

# Legal Implications of Perinatal Substance Use

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# Objectives

- Review current state and federal statutes affecting patients affected by perinatal substance use and substance use disorders
- Introduce 2021 statute change that affects perinatal substance use reporting
- Discuss best practice for perinatal care in the context of current state and federal statutes

## Acknowledgements

- Perinatal Substance Use and Perinatal Mental Health Project ECHO-Hennepin Health
- Minnesota Medical Association



# Disclosures

- Research support from NIH/NIDA
- Advisory Board – SAFEST Choice learning collaborative
- Worked on 2021 Minnesota statute change

- ***Person-centered language:*** Not all people who give birth identify as either women or mothers. I will attempt to utilize inclusive and person-centered language in my presentation, acknowledging that words like “maternal” are often used to describe perinatal health events and may be used when no currently accepted alternatives exist

2021

## A Case to Start

- A 29 year-old patient comes to your office to initiate pregnancy care
- During routine substance use screening, she identifies that she uses opioids daily, mostly fentanyl
- You discuss the risks of use in pregnancy and for her long-term health, and offer referral to treatment
- She opts not to initiate treatment at this visit
- You inform her that Minnesota statute mandates that you make a report to her county of residence
- She becomes very angry and leaves without scheduling another appointment

## Another Perspective

- You are 29 years old, mother to a 6 year-old daughter, and you are working full time. After feeling unwell for a few weeks, you take a pregnancy test and it is positive. After spending 20 minutes on the phone during your lunch break, you get a first pregnancy visit but it isn't for 6 weeks.
- You have been using fentanyl, and need to use daily so that you don't feel sick. It is becoming more and more expensive and you know you need treatment but aren't sure where to start. You didn't have insurance for a long time and are scared to call your employer-based insurance to ask about coverage.

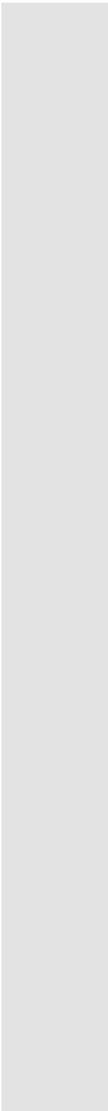
## Another Perspective

- You know that you are a good parent and that your child is supported, healthy and safe. You just need a little more time to arrange things so that you can get into treatment, and you will have to ask off work to go to another clinic.
- The healthcare provider that you see for your first pregnancy visit tells you that she will be contact Hennepin County (where you live) and if you don't get into treatment soon, they might have to put you on a hold to get you to do what will keep your baby safe.
- You feel so angry at yourself for thinking that you could trust this person to understand and to help you, when you just met her. You leave without scheduling another visit.



## Avoid Misconceptions

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- Continued drug use should not be assumed to reflect a lack of desire to quit using drugs
  - Limited insurance coverage exists for substance use treatment
  - Treatment can be expensive, with limited space, and may not accommodate childcare/family/work responsibilities
- 

## Five Key Values

### **THE WHITE HOUSE EXECUTIVE OFFICE OF THE PRESIDENT OFFICE OF NATIONAL DRUG CONTROL POLICY**

Having SUD in pregnancy is not, by itself, child abuse and neglect.

Criminalizing SUD in pregnancy is ineffective and harmful.

Everyone has a right to effective treatment.

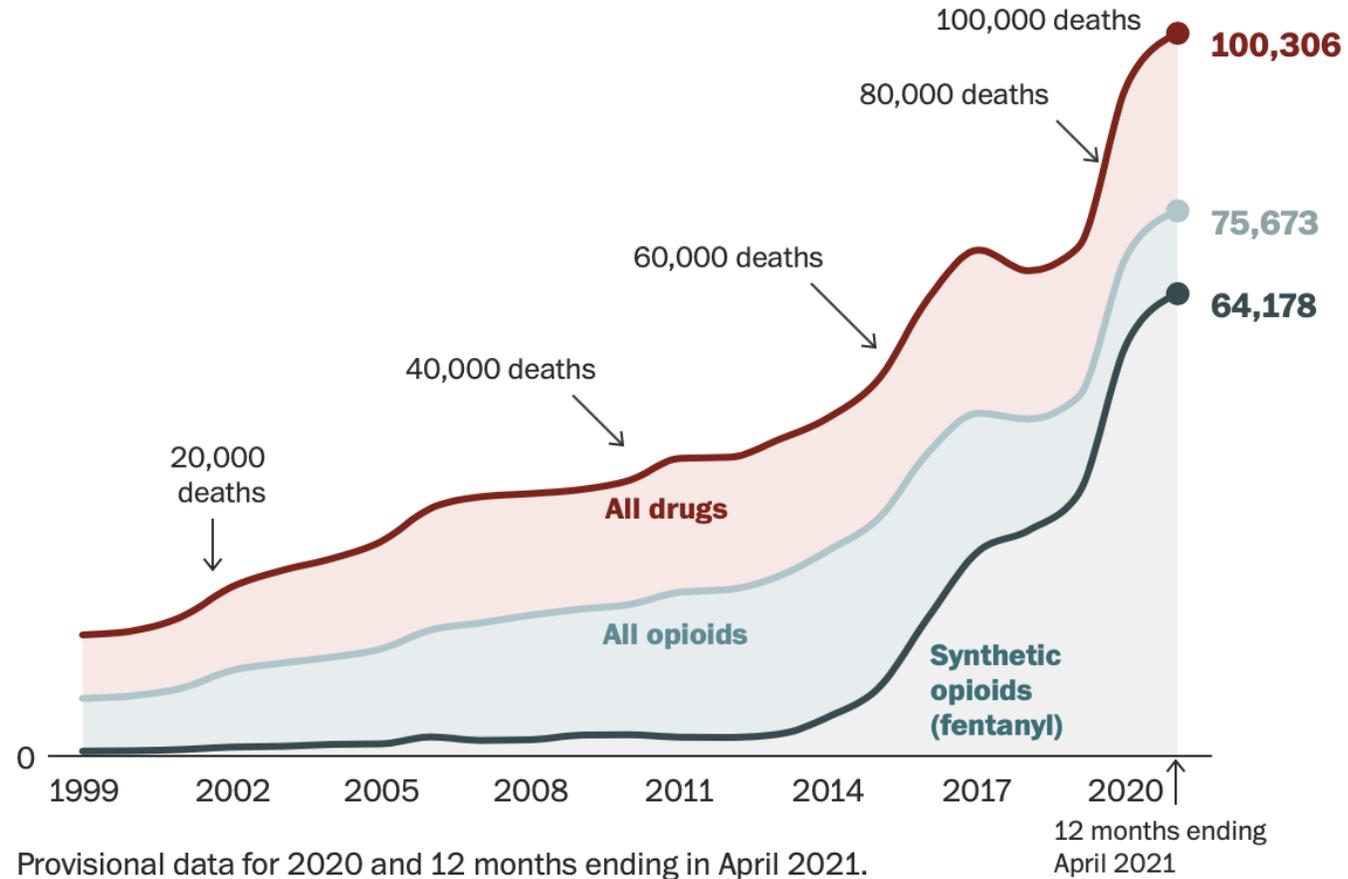
Pregnant people using substances should be encouraged to access support and care systems.

Improving coordination of public health, criminal legal systems, treatment and early childhood systems can optimize outcomes and reduce inequities.



# Examining the data

## U.S. drug overdose deaths per year



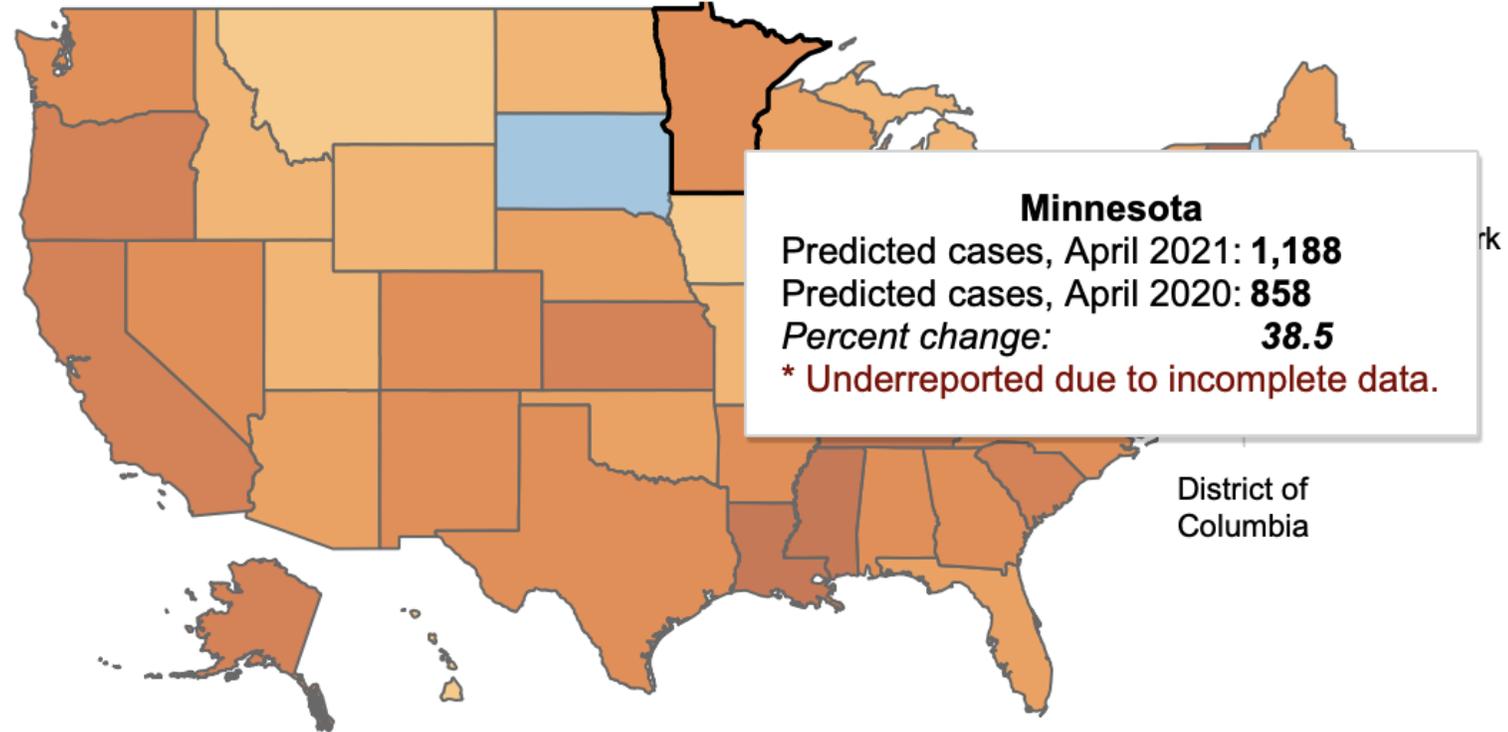
Provisional data for 2020 and 12 months ending in April 2021.

12 months ending  
April 2021

Source: [Centers for Disease Control and Prevention, National Center for Health Statistics](#)

DAN KEATING / THE WASHINGTON POST

**Figure 1b. Percent Change in Predicted 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction:  
April 2020 to April 2021**



**Legend for Percent Change in Drug Overdose Deaths Between 12-Month Ending Periods**



Table. Drug Overdose Mortality Rates Among Pregnant or Postpartum Persons and Those of Reproductive Age From 2017 to 2020<sup>a</sup>

Year	Pregnant or postpartum			Reproductive age (aged 15-44 y) <sup>b</sup>		
	No. of persons	No. of live births <sup>c</sup>	Drug overdose mortality rate per 100 000 (95% CI) <sup>d</sup>	No. of persons	Population	Drug overdose mortality rate per 100 000 (95% CI) <sup>d</sup>
2017	252	3 844 260	6.56 (5.78-7.43)	9191	63 958 243	14.37 (14.08-14.67)
2018	266	3 780 401	7.04 (6.23-7.95)	9198	64 171 698	14.33 (14.04-14.63)
2019	304	3 736 144	8.14 (7.26-9.12)	9433	64 325 356	14.66 (14.37-14.96)
2020	427	3 602 653	11.85 (10.77-13.05)	12 756	64 543 832	19.76 (19.42-20.11)
<b>Total</b>	<b>1249</b>	<b>14 963 458</b>	<b>8.35 (7.89-8.83)</b>	<b>40 578</b>	<b>256 999 129</b>	<b>15.79 (15.64-15.94)</b>
Absolute change rate (95% CI) [relative change %] <sup>e</sup>						
2017-2020			5.30 (3.90-6.72) [80.81]			5.39 (4.94-5.85) [37.53]
2019-2020			3.72 (2.25-5.20) [45.67]			5.10 (4.65-5.55) [34.77]

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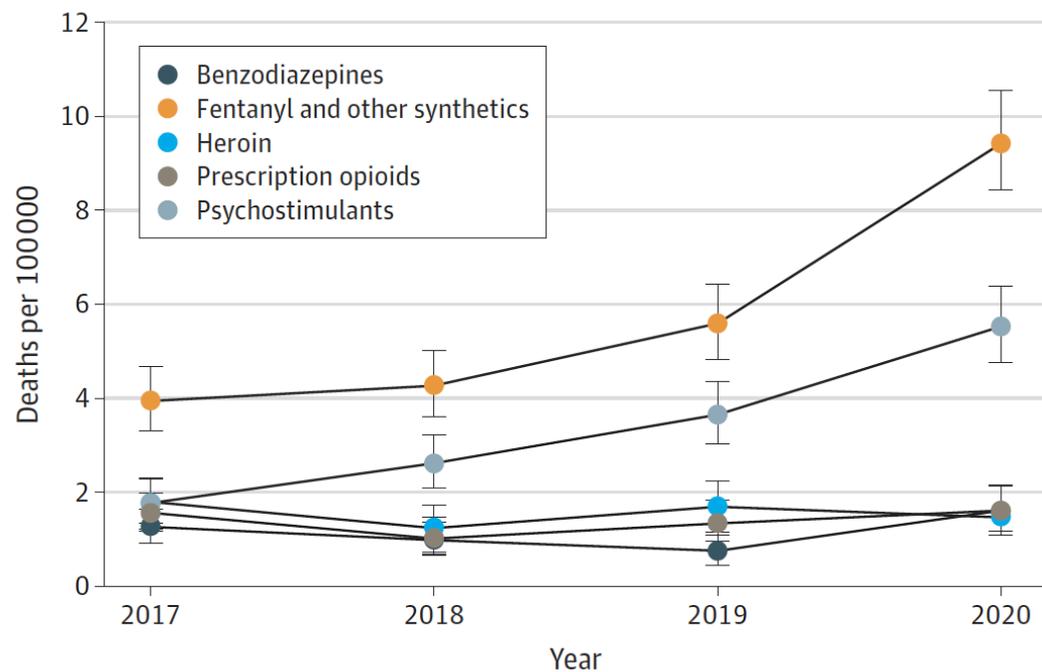
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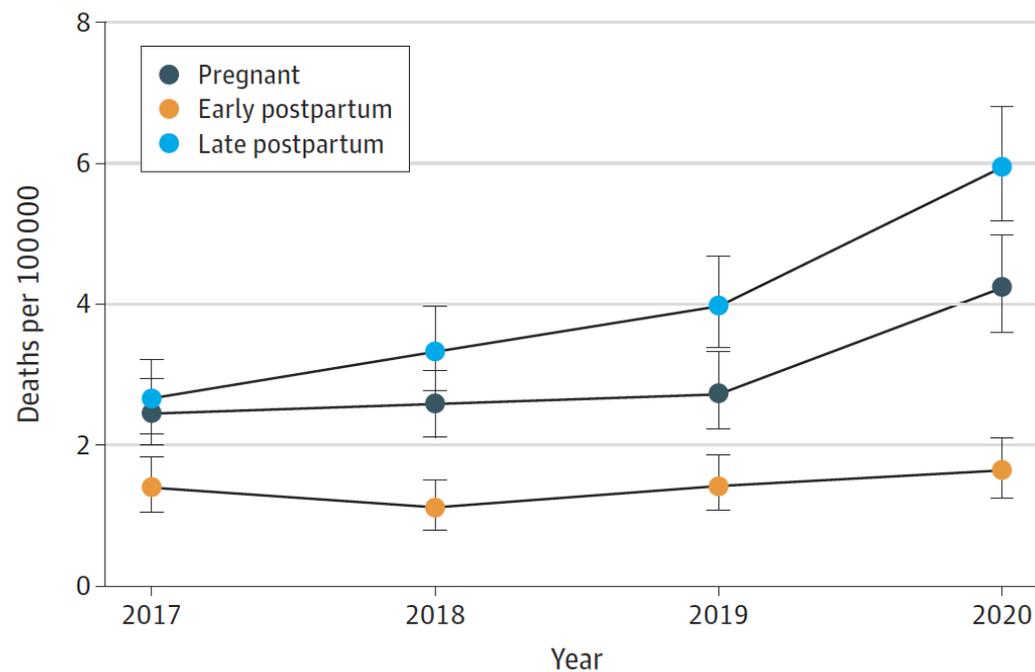
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Figure. Pregnancy-Associated Drug Overdose Mortality

A Drug types involved



B Pregnancy timing from 2017 to 2020



## What does this mean?

- Perinatal overdose has drastically risen and must be addressed
- Efforts must focus on identifying and engaging pregnant people with substance use disorders
  - Unique time – health system interaction is often inevitable
  - Improved outcomes with engagement in care
  - Focus must be during AND after pregnancy

# Examining the statutes



# Minnesota Mandatory Perinatal Reporting

- Before July 2021, perinatal substance use reporting was mandated except for alcohol and cannabis
- Barrier to universal substance use screening
- Mandatory reporting is a factor in decreased prenatal care access with untreated substance use disorder
- Decreased prenatal care has been associated with an increase in adverse pregnancy outcomes

## **626.5561 REPORTING OF PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES.**

Subdivision 1. **Reports required.** A person mandated to report under section 626.556, subdivision 3, shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive. Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive. An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the local welfare agency. Any report shall be of sufficient content to identify the pregnant woman, the nature and extent of the use, if known, and the name and address of the reporter.

## Compare states by

Substance abuse during pregnancy is a crime

Women have been prosecuted for drug use during pregnancy

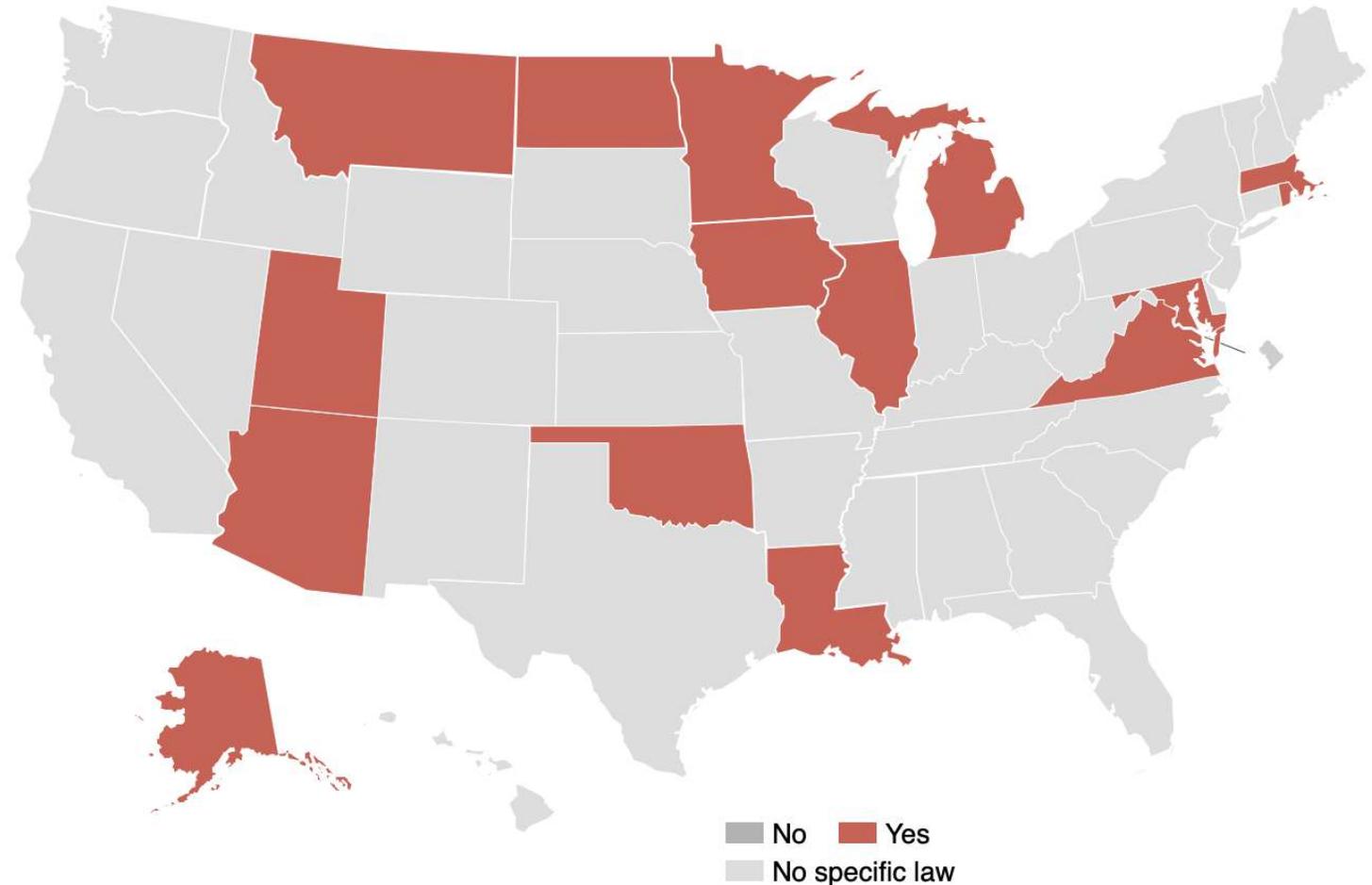
Substance abuse during pregnancy is child abuse

Substance abuse during pregnancy is grounds for civil commitment

Health care workers must report drug abuse during pregnancy

Fifteen states have laws requiring health care workers to report to authorities if they suspect a woman is abusing drugs during pregnancy.

Testing is required if drug use during pregnancy is suspected



projects.propublica.org, accessed 2021

# Mandatory Reporting

- Mandatory substance use reporting has been associated with barriers to care:
  - Patients leave care after initial report
  - Patients are fearful to engage in initial care
  - Patients avoid disclosure of substance use
  - Providers are fearful to screen patient for substance

# Original Article

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## Prenatal Care Reduces the Impact of Illicit Drug use on Perinatal Outcomes

**Ayman El-Mohandes, MD, MPH**

**Allen A. Herman, MD, PhD**

**M. Nabil El-Khorazaty, PhD**

**Pragathi S. Katta, MPH**

**Davene White, RN, NNP**

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### **CONCLUSIONS:**

In infants exposed to IDU, a reduction in risk for prematurity, LBW, and SGA, was consistently demonstrated with improved levels of PNC. In high-risk populations, health care should seek to reach mothers early, especially those identified at risk for IDU, and deliver PNC to them effectively.

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Prenatal care reduces preterm birth, even with ongoing substance use

Prenatal care improves infant birthweight, even with ongoing substance use

(d) The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation.

Sec. 56. Minnesota Statutes 2020, section 260E.31, subdivision 1, is amended to read:

Subdivision 1. **Reports required.** (a) Except as provided in paragraph (b), a person mandated to report under this chapter shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including but not limited to tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.

(b) A health care professional or a social service professional who is mandated to report under this chapter is exempt from reporting under paragraph (a) ~~a woman's use or consumption of tetrahydrocannabinol or alcoholic beverages during pregnancy~~ if the professional is providing or collaborating with other professionals to provide the woman with prenatal care, postpartum care, or other health care services, including care of the woman's infant. If the woman does not continue to receive regular prenatal or postpartum care, after the woman's health care professional has made attempts to contact the woman, then the professional is required to report under paragraph (a).

# What Changed?

- Providers are not required to report pregnant patients when they first identify substance use
  - Time to develop a therapeutic relationship
  - Time to get a patient in for treatment if/when they are ready
  - Patients can come for care even if they aren't ready for substance use treatment, and will have better pregnancy outcomes
- Always an option to report

# What Changed?

- Conditional requirement to report - patient is lost to follow up despite efforts to contact them
- “If the women does not continue to receive regular prenatal or postpartum care, after ..attempts to contact the woman, then the professional is required to report.”
- ? Does care in the ED count?
- What do “continue” and “regular care” mean?

# What Changed?

- Who does this apply to?
  - Professionals (or delegates): healing arts, social services, hospital administration, psychology/psychiatry, child care, education, correctional staff, probation officers, law enforcement and clergy

## Implications

- More patients are engaging in ongoing prenatal care, even with ongoing substance use
- Less patients are accessing the resources that are linked to mandatory reporting in counties with supportive programming
- Programming revisions are necessary to expand service access

## Prenatal reporting vs. toxicology testing vs. infant testing

- Legislation change *only* addresses mandatory reporting of substance use in pregnancy
- It does *not* change separate legislation related to toxicology testing in pregnancy surrounding delivery or testing of infants (urine, meconium, cord segment) surrounding birth

# Toxicology testing

- **626.5562 TOXICOLOGY TESTS REQUIRED.**
- Subdivision 1. **Test; report.**
- A physician *shall* administer a toxicology test to a pregnant woman under the physician's care or to a woman under the physician's care within eight hours after delivery to determine whether there is evidence that she has ingested a controlled substance, *if the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose.*

# LIMITATIONS OF BIOLOGIC TESTING

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Short detection window

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Does not test for alcohol or tobacco

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Does not capture binge or intermittent use

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Not a trust building method to open discussion about use

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Not linked to intervention and referral to treatment

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False negatives and positives are a real concern

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Mandatory reporting, criminalization of use during pregnancy

## Compare states by

Substance abuse during pregnancy is a crime

Women have been prosecuted for drug use during pregnancy

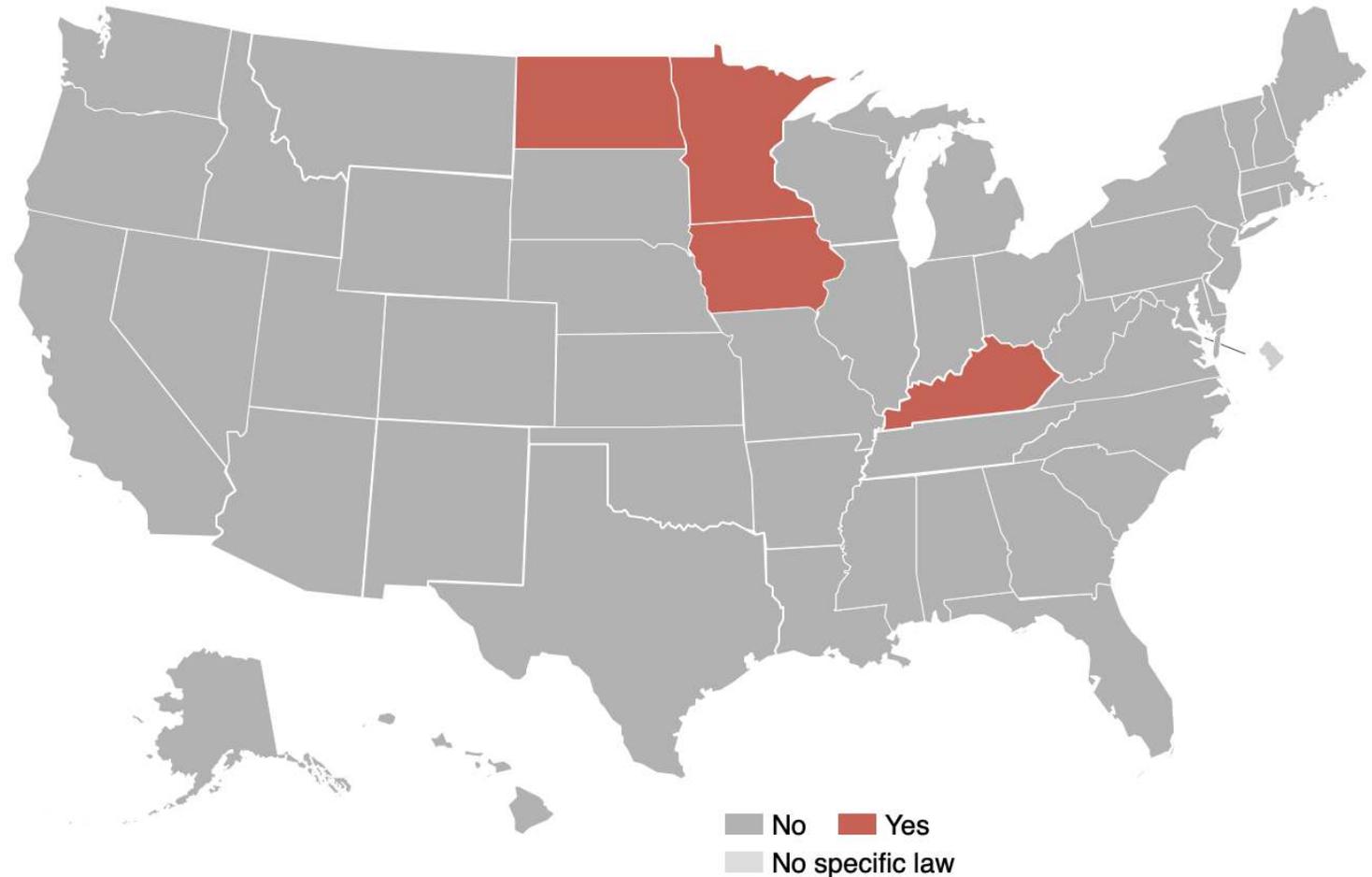
Substance abuse during pregnancy is child abuse

Substance abuse during pregnancy is grounds for civil commitment

Health care workers must report drug abuse during pregnancy

Testing is required if drug use during pregnancy is suspected

Most states do not have a law that requires hospitals to test infants and new moms for controlled substances. In Minnesota and North Dakota, a test is required if there are drug-related complications at birth.



What does this mean?

*"obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose"*

- Mother tested positive for use of reportable substances during this pregnancy
- Mother declines drug testing
- Current or prior illicit or unprescribed drug use including maternal self report
- Altered mental status suggestive of influence and/or withdrawal from drug(s)
- Physical signs suggestive of drug use such as IV track marks, visible tooth decay, sores on face, arms or legs
- Conditions possibly attributable to drug use: CVA, MI, HTN not explained by chronic HTN or hypertensive disorder of pregnancy
- Previous infant exposure to prenatal drug use including prior child with fetal alcohol syndrome
- Active alcohol use during current pregnancy
- Active tobacco use during current pregnancy (including smoking, vaping/e-cigarette use, chewing)
- Unexplained hepatitis B or C, syphilis or HIV within the last 3 years
- No or unknown/undocumented prenatal care, late prenatal care (>16 weeks at presentation) and/or poor prenatal ( $\leq 4$  visits)
- Obstetrical events: Abruption in the absence of trauma or preeclampsia, previous unexplained fetal demise, stillbirth, precipitous delivery (less than 3 hours from beginning of labor until birth), and out of hospital birth
- Unexplained poor maternal weight gain during pregnancy
- Utilization of emergency room and/or health care visits triggering prescription monitoring program (PMP) query
- Currently enrolled in a substance abuse treatment program
- Current or history, within the past 3 years, of domestic violence by current partner
- History of child abuse, neglect, and/or prior child protective services involvement
- History/current incarceration
- Maternal partner substance abuse
- Request of county or tribal child protection agency
- Maternal risk factors present
- Maternal toxicology testing during the pregnancy
- Clinical signs consistent with withdrawal (e.g., high pitched cry, irritability, hypertonia, lethargy, disorganized sleep, sneezing, hiccups, drooling, diarrhea, feeding problems, or respiratory distress).
- Unexplained birth <37 weeks
- Unexplained BW <10th%ile
- Unexplained OFC <10th%ile
- Unexplained congenital malformation of the GI/GU or abdominal wall
- Unexplained seizures, stroke or brain infarction

# Pregnancy Screening Criteria

- Altered mental status, including loss of consciousness, slurred speech
- Respiratory arrest
- Seizure of unknown etiology (no seizure d/o, not consistent with preeclampsia)
- Stroke
- Myocardial infarction or cardiac arrest
- Illicit drug use, unprescribed use of substances, or excessive/habitual alcohol use during this pregnancy, including maternal self-report or positive toxicology testing during this pregnancy
- Enrollment in a substance use treatment program during this pregnancy

# Newborn Screening Criteria

- Newborns of patients who met pregnancy criteria for screening/confirmatory testing. This includes newborns of patients who declined screening for themselves when indicated
- Clinical signs in the newborn consistent with withdrawal from in-utero substance exposure
- Abandoned infants that fall within the safe harbor exception

# Comparison of Questionnaire Screening and Urine Toxicology for Detection of Pregnancy Complicated by Substance Use

*JAMES T. CHRISTMAS, MD, JANET S. KNISELY, PhD, KATHRYN S. DAWSON, MS,  
MARA J. DINSMOOR, MD, SANDY E. WEBER, MS, RN, AND  
SIDNEY H. SCHNOLL, MD, PhD*

- Prospective screening of all new OB care patients
- 19% admitted to substance use in pregnancy
- Only 50% of those admitting to current use had toxicology positive for any substance

Racial differences In indication for OB toxicology testing and the relationship of indications to test results – Perlman et al 2021

- Only testing indication associated with a positive test  
→ current or prior substance use (49% positive)
  - Abruption – 5.2%
  - Hypertension – 1.6%
  - Preterm labor, preterm birth – 14.5%
- Black birthing people 4-5x more likely tested for indications not clearly associated with illicit use
- No indication for urine toxicology documented:
  - White– 9%
  - Black– 20%
- Odds of toxicology testing for indication other than reported substance use:
  - Black 3.25

## Next Steps

- Urine toxicology is not an appropriate way to screen for substance use
- Without guidance, it may be used in ways that reinforce bias and structural racism
- BUT – it is the law to use this testing in Minnesota
- What is the best thing to do for our patients within the structure of current legislation?

## Declining SUD treatment in pregnancy

- Several statutes addressing patients declining treatment :
  - Emergency Admission “72 hour hold”
  - Civil commitment

Sec. 33. [253B.051] EMERGENCY ADMISSION.

Subdivision 1. Peace officer or health officer authority. (a) If a peace officer or health officer has reason to believe, either through direct observation of the person's behavior or upon reliable information of the person's recent behavior and, if available, knowledge or reliable information concerning the person's past behavior or treatment that the person:

(1) has a mental illness or developmental disability and is in danger of harming self or others if the officer does not immediately detain the patient, the peace officer or health officer may take the person into custody and transport the person to an examiner or a treatment facility, state-operated treatment program, or community-based treatment program;

(2) is chemically dependent or intoxicated in public and in danger of harming self or others if the officer does not immediately detain the patient, the peace officer or health officer may take the person into custody and transport the person to a treatment facility, state-operated treatment program, or community-based treatment program; or

(3) is chemically dependent or intoxicated in public and not in danger of harming self, others, or property, the peace officer or health officer may take the person into custody and transport the person to the person's home.

(b) An examiner's written statement or a health officer's written statement in compliance with the requirements of subdivision 2 is sufficient authority for a peace officer or health officer to take the person into custody and transport the person to a treatment facility, state-operated treatment program, or community-based treatment program.

(c) A peace officer or health officer who takes a person into custody and transports the person to a treatment facility, state-operated treatment program, or community-based treatment program under this subdivision shall make written application for admission of the person containing:

# Emergency Admission

- “is chemically dependent....and in danger of harming self of others if the officer [peace officer or health officer] does not immediately detain the patient”
- “may take the person into custody and transport to an examiner or treatment facility”
- May be held up to 72 hours (excluding weekend, holidays)
- Evaluation within 48 hours
- Court hearing as soon as possible

**ARTICLE 6**  
**CIVIL COMMITMENT**

Section 1. Minnesota Statutes 2018, section 253B.02, subdivision 4b, is amended to read:

- Next steps include prepetition screening
- Petition for commitment
- Includes written statement by examiner
- Court hearing for commitment within 14 days

## Compare states by

Substance abuse during pregnancy is a crime

Women have been prosecuted for drug use during pregnancy

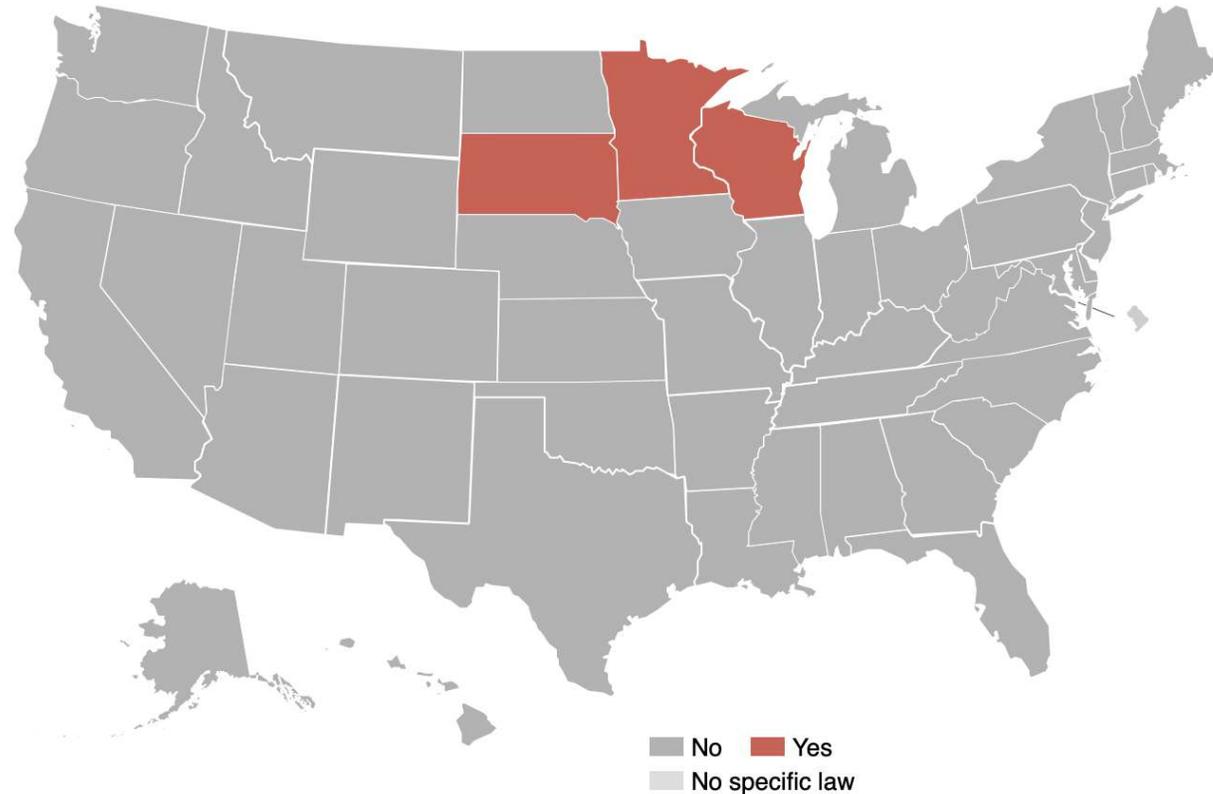
Substance abuse during pregnancy is child abuse

Substance abuse during pregnancy is grounds for civil commitment

In three states — Minnesota, South Dakota and Wisconsin — women who use drugs during pregnancy can be involuntarily committed to a treatment program. The Wisconsin law is especially draconian: A woman can be detained against her will for the duration of her pregnancy, her fetus has its own court-appointed lawyer, she can lose custody of her baby after birth — and the proceedings are mostly secret.

Health care workers must report drug abuse during pregnancy

Testing is required if drug use during pregnancy is suspected



## The Data: Involuntary Commitment

- Individuals subjected to involuntary treatment 2.2 x more likely to die from overdose compared to voluntary treatment
- 34% patients reported relapsing to drug use the day they were released from civil commitment
- Less than 20% patients received medication treatment during commitment
- 7% followed up with addiction treatment after release

HOWEVER.....

- **2021 survey, 60.7% of addiction physicians favored the use of civil commitment for substance use disorders!**

# One Practice Perspective

- Practice-wide decision not to place a hold if a patient is not ready to enter treatment at the time of care
- Support ongoing collaboration and later willingness to accept help for treatment as trust develops
- No data that involuntary treatment is helpful and may be harmful
- Hold is placed if patient is danger to self or others (i.e. potentially lethal overdose as indication for evaluation, suicidal/homicidal ideations or plan)

# CAPTA

- Child Abuse Prevention and Treatment Act
- Federal funding states and tribal organizations
- Plan to identify and assess infants with potential substance exposure – revised to address the opioid epidemic 2010, 2016
- Ensure safety and well-being of infants following discharge
- Required to notify CPS of the occurrence of the child's birth and have a plan of safe care (POSC)

→ CAPTA specifies that the notification does not constitute a federal definition of child abuse, but nearly half the states consider substance use in pregnancy as child abuse or neglect

**IN MINNESOTA, SUBSTANCE  
USE IS VIEWED AS CHILD  
ABUSE OR NEGLECT**



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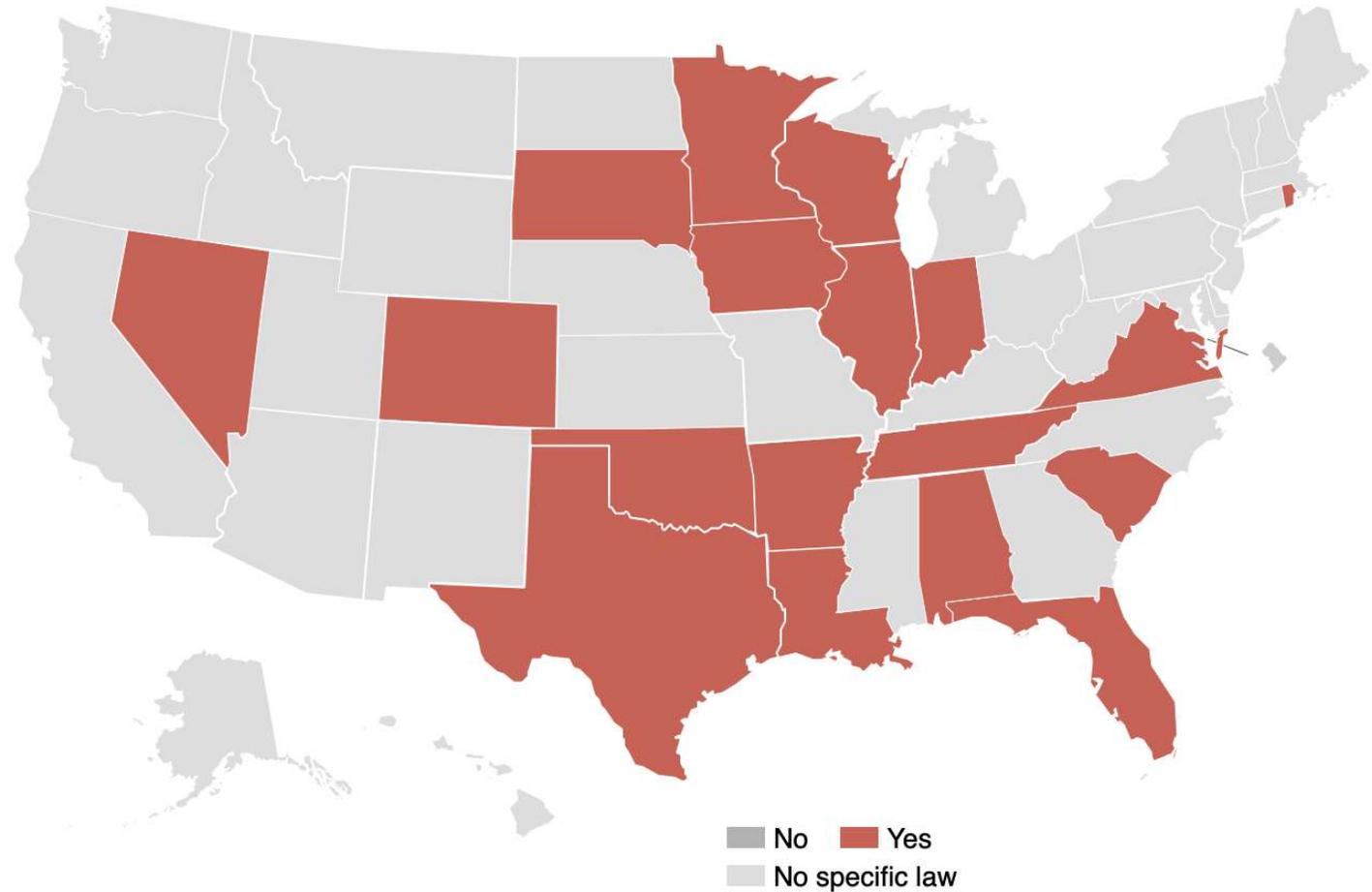
Substance abuse during pregnancy is child abuse

Eighteen states have laws that say drug use during pregnancy is child abuse.

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# CAPTA and Connecticut

- Novel pathway in which substance-exposed infants:
  - Exposure but no concern for abuse or neglect – deidentified CAPTA notification and a plan of safe care (POSC)
  - Exposure and concern for abuse or neglect – add state maltreatment report/referral
- This state does not identify infant prenatal substance exposure as child abuse or neglect

# CAPTA and Connecticut

- 8% of total Connecticut births with a notification
- Over three quarters of notifications (79%) involved cannabis
- 21% involved opioid exposure
- Black birthing people were disproportionately overrepresented in notifications
- Over half of identified prenatal substance exposure cases were diverted from CPS reporting

# CAPTA and Connecticut

➤ **What is the difference between a report and notification?**

A DCF report or referral, sometimes called a “136”, is made when mandated reporters or anyone has concerns about the safety of a child. DCF staff determine if the information meets the statutory definitions of abuse or neglect.

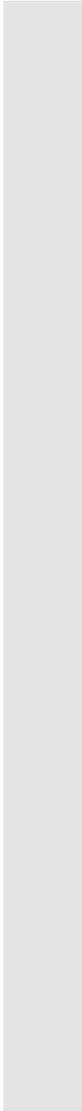
A CAPTA notification to DCF would occur when a newborn has been prenatally exposed to substances but there are no concerns about safety or well-being. This notification does not contain any personally identifying information.

# Summary

- Statutes guiding care with perinatal substance use in Minnesota are important to understand and apply
- Unintended consequences of current statutes, at both a state and federal level, may cause unnecessary harm to patients and families
- Advocacy for statute revisions and modifications is important for providers and administrators seeking to reduce maternal and newborn adverse outcomes in our state

# References

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# QUESTIONS?

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