MATERNAL DRUG USE AND NAS

Tracking down good data around drug use while pregnant is a struggle, other than that of the alarmingly high and rising rates of use. Government responses to drug use are relatively new. Punitive responses started in the 80s and have blossomed from there. Some states can take the soon to be mother into custody to protect the fetus. This contradicts other states theories of intervention. New Jersey has instead launched a public information campaign, encouraging pregnant mothers, with laws and policy to support them. After Tennessee gaining national attention for its Safe Harbor Law, implementation was obstructed after a more punitive law was passed a year later.

MONTANA GENERAL VIEW

Currently, in the State of Montana reporting laws for providers is not streamlined. Addiction treatment providers are bound by Federal law protecting patient’s rights, so do not report pregnant mothers. However, this same law does not apply outside of addiction treatment. Primary care providers are able to make their own decisions regarding reporting. For example in Great Falls, some primary care providers may report all instances of use of women carrying children, however others have a policy of not reporting to encourage treatment (as long as the mother is not the caregiver for other children). The latter providers would need to trust that punitive measures would not be taken, before they would be willing to work with government entities to report.

Some work has been done through child and family services, seeking to provide preventative case management and resource referral. However, this has been halted as policy does not support it.

A broader struggle for women’s rights and choice is consistent seeking by certain groups to minimize and make illegal resources women have for family planning. This places women’s choice policy on a defensive, making it harder for women’s autonomy and supporting her to be on the offensive.

Currently, Kalispell has an active treatment program for soon to be mothers with a drug addiction, modeled after Oregon. Benefis, in Great Falls has
recently received a grant to implement a similar program. In our rural state, concerns around the stigmatization of drug use, especially for a woman carrying a child is great. The punitive response from the 80’s likely has shaped much of this. Creating a decriminalized view of drug use will likely help women and men seek help sooner and more often.

**Montana Law**

**Chemical Dependency Centers**

Under 42 CFR 2.2(b)(1): The regulations in this part prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstance exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.⁴

**General Health Facilities**

41-3-201 (3): A professional listed in subsection (2)(a) or (2)(b) involved in the delivery or care of an infant shall report to the department any infant known to the professional to be affected by a dangerous drug, as defined in 50-32-101.

41-3-207 Penalty for failure to report: (1) Any person, official, or institution required by law to report known or suspected child abuse or neglect who fails to do so or who prevents another person from reasonably doing so is civilly liable for the damages proximately caused by such failure or prevention. (2) Any person or official required by law to report known or suspected child abuse or neglect who purposely or knowingly fails to report known child abuse or neglect or purposely or knowingly prevents another person from doing so is guilty of a misdemeanor.⁴

**An overview of other states:**

**Tennessee’s Safe Harbor Law: Gutted for Two Years**

Tennessee passed its Safe Harbor Act in 2013, protecting “the rights of pregnant women who seek drug treatment by giving them first priority in treatment facilities, in addition to providing some protections from termination of her parental rights and dependency and neglect proceedings when -or if- treatment is successfully completed.”⁵ The Act resulted from collaboration of health officials across the state ad was supported Nationally.⁵ One important aspect of maternal drug use that was not addressed in the Safe Harbor act was funding for clinics to ensure sufficient accessibility.⁵ Unfortunately, the spirit of the law was gutted in 2014, when Tennessee became the first state to “pass a law criminalizing women for their pregnancy outcomes”⁶ establishing criminal penalties for maternal drug use.⁵ However, the law sunset as of July 1, 2016.⁶

**Illinois**

“The Illinois’ Department of Human Services Division of Substance Use Prevention and Recovery (IDHS/SUPR) considers pregnant women to be a priority population.

IDHS/SUPR requires that providers maintain current policies and procedures that reflect the special
needs of patients who are pregnant. Regulations require prenatal care and other gender specific services be provided either by the opioid treatment provider (OTP) or by referral to appropriate health care providers. IDHS/SUPR requires programs to accept pregnant patients without regard to their ability to pay or the size of the program’s existing population. This is a standard of practice in the field. IDHS/SUPR funds special programs for pregnant women and women with dependent children. These programs will treat families as a unit and admit children with their mothers as appropriate.”


“The New Jersey Department of Health has launched a “Help Yourself. Help Your Baby. Get Treated” (#GetTreated4Baby) public and provider awareness campaign to educate pregnant women and their healthcare providers about the importance of getting screened and treated. The campaign consists of opioid-dependence prevention posters, targeted bus and corner store advertising, promoted social media messages, a robust webpage with information for consumers and providers, and outreach to community partners and healthcare providers.”

“States such as New Jersey have taken more of a personhood stance. New Jersey does not provide many rights to a fetus. New Jersey’s statutory definition for “abused or neglected child means a child less than 18 years of age.” (N.J.S.A. 9:6-8.21(c)(4)(b)). In addition, New Jersey law places emphasis on protecting a child after birth and, as a result, focuses on a child’s condition after birth. Not every instance of drug use will result in a court being able to substantiate a finding of abuse. Although this article is not a forum for an abortion debate, as Roe v. Wade (1973) is well settled law, clarifying and understanding whether states take a personhood or parenthood stance is a critical aspect of how state statutes are formed.”

“In a New Jersey Supreme Court case decided in February 2013, prenatal drug use by a mother may not result in a finding of abuse or neglect to a “child” if there is no evidence of “actual harm,” “imminent danger,” or “substantial risk” upon the birth of the child. N. J. Dept. of Children and Families v. A.L., 213 N.J. 1, 8 (2013). Moreover, the court limited the conditions of abuse and neglect to applying only after the birth of the child, stating that there could be no “actual harm,” “imminent danger,” or “substantial risk” to a fetus. Id.”

Additionally, New Jersey has outlined policies for collaborative treatment approach, using information resources such as the World Health Organization, the American Society of Addiction Medicine, and the American College of Obstetricians and Gynecologists. The call for collaboration is for “professionals in the child welfare, judicial, medical (including obstetrics, pediatrics, substance abuse treatment, and mental health), and addiction treatment systems.”

**Why treatment?**

“Laws punishing pregnant women have been widely condemned by addictions experts, women’s rights advocates, and the medical community, including the American Medical Association and American College of Obstetricians and Gynecologists.” Not only do punitive approaches deter women from seeking treatment, they could also drive women to stop use on their own. The
variability in dosage can cause fetal hypoxia and fetal death. The World Health Organization and the United Nations Office on Drugs and Crime, compiled a draft of “International Standards for the Treatment of Drug Use Disorders” for field testing. The Standards devote an entire chapter to Special Populations, one of which is pregnant women. They standards state: “Best outcomes are for treatment that use all evidence based treatments while addressing the myriad of complex medical and psychosocial problems.” Additionally, “the vast majority of these women are conflicted, ashamed, and guilt-ridden about what they often see as their inability to ‘control’ their substance-using behavior.” punitive measures would assist in the rehabilitation, at this point.

References