MINNESOTA

Task Force on Pregnancy Health and Substance Use Disorders

Recommendations to the Minnesota Legislature

12/01/2024

Contact information

Minnesota Department of Health
Maternal and Child Health
625 N. Robert St.
St. Paul, MN 55155-2538
(651) 201-3650
health.mch@state.mn.us

www.health.state.mn.us

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About this report

The Minnesota Department of Health engaged Management Analysis and Development to facilitate the task force and draft a report on their behalf. The task force adopted recommendations in this report on October 10, 2024.

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Executive summary

Laws of Minnesota 2023, chapter 70, article 4, section 110, required the Commissioner of Health to convene a Task Force on Pregnancy Health and Substance Use Disorders to recommend protocols for when physicians, advanced practice registered nurses, and physician assistants should administer a toxicology test and requirements for reporting for prenatal exposure to a controlled substance.

The task force was composed of twenty members from various backgrounds who were appointed by different professional associations, councils, and organizations. It met seven times from December 2023 to October 2024. The task force work was guided by leadership from two co-chairs and work got done through various workgroups at three distinct time periods. Throughout its discussions, the task force emphasized the importance of developing recommendations that were centered on people and their culture, valued an individual's agency, were trauma informed, and recognized that substance use disorder is a disease that affects the whole family.

Key research informing the recommendations

Substance use disorder is a chronic, relapsing disease. Substance use disorder (SUD) is a medical condition defined by the inability to control use of a substance(s) despite knowing the harmful consequences. The Center for Disease Control (CDC, 2024 May 15) states the prevalence of SUD in the United States is high: in 2020, 14.5 percent of the US population over the age of twelve had an SUD in the previous year, which is 40.3 million people total. SUD is a chronic disease with cognitive, behavioral, and physiological symptoms.

Pervasive stigma and misunderstanding of substance use exists. According to a World Health Organization survey of fourteen countries, SUD and alcohol use disorder are respectively the number one and four most stigmatized conditions across countries (Room et al., 2021). Pregnant people who misuse substances or with SUD often feel intense fear and shame, as there is persistent stigma and bias in the healthcare system regarding substance use. An estimated 28 percent of the individuals who do not receive treatment for substance use disorder report reasons related to stigma for not accessing treatment (CBHSQ, 2017).

Punitive laws and practices decrease prenatal care and are associated with worse outcomes for infants and pregnant/birthing persons. Minnesota has some of the most punitive laws in the United States for substance use during pregnancy. Punitive measures have been associated with poorer outcomes for pregnant people and their infants. People who report using substances during pregnancy are less likely to seek care during pregnancy (Son et al., 2018), at rates of nearly three times greater than pregnant people who did not report use (Nidey et al., 2022).

Toxicology testing is a poor and incomplete way to assess persistent misuse of substances. Both research and practice on toxicology testing point to significant problems with the use and interpretation of toxicology tests. A negative test provides no indication of current substance use or whether substance use is an important consideration in the birthing person's or infant's medical condition. Toxicology testing has many limitations that are frequently underappreciated (Algren & Cristian, 2015).

Family care plans provide support and resources to improve care coordination for the parent-infant dyad. Family care plans, also known as Plans of Safe Care, have been a requirement under the Child Abuse Prevention

and Treatment Act (CAPTA) since the passage of the Comprehensive Addiction and Recovery Act (2013)(H.R. 14, 2003). Family care plans are designed to improve infant safety and promote recovery options for caregivers (NCSACW n.d).

Multidisciplinary teams identify safety concerns and keep families safe. Multidisciplinary collaboration has become firmly established as a critical factor within healthcare and child protection (WHO, 2010; Minnesota Statutes 2023, section 260E.02). There is evidence that when healthcare teams across disciplines practice collaboratively it can improve the delivery of person-centered care and lead to improved patient and health systems outcomes (Brandt et al., 2014; Reeves et al., 2017; Sangaleti et al., 2017). Child Protection Services (CPS) cannot always keep the worse outcomes from happening. It takes a community to keep families safe.

Healthcare providers continually assess concerns for safety. Healthcare providers constantly evaluate child safety concerns and assess whether a parent can adequately and safely care for their infant, or if there is reason to believe that the family's situation poses a risk to the child. A healthcare providers' ethical principle of nonmaleficence posits they must "… weigh the benefits against burdens of all interventions and treatments, to eschew those that are inappropriately burdensome, and to choose the best course of action for the patient" (Varkey, 2021).

Recommendations

Task force members developed six recommendations intended to offer a more equitable approach to testing and reporting, reduce stigma, and provide better care and support to those experiencing substance use disorder. The task force's complete recommendations and rationale is in the body of this report, starting on page nine.

Recommendation 1: Change punitive laws that criminalize prenatal substance use or define it as child maltreatment.

The task force recommends changing existing laws that mandate toxicology testing and require a report to Child Protection Services (CPS) for substance use alone or that classify substance use by pregnant or birthing individuals as child abuse or neglect.

Recommendation 2: Implement universal screening using a validated screening tool.

The task force recommends using a validated screening tool to identify substance use disorders in pregnant people. Recommended screening timing should correspond to the American College of Obstetrics and Gynecology's (ACOG, 2018) recommendation for perinatal mental health screening because substance use disorder and mental health conditions have a high comorbidity.

Recommendation 3: Conduct toxicology testing only when it serves a medical treatment purpose.

Toxicology testing is indicated when it will change the medical management of the pregnant person or newborn infant. Testing should occur when obvious signs of withdrawal or recent substance use pose a risk to the infant or would alter medical management for the infant and/or the pregnant, birthing, or postpartum person.

Recommendation 4: Develop family care plans early in pregnancy.

Healthcare systems should create standard operating procedures and processes to support the development of family care plans to ensure patients receive appropriate referrals for substance use care, and to provide community support, resources, and services that build on the patient's strengths.

Recommendation 5: Create a uniform process for notification and reporting to the Department of Children, Youth, and Families and the local child welfare after birth.

The task force recommends creating a notification system that will serve as a more nuanced pathway to support families with substance use disorders. The notification system will be separate from the Minnesota state system for reporting alleged abuse and neglect. Notifications are intended for monitoring, federal compliance, and public health planning to create a system of support to improve care coordination and health outcomes for the parent-infant dyad.

Recommendation 6: Support implementation of task force recommendations and develop data-informed best practice guidelines.

The task force recommends a multidisciplinary workgroup lead the implementation of recommendations and the development of data-informed best practice guidelines. Support for implementations also requires sustained investments in funding, data and evaluation, and education and training.

Task force full report

Background

This report presents the findings and recommendations from the Task Force on Pregnancy Health and Substance Use Disorders. The Minnesota Department of Health's Child and Family Health Division provided administrative support and conducted research for the task force. This division is responsible for providing statewide leadership and public health information essential for promoting, improving, or maintaining the health and well-being of women, children, and families throughout Minnesota. The Minnesota Department of Health (MDH) partnered with Minnesota's Management Analysis and Development (MAD) team for consultation services to plan, convene, and facilitate the work of the task force. MAD drafted this report on behalf of the task force.

Task force charge and duties

Laws of Minnesota 2023, chapter 70, article 4, section 110, required the Commissioner of Health to convene a Task Force on Pregnancy Health and Substance Use Disorders to recommend protocols for when physicians, advanced practice registered nurses, and physician assistants should administer a toxicology test and requirements for reporting for prenatal exposure to a controlled substance with the following two duties:

- The task force shall develop recommended protocols for when a toxicology test for prenatal exposure to a controlled substance should be administered to a birthing parent and a newborn infant. The task force must also recommend protocols for providing notice or reporting of prenatal exposure to a controlled substance to local welfare agencies under Minnesota Statutes, chapter 260E.

- No later than December 1, 2024, the task force must submit a written report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services on the task force's activities and recommendations on the protocols developed.

The task force was composed of twenty members from various backgrounds who were appointed by different professional associations, councils, and organizations. Refer to Appendix A for the full law and Appendix B for a full list of task force members and who appointed them.

Task force process

The task force met seven times from December 2023 to October 2024. To ground the work of the task force, an orientation took place in October 2023, during which the task force reviewed a draft charter and operating procedures. Refer to Appendix C for task force member responsibilities and general procedures. In addition, task force members were interviewed in the fall of 2023 to create a shared foundation that guided the work of the task force. Eighteen members completed interviews with a senior management consultant with Management Analysis and Development (MAD). A first-round interview summary was shared during the December 2023 task force meeting. Additional interviews were conducted with newly appointed task force members, and the MAD team updated the interview summary and shared findings in March 2024. Refer to Appendix D for the full summary.

The task force interviews showed common values that shaped the way they approached development of the recommendations. These values are:

- **People centered.** People are people first. Treat people as human beings. Believe them. They are the experts in their own lives.
- **Self-determination.** People have their own agency. Meet people where they are.
- **Trauma informed, culturally centered.** Recognize the intergenerational impacts of historical and cultural trauma, including adverse childhood events (ACEs) and honor culturally centered approaches.
- **Family based.** Substance use is not one person's disease or struggle. It affects everyone in the family. There is trauma with family separation. Whole family solutions are deeply important.

The task force interviews uplifted three common hopes for the creation of recommendations:

- **Better care and supports.** Often our systems, structures, and processes put the health of the pregnant person and health of the infant in conflict instead of seeing their health as interrelated and interconnected. Punitive laws and practices perpetuate this disparity and criminalize SUD. It is important to maintain a commitment to the health and safety of both pregnant people and infants.
- **Reducing stigma and fear.** There is pervasive stigma and misunderstanding of perinatal substance use. Pregnant people often also feel intense fear and shame. It is vital pregnant people can access the compassionate care they need without fear or stigma regardless of cultural background.
- **Equitable and ethical testing and reporting.** Testing and reporting of pregnant people who have SUD instills mistrust in the healthcare system and often re-traumatizes patients. Those with SUD are often stigmatized, mistreated, and subject to poor medical experiences and experiences with Child Protection Services (CPS). An egalitarian approach to testing and reporting that results in clear standards implemented consistently is required.

The task force interviews also surfaced many initial considerations for testing and reporting that provided a foundation for early task force learning, dialogue, and work. Refer to Appendix C for the full interview summary.

The task force work was guided by leadership from two co-chairs and work was completed through various workgroups at three distinct time periods. The first two workgroups formed in February 2024 to develop initial protocols for testing and reporting that were presented at the fourth task force meeting in June 2024. Over the summer, another workgroup integrated the testing and reporting protocols to develop a set of ten draft recommendations that were presented during the fifth meeting in August 2024. For approximately four weeks, task force members gathered input from community members and stakeholders with a special emphasis on hearing the perspectives, experiences, and feedback of individuals and populations most likely to be impacted and most likely not to agree with the proposed recommendations. The task force discussed the input received during its September 2024 meeting and a final workgroup convened to make changes to the draft recommendations. Final recommendations were unanimously approved during the final task force meeting. Refer to Appendix E for more information about the path to task force recommendations.

Research for task force recommendations

The Minnesota Department of Health (MDH) created a resource library before the work of the task force began. An initial literature review conducted by MDH provided a foundation, and task force members were invited to contribute to the resource library. As the draft protocol outlines and recommendations were developing, task force members and MDH conducted additional research to ground the recommendations. In total, more than one hundred resources were reviewed and ultimately included within the resource library.

Research findings in seven areas are shared below, as they had significant impact on the development of recommendations.

Substance use disorder is a chronic, relapsing disease

Substance Use Disorder (SUD) is a medical condition defined by the inability to control use of a substance(s) despite knowing the harmful consequences. The American Psychology Association (APA) has eleven DSM-5 criteria for diagnosing SUD (American Psychiatric Association 2013). SUDs range from mild to severe depending on the number of criteria met. The Centers for Disease Control (CDC, 2024, April 15) states the prevalence of SUD in the United States is high: in 2020, 14.5 percent of the US population over the age of twelve had an SUD in the previous year, which is 40.3 million people total. Substance use includes opioid use, alcohol use, cannabis use, and other drug use disorders. SUD is considered a chronic disease with cognitive, behavioral, and physiological symptoms. SUD affects people from all racial, ethnic, and socioeconomic backgrounds. The Office of the Surgeon General estimates the annual economic impact of substance misuse to be $249 billion for alcohol misuse and $193 billion for illicit drug use (DHHS, 2023, August 31).

Return-to-use rates for substance use disorders are also high, at 40-60 percent. Although SUD is a chronic and relapsing disease, recovery is possible for anyone with an SUD with effective supports and resources. Healthcare providers who care for people with SUD believe it should be treated like other chronic illnesses, with relapse signaling the need for modified treatment (Sim et al., 2016).

Prenatal substance use is a significant public health issue. Overdose is a leading cause of maternal fatality during pregnancy and postpartum (Smid & Terplan, 2022). Nearly one in five pregnant individuals report having nicotine, alcohol, or illicit substance use in the last month, with almost 15 percent of those meeting the criteria for SUD (Smid & Terplan, 2022). Children living in households where one or both parents misuse substances face increased risks. The risks of parental substance misuse include oversedation and overdose, which put children at risk for neglect, as well as increased risk of abuse or exposure to household violence (Spehr et al., 2017). Research has found that outcomes for substance-exposed infants and their families are influenced more by postnatal cumulative environmental risks than prenatal substance exposure itself. Early interventions to reduce cumulative socioeconomic and environmental risk factors such as homelessness, domestic violence, poverty, and maternal depression have been shown to significantly improve infant development (Muir et al., 2022 and Seiger et al., 2022).

Pervasive stigma and misunderstanding of substance use exists

The personal experiences and challenges for someone with SUD are often underappreciated in society. Many people face rejection of family and friends and a large majority of people in the United States see SUD as a moral failing rather than a public health issue (Medina et al., 2022). According to a World Health Organization survey of fourteen countries, SUD and alcohol use disorder are the number one and four most stigmatized conditions across countries when compared with other conditions such as mental illness, HIV-positive status, physical disability, and having a criminal record (Room et al., 2021).

Pregnant people who misuse substances or with SUD often feel intense fear and shame because there is persistent stigma and bias in the healthcare system regarding substance use. Historical trauma influences this fear in addition to current laws, policies, and practices. American Indian patients with a substance use disorder may be even more fearful of seeking care during pregnancy due to historical trauma related to child removal (Mitchell-Foster et al., 2021). Black patients may have mistrust in the system due to historical trauma related to Black bodies being used for medical research (Anani et al., 2022).

Black patients are more likely to have urine toxicology testing at any point during pregnancy compared with white patients or patients of another race, regardless of whether they have a history of substance use. However, Black patients do not have a higher likelihood of a positive test (Jarlenski et al., 2023), and race is not predictive of urine toxicology results at labor and delivery (Son et al., 2018). This research points to discrimination in testing. A qualitative study of US-based obstetric and pediatric providers found that the providers acknowledged bias in how drug use screening and testing protocols are implemented (Jarlenski, et al., 2019). An evaluation conducted in the state of New Mexico found that not having a universal screening policy led to discriminatory or biased screening practices, with over- or underdiagnosis of SUD or substance-exposed infants for certain groups (NM LFC, 2023).

Stigma around SUD contributes to the disparity between the number of people who need treatment for SUD and those who receive it. An estimated 28 percent of the individuals who do not receive treatment for substance use disorder report reasons related to stigma for not accessing treatment (Center for Behavioral Health Statistics and Quality 2017). In general, people in the US have negative feelings toward people who have an SUD and do not consider it to be a chronic illness (CDC, 2024, April 15). Stigma influences healthcare providers' actions. Healthcare providers have been found to decline prescribing medication-assisted therapy, despite it being a useful and effective way to overcome addiction (CDC, 2024, April 2). The CDC (2024, April 25)

also highlighted a failure to include SUD education in curricula for healthcare workers, first responders, and law enforcement.

Van Brakel et al. (2019) studied efforts to combat stigma in healthcare and found information-related interventions, such as trainings and education, to reduce stigma are the most used approach. Promising practices for reducing SUD bias include building knowledge about addiction and therapies, using clinical and neutral language when documenting or talking about patients with SUD, and addressing individual or personal implicit biases. In addition, encouraging connection between persons affected by a particular condition and providers has been shown to be effective in improving attitudes and changing negative stereotypes. (Ginther & McNally, 2024). A study in Indonesia examined the effectiveness of an addiction medicine training as part of medical school curriculum and found improved understanding of addiction, better attribution of addiction to psychological factors, and less demoralized views of addiction (Ayu et al., 2022). These results from around the world show promise for training and education to combat bias and stereotypes regarding substance use.

Punitive laws and practices decrease prenatal care and are associated with worse outcomes for infants and pregnant/birthing persons

Minnesota has some of the most punitive laws in the United States for substance use during pregnancy. Minnesota is:

- One of twenty-four states that designate prenatal substance exposure and/or substance use as child abuse or neglect (LAPPA, 2024)
- One of only five states where pregnant women with substance use can be involuntarily committed to a treatment program (Bruzelius et al., 2024)

State laws have been changing on the topic of substance use in pregnancy, so exact numbers on testing laws is difficult to find. Minnesota is part of a small group of states who require healthcare providers to report substance use during pregnancy and part of a few states where a toxicology test is required if there are drug-related complications at birth (LAPPA, 2024; If/When/How Lawyering for Reproductive Justice 2024; Dailard & Nash, 2000).

Previous research has examined the effects of punitive prenatal substance use policies on maternal and infant health outcomes, finding no reductions in neonatal abstinence syndrome incidence and decreases in admissions to SUD treatment for pregnant people (Atikin 2020; Faherty et al., 2022; Faherty et al., 2019; Kozhimannil et al., 2019). Punitive measures have been associated with poorer outcomes for pregnant people and their infants. A study by Meinhofer et al. (2022) suggest punitive prenatal substance use policies are not effective in reducing adverse birth outcomes and may reduce use of prenatal care and increase neonatal drug withdrawal syndrome (Meinhofer et al., 2022). The American Academy of Pediatrics “reaffirms its position that punitive measures taken toward pregnant women are not in the best interest of the health of the mother-infant dyad.” Austin et al. (2022) found by analyzing Pregnancy Risk Assessment Monitoring System (PRAMS) data across the nation that mandated reporting policies are associated with lower rates of antenatal care and postnatal care among patients who use substances. Pregnant people in states with mandated reporting were less likely to start prenatal care in a timely way, to receive adequate prenatal care, or to receive any postnatal care.

People who report using substances during pregnancy are less likely to seek care during pregnancy (Son et al., 2018), at rates of nearly three times greater than pregnant people who did not report use (Nidey et al., 2022). Stone (2015) stated, "by adopting policies that scare women away from treatment, clinics and health organizations lose the opportunity to intervene and promote maternal and infant health." Pregnant people afraid of detection avoided medical care, which included scheduling visits around their substance use so that any tests would come up negative, skipping visits, or avoiding prenatal care altogether. This fear makes patients reticent to discuss substance use with their healthcare providers (English & Greyson, 2022). Additionally, research has shown that in states with more punitive substance use policies (like Minnesota), infants placed into foster care have lower chances of reunification with their birth parents (Sanmartin et al., 2020).

Seiger et al. (2022) found that community- and home-based integrated substance use services lead to pregnant people attending more prenatal care visits and having lower risk for premature delivery. Roberts & Nuru-Jeter, (2010) found the baby's health was the primary motivator to take the risk of staying in prenatal care. "When providers appeared to 'understand' and supported women for progress in reducing use, it was easier for women to attend and engage in subsequent prenatal care, even if they continued drug use" (Roberts & Nuru-Jeter, 2010).

According to the 2018 National Survey of Substance Abuse Treatment Services, Minnesota ranks among the lowest states in providing treatment services for pregnant and postpartum people with substance use disorders (SAMSHA, 2018). Kozhimannil et al. (2019) analyzed care-seeking behaviors of pregnant people with SUD and found states with only criminal-justice-system-oriented-policies have a lower proportion of pregnant admissions to substance use treatment programs and was consistent across ages (other than 15–24-year-olds) and racial groups. The results from this study suggest that criminalizing substance use leads to less enrollment in treatment relative to other people of reproductive age.

Toxicology testing is a poor and incomplete way to assess persistent misuse of substances

Both research and practice on toxicology testing point to significant problems with the use and interpretation of toxicology tests. Toxicology testing is a poor and incomplete way to assess substance use. A negative test provides a feeling of certainty that is not justified because it provides no indication of current substance use or whether substance use is an important consideration in the birthing person's or infant's medical condition.

Toxicology testing has many limitations that are frequently underappreciated. These limitations require caution when performing, interpreting, and acting on results. Algren & Cristian (2015) highlight major concerns with toxicology tests for substance use.

- **Limit of detection:** Each drug that is tested has a minimal amount that must be present to find the substance (limit of detection)—this can result in false negatives if the person has used a substance but the amount in their system at time of testing is quite low.
- **Drug absorption:** Different tests and different drugs influence how long a substance is detectable in one's system. This can range from 24 hours to six weeks, depending on the drug, the amount used, and the test employed. Urine toxicology tests, the most common tests used during pregnancy, generally have a detection window of 24–72 hours, which varies depending on what substance is being tested for.

- **False positives:** Different prescription or illicit drugs can produce false negatives and false positives. For example, sertraline (a drug very commonly used for depression, and particularly for women who are pregnant or postpartum) can give a false positive result for benzodiazepine use. Ibuprofen can cause false positives for marijuana. Confirmation of these preliminary results may take extended time during which these false positives results have been acted upon. Further, these tests cannot differentiate between prescribed opiates and the same opiate that was illicitly obtained or misused. For example, it would be impossible to confirm that a positive result for fentanyl was from fentanyl given to a laboring person for pain or from previous illicit fentanyl use. More than twenty-two common medications may trigger a false positive for a urine toxicology test for amphetamines and still may not be able to differentiate between non-prescribed and prescribed amphetamines (for example medications prescribed for ADHD).

Toxicology testing of an infant is used to identify an untreated substance use disorder in the birthing person. This is primarily useful for forensic purposes and not for immediate medical care of the infant. Like toxicology testing of birthing people, toxicology testing for infants is problematic for several reasons, including:

- **Physical signs of substance use:** Identifying infants with substance exposure is challenging because some of the symptoms can look like common neonatal problems (such as low blood sugar or fatigue from the birth process). The occurrence and clinical presentation of Neonate Opioid Withdrawal Syndrome (NOWS) can differ depending on what type of substance the person was using, how recently, how much, and other factors related to absorption and circulation of the substance. Withdrawal symptoms could start within twenty-four hours if the pregnant/birthing person recently used heroin but can take days to present from use of other opioids (including methadone). This means that the parent-infant dyad might not be recognized as needing testing until they have already left the hospital (Patrick et al., 2020).
- **Toxicology test timing:** Infant urine drug tests must be done nearly immediately to detect substances because these are metabolized quickly and gone within a few days. Positive urine tests would indicate very recent use of substances, not remote use earlier in pregnancy (Patrick et al., 2020). In addition, confirmatory tests for infants can take multiple days. By the time the confirmatory test comes back, the infant may be discharged, so determining what response is best becomes more complex, with more delays. Follow-up also likely involves a different healthcare provider, which can lead to gaps in important information.
- **Testing sample:** There is no perfect toxicology test to serve the multiple purposes of medical management, assessing problematic substance use, and testing for infant safety. Even the preferred method by the American Academy of Pediatrics of meconium testing provides no information on timing, extent, or chronicity of exposure during pregnancy, unlike urine toxicology testing which for most illicit substances indicates acute exposure near the time of birth and a higher likelihood of birthing person substance use disorder.

Family care plans provide support and resources to improve care coordination for the parent-infant dyad.

The Centers for Disease Control and Prevention states that ensuring the well-being of children is a shared responsibility, and the prevention of child abuse and neglect requires key sectors of society working together to focus on comprehensive strategies and approaches (CDC, 2024, May 16). The importance of using a parent-infant dyad lens to provide integrated care services is critical (Lisonkova et al., 2019; Glazer et al., 2021).

Family care plans, also known as Plans of Safe Care, have been a requirement under the Child Abuse Prevention and Treatment Act (CAPTA) since the passage of the public law 108-36, Keeping Children and Families Safe Act of 2003. The National Center on Substance Abuse and Child Welfare (NCSACW n.d) states that a Plan of Safe Care is "designed to improve the 1) safety and well-being of infants affected by prenatal substance exposure and 2) recovery outcomes for their caregivers."

> **Important notes about language:** Many states have shifted away from using the language of "Plan of Safe Care" to "Family Care Plan" in alignment with proposed changes from the CAPTA reauthorization Act of 2021. The task force supports the adoption and use of family care plans.
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> Additionally, Minnesota's Best Practice Guide for Responding to Prenatal Exposure to Substance Use (DHS 2020), which provides direction to child welfare staff about the development of Plans of Safe Care, outlines, "The plan of safe care consists of both a written safety plan and a service plan." This guidance is based on the current response protocols where all reports of prenatal exposure receive a child protection response. If implemented, new recommendations would require current guidance to shift. The task force uses a family care plan as an equivalent to a service plan. The family care plan is not a written safety plan. When safety concerns are present that reach a threshold for concerns for child abuse or neglect, a report to CPS is required. A written safety plan would continue to be required in a child protection response.

Implementation of family care plans are a critical tool to improve care coordination across multiple systems and ultimately to improve health outcomes for the parent-infant dyad. According to the Model Substance Use during Pregnancy and Family Care Plans Act (LAPPA, 2023), "The sooner a pregnant individual engages in treatment and supportive services as facilitated by a family care plan, the better the outcomes for both parent and child." Research led by Seiger et al. (2022) also found that developing a family care plan is more effective during prenatal care, rather than in the immediate postnatal period. This study recognized that punitive policies that consider substance use during pregnancy to be child abuse or neglect reduce prenatal care and thus make it difficult to develop family care plans early in pregnancy.

In New Mexico, inconsistencies and bias in screening, testing, and reporting prompted a new policy to standardize use of family care plans (Sharp et al., 2023), and there is evidence that implementation of the policy has worked (NM LFC, 2023). Data presented within the "Program Evaluation: Implementation and Outcomes of the Comprehensive Addiction and Recovery Act" (NM LFC, 2023) states, "Infants with a plan of care experienced mortality rates similar to that as infants without substance exposure (5.9 compared to 5.0 deaths per 1,000 live births)." This suggests evidence of successful program implementation, given that the infants who are "born substance-exposed" are likely a higher-risk group. Furthermore, infant mortality rates in New Mexico have

declined to their lowest level since 1999 following program implementation, and rates of infant removal are down (NM LFC, 2023).

Multidisciplinary teams identify safety concerns and keep families safe.

Multidisciplinary collaboration has become firmly established as a critical factor within healthcare and child protection (WHO, 2010; Minnesota Statutes 2023, section 260E.02). There is evidence that when healthcare teams across disciplines practice collaboratively it can improve the delivery of person-centered care and lead to improved patient and health systems outcomes (Brandt et al., 2014; Reeves et al., 2017; Sangaleti et al., 2017). No single person providing care to a pregnant or birthing person and their infant has full information or understanding of their circumstances and varied needs. Multidisciplinary teams work because the varied expertise and training of each team member can be leveraged to improve care and outcomes. While a child protection professional brings expertise in infant safety, an addiction medicine physician brings expertise in substance use disorder as a chronic, relapsing disease and their work together can provide better support and services. The safety and well-being of the infant is interconnected with the safety and well-being of the parent and so the safety and well-being of the parent-infant dyad must be prioritized to support the goals articulated within the Minnesota Indian Family Preservation Act, Minnesota African American Family Preservation and Child Welfare Disproportionality Act, and federal Family First Prevention Services Act.

Child Protection Services (CPS) cannot always keep the worst outcomes from happening. The State of Minnesota recognizes it takes a community to keep families safe. All Minnesota counties are required by law to establish a multidisciplinary child protection team, which “may provide public and professional education, develop resources for prevention, intervention, and treatment, and provide case consultation to the local welfare agency or other interested community-based agencies” (Minnesota Statutes 2023, section 260E.02).

Healthcare providers continually assess concerns for safety.

As mandated reporters, healthcare providers are required to report concerns for child maltreatment, and anyone may voluntarily report suspected child abuse or neglect to the local child protection or law enforcement agency. Acting in good faith, mandatory and voluntary reporters are immune from civil and criminal liability as outlined in Minnesota Statutes 2023, section 260E.34.

Healthcare providers constantly evaluate child safety concerns and assess whether a parent can adequately and safely care for their infant, or if there is reason to believe that the family's situation poses a risk to the child. For example, if a family is in a minor car accident and it is discovered that a toddler was not in a car seat, the healthcare provider must decide whether to report this to Child Protection Services (CPS) for possible neglect, or simply provide the family with a car seat. When a healthcare provider sees a child with a broken bone, they must evaluate whether the injury matches the story provided and other contextual factors before deciding whether it should be reported to CPS. In short, healthcare providers are constantly assessing child safety concerns.

Healthcare providers do not make automatic and state-mandated reports to Child Protection Services (CPS) when infants and children are growing up in families where there are other risk factors associated with child maltreatment, such as poverty, a birthing person’s mental illness, or homelessness, unlike the current state

statute for prenatal exposure to a substance. Maternal mental health disorders, including mood disorders such as depression, are strongly associated with reports to CPS in the first year of life. Analysis of several large data sets of CPS reports in California found that when mental health disorders and substance use co-occur, the risks for being reported to CPS are magnified (Hammond et al., 2017). However, despite no mandated reporting to CPS for maternal mental health conditions, the data in this study shows that most reports to CPS (77.2%) are made within the first month of life. The authors even say in their paper that "this early reporting pattern indicates that those making a report to CPS were concerned about the mother's capacity to care for her infant shortly after delivery and responded proactively" (Hammond et al., 2017). Although this paper does not indicate from where these reports are arising, other research shows that most reports to CPS around the issue of prenatal substance use arise from healthcare providers (Jarlenski et al., 2017) and reports have increased over the past decade with persistent and notable racial inequities in investigations (Edwards et al., 2023).

Research by Maclean et al. (2022) finds that in states that move from more punitive to less punitive policies, healthcare providers continue to make the same number of mandated reports as before. Most of these reports to CPS are for neglect, principally concerns around parental capacity to meet the infant's immediate needs or supervision, not for physical maltreatment. Minnesota vital records data from 2014 to 2018 indicates that there are about 70,000 births per year and about 300-400 infant deaths per year. In 2021, 311 infants died and about 75 percent of these deaths were due to obstetric conditions, sudden unexpected infant death (SUID), congenital anomalies, or prematurity (MDH 2021; Ely & Driscoll, 2023). Only a few percent are attributed to inflicted injury, which rarely occurs in the first month of life.

The ethical principle of nonmaleficence, commonly known as the "no harm principle," is fundamental within the professional standards, licensure, and codes of ethics of most healthcare professionals. Nonmaleficence is the obligation of a physician not to harm the patient. All healthcare professionals must "… weigh the benefits against burdens of all interventions and treatments, to eschew those that are inappropriately burdensome, and to choose the best course of action for the patient" (Varkey, 2021). Healthcare providers do their best to make reasonable decisions and invite others to help make decisions when working with pregnant and birthing people who are using and misusing alcohol and other substances, and their infants. These situations are complex and challenging and even with the best interventions, bad outcomes will still occur.

Task force recommendations

This section of the report lists six recommendations from the task force. The recommendations form a plan to create more equitable and research-based processes for testing and reporting that aim to improve health outcomes of the parent-infant dyad.

The six task force recommendations never take away the ability of a healthcare provider to make a report if concerns for infant safety exist. Anyone may voluntarily report suspected child abuse or neglect to the local child protection or law enforcement agency, and Minnesota law requires professionals working with children to make a child protection report if they know of or have reason to believe a child:

- Is being neglected or abused, or
- Was neglected or abused in the preceding three years

In short, the task force recommendations will not change current practices where healthcare providers report to CPS when there is a reasonable belief of concern for the infant's safety.

Recommendation 1: Change punitive laws that criminalize prenatal substance use or define it as child maltreatment.

The task force recommends changing existing laws in three main areas:

- Repeal the mandatory toxicology testing law.
- Eliminate laws that require mandated reports to Child Protection Services (CPS) for substance use alone or that classify substance use by pregnant or birthing individuals as child abuse or neglect.
- Create a new law that outlines notification is not a report of child abuse or neglect.

Repeal the current law requiring toxicology tests

The task force strongly recommends repealing Minnesota Statutes 2023, section 260E.32. The beginning of the statute is included below:

> a) 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

Required toxicology tests do not support patient-centered care and often do not help with the medical management of the pregnant or birthing person and their infant. As stated in this report, toxicology testing is not recommended by most medical organizations. Many factors influence the usefulness of the results so a more nuanced approach to perinatal and newborn testing is needed rather than a legislatively mandated one. The intent of this mandate is presumed to be a safety screening for infants; however, the task force is recommending a more thoughtful approach to screening infant safety. See recommendations 4 and 5.

A significant minority of states have laws requiring toxicology testing. State laws have been changing on the topic of substance use in pregnancy, so exact numbers on testing laws is difficult to find. Minnesota is part of a small group of states that require healthcare workers to report drug use during pregnancy and part of a few states where a toxicology test is required if there are drug-related complications at birth (If/When/How Lawyering for Reproductive Justice 2024; Dailard & Nash, 2000).

Repeal laws that define substance use as neglect or maltreatment

Delete Minnesota Statutes 2023, section 260E.03 subdivision 15(5) that reads,

> "(5) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder."

Any reports to child protection would fall under other definitions of alleged maltreatment (i.e., neglect). If substance use remains the primary concern, Minnesota Statutes 2023, section 260E.03, subdivision15(a)(7) would capture these concerns, which reads, "(7) chronic and severe use of alcohol or a controlled substance by a person responsible for the child's care that adversely affects the child's basic needs and safety." The deletion of Minnesota Statutes 2023, section 260E.03, subdivision 15(5) would make Minnesota Statutes 2023, section 260E.31 no longer applicable and therefore obsolete. The task force recommends eliminating laws that require reporting to CPS for substance use alone or that classify substance use by pregnant or birthing individuals as child abuse or neglect.

Create a new law that outlines notification is not a report of child abuse or neglect.

Changes in law need to better reflect the new notification system, which is built on the premise that a substance use is not an immediate sign of child abuse or neglect. First the notification system (recommendation 5) must be created, and then new statute language can be created to better reflect the new systems. An example to follow in creating full statute language can be found in Appendix F from the *Model Substance Use During Pregnancy and Family Care Plans Act*. The table below gives a high-level overview of the changes, which allow for a more nuanced approach to notification of concerns to child welfare.

Topic	**Current language in Minnesota Statutes 2023, section 260E.31**	**Proposed new language**
Notification by healthcare professionals.	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.	A healthcare professional, or an appointed delegate, involved in the delivery or care of an infant born affected by parental substance use or experiencing withdrawal, shall, within 72 hours of the birth of such infant, submit a confidential notification to the Department of Children, Youth, and Families via an online portal or in writing in a form and in a manner as prescribed by the Department of Children, Youth, and Families by rule, pursuant to the requirements of the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. Sec. 5101, et seq., and the Comprehensive Addiction and Recovery Act (CARA) of 2016, P.L. 114–198, and any subsequent amendments thereto. A notification shall not be construed to be a report of alleged child abuse or neglect.

Topic	Current language in Minnesota Statutes 2023, section 260E.31	Proposed new language
Notification is not a report of child abuse or neglect.		Notwithstanding any other law to the contrary, neither: (1) Use of a controlled substance, prescription drug, non-prescription drug, alcohol, cannabis, or other potentially harmful substance while pregnant; nor (2) Giving birth to an infant born affected by parental substance use or an infant experiencing withdrawal, is, in and of itself, a report, finding, or presumption of alleged child abuse or neglect, and a notification made pursuant to this section shall not result in an investigation by the Department of Children, Youth, and Families, removal of the child, criminal sanctions, or other punitive measures against the birthing individual.
Report of alleged child abuse or neglect	Upon receipt of a report of prenatal exposure to a controlled substance required under subdivision 1, the local welfare agency shall immediately conduct an appropriate assessment and offer services indicated under the circumstances. Services offered may include but are not limited to a referral for substance use disorder assessment, a referral for substance use disorder treatment if recommended, and a referral for prenatal care. The local welfare agency may also take any appropriate action under chapter 253B, including seeking an emergency admission under section 253B.051. The local welfare agency shall seek an emergency admission under section 253B.051 if the pregnant woman refuses recommended voluntary services or fails recommended treatment.	Nothing in this section shall prevent a healthcare professional or other person from making a report of alleged child abuse or neglect to the local welfare agency if factors other than substance use by the birthing individual are present that impact the health or safety of the newborn infant.

Improving the health of pregnant and birthing people who are misusing alcohol and other substances, and their infants, requires the provision of compassionate, trauma-informed, and non-stigmatizing care. Providing this

care does not imply that healthcare providers will ignore or not respond to legitimate concerns for infant safety. Healthcare providers can decide when mandated reported is necessary rather than having it dictated to them by state statute. It is still necessary to report to CPS when there are concerns for child safety. Mandated reporting should continue, but substance use alone should not be a criterion for a report to CPS. Currently, Minnesota Statutes 2023, section 260E.08 outlines criminal and civil penalties for failure to report and this would still be valid when concerns of child safety are suspected.

Recommendation 2: Implement universal screening using a validated screening tool.

The goal of any screening should be to gather information from patients about their substance use to improve prenatal care and provide support. Screening is effective and identifies more cases of substance use than toxicology testing alone. Many professional organizations, including the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, World Health Organization, American Society of Addiction Medicine, and the Society for Maternal-Fetal Medicine, recommend universal screening using a validated screening tool. None of these organizations recommend universal toxicology testing. Studies show that selective toxicology testing, in addition to universal screening, can be valuable when it impacts medical care for the birthing person or newborn. No professional organization recommends universal or selective toxicology testing alone.

The task force recommends using a validated screening tool to identify substance use disorders in pregnant people. Healthcare systems should choose the tool that best meets their needs. Unexpected results should trigger specific actions based upon evidence-based protocols as suggested in recommendation 4. It is important to note that an evidence-based screening tool for SUD is not an infant safety assessment.

The following publicly available screening tools are recommended for use during pregnancy:

- 5Ps-Screening-Tool-and-Follow-Up-Questions
- CRAFFT screening tool
- Substance-Use-Risk-Profile-Pregnancy-Scale
- NIDA Quick Screen

Recommended screening timing should correspond to the American College of Obstetrics and Gynecology's recommendation for perinatal mental health screening because substance use disorder and mental health conditions have a high comorbidity. Screening is recommended early in pregnancy to reduce potential harm from substance exposure and to identify those who may benefit from treatment and support. Ideally, screening should also occur later in pregnancy (e.g. at 24 to 28 weeks gestational age). Mental health screening typically happens at the comprehensive postpartum visit to identify onset that occurs in late pregnancy or early postpartum. Substance use screening would deviate from this schedule because it is medically helpful to screen as part of the birth intake process because medical management of withdrawal is a concern at the time of birth. In addition, the American Academy of Pediatrics recommends screening for depression at well-child visits in the first postpartum year and substance use screenings could be added. A healthcare provider for the pregnant person should expect a care referral if a positive screen is identified in the pediatric setting. Pregnant people with a history of substance use may need more frequent monitoring. Re-administering screening tools can facilitate monitoring of symptoms and follow-up care with the goal of full symptom remission.

Concerns for substance use identified via screening or while providing routine prenatal or postpartum care should prompt a consult with an appropriate practitioner or support team. This consult should include a detailed psychosocial assessment and recommendations for clinical interventions and referral to resources and other supportive services as outlined in recommendation 4 below.

Recommendation 3: Conduct toxicology testing only when it serves a medical treatment purpose.

Toxicology testing is indicated when it will change the medical management of the pregnant person or newborn infant. Testing occurs when obvious signs of withdrawal or recent substance use pose a risk to the infant or would alter medical management for the infant and/or the pregnant, birthing, or postpartum person.

Recommended indications for newborn toxicology testing:

1. If infant develops clinical signs of withdrawal without explanation after first obtaining substance use history from birthing person.
2. To determine appropriate medications for treating newborn withdrawal symptoms and/or to preclude other diagnostic testing.
3. To determine if a longer observation period is needed or neonatal opioid withdrawal syndrome (NOWS) pathway is indicated.
4. If newborn's birthing parent meets criteria for toxicology testing and results would alter medical management of infant.

Recommended indications for pregnant, birthing, or postpartum person toxicology testing:

1. Concerns for oversedation, or impairment in the post-partum period should prompt an immediate consult to the patient's medical provider for further assessment.
2. When the toxicology test would change the medical management of the pregnant person and/or infant.

Informed consent is best practice in all cases. If toxicology testing is indicated for the newborn, but consent is not obtained from the birthing person or guardian, testing should only occur when there is a compelling medical need. If toxicology testing is indicated for the pregnant, birthing, or postpartum person or infant based on the criteria listed, the multidisciplinary team should engage in a thorough informed consent conversation with the birthing person and/or legal guardian. Informed consent is required by the Joint Commission on Accreditation and Certification and requires a clear explanation of why testing is indicated, potential benefits of testing, such as understanding all known or unknown exposures and guiding medical management of the dyad, and potential risks of testing, including the possible legal, criminal, or child welfare consequences. Informed consent should also include the risks and benefits of refusing consent for testing.

If there are legitimate reasons (e.g., concerns regarding untreated substance use, concerns about parental capacity) to ask for that information and the healthcare provider does so in a patient-centered and compassionate manner and permission is not granted by the patient, then that might be a solid indication for the healthcare provider to make a report to CPS. Healthcare providers need to decide if refusal to consent to a test or procedure that is indicated for the health of the child represents medical neglect and a report to CPS.

A future team will need to update best practices in toxicology testing; see recommendation 6.

Recommendation 4: Develop family care plans early in pregnancy

The Child Abuse Prevention and Treatment Act (CAPTA), originally passed in 1974, has been revised more than twenty times. As the foundational child-protection legislation in the United States, CAPTA was revised in the early 2000s and 2010s to cover infants with prenatal substance exposure requiring states to notify Child Protection Services (CPS) and develop plans of safe care, referred to as "family care plans" in this report (Lloyd Sieger et al., 2021). The earlier a pregnant individual engages in treatment and supportive services as facilitated by a family care plan, the better the outcomes for both parent and child (LAPPA, 2023).

Using an integrated, systems-level approach, healthcare systems should develop standard operating procedures and processes to support the development of family care plans to ensure patients receive appropriate referrals for substance use care and to provide community support, resources, and services that build on the patient's strengths. Healthcare providers within healthcare systems should also receive formal education on SBIRT—Screening, Brief Intervention Referral to Treatment. The following steps outline a uniform process for developing a family care plan during pregnancy:

1. Healthcare providers recognize concerns related to the health and safety of pregnant people early to prevent future problems.
2. Healthcare providers conduct universal screening for behavioral health concerns, including substance use, with a validated tool.
3. Healthcare provider has a conversation to discuss concerns and unexpected results/reactive screen with patient, gathering more information about their history and relevant context.
4. When additional healthcare providers are involved with the patient's healthcare and/or are available within the healthcare system, a multidisciplinary team check-in should occur with patient.
5. Healthcare provider(s) consult with patient and community-based professionals (e.g., social work, local public health, mental health, substance use, and peer recovery specialists) if available to secure services and supports.
6. Healthcare providers(s) and/or community-based professionals initiate a family care plan.

A pregnant person's records related to substance use disorder education, prevention, training, treatment, rehabilitation, or research cannot be used or accessed by other healthcare providers without written patient consent or a court order (HHS 2024). These confidentiality protections, outlined in 42 CFR Part 2, aim to mitigate concerns that fear, stigma, and discrimination discourage people from seeking support and services. Given this federal rule, the task force recommends that accountability, oversight, and management of family care plans should be the responsibility of a case manager the patient determines. This may include any member of the multidisciplinary team with a role to secure services and supports with whom the patient has a trusting relationship. Multidisciplinary teams work because the varied expertise and training of each team member can be leveraged to improve care coordination across multiple systems and ultimately improve health outcomes for the parent-infant dyad. Research support is presented above in the section on multidisciplinary teams.

The National Center on Substance Abuse and Child Welfare has created a Plans of Safe Care Learning Modules Series (NCSACW n.d) that takes a health system approach and may be useful in the implementation of this and all other task force recommendations. NCSACW's in-depth technical assistance can also provide useful context

and understanding about how other states are making systems improvements, including how to approach notification and who is responsible in their management.

The development and use of family care plans has potential to divert lower-risk situations away from Child Protection Services to allow Child Protection Services to prioritize their efforts with higher-risk situations where thorough assessments and investigations are needed most. Consider this analogy: We use chemotherapy (CPS) for cases of cancer (e.g., active untreated substance misuse, inability to adequately meet infant's needs); we probably do not need chemotherapy (CPS) to treat the common cold (e.g., marijuana use, someone in Medication Assisted Treatment, a person with good social support). In summary, while family care plans may reduce unnecessary family surveillance and inefficient use of CPS resources, family care plans do not minimize or change healthcare providers' reporting to CPS when there is a reasonable belief of concern for the infant's safety.

Recommendation 5: Create a uniform process for notification and reporting to the Department of Children, Youth, and Families and the local child welfare after birth.

Create a notification system that meets the requirements of the Child Abuse Prevention and Treatment Act

The task force recommends the Department of Children, Youth, and Families create a notification system that meets compliance with the federal Child Abuse Prevention and Treatment Act (CAPTA). This notification system will serve to develop a more nuanced pathway to support families with substance misuse and substance use disorders. The notification system will be separate from the Minnesota state system for reporting alleged abuse and neglect. Notifications are intended for monitoring, federal compliance, public health planning, and to create a system of support to improve care coordination and health outcomes for the parent-infant dyad.

The National Center on Substance Abuse and Child Welfare (NCSACW) helps states improve outcomes for infants and their families affected by prenatal substance exposure. As a technical assistance resource center, NCSACW developed a series of briefs, including one focused on identification and notification (NCSACW 2021). NCSACW states, "Child welfare agencies that distinguish between a notification and report can help communities see a distinction between prenatal substance exposure alone and prenatal substance exposure accompanied by child safety concerns and risk factors. They can also target services and supports more precisely to prevent child welfare involvement and meet families' needs. When various community partners share responsibility with child welfare for developing and providing oversight of Plans of Safe Care, families are likely to have more timely access to a broader array of services and supports" (NCSACW 2021).

Every time a provider submits a notification, they should engage in a conversation with the family to create a family care plan for the newborn infant born affected by parental substance use disorder or experiencing withdrawal from drugs or alcohol which shall address substance use disorder treatment, mental health or other medical treatment, housing, education, employment, transportation, legal, and other needs of the infant, the birthing individual, and the infant's caregivers and family members (LAPPA, 2023). Family care plans are intended to improve the safety and well-being of infants affected by prenatal substance exposure as well as recovery outcomes for their caregivers. Refer to recommendation 4 for more detail.

Implement a uniform process for notification and reporting to the Department of Children, Youth, and Families and the local child welfare after birth.

The following steps outline a uniform process for a **birthing/postpartum person** that may lead to a notification or report to local child welfare:

1. Healthcare providers recognize concerns related to the health and safety of the infant, birthing, and/or postpartum person.
2. Healthcare provider discusses concerns and completes targeted screening to gather more information about their history and relevant context.
3. Multidisciplinary team check-in occurs with patient to determine existing supports and services (including existing family care plan), to assess patient readiness for change, and to assess child safety concerns and circumstances.
    - If YES for concerns for child safety, then report to local child welfare.
    - If NO for concerns for child safety, then continue with Step 4.
4. Confirm whether a family care plan exists.
    - If YES, notify designated case manager and/or providers and community-based professionals already working with the patient so they can continue work with the patient and make necessary updates to the family care plan to reflect current needs.
    - If NO, then continue with Step 5.
5. Healthcare provider(s) consult with patient and community-based professionals (e.g. social work, local public health, mental health, substance use, and peer recovery specialists) if available to secure services and supports.
6. Healthcare providers(s) and/or community-based professionals initiate family care plan.
7. Healthcare provider(s) submit a confidential notification to a Child Abuse Prevention and Treatment Act (CAPTA) Notification Portal.

Child safety concerns and circumstances

The task force recommends the multidisciplinary team use the PASS acronym outlined within the *Resource Guide for Mandated Reporters of Child Maltreatment Concerns* (DCYF, 2024) as a tool to support critical thinking in their reporting decision-making process:

- **Pause**. Take a moment to slow down before taking any further action.
- **Analyze**. What information suggests there is a reason to believe a child has been maltreated?
- **Self-reflect**. Ask yourself questions to check your bias.
- **Support or report**. Determine if supportive resources are needed, or report if required.

Several states have developed risk assessments for substance-affected infants to help healthcare providers determine whether the situation warrants a maltreatment report to CPS. The *Newborn Risk Assessment for Substance-Affected Newborns* includes a list of three newborn vulnerabilities and ten parental/caregiver risk factors healthcare providers are asked to assess as low, moderate, or high risk. Guidance is provided for each factor and each level of risk and then healthcare providers are asked to determine an average level of risk to support decision-making on whether to make a report (Child Protection Hotline, 2023).

Boston Medical Center implemented a clinical practice guideline in May 2021 to inform reporting decisions for prenatal substance exposure. A recent study examined the short-term impacts of this policy change and found a reduction in CPS reports with no significant changes in custody at discharge or length of stay (Khazanchi et al., 2024). Study authors noted the possible benefits that could result if CPS reporting was based on "…expert-

defined protective concerns rather than categorical mandates, including decreases in family surveillance, efficient use of limited state resources, and reduction of stigma" (Khazanchi et al., 2024). The clinical practice guideline emphasizes the critical role of a multidisciplinary approach and outlines the following specific protective concerns that should prompt a report:

- Presence of untreated substance use disorder.
- Resumption of substance use with evidence of lack of control or negative consequences of use.
- Lack of follow-up or other indication concerning for continued substance use.
- Relevant history of CPS involvement or loss of custody of other children.
- Lack of parental capacity to care due to untreated psychiatric disorder.
- Pattern of parental behavior that raises concerns for the safety of the infant.

The task force offers the following additional recommendations to aid healthcare providers in their reporting decision-making process:

- A report should be filed only when specific protective concerns are identified as outlined above.
- There should be no practice of "automatic" filing due to reported substance use during pregnancy.
- If substance use is reported during pregnancy, an assessment should be performed to evaluate for the presence of specific underlying protective concerns as outlined in the bullets above and recommendation 4.
- If cannabis use is reported during pregnancy and no protective concerns have been identified, then a report should not be filed.
- If medications are prescribed to treat opioid use disorder in pregnancy and no protective concerns have been identified, then a report should not be filed.
- If an infant experiences neonatal opioid withdrawal syndrome (NOWS)/neonatal abstinence syndrome (NAS) due to medications prescribed during pregnancy and no protective concerns have been identified, then a report should not be filed.
- Toxicology testing results should not be the sole basis upon which a report is filed, and use of urine and meconium testing for neonates should be limited to when testing is clinically indicated and when results will change medical management.

Recommendation 6: Support implementation of task force recommendations and develop data-informed best practice guidelines.

The task force recommends that a multidisciplinary workgroup lead the implementation of recommendations and the development of data-informed best practice guidelines. Together, the Minnesota Department of Health (MDH) and Department of Children, Youth and Families (DCYF) could be responsible to provide leadership and administrative support for this work. The task force recommends cross-agency and cross-sector facilitation led by Minnesota's Children's Cabinet to convene and align various agencies across the state enterprise with impacted entities at the county and community level.

An early and critical action for this multidisciplinary group would be to take advantage of the in-depth technical assistance offered by the National Center on Substance Abuse and Child Welfare (NCSACW) as their mission is "to improve family recovery, safety, and stability by advancing practices and collaboration among agencies, organizations and courts working with families affected by substance use and co-occurring mental health

disorders and child abuse or neglect" (NCSACW n.d.). MDH and DCYF are engaging with NCSACW on their expertise for health system improvements and guidance to help support implementation priorities noted below.

Piloting the implementation of recommendations in select counties, both urban and rural, prior to statewide implementation may be of benefit to test recommendations in practice and reduce the risk of failure. Pilot testing would be accelerated if the multidisciplinary group consults with counties and Tribal nations with existing programs already working to shift clinical practice from punitive to supportive approaches. Three existing Minnesota programs include:

- Project CHILD (Hennepin County)
- Mother First (Ramsey County)
- Families First (Red Lake Indian Health Services, Beltrami, Clearwater, Cass, Koochiching, Hubbard, and Itasca Counties)

The task force also recommends Minnesota continue learning from other states who have already implemented similar policies and programs, including but not limited to New Mexico, Illinois, Pennsylvania, Colorado, and Connecticut. As implementation of recommendations gets underway, the task force encourages particular attention is made to the following issues:

- **Funding sustainability:** Healthcare providers should be incentivized and rewarded to provide universal screening, conduct assessments, and develop family care plans. The Model Substance Use During Pregnancy and Family Care Plans Act includes specific recommendations that would help support ongoing reimbursement, as funding is a major concern for the State of Minnesota (LAPPA, 2023). For instance, including the family care plan as an allowable Medicaid expense and creating a service billing code for family care plan activities is a strategy to incentivize healthcare provider participation. In addition, exploring feasible ways to build partnerships with local and county opioid settlement funds, the behavioral health program within the Minnesota Department of Human Services, and other state and community partnerships and projects is critical to build sustainable funding models.
- **Data and evaluation:** There is a clear need to collect and analyze data to understand if the implementation of task force recommendations has the intended outcome to improve safety and well-being of the parent-infant dyad. The creation and adoption of a separate notification system will support MDH in continuing to carry out its public health surveillance core function, and consultation with the National Center on Substance Abuse and Child Welfare (NCSACW) will help the multidisciplinary group determine shared metrics for evaluation.
- **Education and training:** Resources for healthcare providers are prolific. The multidisciplinary group could curate specific educational and training resources by topic or recommendation. There is a need for broader education and training, including in addiction medicine, mental health, and harm reduction approaches. NCSACW and the Minnesota Child Welfare Training Academy have numerous resources to begin. In addition, existing groups within Minnesota are already focused on educating and training healthcare providers, including the Minnesota Perinatal Quality Collaborative as outlined in Minnesota Statutes 2023, section 145.9572, the Proof Alliance as outlined in Minnesota Statutes 2023, section 145.267, and Project ECHO, which links experts to healthcare teams in any community.

Foundational work to successfully implement task force recommendations will include the development of data-informed best practice guidelines to care for pregnant, birthing, and postpartum individuals, their infants, and families experiencing substance misuse or substance use disorders. Best practice guidelines will also address ways to reduce bias in testing and reporting to better support families with substance use disorders. These guidelines could address:

1. Updates to the *Minnesota's Best Practice Guide for Responding to Prenatal Exposure to Substance Use* (DHS 2020), which provides direction to child welfare staff.
2. Systematic dissemination of existing Minnesota programs that work, including, for example, Project CHILD, Mothers First, Families First, and Eat, Sleep, Console.
3. Reducing systemic and personal bias in testing and reporting.
4. Implementing strength-based, trauma-informed care for pregnant people and families affected by substance use.
5. Updates for universal screening best practices, including research-based tools and what to do with unexpected results or a reactive screen.
6. Indications for toxicology testing in pregnancy, at delivery and/or newborn testing, including the benefits and disadvantages of specific toxicology methods, recommendations for a standard toxicology panel, and process for when test confirmation is needed.
7. Best practices to improve transparency, communication, and understanding of protocols with pregnant people and their families.
8. Best practices around patient-informed consent and result disclosure.
9. Support for healthcare institutions to identify, monitor, and address bias in testing, reporting, and outcomes.
10. Recommendations around breastfeeding and substance use disorders.
11. Guidance on development and implementation of family care plans.
12. Adapt existing newborn risk assessments, including from Massachusetts, California, and Connecticut.
13. Develop and maintain a list of Minnesota resources for families affected by substance use. This can be general parenting resources such as Family Partnership, Help Me Grow, Early Childhood Family Education (ECFE), and specific SUD programs.
14. Hotline for healthcare providers to get help with specific patient scenarios, unexpected or reactive toxicology results and support in interpretation, the development of family care plans, etc. This may be especially helpful for healthcare providers in rural areas.

Conclusion

Successful implementation of the Task Force on Pregnancy Health and Substance Use Disorders recommendations requires focused, sustained investment in the development of a robust behavioral health system in the State of Minnesota—a system that strengthens access to critical supports and resources for pregnant people and their families. From the first meetings of the task force, members have echoed the ways in which our current systems do not support the health and well-being of pregnant people or infants. Improvements to the larger systems and supports must include family-centered treatment, mental health, housing, childcare, transportation, education, employment, and other social determinants of health, especially in remote and rural areas.

Numerous existing groups within Minnesota are working diligently to improve systems and supports for Minnesotans experiencing substance use disorder. The task force encourages state investment in their work. Three existing efforts provide additional direction for state action:

- The Integrated Care for High-Risk Pregnancies grant program, established by Minnesota Statutes 2023, section 256B.79 and administered by the Department of Human Services, are working with community-based organizations using a care collaborative approach to addresses African American and American Indian pregnancy-related disparities.
- By the end of the 2024 calendar year, the Behavioral Health Division, within the Department of Human Services, in accordance with Minnesota Statutes 2023, section 254A.03, will submit a biennial report to the governor that outlines current public services and provides recommendations related to increase of coordination and quality of services, and decrease of service duplication and cost.
- By February 2025, the task force on holistic and effective responses to illicit drug use, in accordance with Laws of Minnesota 2024, chapter 123, article 25, section 17, and directed by the Office of Addiction and Recovery will provide recommendations to implement and fund policies that address illicit drug use with the goal to promote the health and safety of individual and communities while reducing and preventing harm to users of illicit drugs.

In conclusion, the Task Force on Pregnancy Health and Substance Use Disorders asks the legislature and a future multidisciplinary group tasked with implementation of these recommendations to remember that substance use disorder is no one person's disease or struggle. It affects everyone in the family and has impacts on our larger community. Whole family solutions that recognize the intergenerational impacts of historical and cultural trauma, treat people as human beings and the experts in their own lives, and honor culturally centered approaches are deeply important and result in better outcomes.

Appendix A: The law for the Task Force on Pregnancy Health and Substance Use Disorders

Laws of Minnesota 2023, chapter 70, article 4, section 110.

TASK FORCE ON PREGNANCY HEALTH AND SUBSTANCE USE DISORDERS.

Subdivision 1.

Establishment.

The Task Force on Pregnancy Health and Substance Use Disorders is established to recommend protocols for when physicians, advanced practice registered nurses, and physician assistants should administer a toxicology test and requirements for reporting for prenatal exposure to a controlled substance.

Subdivision 2.

Membership.

(a) The task force shall consist of the following members:

(1) a physician licensed in Minnesota to practice obstetrics and gynecology who provides care primarily to medical assistance enrollees during pregnancy appointed by the American College of Obstetricians and Gynecologists;

(2) a physician licensed in Minnesota to practice pediatrics or family medicine who provides care primarily to medical assistance enrollees with substance use disorders or who provides addiction medicine care during pregnancy appointed by the Minnesota Medical Association;

(3) a certified nurse-midwife licensed as an advanced practice registered nurse in Minnesota who provides care primarily to medical assistance enrollees with substance use disorders or provides addiction medicine care during pregnancy appointed by the Minnesota Advanced Practice Registered Nurses Coalition;

(4) two representatives of county social services agencies, one from a county outside the seven-county metropolitan area and one from a county within the seven-county metropolitan area, appointed by the Minnesota Association of County Social Service Administrators;

(5) one representative from the Board of Social Work;

(6) two Tribal representatives appointed by the Minnesota Indian Affairs Council;

(7) two members who identify as Black or African American and who have lived experience with the child welfare system and substance use disorders appointed by the Cultural and Ethnic Communities Leadership Council;

(8) two members who are licensed substance use disorder treatment providers appointed by the Minnesota Association of Resources for Recovery and Chemical Health;

(9) one member representing hospitals appointed by the Minnesota Hospital Association;

(10) one designee of the commissioner of health with expertise in substance use disorders and treatment;

(11) two members who identify as Native American or American Indian and who have lived experience with the child welfare system and substance use disorders appointed by the Minnesota Indian Affairs Council;

(12) two members from the Council for Minnesotans of African Heritage;

(13) one member of the Minnesota Perinatal Quality Collaborative; and

(14) one designee of the commissioner of human services with expertise in child welfare.

(b) Appointments to the task force must be made by October 1, 2023.

Subdivision 3.

Chairs; meetings.

(a) The task force shall elect a chair and cochair at the first meeting, which shall be convened no later than October 15, 2023.

(b) Task force meetings are subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subdivision 4.

Administrative support.

The Department of Health must provide administrative support and meeting space for the task force.

Subdivision 5.

Duties; reports.

(a) The task force shall develop recommended protocols for when a toxicology test for prenatal exposure to a controlled substance should be administered to a birthing parent and a newborn infant. The task force must also recommend protocols for providing notice or reporting of prenatal exposure to a controlled substance to local welfare agencies under Minnesota Statutes, chapter 260E.

(b) No later than December 1, 2024, the task force must submit a written report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services on the task force's activities and recommendations on the protocols developed under paragraph (a).

Subdivision 6.

Expiration.

The task force shall expire upon submission of the report required under subdivision 5, paragraph (b), or December 1, 2024, whichever is later.

Appendix B: Task force members and nominating groups

Member	Nominating groups
Cresta Jones	American College of Obstetricians and Gynecologists.
Kurt DeVine, Co-chair	Minnesota Medical Association
Meagan Thompson	Minnesota Advanced Practice Registered Nurses Coalition
Lisa Edmundson	Minnesota Association of County Social Service Administrators.
Alexandra Kraak	Minnesota Association of County Social Service Administrators.
Heidi Holmes	Board of Social Work
Shanna Vidor	Minnesota Indian Affairs Council
Margarita Ortega	Minnesota Indian Affairs Council
Tanisha Brown	Cultural and Ethnic Communities Leadership Council
Amal Ali	Cultural and Ethnic Communities Leadership Council
Kristen Bewley	Minnesota Association of Resources for Recovery and Chemical Health
Caroline Hood	Minnesota Association of Resources for Recovery and Chemical Health
Frances Prekker	Minnesota Hospital Association
Kari Gloppen	Minnesota Commissioner of Health
Tamara Desjarlais	Minnesota Indian Affairs Council
Marlena Hanson	Minnesota Indian Affairs Council

Member	Nominating groups
Brittany Wright, Co-chair	Council for Minnesotans of African Heritage
Hannaan Shire	Council for Minnesotans of African Heritage
Chris Derauf	Minnesota Perinatal Quality Collaborative
Rebecca Wilcox	Commissioner of Human Services

Appendix C: Task force charter and operating procedures

As of January 18, 2024

Statutory Authority

Laws of Minnesota 2023, chapter 70, article 4, section 110, requires the Commissioner of Health to convene a Task Force on Pregnancy Health and Substance Use Disorders (TFPSUD) to recommend protocols for when physicians, advanced practice registered nurses, and physician assistants should administer a toxicology test and requirements for reporting for prenatal exposure to a controlled substance.

Membership

Members will include persons from various backgrounds. The Task Force members shall consist of the following members:

1. A physician licensed in Minnesota to practice obstetrics and gynecology who provides care primarily to medical assistance enrollees during pregnancy appointed by the American College of Obstetricians and Gynecologists.
2. A physician licensed in Minnesota to practice pediatrics or family medicine who provides care primarily to medical assistance enrollees with substance use disorders or who provides addiction medicine care during pregnancy appointed by the Minnesota Medical Association.
3. A certified nurse-midwife licensed as an advanced practice registered nurse in Minnesota who provides care primarily to medical assistance enrollees with substance use disorders or provides addiction medicine care during pregnancy appointed by the Minnesota Advanced Practice Registered Nurses Coalition.
4. Two representatives of county social services agencies, one from a county outside the seven-county metropolitan area and one from a county within the seven-county metropolitan area, appointed by the Minnesota Association of County Social Service Administrators.
5. One representative from the Board of Social Work.
6. Two Tribal representatives appointed by the Minnesota Indian Affairs Council.
7. Two members who identify as Black or African American and who have lived experience with the child welfare system and substance use disorders appointed by the Cultural and Ethnic Communities Leadership Council.
8. Two members who are licensed substance use disorder treatment providers appointed by the Minnesota Association of Resources for Recovery and Chemical Health.
9. One member representing hospitals appointed by the Minnesota Hospital Association.
10. One designee of the commissioner of health with expertise in substance use disorders and treatment.
11. Two members who identify as Native American or American Indian and who have lived experience with the child welfare system and substance use disorders appointed by the Minnesota Indian Affairs Council.
12. Two members from the Council for Minnesotans of African Heritage.
13. One member of the Minnesota Perinatal Quality Collaborative; and
14. One designee of the commissioner of human services with expertise in child welfare.

Terms of Appointment

Task force members shall serve the full term. The full term is until the Task Force submits a written report to the State Legislative chairs and minority members of the committees and divisions with jurisdiction over health and human services on the Task Force's activities and recommendations on or before December 1, 2024, whichever comes first.

Co-Chairs

The co-chairs will work in conjunction with MDH Program Staff and MAD consultants to help create and maintain the processes, structure, and meeting agendas that allow the Task Force to be effective and efficient. The Task Force shall elect co-chairs at the first meeting. Full Task Force meetings are subject to the Minnesota Open Meeting Law under Minnesota Statutes 2023, chapter 13D. The duties of the co-chairs include:

1. Lead Task Force meetings, in conjunction with the facilitator, including discussions to systematically determine the development of recommended protocols.
2. At the request of the Commissioner, be the spokesperson and representative for the Task Force, such as by serving as a key presenter for Pregnancy Health and Substance Use Disorders data or responding to media inquiries.
3. Participate in up to 12 planning meetings with MDH staff, to strategically guide the work of the Task Force, update MDH staff on workgroup meeting discussions, and review formal meeting minutes and notes circulated to Task Force members with MDH staff.
4. Determine the need for and appoint Task Force members to workgroups as needed to carry out the Task Force 's work.
5. May request whether portions of meetings could be closed to the public in accordance with the Open Meeting Law in order to receive private health data or other not public data under Minnesota Statutes 2023, section 13D.05, subdivision 2(a) in consultation with MDH legal.
6. Additional co-chairs may be selected after December 7, 2023 to support the Task Force's ability to address legislatively determined activities.

Administrative Support

The Commissioner will ensure MDH staff, space, and other resources are available to support the work of the Task Force.

Orientation

Orientation will be provided by Minnesota Department of Health staff to all newly appointed members no later than one month after their first Task Force meeting.

Additional training may be provided based on emerging best practices. Examples of subjects may include but are not limited to trauma informed approaches, implicit bias, addressing social determinants of health, or an in-service on emerging pregnancy and substance use disorder (SUD) policy recommendations nationally.

Social Determinants of Health Work

In alignment with MDH's core mission, identifying and addressing discrimination and racism and its impacts on perinatal health outcomes is imperative to this Task Force's work. As partners in learning and applying anti-racism models to the work, the Task Force will participate and collaborate amongst its members and with others to develop and refine methodology to identify discrimination in pregnant patients impacted by a SUD. The goal is to develop actionable steps to address these structures and listen to Task Force members to advance health equity in all sectors of maternal health work.

Responsibilities of Task Force Members

In accepting their appointment to the Task Force, members are expected to:

1. Participate in a one-hour interview with facilitator to create a shared foundation around the issues, hopes, and key considerations for the Task Force to address.
2. Attend all task force meetings.
3. Serve on workgroups as requested by the co-chairs.
4. Prepare for active participation in discussions and decision-making by reviewing meeting materials in advance.
5. Seek to understand the opinions, perspectives, and lived experiences of others.
6. Proactively engage and communicate with key stakeholders with special emphasis on informing and gathering input from the association, board, or council that appointed you to the Task Force.
7. Abstain from voting where a conflict of interest may exist. A conflict of interest exists if one of the following conditions applies:
    - the member has a direct financial interest in the matter under consideration.
    - the member has an indirect financial interest in the matter under consideration and is not free from personal bias, prejudice, or preconceived notion as to make it possible for them to objectively consider the evidence presented and base their decision solely on the evidence.
    - the member has placed themself in a position where they find it difficult, if not impossible, to devote themself to a consideration of the matter with complete loyalty of purpose to the public interest.
8. Refrain from writing letters or engaging in other kinds of communication in the name of the Task Force unless the Commissioner specifically authorized such communication.
9. Review and provide feedback on the draft legislative report, agendas, meeting notes, and other documents as needed.

Duties and Deliverables

- The Task Force shall develop recommended protocols for when a toxicology test for prenatal exposure to a controlled substance should be administered to a birthing parent and a newborn infant. The Task Force must also recommend protocols for providing notice or reporting of prenatal exposure to a controlled substance to local welfare agencies under Minnesota Statutes, chapter 260E.

- No later than December 1, 2024, the Task Force must submit a written report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services on the Task Force's activities and recommendations on the protocols developed.

Meetings and Reimbursement

The section applies to the meetings of the Task Force.

- **Frequency**: The Task Force will meet seven times every other month starting December 7, 2023. The Task Force co-chairs may call additional meetings as necessary, and frequency of regular Task Force meetings may be reevaluated by the co-chairs as necessary. Information can be found at: TFPSUD MDH webpages https://www.health.state.mn.us/people/womeninfants/womenshealth/tfpsud/index.html.
- **Cancellations**: Meetings may be cancelled and rescheduled by co-chairs or by the Commissioner. Task Force members will be notified of cancellations in as timely a manner as possible.
- **Compensation and Expense Reimbursement:** A voting Task Force member carrying out the above-described duties may be compensated at the rate of $55 per day spent on Task Force activities, when authorized by the Committee, plus expenses in the same manner and amount as authorized by the MMB Commissioner's Plan (https://mn.gov/mmb/employee-relations/labor-relations/labor/commissioners-plan.jsp).
  Members who, because of time spent attending Task Force meetings, incur childcare expenses that would not otherwise have been incurred, may be reimbursed for those expenses upon Task Force approval. The following constitutes a day spent on the task force or activities applicable for reimbursement:
    - Full attendance at a Task Force meeting, whether virtually or in person.
    - Attendance at up to four additional work group meetings outside of regularly scheduled Task Force meetings. Maximum reimbursement per fiscal year (July 1 to June 30).
    - Working on a request to review the final draft report.

  State employees or employees of political subdivisions must not receive the daily compensation for activities that occur during working hours for which they are compensated by the state. However, a state subdivision employee may receive the daily payment if the employee uses vacation time or compensatory time accumulated in accordance with a collective bargaining agreement or compensation plan for task force or subgroup activity.
- **Quorum**: The presence of 11 Task Force members constitutes a quorum at Task Force meetings.

General Procedures and Conduct of Meetings

The Task Force is intended to function as an advisory group to identify, review, and provide recommendations for policy related to pregnancy health and SUD occurring in Minnesota's birthing population.

Meetings will be held on a virtual platform or in person. Monthly emails will be circulated to members with any communication updates or meeting notices.

All documents and working materials will be housed on the MDH SharePoint website for members to access during their tenure.

Conduct of Business:

1. Task Force members will receive the agenda, past meeting minutes, and other pertinent information at least four working days prior to each meeting.
2. Each member is entitled to only one vote on any issue. The co-chairs are voting members of the Task Force. There will be no voting by proxy.
3. All votes are conducted by roll call, so each member's vote can be identified and recorded in accordance with Minnesota Statutes 2023, section 13D.015; Electronic voting will typically be conducted to streamline the process.
4. Task Force discussions will work toward consensus using a gradients of agreement scale, for example the Fist to Five tool.
5. Task Force discussions will be brought to closure so a decision can be made once 80 percent consensus has been achieved.
6. Members can choose to abstain from a vote.
7. Minutes will be kept of all Task Force meetings and maintained according to established records retention schedule.
8. Approved minutes and agendas will be available on the Task Force website.

Task Force agreements

Group agreements are guidelines for behavior and interaction. Group agreements are a tool to create an inclusive, participatory space and to foster shared accountability. The following agreements were developed by Violence Free Minnesota and adapted with permission.

1. All who enter this space are welcome.
2. All who enter this space are here because they care deeply about pregnant people and infants impacted by substance use disorders and want their voices heard.
3. All who enter this space have their own unique experiences and stories that brought them here and as such, each of us will respect and accept different lived experiences and perspectives. Agreement is optional.
4. We cannot promise no harm will come from this space as each of our experiences related to pregnant people and infants impacted by substance use disorders shows in different ways.
5. Each person is on their own unique healing journey. This does not validate causing harm, but helps understand why it could happen.
6. If harm enters the space, we will pause.
7. Most often, in spaces such as the one we will collectively enter, conflict is not personal.
8. Not all conflict results in harm.
9. Conflict often does not come from the current events it shows up in. Most often the trigger that is activated from the current event influences how a person can show up.
10. Expect and accept challenging moments and breathe through them before reacting.
11. Practice engaged listening.
12. Each person will be given space to speak.

Work Groups

Work groups will be established to assist the work of the Task Force. The co-chairs will request for volunteer members based on their experience and interest to serve.

Work groups will be given a specified charge and period to fulfill that charge and will present a final report or recommendations to the Task Force for approval.

Amendments

Amendments to this Charter and Operating Procedures may be made only after notification to the full Task Force at least ten days in advance of a regularly scheduled meeting. Amendment requires a vote of two-thirds of the members present or by a virtual vote if meeting.

Appendix D: Interview summary report

Last updated: 3/7/24

Management Analysis and Development (MAD) identified the following themes and ideas from interviews with eighteen task force members. The task force must recommend protocols for providing notice or reporting of prenatal exposure to a controlled substance to local welfare agencies under Minnesota Statutes, chapter 260E. The purpose of the interviews was to create a shared foundation around the issues, hopes, and key considerations for the task force to address.

Shared foundation

- Diverse professional disciplines, perspectives, and experiences are represented on the task force. It is important task force members recognize the lens they bring and stay committed to learning from others to successfully fulfill the duties of the task force.
- Substance use disorder (SUD) is a disease and mental disorder that affects a person's brain and behavior that is not well understood across society or by all healthcare and social service providers. Punitive approaches and policies are not effective and can lead to more negative outcomes.
- Systemic and implicit bias exists in who receives testing and is reported to local welfare agencies. The impacts of disproportionate testing and reporting of black and indigenous communities is significant.

Shared values

- **People centered.** People are people first. Treat people as human beings. Believe them. They are the experts in their own lives.
- **Self-determination.** People have their own agency. Meet people where they are and have real conversations about their readiness for change.
- **Trauma informed, culturally centered.** Recognize the intergenerational impacts of historical and cultural trauma, including adverse childhood events (ACEs) and honor culturally centered approaches.
- **Family centered support and services.** Substance use is not one person's disease or struggle. It affects everyone in the family. There is trauma with family separation. Whole family solutions are deeply important.

Shared hopes

- **Better care and supports.** Often our systems, structures, and processes put the health of the pregnant person and health of the infant in conflict instead of seeing their health as interrelated and interconnected. Punitive laws and practices perpetuate this disparity and criminalize SUD. It is important to maintain a commitment to the health and safety of both pregnant people and infants.
- **Reducing stigma and fear.** There is pervasive stigma and misunderstanding of perinatal substance use. Pregnant people often also feel intense fear and shame. It is vital pregnant people can access the compassionate care they need without fear or stigma regardless of cultural background.
- **Equitable and ethical testing and reporting.** Testing and reporting of pregnant people who have SUD instills mistrust in the healthcare system and often is re-traumatizing patients. Those with SUD are often stigmatized, mistreated, and subject to poor medical experiences and experiences with Child Protective

Services (CPS). An egalitarian approach to testing and reporting that results in clear standards implemented consistently is required.

Key considerations

Task force members repeatedly acknowledged that trusting relationships, collaboration among all responsible, and transparent communication leads to better outcomes for pregnant people and their infants as reflected in these comments:

- *The longer you work with someone, the better it goes. Having honest conversations with people.*
- *Problem solve together. Through continued communication, we can get better.*
- *One person that follows the person throughout and this leads to better planning and preparation.*
- *The longer we are able to work with a family. When moms in treatment for over a year and we can work with them the recovery sticks. They have been able to be fully supported.*
- *Local level collaboration. Some of that is building trust. There is a lot of misinformation about what child welfare does and doesn't do and for good reason. Those relationships being established leads to better outcomes with common goals.*
- *To have a better bridge between hospital social worker and county social worker. The handoff is critical.*
- *When we [treatment center] are a full part of the team with the probation officer and CPS, then there are better outcomes. When everyone is at the table and every voice at that table matters instead of one voice being outsized.*
- *When we talk about people having a controlled substance, you look at them as an addict. But you need to build trust with them. Need to ensure they are not judged. People are often not honest and leave important information out when working with others.*

Task force members also discussed the importance of broader education, including addiction medicine, mental health, and harm reduction approaches in leading to better outcomes. "We treat gestational diabetes. This should not be a shameful or terrible experience," one task force member commented. Learning from the evolution of patient care approaches to HIV and depression could also provide lessons for the task force as reflected in this comment: "Depression is another great example in how we could approach SUD. It is routine part of screening. When I first came to [organization], physicians weren't always comfortable asking patients about depression." Continuing to shift mental models and paradigms about how people think and approach pregnant people with substance use disorder will take time and commitment.

Below is a summary of themes and ideas to consider in the development of recommended protocols for testing and reporting.

Testing

There is a lack of clarity surrounding the goals of toxicology testing. Task force members shared how testing made it challenging to build meaningful relationships with patients. Toxicology testing does not provide data about the prevalence of use or the safety of the infant. In general, the healthcare, social services, and criminal justice systems have been too reliant on toxicology testing which drive subsequent responses that are punitive. One task force member noted, "…it's a slippery slope to incarceration."

Most task force members outlined the role provider bias and discrimination plays in who gets tested, as reflected in this comment: “People are tested based on the color of their skin and how much money they have. It’s problematic when providers decide to test or not. There are also inconsistencies in the response to positive tests and a lot of bias laid into it. Whether you test or not, we need consistency and if you test how is the data consistently used?”

The following are key items to consider in the development of recommended protocols for testing:

1. Create a shared understanding of why to test. Is the goal to identify infants with exposure to substances or to look for problem use? The indications for toxicology testing should be standardized, uniform, and evidence-based. For example, the current law requires testing for patients who are at high risk for obstetrics complications when the data show that the only indication for SUD is a previous history of substance use.
2. Provide clear standards about what circumstances must exist for healthcare providers to separate the infant from their parent while still in the hospital after a positive test.
3. Explore the benefits of universal screening and/or testing after patient consent. As one task force member shared, “I use universal testing as a tool for conversation. I don’t use it as an opportunity as a “gotcha.”
4. Develop uniform methods of testing the pregnant person and infant. For example, while the umbilical cord is the gold standard for infants, meconium and urine are still collected. Additional examples of issues to address are that some healthcare institutions perform urinalysis (UA) on pregnant people after they were given fentanyl during labor and if a pregnant person is taking Wellbutrin, an antidepressant drug, it can show up as methamphetamine without a confirmatory test.
5. Use toxicology data to help, not punish. Ensure toxicology testing is connected to community-based services and supports. As one task force member noted, "If the data is used to help and the linkage is made in a safe and affirming way, that’s when I see toxicology testing working.”
6. Recognize that confirmatory tests for infants can take multiple days. By the time the confirmatory test comes back, the infant may be discharged, so determining what response is best becomes more complex, with more delays. Follow-up also likely involves a different medical provider such as a pediatrician, which can lead to gaps in important information.

Reporting

Mandatory reporting leads to decreased prenatal care. In addition to feeling shame, pregnant people are often afraid of family separation and incarceration. Task force member comments reflected the fear and a lack of trust in these comments:

- *The providers don’t want to ask and ruin their [pregnant person’s] life and pregnant people may not tell the truth about using because of the fear of losing their baby.*
- *The hardest part in working with CPS and providers and the biggest fear is that if they are truthful, they are going to get their kids taken away.*
- *Fear of the systems is the overall umbrella. You think the worst. The system is more reactive and less prevention oriented. Communication is important. We are not out here to get your kid.*
- *A lot of patients are terrified of social work and ICWA. There is a lot of history. I am legally required to make a report. I don’t want them to be afraid to come back to me or seek care. If someone had a negative reaction with a social worker in the past, then they won’t get prenatal care.*

- *Once we start doing the testing and get the results, you are stuck. You move from a healer to a reporter and this is a real problem. It does not address the fundamental problem, which is the safety of the infant; not the exposure itself.*

Reporting after a positive test and the subsequent responses from all involved is inconsistent. There is a significant need to improve care coordination, communication, and relationships among everyone responsible for providing care and support to pregnant people and their families. Pregnant people's experiences within social services and the criminal justice systems can be particularly difficult. While some CPS staff or probation officers may have a punitive response, others respond in a supportive way that considers the context and history. One task force member commented, "That lever in the CPS zone is powerful as they have a lot of discretion."

Most task force members expressed a shared hope that pregnant people could be connected to supports and services earlier rather than having the first interaction with child welfare during labor and delivery. One member commented, "Ideally, you'd scaffold people into a relationship with CPS. If there was going to be a report and they are using drugs, then how do you get them connected to services earlier?" Another member shared, "When you report to them [child welfare], we can get the family services to an extent but why do we have to report people in order to get them services? Can't people get these services universally?"

There are circumstances when the infant should not be with the parent. In most situations, the ultimate focus should be on keeping families together when it is safe. Several members shared:

- *If they are positive at birth, they go on a 72-hour hold and this can change the whole dynamic. We see an incredible increase in post-partum depression that can lead to substance use when they don't have that initial connection with their babies.*
- *My belief is that you treat the pregnant person and thus treat the newborn.*
- *My job is to keep families together and to get them out of this together.*

The following are key items to consider in the development of recommended protocols for reporting:

1. Understand the circumstances that lead to an infant being harmed or neglected and incorporate these circumstances within the recommended protocols to test and report.
2. Acknowledge that return to use is part of the recovery process. As reflected in this task force member comment, "What we know about SUD is there will be relapse and we need to plan for that, instead of taking kids away and going to court."
3. A recent revision to Minnesota Statutes 2023, section 260E.31 includes an exemption from reporting of substance use in pregnancy. However, there have been no changes to Minnesota Statutes 2023, section 260E.32 requiring toxicology testing after delivery of infants. This inconsistency in reporting is problematic. As one task force member noted, "Personally, how do I have a conversation with a new mom with a baby who is hours old when I am required to test and report? I try to make it as non-judgmental as possible. There is no way to sugar coat this reality to a mom."
4. Gain clarity within Minnesota Statutes 2023, section 260E.31 about what "regular prenatal or postpartum care" means and what "habitual or excessive" alcohol use means and who gets to decide. There are multiple providers within a single healthcare system and leaving the decision up to the healthcare system can perpetuate systemic bias and discrimination.

5. Recognize that legislative changes to the definition of child abuse and neglect is important and out of scope for the task force.
6. Define a protocol for reporting that upholds the dignity of the individual and instills supportive relationships with all providers. Envision what a system would look like in which pregnant people with SUD receive the right treatment for their needs and for their family.
7. Consider what happens after a positive report. Few providers understand SUD as a disease and mental disorder that affects a person's brain and behavior. One task force member supported this concern stating, "I don't think providers have the resources in their toolkit. I think the hardest part is trying to get people moving up stream to get the right kind of support." Additionally, the lack of sufficient systems and supports for pregnant people and their families, including family-centered treatment, housing, childcare, transportation, education, employment, and other social determinants of health is real and outside the scope of the task force. Coordination among these systems may be especially challenging in remote and rural areas.
8. Provide clear direction on who to contact to make a report, particularly in rural areas of Minnesota and people living within the eleven Tribal nations that share their geography with Minnesota. Access to services can be limited in rural and tribal communities.
9. Explore whether a different agency, other than the local child welfare agency, could respond to a report and be responsible for developing Plans of Safe Care by learning about innovative approaches and practices in Minnesota and nationally.
10. Learn more about the characteristics and practices of a new program within Project Child focused on pregnant people who have previously experienced Termination of Parental Rights or Transfer of Legal Custody, especially around what standard indications were used to determine when an infant must be separated from their parent. This Hennepin County program started as a pilot in April 2022 and all fourteen individuals who have participated to date gave birth to infants that went home with them.

Additional questions and items to note

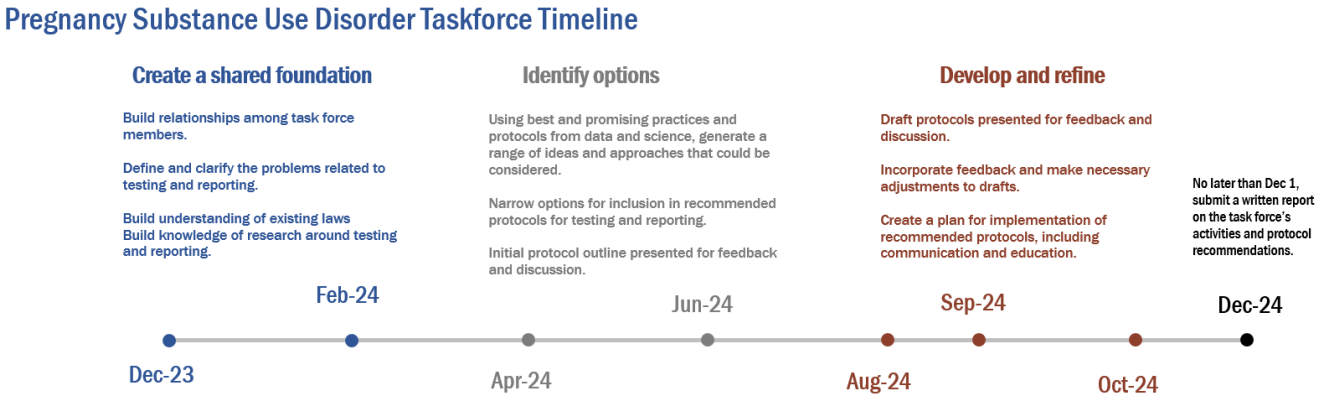
- The task force needs to address which substances qualify for testing and reporting. The task force expressed a desire to be inclusive of both legal and illegal substances. While there may be less stigma associated with alcohol use for example, prenatal alcohol exposure is the number one cause of birth defects. Definitions outlined in separate state statutes should be reviewed by the task force in deciding whether to include alcohol within the recommended protocols as the law that created the task force specifies protocols are to be developed for controlled substances.
    - Minnesota Statutes 2023, chapter 152 defines a controlled substance and excludes "distilled spirits, wine, malt beverages, intoxicating liquors or tobacco."
    - Minnesota Statutes 2023, section 253B.02 defines a chemically dependent person, which includes alcohol use.
    - Minnesota Statutes 2023, section 260E.31 includes "habitual or excessive" alcohol use for mandated reporting.
- An earlier draft of this legislation included the following additional duties. While they were not included in the final version of Laws of Minnesota 2023, chapter 70, article 4, section 110, they provide important context:
    - Discuss and evaluate family-centered substance use disorder treatment models.

    - Provide recommendations for addressing barriers and increasing access to family-centered substance use disorder treatment services, including licensing for treatment providers and funding barriers.
    - Evaluate the effectiveness of involuntary civil commitment during pregnancy and provide any recommendations for policy and practice changes related to involuntary civil commitment during pregnancy.
- While the duties of the task force focus on development of recommended protocols for testing and reporting, the task force might also want to offer recommendations about the education process for all healthcare systems, including audits, about the recommended protocols to support implementation across Minnesota.

Appendix E: The path to task force recommendations

Task force meetings and topics

Task force meetings were facilitated by senior management consultants from Minnesota Management and Budget's Management Analysis and Development (MAD). All meetings were hosted in an online platform. Meetings were streamed via YouTube live to allow for public viewing. All meeting materials were archived on a SharePoint site. The task force met bimonthly from December 2023 to October 2024.



MAD consultants partnered with MDH staff and co-chairs to design a meeting arc and overall topics. The timeline shown above:

- **Creating a shared foundation**
  - The first meeting in December focused on building relationships among task force members, reflecting on preliminary findings from task force interviews, and electing co-chairs.
  - The second meeting in February focused on strengthening relationships while building a common knowledge of the existing laws, issues, and best and promising protocols and guidelines related to testing and reporting. Task force member, Rebecca Wilcox, presented on Minnesota Statutes 2023, chapter 260E.
- **Identifying options**
  - The third meeting in April focused on understanding the research and learning from the state of Connecticut's approach.
  - The fourth meeting in June focused on reviewing first draft outlines of the testing and reporting protocols. Individually, task force members did a pulse check to assess level of agreement on the draft outlines. Every task force member who participated indicated they supported the direction.
- **Develop and refine**
  - The fifth meeting in August focused on discussion of ten draft recommendations and the task force voted, with 100 percent consensus, to share draft recommendations with community members for input.

- The sixth meeting in September focused on analyzing feedback from community members to determine what changes were needed to the draft recommendations.
- The seventh and final meeting in October focused on discussion and final approval of recommendations.

How the task force developed recommendations

The task force work was guided by leadership from two co-chairs and work got done through the creation of various workgroups at the three distinct time periods.

- First phase: The first two workgroups formed in February 2024 to develop initial protocols for testing and reporting that were presented at the fourth task force meeting in June 2024. Task force members volunteered for either a workgroup on testing or a workgroup on reporting. It was also an option to not join a workgroup.
- Second phase: Over the summer, a single workgroup was formed to work on the next draft of the protocols with the goal to stitch together the testing and reporting protocols. Task force members could sign up to be developers of content or editors. This workgroup developed a set of ten draft recommendations that were presented during the fifth meeting in August 2024.
- Third phase: The final workgroup convened between the sixth and final meeting to make changes to the draft recommendations based on community input and the task force discussion that occurred during the September 2024 meeting.

Community input summary

For approximately four weeks, task force members gathered input on the ten draft recommendations from community members and stakeholders with a special emphasis on hearing the perspectives, experiences, and feedback of individuals and populations most likely to be impacted and most likely not to agree with the proposed recommendations. Feedback was shared via an electronic survey link. The task force received feedback from twenty-four unique groups or individuals. They are listed below.

1. Project ECHO participants (August 14, seventy participants)
2. Midwest Children's Resource Center
3. Minnesota Perinatal Quality Collaborative
4. Frontline Professionals Advocating for Child Safety
5. District County Judges (two people from North Central, Southeast)
6. Native American Community Clinic
7. State Representative
8. Minnesota Department of Health
9. Olmsted County CPS Supervisors
10. Center for Safe and Healthy Children—University of Minnesota
11. Child Safety and Family Preservation team—DCYF
12. County Child Welfare
13. Olmsted County Health Housing and Human Services
14. DCYF Child Safety and Permanency Administration's American Indian (AI) Well-being Unit
15. Hennepin County Behavioral Health Project CHILD

16. Community member, mother, mental health provider, drug and alcohol counselor and residential substance use administrator
17. American Indian team—BHD DHS
18. Minnesota Prairie County Alliance and MACSSA Children's Committee
19. Wayside Recovery Center
20. Brown County
21. Village Arms
22. DYCF Implementation Office
23. DHS (two separate submissions)
24. Family Physician

Positive feedback

The majority of feedback received was positive and supported the recommendations from the task force. A few positive comments are provided:

- "I agree with the recommendations. I am hopeful that with these new recommendations there will also be resources and education for parents community and providers as they navigate the residual stigma in the context of substance use."
- "I am in favor of all of these recommendations and am so grateful that this Task Force was established. I think the verbal/written screening and the notification system are great ways to identify individuals who need support/resources."
- "Current policy and practice create barriers for people who are pregnant. These changes will decrease decision making that may be biased."

Areas of concern

Community input was summarized to highlight main areas of concern. These concerns were discussed during the September meeting. Changes to the recommendations were made based on the input.

There were concerns about the perception of shifting responsibility to assess child safety from child welfare to healthcare providers given their current scope of practice.

Shifting responsibility to assess child safety from child welfare to healthcare providers poses risks. There was concern that most healthcare providers lack necessary training and skills to assess for child safety, especially for long-term interventions. The task force should work to answer the question, "Whose responsibility is it to assess child safety?" and "How can the expertise of all professionals be leveraged to assess child safety?"

There were concerns regarding an inadequate approach to assess child safety.

While community input supported the task force recommendations calling for increased screening for substance use in pregnancy, several comments called attention to SUD screening not being interchangeable with a safety assessment. Some noted that the recommendations were vague on what is included in a safety assessment, which tools would be used, and who would be responsible.

There were concerns about a lack of clarity related to who is accountable to oversee Plans of Safe Care and evidence they keep children safe.

The current "Minnesota's Best Practice Guide for Responding to Prenatal Exposure to Substance Use" maintains a clear line of responsibility for managing Plans of Safe Care with a single agency, the Department of Children, Youth, and Families. Task force recommendations outline providers and/or community-based professionals can initiate Plans of Safe Care and the resulting concern is reflected in this comment from the Frontline Professionals Advocating for Child Safety, "…In the TF recommendations, the POSC can potentially be developed and monitored by providers with no specific training in infant safety. There is no accountability for anyone elected to oversee the POSC, and participation is entirely voluntary. Failure to participate in the POSC is not an indication to report to child protection. The TF proposal make the POSC a meaningless exercise that does not assist in assuring child safety."

The purpose of the blind notification system is unclear.

A family physician shared, "More language needs to be added as to exactly what the notification system serves, and how this would support pregnant persons, the newborn, and their household members." While there was an understanding that the notification system would satisfy federal requirements if "…parental substance use (by itself), is not neglect or abuse, what is the rational to have to notify at all?" Comments added concerns about a gap in services, unfunded mandates, lack of tracking data, and the need for a multidisciplinary approach.

Training and education will be necessary.

From the beginning, task force members articulated the need for robust training and education to effectively implement recommendations. Community input emphasized this too.

Appendix F: Sample language to create a new law that outlines notification is not a report of child abuse or neglect.

The following is sample wording recommended by the Model Substance Use During Pregnancy and Family Care Plans Act.

SECTION VI. NOTIFICATION TO [DEPARTMENT].

(a) Notification by healthcare professionals.—A healthcare professional, or an appointed delegate, involved in the delivery or care of an infant born affected by parental substance use disorder or experiencing withdrawal, shall, within [n] [hours/days] of the birth of such infant, submit a confidential notification to the [department] via an online portal or in writing in a form and in a manner as prescribed by the [department] by rule, pursuant to the requirements of the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. Sec. 5101, et seq., and the Comprehensive Addiction and Recovery Act (CARA) of 2016, P.L. 114-198, and any subsequent amendments thereto. A notification shall not be construed to be a report of alleged child abuse or neglect. 79 Id. 80 Id. 81 Id. 82 Id. 83 Id. 84 Id. Model Substance Use during Pregnancy and Family Care Plans Act 24 Return to Table of Contents

(b) Duties of [department].—The [department] shall:

(1) Create a system to allow healthcare professionals, or their appointed delegate, to submit the notification required by subsection (a) via an online portal through the [department]'s website or in writing, so long as no identifying information is transmitted;

(2) Ensure that no identifying information, including the identity of the individual submitting the notification, is submitted through the online portal;

(3) Establish the information required to be submitted with the notification which shall include, at a minimum, the following:

(A)The zip code where the birthing individual resides or, if unhoused, of the facility where the birth occurred;

(B) The race/ethnicity of the birthing individual and the race/ethnicity of the infant;

(C) Whether the infant was born preterm, as defined in [insert reference to state law or other reference material];

(D)The name of the substance or substances the birthing individual used during the pregnancy, if known;

(E) Whether an authorized healthcare professional prescribed, dispensed, administered, or furnished such substance or substances to the birthing individual;

(F) The name of the substance or substances by which the infant was affected;

(G)Whether the birthing individual had a prenatal family care plan;

(H)Whether the birthing individual was offered, or referred to, services including, but not which referral was made;

(I) Whether the healthcare professional making the notification required by subsection (a) made a concurrent report to the [department] alleging child abuse or neglect by the birthing individual; and

(J) Any other information required to be submitted by rule; and

(4) Promulgate such rules and regulations as are necessary to effectuate the provisions of this section. Model Substance Use during Pregnancy and Family Care Plans Act 25 Return to Table of Contents

(c) Toxicology tests.—Notwithstanding any other law to the contrary, a toxicology test of the birthing individual during the prenatal or postpartum period, or of the newborn infant at the time of birth, showing the presence of drugs is not a sufficient basis by itself for making a report to the [department] of child abuse or neglect.85

(d) Notification is not a report of child abuse or neglect.—Notwithstanding any other law to the contrary, neither:

(1) Use of a controlled substance, prescription drug, non-prescription drug, alcohol, cannabis, or other substance while pregnant; nor

(2) Giving birth to an infant born affected by parental substance use disorder or an infant experiencing withdrawal, is, in and of itself, a report, finding, or presumption of alleged child abuse or neglect, and a notification made pursuant to this section shall not result in an investigation by the [department], removal of the child, criminal sanctions, or other punitive measures against the birthing individual.

(e) Report of alleged child abuse or neglect.—Nothing in this section shall prevent a healthcare professional or other person from making a report of alleged child abuse or neglect to the [department] if factors other than substance use by the birthing individual are present that impact the health or safety of the newborn infant.

(f) Confidentiality.—Except as otherwise provided for in this Act, the information submitted to the notification portal pursuant to subsection (a) is confidential and not subject to subpoena, discovery, or open records laws pursuant to [insert reference to state open records law]. Nothing in this subsection shall prevent child welfare caseworkers or other individuals with a state or local child welfare services agency from obtaining identifying information on a pregnant or postpartum individual or infant born affected by parental substance use or withdrawal symptoms for the purpose of participating in a multidisciplinary collaboration with other agencies, entities, and individuals in order to provide services to the pregnant or postpartum individual, infant, and other family members pursuant to a prenatal or postnatal family care plan.

Appendix G: References

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