

But our reading of some of the research sent to us by physicians seems to be less clear-cut. The article "State Policies Targeting Alcohol Use During Pregnancy and Alcohol Use Among Pregnant Women 1985-2016: Evidence from the Behavioral Risk Factor Surveillance System" takes a deep dive into alcohol abuse during pregnancy. It breaks down policies by states into supportive, punitive, and no policies at all. The results are mixed. On page 3 of the article it says and I'm quoting:

“Relative to having no policies, supportive policy environments were associated with more any drinking, but not binge or heavy drinking.” So that means supportive policies encourage moderate drinking but not heavy drinking. It goes on to say: ”Of individual supportive policies, only the following relationships were statistically significant: Mandatory Warning Signs was associated with lower odds of binge drinking; Priority Treatment for Pregnant Women and Women with Children was associated with higher odds of any drinking.” This means that warning labels, as on cigarettes, help avoid binge drinking, but policies that give priority to pregnant women actually increase drinking in general although not necessarily heavy drinking. Finally, the article states that “Relative to no policies, punitive policy environments were also associated with more drinking, but not with binge or heavy drinking.” So states with an overall punitive approach encouraged drinking overall, but didn’t worsen binge or heavy drinking. And finally, “Of individual punitive policies, only Child Abuse/Neglect was associated with lower odds of binge and heavy drinking. Mixed policy environments were not associated with any alcohol outcome.” What this means is that simply having a law on the books that SUD during pregnancy is considered child maltreatment somehow had the effect of reducing binge and heavy drinking, although it’s not clear why because it’s not connected to practices such as whether there was mandated reporting of SUD or if SUD was criminalized. The net result of all this is that, as the authors state in their summary and conclusions: “Most policies targeting alcohol use during pregnancy do not appear to be associated with less alcohol consumption.”

So in short, it’s a bit of a muddle. There doesn’t seem to be as clear a relationship between policies around mandated reporting as the medical associations statements would suggest. And while an aggressive outreach strategy seems to be the most promising approach, it seems like the alternative of mandating medical personnel to report substance abusing pregnant women to child protection might not make things as bad as the medical associations are saying.

It’s important to always keep in mind that FASD is a bell that can’t be un-rung, the developmental damage to a child can’t be repaired later. So perhaps the best we can do with the state of knowledge at this point is to promote outreach efforts while keeping a watchful eye on the research, and be open to more restrictive reporting policies should the data support that.

The one exception to this line of thinking is the process of civil commitments for SUD. Civil commitments apply to all citizens, not just pregnant women. There is a body of law and a process and a constellation of agencies and services built around involuntary commitments in situations where people are a danger to themselves or others. Physicians, child protection units, and social service agencies don’t really have a role in that process or leverage to influence decisions. It has a life of its own.

Assuming, though, that the medical associations are correct, the sensible strategy would be to put as much effort as possible into creative outreach to high risk pregnant women so they can get the prenatal care they need for themselves and the child. I recall from some work I did years ago the Public Health Nurses devised strategies for doing just that, and had significant success. I would love to see some current research on this topic to see if it has held up over time.

It seems like physicians could have a conversation with their patients that while they don’t have to report them for SUD while they are pregnant, once they give birth child protection is almost

certain to get involved. So it is to the mother's benefit to work with the physician to do whatever is necessary to ensure that the child is born drug-free.

Another area of controversy is whether prenatal drug abuse has long-term developmental consequences. The physicians we have talked with about this say that there is not very good information one way or the other about this issue. I have trouble understanding that in several ways. First, it simply doesn't make common sense that ingesting a powerful narcotic, which can easily pass over the placenta to the fetus, would not have some detrimental effect. Second, taking a position that we shouldn't have policies that try to intervene in prenatal drug use strikes me as similar to the situation with hazardous chemicals. For decades companies like 3M got away with pumping PFCs into our groundwater with the argument that it wasn't proven yet they did any harm. According to an estimate prepared last week for the Minnesota Pollution Control Agency, it did a lot of harm, and it will cost at least $14 billion to clean up this particular hazardous waste, just in this state. Here we are taking a similar argument with the lives of children, saying that we can continue to not worry about prenatal opioid, meth, and fentanyl use because it hasn't been proven yet that it does much harm.

However perhaps there is some proof of harm. There is a link in the blog to an article entitled "Developmental Consequences of Fetal Exposure to Drugs: What We Know and What We Still Must Learn" which summarizes current knowledge about this topic. I recommend if you click on the link go straight to figure 3, which summarizes what is known about the impact of various drugs, plus alcohol and nicotine on the fetus.

All of this is to say that in the immediate term the most prudent policy may be to maximize efforts to engage women in prenatal care when they are abusing alcohol or drugs, that we should weigh our policies more strongly in favor of infants once they are born, and that we should be alert to adjust these policies as we get better information about SUD in pregnant women.

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