MDPQC Substance Use Learning Event

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Birth Equity and Health Justice: A Critical Examination of Test and Report

Tuesday, September 10th, 2024 at 12-1pm

Join us for a presentation from Dr. Mishka Terplan, Erin Miles Cloud, JD, and Jessica Maranto discussing mandatory reporting for drug testing in Maryland, why health professionals report, alternatives to over reporting, how the child welfare system is involved, and The Child Abuse Prevention and Treatment Act (CAPTA). This event features a patient story highlighting an important perspective on how reporting can impact family well-being.

Click Here to Register: https://tinyurl.com/bddun5yy

Birth Equity and Health Justice: A Critical Examination of Test and Report

MDPQC
Tuesday September 10, 2024

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. 41,553 © 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 Janu-

Text of Pay Board statement appears on Page 27.

ary, 1970. Its precise impact during Phase Two of the economic stabilization program was not entirely clear.

Pay Board officials said that under the Government's guidelines there was ample justifica-

gress, the Pay Board said, and raises of 2.8 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 SARTIN 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, all 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 Denes 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 Pakistans in East Pakistan had become a rout as Indian troops contused to push the foe into an ever-

“If I Wasn’t Poor, I Wouldn’t Be Unfit”

The Family Separation Crisis in the US Child Welfare System

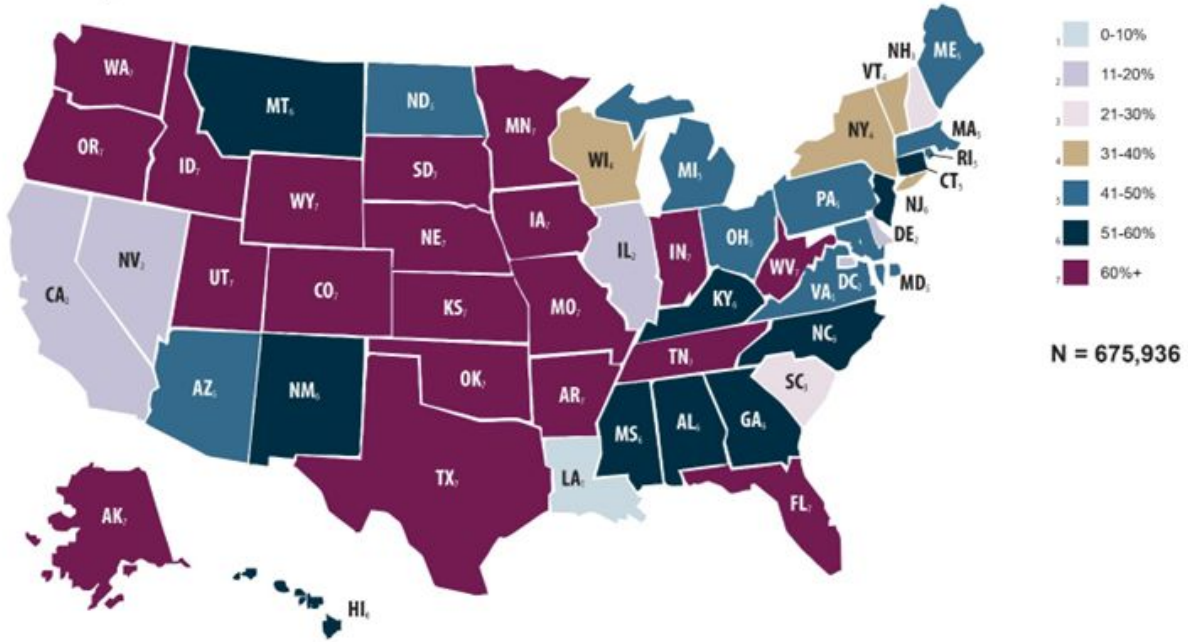
HUMAN RIGHTS WATCH

ACLU

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%



N = 675,936

State Policies on Drugs and Pregnancy have Increased and are Increasingly Punitive

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+

Mandatory Reporting Does Not Improve Population Health Outcomes

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

“Test and Report” Provider Culpability

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

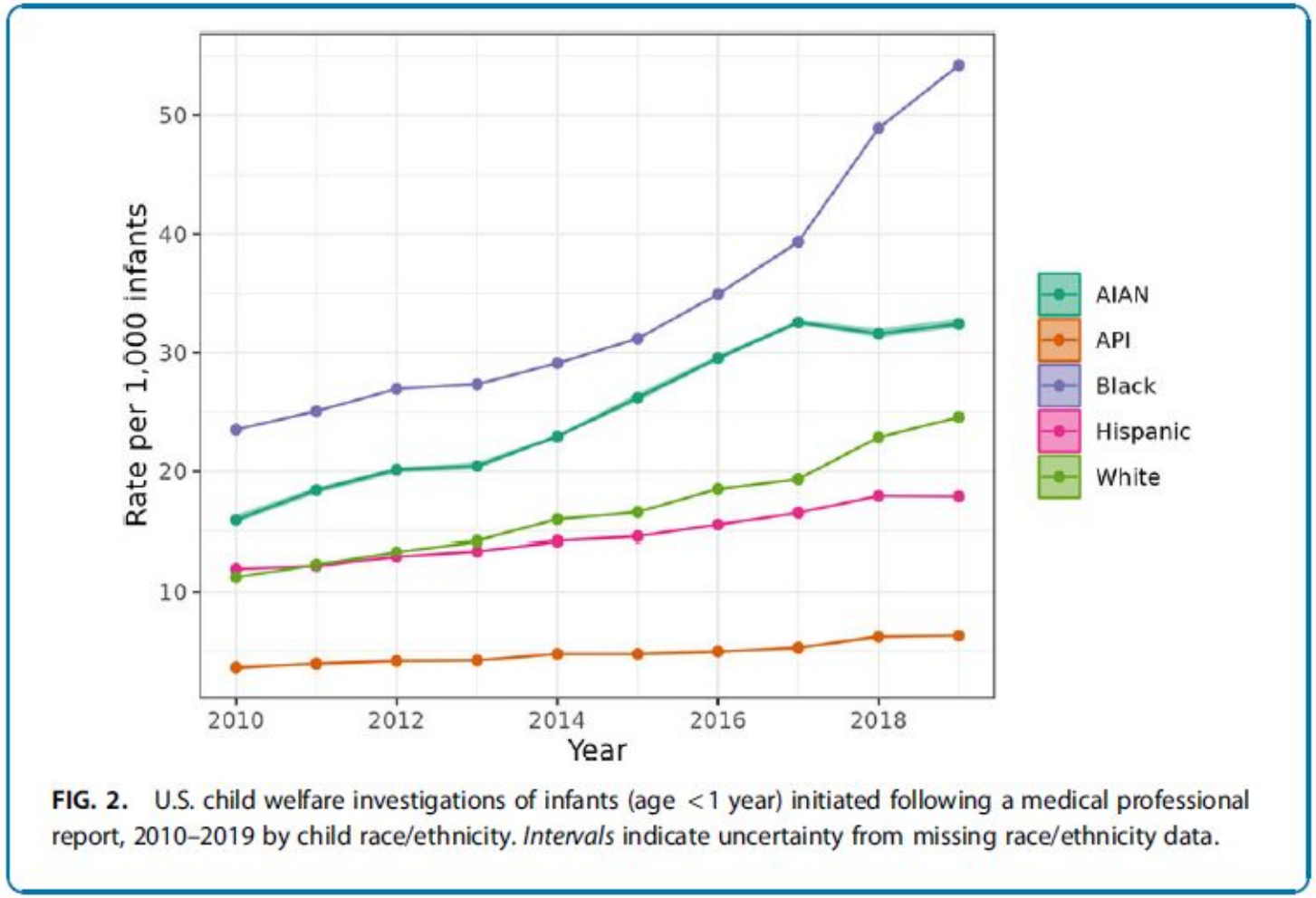


FIG. 2. U.S. child welfare investigations of infants (age <1 year) initiated following a medical professional report, 2010–2019 by child race/ethnicity. *Intervals* indicate uncertainty from missing race/ethnicity data.

HHS 2020 https://www.childwelfare.gov/pubs/factsheets/cpswork/; Edwards F et al, *Health Equity*, 2023; AAP 2015 https://pediatrics.aappublications.org/content/135/5/948

Assessment: Screening and Testing

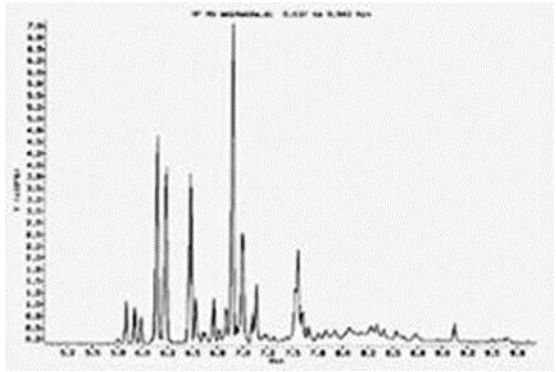
What is a Drug Test?

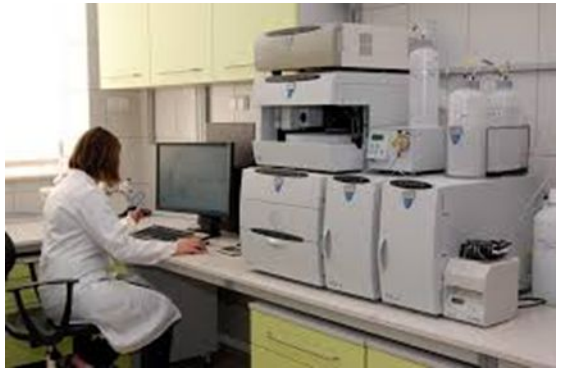
Presumptive

- 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	Substance tested via immunoassay	Potential agents causing false-positive result
Alcohol[20]	Short-chain alcohols (eg, isopropyl alcohol)	Cannabinoids[1,8,43-48]	Dronabinol
			Efavirenz
Amphetamines[21-40]	Amantadine		Hemp-containing foods
	Benzphetamine		NSAIDs
	Bupropion		Proton pump inhibitors
	Chlorpromazine		Tolmetin
	Clobenzorex[b]	Cocaine[49-51]	Coca leaf tea
	l-Deprenyl[c]		Topical anesthetics containing cocaine
	Desipramine	Opioids, opiates, and heroin[8,12,52-63]	Dextromethorphan
	Dextroamphetamine		Diphenhydramine[e]
	Ephedrine		Heroin
	Fenproporex[b]		Opiates (codeine, hydromorphone, hydrocodone, morphine)
	Isometheptene		Poppy seeds
	Isoxsuprine		Quinine
	Labetalol		Quinolones
	MDMA		Rifampin
	Methamphetamine		Verapamil and metabolites[e]
	l-Methamphetamine (Vick's inhaler)[d]	Phencyclidine[8,52,64-70]	Dextromethorphan
	Methylphenidate		Diphenhydramine[e]
	Phentermine		Doxylamine
	Phenylephrine		Ibuprofen
	Phenylpropanolamine		Imipramine
	Promethazine		Ketamine
	Pseudoephedrine		Meperidine
	Ranitidine		Mesoridazine
	Ritodrine		Thioridazine
	Selegiline		Tramadol
	Thioridazine		Venlafaxine, O-desmethylvenlafaxine
	Trazodone	Tricyclic antidepressants[71-81]	Carbamazepine[f]
	Trimethobenzamide		Cyclobenzaprine
	Trimipramine		Cyproheptadine[f]
Benzodiazepines[16,41,42]	Oxaprozin		Diphenhydramine[f]
	Sertraline		Hydroxyzine[f]
			Quetiapine

Moeller KE, Mayo Clinic Proc, 2008

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.

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.

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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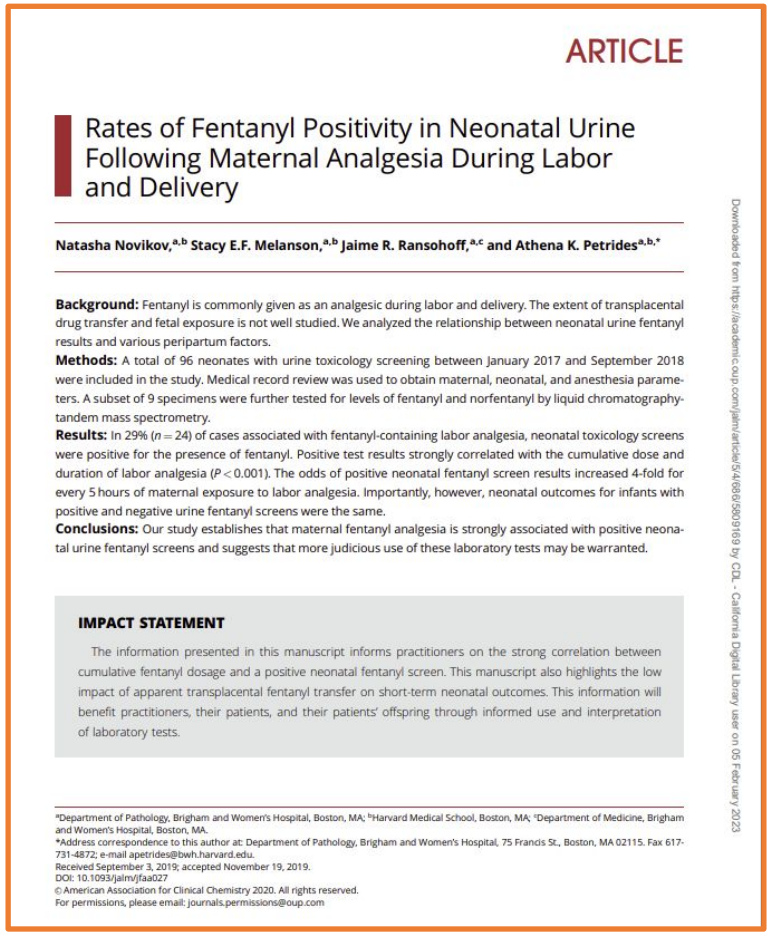
https://doi.org/10.1016/j.ajog.2022.11.1293 Get rights and conte

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.

[a]Department of Pathology, Brigham and Women's Hospital, Boston, MA; [b]Harvard Medical School, Boston, MA; [c]Department of Medicine, Brigham and Women's Hospital, Boston, MA.
*Address correspondence to this author at: Department of Pathology, Brigham and Women's Hospital, 75 Francis St., Boston, MA 02115. Fax 617-731-4872; e-mail apetrides@bwh.harvard.edu.
Received September 3, 2019; accepted November 19, 2019.
DOI: 10.1093/jalm/jfaa027

Drug Tests: Poor Quality Information that is Misinterpreted

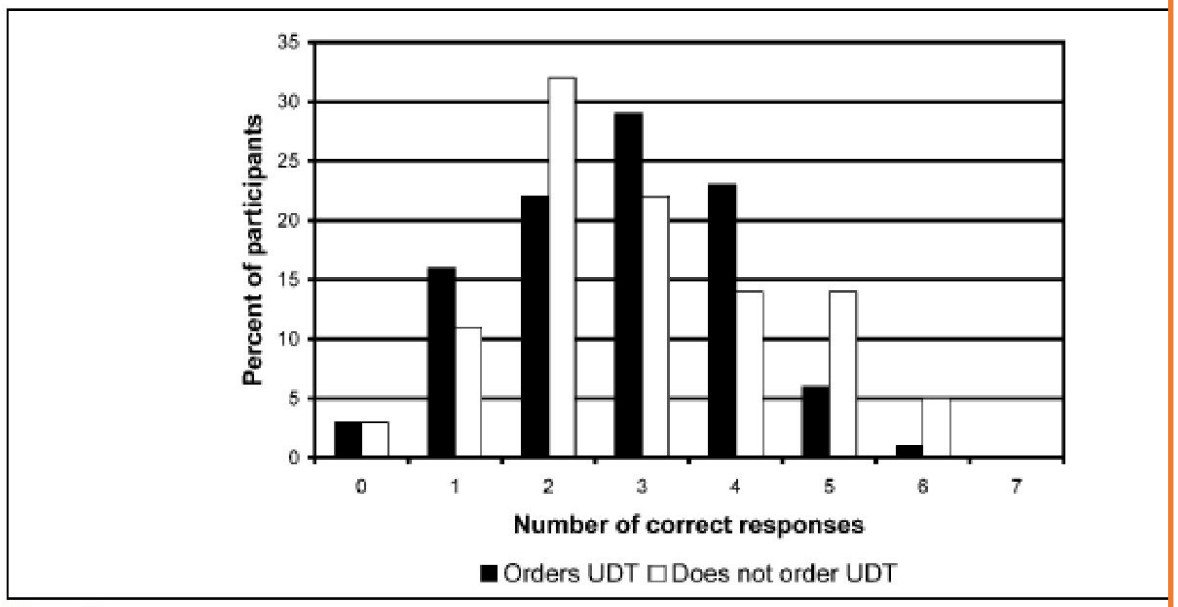


Figure 2.

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 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."

ASAM Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People, 10, 2022

Drug Testing NOT required in CAPTA and NOT criteria for reporting

Professional Society Recommendations are Clear:

- 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

Consent Required for Testing

"Test or Talk: Empiric Bias and Epistemic Injustice" Terplan M, AJOG, 2022

Screening vs. Testing Professional Society Recommendations

Universal Screening:

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

Voluntary
(ACOG, SAMHSA, CDC)

Testing:

Not Recommended

Not an appropriate measurement of addiction

Consent Required
(ACOG, ASAM, SAMHSA)

Newsweek

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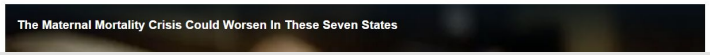
U.S. | Pregnancy Hospitals Drug Testing In-Depth

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

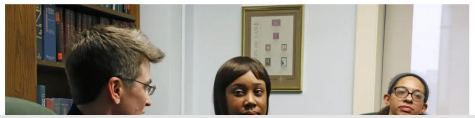


HEALTH-FITNESS

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



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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

“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

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

Provider Assumptions:
Social/Legal Distinctions = Biological/Public Health

Known Teratogens: ACE-Inhibitors, Alcohol, Carbamazepine, Diethylstilbetrol (DES), Isotretinoin, Phenytoin, Tobacco, Valproic Acid (partial list)

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

DOI: 10.1177/1077559521990116
journals.sagepub.com/home/cmx
SAGE

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

Table III. Foundational principles for the clinical definition of opioid withdrawal in the neonate

1. Substance use disorder is a disease requiring compassionate, ethical, equitable, and evidence-based care.
2. The maternal–neonate dyad is the appropriate subject of care; this definition is intended to identify clinical and supportive care needs of the dyad; shared interests should be prioritized.
3. A diagnosis of NAS or NOWS does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.
4. Environmental factors, family influences, and social structures strongly influence neonatal outcome and should be recognized.

THE JOURNAL OF PEDIATRICS • www.jpeds.com ORIGINAL ARTICLES

Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate

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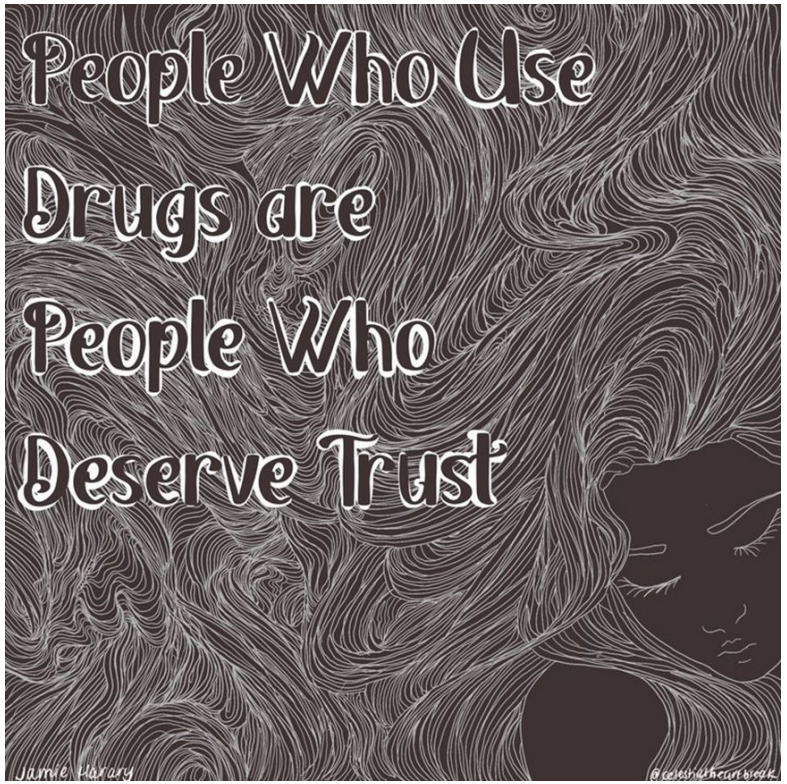
Objective To standardize the clinical definition of opioid withdrawal in neonates to address challenges in clinical care, quality improvement, research, and public policy for this patient population.
Study design Between October and December 2020, we conducted 2 modified-Delphi panels using ExpertLens, a virtual platform for performing iterative expert engagement panels. Twenty clinical experts specializing in care for the substance-exposed mother–neonate dyad explored the necessity of key evidence-based clinical elements in defining opioid withdrawal in the neonate leading to a diagnosis of neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS). Expert consensus was assessed using descriptive statistics, the RAND/UCLA Appropriateness Method, and thematic analysis of participants' comments.
Results Expert panels concluded the following were required for diagnosis: in utero exposure (known by history, not necessarily by toxicology testing) to opioids with or without the presence of other psychotropic substances, and the presence of at least two of the most common clinical signs characteristic of withdrawal (excessive crying, fragmented sleep, tremors, increased muscle tone, gastrointestinal dysfunction).
Conclusions Results indicate that both a known history of in utero opioid exposure and a distinct set of withdrawal signs are necessary to standardize a definition of neonatal withdrawal. Implementation of a standardized

Birth is not Safe for People who use Drugs

Discrimination is a Patient Safety Issue



https://www.movementforfamilypower.org/

Art: IG: @celestialhearetbreak

"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*

Pregnancy and Addiction: Mutual Mistrust

Provider

- Mistrust (often) misplaced
- Rooted in discrimination and prejudice
- Consequences of misplaced trust are minor

Patient

- Mistrust warranted by people who experience oppression
- Legitimate: historic memory and everyday discrimination
- Consequences of misplaced trust are severe

Power Differential
Risk/Vulnerability Different
Responsibility for Overcoming Mistrust Rests with Providers

Thank You mterplan@friendsresearch.org

Doingrightbybirth.org

CLINICIAN CONSULTATION CENTER
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Substance Use Warmline
Peer-to-Peer Consultation and Decision Support
10 am – 6 pm EST Monday - Friday
855-300-3595

Free and confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care

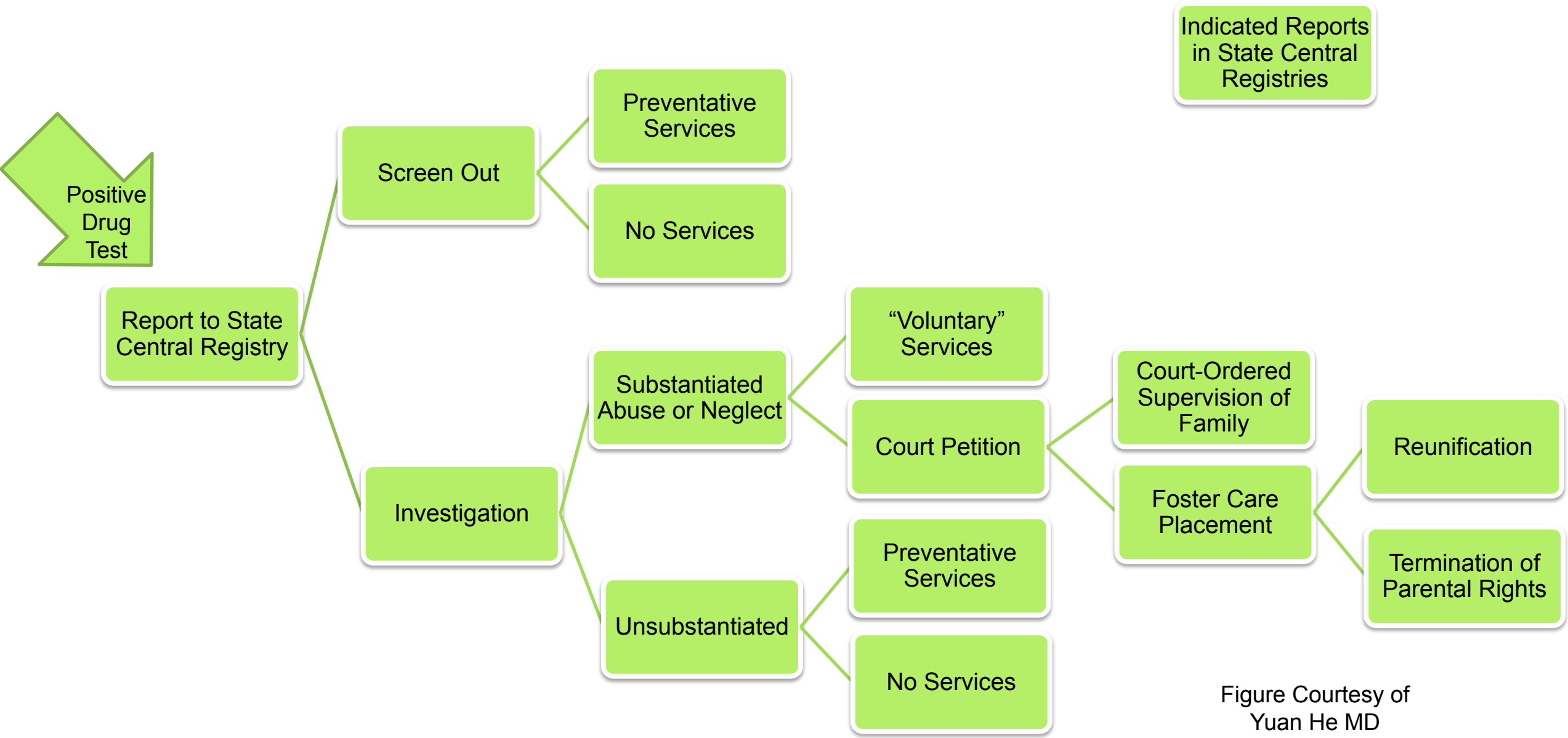

Figure Courtesy of Yuan He MD

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

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.

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

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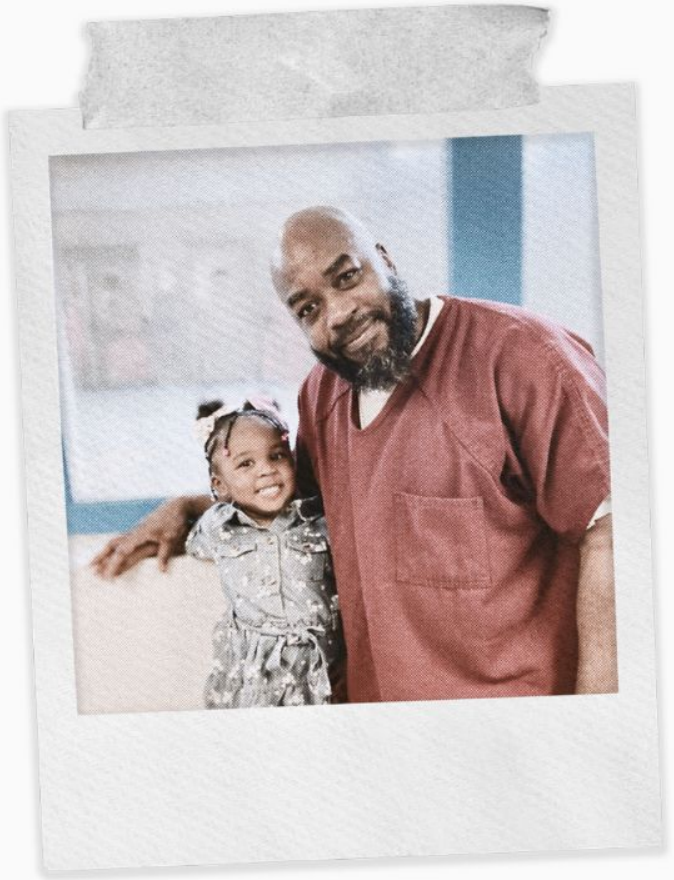


We all have a right to hug our family.

Why Family Policing and Not Child Welfare System?

"The idea of family policing isn't a recent development. Historically, Black and brown communities have always perceived social workers and the foster system as another form of law enforcement that surveilled, criminalized, and investigated their families." – Brianna Harvey

The Paradox of Protection

Today, caseworkers are not only expected to navigate this paradoxical role as helper and investigator; they must also navigate multi-system partnerships between departments and agencies within the larger "Child Welfare" system that have historically ignored family autonomy. These systems include punitive institutions like the courts and police departments. (Roberts)

The Paradox of Protection

- Joint Investigations/Training
- Special Police Units/ MultiDisciplinary Teams
- Normalizing Policing and Investigation as the Primary Intervention

(Cross et al. 2015; Cross, Finkelhor, and Ormrod 2005).
(Roberts 2002; Kim et al. 2016; Wildeman et al. 2014)

Policing not Protecting

Funds Continue to Flow to Investigation, not Material Support

The terms family "policing" and family "regulation" are neither provocative nor hyperbolic. It recognized the constrained capacity of frontline workers to provide treatment, support, or material resources to families and the predominate investigatory role.

The Trauma of Removal

The Birth to Criminalization Pipeline

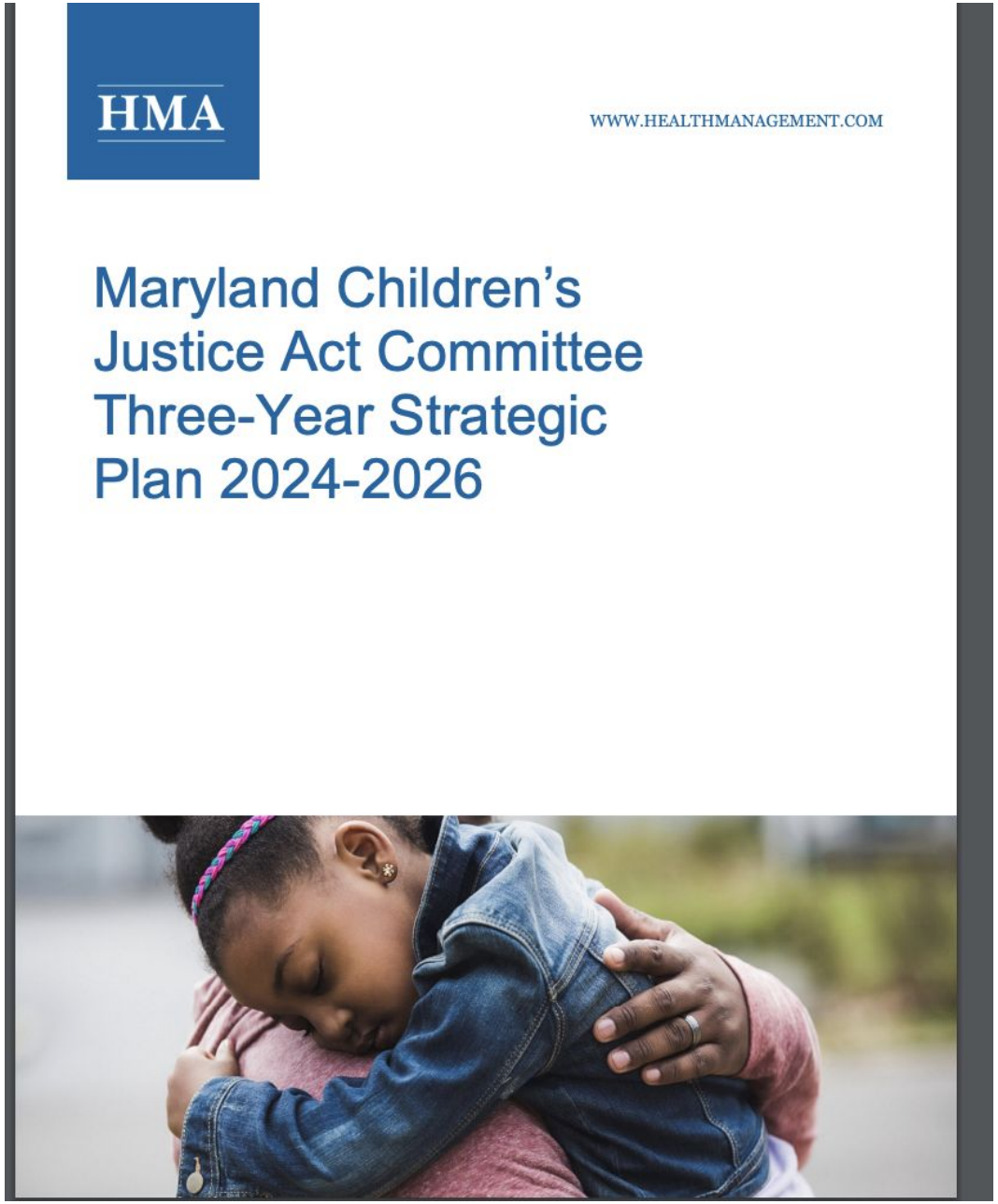
The Birth to Criminalization Pipeline

We are not Preventing Abuse

- For example, a study of Baltimore, Maryland found that sexual abuse in foster placements was substantiated at four times that of the general population. (Trivedi at 542). A similar study from Indiana found that physical abuse in foster placements occurred at three times the rate of the general population, and sexual abuse at twice the rate of the general population.[26]

a. Research shows that expanding the child welfare system has done little to nothing to actually protect children from serious harm. In fact, research shows that each additional $1,000 that states spend on public benefit programs annually per person living in poverty is associated with a 7.7% reduction in child fatalities due to maltreatment. Public benefits are also positively associated with reductions in foster placements (Puls, 2021).

b. There is no evidence to prove that expanding mandated reporting laws are actually protecting children.



Where are medical providers?

Restricted access | Research article | First published online April 18, 2016

Saving Children, Controlling Families: Punishment, Redistribution, and Child Protection

Frank Edwards View all authors and affiliations

Volume 81, Issue 3 | https://doi.org/10.1177/0003122416638652

Abstract

This study shows that state efforts at child protection are structured by the policy regimes in which they are enmeshed. Using administrative data on child protection, criminal justice, and social welfare interventions, I show that children are separated from their families and placed into foster care far more frequently in states with extensive and punitive criminal justice systems than in states with broad and generous welfare ...owever, large welfare bureaucracies interact with welfare program enrollment to create

You are the connection

Restricted access | Research article | First published online April 18, 2016

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Get citation

What can you do?

Maryland[58]

- 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 is positive, a child abuse or neglect report is **NOT** required.

If
When
How

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The Problem | The History | Our Work | Our Coalition | Resources | Take Action

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HEALTH

JUSTICE

REPRODUCTIVE JUSTICE

BIRTHING JUSTICE

BODILY A

DIGNITY

BEYOND DO NO HARM

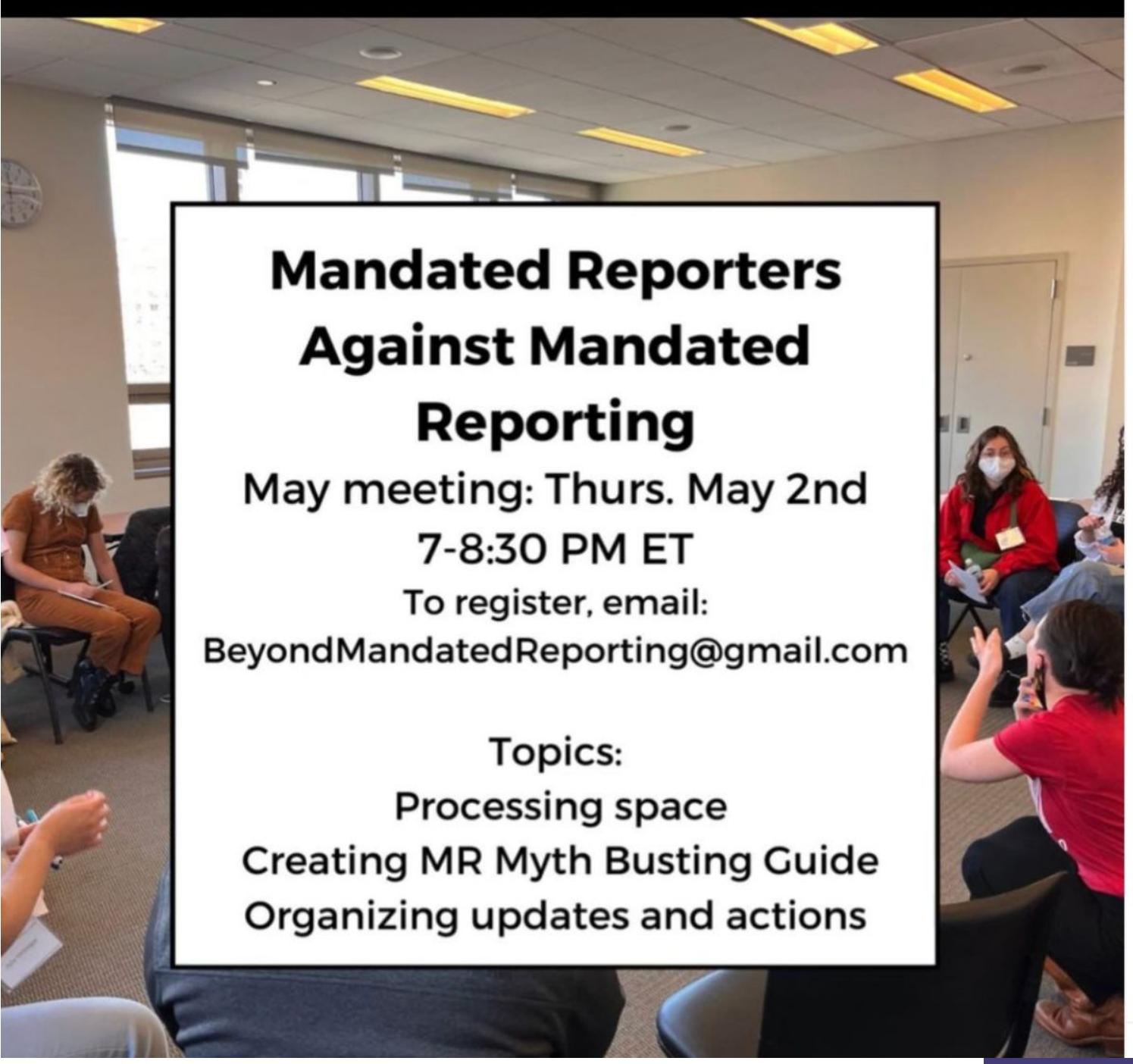
13 Principles for Health Care Providers to Interrupt Criminalization

Resource Documents

Health Care Strategy Consult

Storytelling Media Project

Past Events



beyondreporting Join us tomorrow 5/2 at 7pm EST email for the registration link BeyondMandatedReporting@gmail.com

18w

loladivine__ Hi I sent an email but also realize like my folks above that this may not be virtual?

18w Reply

View replies (2)

hummingbird_divinations Same question. Is this virtual?

18w Reply

View replies (1)

banhmibby where is this located? is there a virtual option?

18w Reply

View replies (1)

@operationstopcps

@upendmovement

@movementforfamilypower

@Blu4Black

@accountablecommunities

@bmorehrc

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The Better Together Program supports families facing investigation by Child Protective Services (CPS) before a case is opened in court, and pregnant women likely to face CPS investigation at birth. We provide legal assistance, community services, and peer support to prevent CPS from removing children from their parents, and keep children in the home with their families whenever possible. Our team of lawyers, a social worker, and parent advocates work with parents to solve problems that could lead to their children being removed.

OUR SERVICES

The Better Together program provides families with individual support, including:

- A Lawyer
- Help with Understanding Your Rights and Responsibilities
- Help with Housing Issues
- Referrals for Substance Use or Mental Health Treatment
- Help with State Benefits
- Supplies for Your Newborn or Children
- Accompanying Parents for Home Inspections and Visits from CPS
- Creating a Plan for Your Children to Remain Home Safely
- Other Services That Your Family May Need

HOW TO GET CONNECTED

Hours: Monday - Friday
9:00 AM - 4:30 PM

(410) 368-0426

opd.bettertogether@maryland.gov

www.opd.state.md.us/bettertogether

219 E. Redwood Street
Suite 900
Baltimore, MD 21202

ABOUT US

The Better Together Early Family Advocacy Program is part of the Parental Defense Division (PDD) of the Maryland Office of the Public Defender in partnership with the Association for the Public Defender of Maryland, Casey Family Programs and the Administrative Office of the Courts' Juvenile and Family Services.

PDD works to prevent family separation and, where families are separated, advocates for reunification of children and their parents.

If a child is ultimately removed, parents working with Better Together will receive representation from the Parental Defense Division of the Office of the Public Defender moving forward.

OUR TEAM

Our Parent Advocates have firsthand experience with CPS. They provide parents with support and resources to help them through the process.

Our Social Workers work closely with parents to identify programs, resources, and supports to overcome family challenges. The goal is to directly tackle those issues that could lead to CPS removing the children.

Our Attorneys provide legal advice and may provide direct legal representation to families at risk of having their children removed and placed in foster care.