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Megan: Hello everyone, and welcome to this Ask the Expert webinar: "Criminalization, Legal Implications of Substance Use During Pregnancy." I'm Megan Hiltner with the Healthy Start EPIC Center. We have approximately 90 minutes set aside for this event. The webinar is being recorded, and the recording along with the transcript and the slides will be posted to the EPIC Center's website following the webinar. The link is posted in the chat box. We do want your participations during the webinar. So if at any point you have any questions or comments, please chat them into the chat box in the left corner of your screen. We will be only taking questions through the chat box. And we also want your feedback on this event. So please take a moment following the webinar to complete the brief survey that will pop up on your screen right after the event.

Here's how we structured the webinar today. First, you'll hear a few welcome remarks from Dawn Levinson. She's the behavioral health advisor to the Division of Healthy Start and Perinatal Services. Then you'll hear from our expert speakers Amber Speakers, Aarin Williams, and Indra Lusero with the National Advocate for Pregnant Women. Then we'll open it up for Q&A and we'll share some resources and wrap up.

Before we get started, we wanna do a quick pretest knowledge check. So please take a moment and respond to these questions on your screen. First question, newborn babies exposed to opioids or...let me get my notes here so I can read the full question to you. Okay, newborn babies exposed to opioids or the medication for opioid use disorder should not breastfeed, is that true or false? So please click on the radio button where of which you think it is the correct answer, true or false. I'll give you a moment to do that. Okay. It looks like we're split, 50-50 here. All right, we're gonna revisit these same questions at the end of the webinar to see if your responses shifted.

So the second question here, must you, without a court order, turn over your patient's confidential medical records to Child Protective Services when they ask? Is that a yes or is that a no? So if you click on the radio button of what you think the answer is, yes or no. All right, folks are responding. Give it one more second here. Okay, looks like the majority of folks think it is no.

All right, now the third knowledge check question here. Can women who use drugs during pregnancy ever be prosecuted for crimes related to their drug use? Is that yes or a no? You'll click on the radio button as we've done before. All right, and it looks like everyone thinks that's yes.

Thanks everybody for taking the time to respond to those question. Our expert speakers today are gonna cover all of those topics in their remarks, but first I'm gonna introduce Dawn Levinson with the Division of Healthy Start and Perinatal Services for a brief welcome. Dawn, over to you.

Dawn: Thanks, Megan. Good afternoon everyone, this is Dawn Levinson. I'm the behavioral health lead in the Division of Healthy Start and Perinatal Services, and I'm a coordinator of all things behavioral health in HRSA's Maternal and Child Health Bureau. I'm pleased to be the division representative on today's webinar. And further, I wanted to note that I'm always available to our grantees if you want to chat or consult about any resources related to mental and/or substance use disorders, and my contact information is up on the screen now and please feel to reach out at any time.

I want to welcome our speakers who I'll introduce in a moment, and again, welcome everyone in our Healthy Start grantee community across the country. Today's webinar about criminalizing women who use substances during pregnancy is a significant and timely topic in light of the opioid addiction and overdose epidemic in our country, but it's not a new one. This webinar will explore consequences of laws that penalize pregnant women instead of supporting them through access to treatment and services. Our speakers will discuss lack of knowledge or awareness among care providers about how to respond when women's health disclosed substance use while pregnant. Our speakers will also describe programs that if partnered effectively with the legal community to address this issue.

And now, I'll take a moment to introduce our speakers today from the National Advocates for Pregnant Women and I'm so pleased that they're joining us today. We're lucky to have such experts with us. So first is Amber Khan who is senior staff attorney and she has represented clients in a variety of civil matters including family law and immigration law. She's also worked in the field of international human rights. Miss Khan received her undergraduate degree from American University, her master's degree from Columbia University, and graduated from George Washington University Law School. Most recently, she served as senior staff attorney at the Center for Family Representation in New York City.

Our second presenter today is Aarin Michele Williams, also senior staff attorney at the National Advocates for Pregnant Women. She's an experienced lawyer barred in New York and New Jersey. She most

recently worked in the New Jersey Office of the Public Defender. In this position, she was a trial attorney for citizens charged with serious crimes. She was identified as a lead attorney within the organization and was a sought-after trial strategy trainer for lawyers. Miss Williams is also an adjunct humanities professor at the New Jersey Institute of Technology where her popular courses explore a variety of socio-political topics, earning her a nomination for the 2017 University Excellence in Teaching Award. She's originally from Georgia and is a proud graduate of Howard University and Rutgers Law School in Newark where she was a member of the Rutgers Law Review. She clerked in the New Jersey Superior Court and interned for leading civil rights organizations. Miss Williams passionately advocates for disempowered populations and believes that her community is owed and deserving of the benefits and fruits of her education.

And finally, Indra Lusero, Staff Attorney, is a reproductive justice attorney and entrepreneur who founded Elephant Circle and the Birth Rights Bar Association to advocate for policy change that supports families and physiologic well-being. Indra's publications include "Challenging Hospital VBAC Bans Through Tort Liability" and "Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery." As a genderqueer Latinx parent, Indra is committed to creating a world where all worlds fit. Without further ado, I turn it over to our speakers. Thank you so much.

Amber: Thank you Megan and Dawn for that introduction. So I'm gonna speak first, this is Amber, to give some information about NAPW and our work, and then Indra and Aarin are both gonna give some more specific examples of our cases and our work. So NAPW's mission, as it says, is to secure the human and civil rights of pregnant and parenting people. We're a national non-profit legal organization and a lot of our work really focuses on sending women from punitive actions. Those actions could be criminal cases as well as civil cases that are in some ways based upon pregnancy. So in other words, that a person is being targeted for punishment because of the fact that they are pregnant. If they were not pregnant, then whatever the action and issue is, it just wouldn't be something that would require government intervention. A lot of our case examples today that Indra and Aarin are gonna go into address the use of drugs, and how allegations of drug use when coupled with pregnancy are treated sometimes by healthcare providers, sometimes by civil child welfare authorities, sometimes by law enforcement, and how all those different things when combined can lead to a prosecution.

We do our work in different ways. We represent people directly who are accused one of these things. We also assist attorneys across the country through a variety of ways. We have assisted in writing motions, providing research, suggesting expert witnesses, just giving some general feedback when needed. We also submit what's called amicus curiae brief in cases across the country on a state and federal level. These are briefs that are friend of the court brief. What that means is that even in a situation where we don't directly represent a party to a case, we can still submit a brief to help explain certain issues to the court that we think are important, and implicate larger policies that we think are important. We also do some amount of legislative commentary. So we might submit comments regarding a law, again on a state or federal level, either supporting or opposing a particular piece of legislation.

These are examples of some of the things that we have seen people prosecuted and punished for including pregnancy loss, which at times we've seen treated as a criminal act. Also abortion, again, it's something that a prosecutor believes had occurred outside of a medical or legal setting. A lot of different actions that seem benign, but again, if perceived to be something that's intentional or outside of the law, we've seen people prosecuted for, and then child abuse and child neglect charges as well.

So as I said, drug use is one of the things that we've seen a lot of. The allegation of drug use and the use of drug laws as a way of really punishing and surveilling pregnant and parenting people. We nor any of the medical professionals that we have worked with certainly are promoting the use of any substance during pregnancy. However, we do think it's worth noting that many of the things that can affect maternal and fetal health are legal including things like tobacco and alcohol or things that are entirely outside of a person's control like environmental toxins or racism or the impact of poverty. But the data, what it does not support is the assumption that the effects of illegal substances pose such a unique or irreparable harm to children that it would support singling that particular thing out as a basis for punishment or as basis for surveillance or to assume that a person doesn't have the ability to safely parent their child.

The years after the very incorrect term of "crack baby" started and all of the media frenzy around that term, it's certainly been seen and demonstrated by medical and scientific data that the assumptions that were used to create that term are simply not accurate, that there isn't the

data or the evidence to prove that prenatal exposure to crack cocaine leads to a permanent medical condition in children. And all of these years later, the generation of children that were being labeled as "crack babies" have grown up and are not just permanently lost generation as one of the quotes in the last slide had labeled them as. And in fact, didn't have any specific set of symptom that is recognized as any particular medical condition or diagnosis.

However, that's certainly not to say that drug use today is still not used as a basis for a lot of these assumptions and a lot of prosecutions, civilly or criminally. Now you heard in the introduction today about the concerns of certainly this regarding opioids and the use of opioids including use by pregnant women. So because of that, I wanted to spend a few moments to talk about neonatal absence syndrome, which I'm sure that audience all knows. It's a diagnosis that may come to some newborn who have been prenatally exposed to opioids including medications as to treatment, methadone and buprenorphine that are also of course opioid-based.

Just wanna highlight a few things. You know, one is that this condition is treatable and transitory. It certainly should not be used as a basis to punish people, or again, as a reason to assume that a person is not able to safely parent their child. Also to point some of these quotes of what are the best ways of treating NAS, which includes maternal-newborn contact, looming in, and breastfeeding as they decrease the severity of NAS. The contact between a parent and a child is likely severely limited if that parent is being investigated by civil child welfare authorities or criminal authorities, and it can lead to a separation between the parent and a newborn baby. That separation certainly has a great impact on the mom, but also has been shown to have a severe developmental impact on the child.

And as a, kind of, larger point, these types of interventions, especially if they are not particularly necessary to protect the child, they serve as a deterrent to others from receiving healthcare, or if I'm being honest, with their healthcare providers. And certainly, I think everyone agrees, especially healthcare providers that that's not what we would want. But maternal and fetal health certainly cannot be advanced by deterring healthcare or an honest communication between physicians and their patients. So with that I'm gonna turn it over to Aarin who's gonna give us some more specific examples in the criminal setting.

Aarin: Thank you, Amber. Hi, everyone. I'm going to, as Amber

indicated, provide some examples of what criminalizing pregnancy looks like. I know that when any of the attorneys from NAPW goes out and speaks to people about these issues, one of the first questions or one of the responses visually that we see with criminalizing pregnancy is the look of confusion. So I'm gonna provide some specific case examples. I'm going to limit my legal jargon and try to focus just on what, you know, happened in those specific cases, and when women have been in contact with medical professionals, and what some of the outcomes are, legal and otherwise.

So I'm gonna start with, in general, an understanding of some of the types of charges often used in healthcare settings. Here is a laundry list of those types of charges, which, frequently, it surprises people that a woman can be charged with murder, manslaughter, feticide, criminal child endangerment, abuse of a court, or even unborn child abuse, or the distribution of a controlled and dangerous substance to an unborn child as a pregnant woman. So I think it's always important to not just talk about people, but for everyone to always have a visual and understanding when you're speaking about someone, you know, what they look like and really put a face to their name. We've been provided permission to use these pictures but I also want everyone to see them and understand, you know, what the faces of this can look like. So it really does look like, you know, all of us.

So I will start in the great state of Florida with Jennifer Johnson here in the middle. Jennifer is a mother, and was at the time a mother and the first woman ever to be convicted of delivery of drugs to a minor through the umbilical cord. Those drugs laws were and are intended to apply to drugs sold to live persons and not the actions of a pregnant woman and her fetus. Miss Johnson was charged after delivery, her two children at two separate times, after she disclosed to doctors that she had used cocaine days before delivering both of them. Despite both children being born healthy and full term, the medical staff called Child Welfare Services. The children were placed with family and Miss Johnson was arrested, placed in jail and charged with two counts of child abuse and two counts of delivery of drugs through the umbilical cord. The articulator rationale was that she distributed the drug that was still in her body to her children through the umbilical cord while she was in labor and during the children's first moment of life. Miss Johnson eventually was sentenced to 14 years of probation where there were a number of arduous conditions, and one of them included, frankly, just monitoring of her reproductive rights. So if or when she ever became pregnant, she had to let her probation officer know.

Here is Casey Shehi [SP] in Alabama. At seven months, Miss Shehi had a toddler and was in a very stressful and overwhelming situation. Her boyfriend at the time had been prescribed legally, Valium, and she took half of it so that she could sleep. Months later she delivered, and when the hospital tested her and her baby, she, Miss Shehi, tested positive for opiates and her son, the little cute baby in her arm, tested negative. She explained the circumstances of her use and was discharged. However, weeks later, she was arrested and charged under Alabama's Chemical Endangerment Law, which was created to prosecute those who brought live children into dangerous environment, like a meth lab. Ultimately, she was able to keep her newborn baby, but lost custody of her young son to her ex-husband and it took years to regain custody again. At the time, the Child Welfare case also opened and she was investigated, had to pay for routine and expensive drug testing, which was additionally difficult because employment was hard to come by because of the stigma attached to those charges.

In general, Alabama has this Chemical Endangerment Law, which was introduced in 2006, and since then, hundreds of pregnant women have been arrested and charged for in utero drug use. The rationale, again, is that pregnant women who are drug using are, and at one point even if the medication was prescribed, are exposing their unborn child to a dangerous environment, the womb. Now this can play out a number of ways not only in Alabama, but frankly, you know, throughout the country even if it's not legal, but throughout the country, when a woman deliver in a medical setting, she or her baby can be tested, or both of them can be tested, or even if she's pregnant and just goes in for a visit and she tests positive for drugs, she can be charged with this crime and be exposed to up to 10 to 20 years of her life based upon her drug use. A lot of these women are low income and women of color, meaning there may be a trend of low receiving Medicaid or Medicare and being served in a public more than private hospitals. So it unfortunately plays upon a number of racist, classist, and sexist stereotypes in its enforcement. And importantly, just for your edification, the prosecutors do not have to establish that the baby was harmed or there was any permanent specs based upon it, they just have to merely establish that a woman used.

Then there's Kenlisia [SP] Jones of Georgia. In the spring of 2015, she went to the hospital after ingesting a safe and legal drug, Misoprostol, to bring on early labor. During her treatment, she advised medical personnel saying, and when her baby did not survive, medical staff called law enforcement child welfare agencies under the assumption

that she had intended on performing an abortion, which was legal. She was charged with malice murder, jailed, and mistreated while in custody. With the help of NAPW, the district attorney dropped the murder charges confirming there was no legal basis to charge her with the murder charge, but the drug possession charges remained opened for years.

There's also Kasey Dischman [SP] of Pennsylvania who sought emergency medical care while pregnant after experiencing a heroin overdose. And Miss Dischman was taken to hospital and consented to emergency caesarian surgery and gave birth to her daughter. While still hospitalized, she was arrested for assault of an unborn child based upon her alleged drug use while pregnant and for violating conditions of her probation after hospital personnel reported her actions to authorities. Ultimately, the felony assault charge was dismissed with NAPW's help also, but the drug possession related charges as well as her violation of probation, which resulted because of her overdose, remains.

And I'm not going to go through every single woman pictured here, but I do think, again, it's important that all these women have been affected by drug use during pregnancy, and some of these women are pictured with their children, and are perfectly "normal."

So I want to move on and also discuss self-induced abortion. Self-induced abortion is not a new phenomenon, but in a post-[inaudible 00:23:50] society, many do not understand why someone would have one. There's a great deal of stigma around it, and for the most part, people hear the term and envision back alley abortions. Women often self-induce because there are few, if any, abortion clinics in the state, abortions are expensive, anti-protests outside of the clinic, and women want to avoid the stigma in their community. There are a variety of TRAP laws in states that not only make it difficult for the providers, but also women. Waiting periods, pre-abortion counseling, and religious counseling and more make it extremely, you know, unrealistic and difficult for someone to have an abortion. So there are a number of safe ways and legal ways to self-induce. However, it is important to keep in mind that even when using these safe options a woman cannot guarantee her pregnancy outcome, which result in a woman or a pregnant person coming to your facility after attempting one. And how that can play out and look legally, I have two examples of.

One would be Anna Yocca in Tennessee. At the end of 2015, according to news reports and documents Miss Yocca attempted to terminate her

pregnancy at home with a coat hanger. She presented at an emergency room and was admitted to the hospital. Days later she consented to having caesarian surgery and gave birth to a premature baby. Based upon medical staff notifying authorities, she was charged and jailed. She was initially indicted for attempted first-degree murder, but once that charge was dismissed, she was indicted with fetal assault, aggravated assault with the weapon, being the hanger, attempted criminal abortion, and attempted procurement of a miscarriage. Miss Yocca unfortunately remained in jail for over a year and she ultimately pled guilty to a charge and received time served.

There's also Miss Bynum in Arkansas. Law enforcement alleged that Miss Bynum took a number of pills to induce an abortion. According to news reports, days later the pregnancy ended with the delivery of a stillborn fetus while she was alone. Investigators say that several hours after that, she went to the hospital asking to see a doctor. She brought the fetal remains with here. Miss Bynum was arrested 5 days later on charges of concealing a birth, a class C felony punishable of up to 6 years in prison and a $10,000 fine, as well as abuse of a court. A class C felony, punishable of up to 10 years in prison and a fine of up to $10,000 as well. Both of these statutes are from the 1800s and are rarely used, but were used in the Bynum case.

Again, understanding the conditions many people you encounter are coming from with who you are treating, it's important to always remain and to always center the woman first, or the pregnant person first. It's really important to keep all of that in mind. And finally for me, a discussion of stillbirth and miscarriage and the criminalization of the same is also important. Approximately 25,000 stillbirths occur annually in the United States, which accounts for 15% to 20% of births. Causes of stillbirths and miscarriages are unknown although many believe, especially in this context, that when a woman who arrives and she tests positive for any illicit drugs, or in some cases even prescribed medicines, must have had some affect on her pregnancy outcome or could have lead to the stillbirth or the miscarriage. However, there exists no affirmative scientific or medical proof that drug use is a direct cause or the cause at all of a stillbirth or a miscarriage.

And as Amber mentioned earlier, there are other things, social determinants, that affects at least 50% of health outcomes of not only infants, but also all people. In our context, what can that look like legally so that you can understand what can happen if you were to report a stillbirth or a miscarriage? For us, that can look like a case that we

[inaudible 00:28:19] and when it was reported and she called the police...excuse me, when she reported to the hospital with the assistance of her husband, she was questioned and ultimately arrested and charged with second degree murder because of their belief that, in fact, her hope was to cause an abortion.

So what I would like for us all to discuss is...so what I would like for us ultimately to come down to is what we can be done from your point of view? Noticeably, all of these case examples and many of the cases NAPW's involved in begin in medical settings. This is also because medical personnel believe they are required to report drug use or abuse in pregnant persons, but it's not always true with respect to criminal or civil child welfare cases.

Now, as I already mentioned, Alabama, for example, has a carved out criminal statute that requires reporting, and Wisconsin has a specific child welfare statute that requires reporting. Other that those two jurisdictions, the law is not always clear and many medical personnel or hospitals interpret law regarding abuse and neglect to mean that a positive toxicology from a pregnant woman or child requires reporting to officials. Indra, momentarily, will touch upon the child welfare sections, but I would like, we would like all Healthy Start grantees and listeners to understand the potential dire consequences of reporting and obligations to do so, and the importance in your role in those consequences.

Understand you always have an ethical duty to your patient first. Much of the healthcare provider's obligation depends upon state law. Healthcare providers should not breach the confidentiality of their patient without knowing the exception or situation where they are required or permitted to do so. If state law does not make it clear that a positive toxicology test, or a mother or child is abused or neglected, and as a mandated reporter one may not be obligated to breach confidential statements or actions and report them. Many state laws are vague in this department. Moreover, it is not beneficial for your patient or the fetus, or once born, the child. Know the policies in your place of business. If the policies are well meaning, but in practice harming people, push back. Understand the difference between use and abuse when it comes to drugs, and take a non-judgmental and holistic approach, understanding your professional organization can sign up. And as mentioned by Amber, that we often have amicus briefs and open letters where we oppose the actions of hospitals or laws and we will have medical professional sign on to help support our physician. And with that, Indra, all you.

Indra: All right. So I wanna talk a little bit more about the child welfare side of things. Aarin talked a little more about some of the potential criminal consequences. What I have here first is a slide that depicts a remedy from the mid-1800s, and this was sold as a medicine to soothe children. You can see this is an alluring advertisement, and the mixture in this medicine was actually a combination of morphine and alcohol. I used it here to emphasize that ideas about what proper parenting looks like are cultural, changeable, and susceptible to bias and fashion. Nonetheless, this is where the civil child welfare system operates. The legal idea behind it is that the state should stand in as a parent when children are at risk with the incredible goal of both preventing child abuse and neglect and protecting children from child abuse and neglect.

So one extreme example of this idea of the state's tremendous role in protecting children is Wisconsin's "cocaine mom" law. This is Act 292 in Wisconsin. This is actually currently being challenged by Tammy Loerschter who's pictured here on the right. Tammy was actually jailed for 18 days in her 2nd trimester of her pregnancy after disclosing to her doctor that she had used methamphetamines, alcohol, and marijuana before she knew she was pregnant. So again, that was ultimately a criminal punishment but it emanates from a law that is very comparable to civil child welfare laws across the country. It's just an extreme example. In this example, there was a hearing where Miss Loerschter did not have counsel present, but her 14-week fetus was immediately appointed counsel, and following the hearing, she essentially had the choice of being forcibly detained indefinitely at a drug treatment facility that provided no prenatal care or going to jail for 30 days where she would also receive no prenatal care. In fact, she ended up incarcerated where she was also denied prenatal care. So generally, child abuse is a state law issue, but there is a federal legislation that provides guidance and funding to states.

The cartoon here on the bottom left depicts the wide range of groups that we've worked that finds that punishment of pregnant women is bad policy in general. Even in states with less extreme measures for child protection, the system is generally punitive and problematic. In fact, studies have shown that fear of child protection is a barrier to care for the majority of substance-using mothers.

Twenty-four states plus the District of Columbia defines substance use during pregnancy as child abuse. There are many problems with laws that make substance use during pregnancy abuse. For one, these laws

drive many women away from seeking healthcare, but these laws also allow children to be removed from parents who are actively getting treatment for a substance use disorder. It also allows parents who don't have a substance use disorder to be investigated and to sometimes have their children removed from their care. This was part of the dynamic in Tammy's case where she was ordered to undergo treatment for a substance use disorder without ever receiving a diagnosis of having a substance use disorder.

Often these laws make a determination based solely on a drug test, which of course does not detect or determine parenting ability. In fact, there is no evidence or consensus for how much of which substance is used on what schedule impact or even impair parenting. Furthermore, infants born to black mothers have been shown to be more likely than those to born to white mothers to even be screened for illicit drugs even though they have comparable rates of use. So even the decision to a drug test is likely to disproportionately impact black families, and of course there are consequences that flow from that.

Okay, Aarin talked a little bit about reporting. So nationally, the latest available data shows that about 7.4 million children had a report made about them being potentially abused or neglected. Of those, the vast majority, about 90% are not found to have been abused or neglected. So this slide depicts, in the orange piece of the pie, those are the reports that ultimately were found to be made against a child who is not abused or neglected. In the small portion of the pie, about 10% of reports made ends up with a finding of some sort of either abuse or neglect, and the majority of those are neglect to over 70%. Neglect, as you can imagine, is even harder to define than abuse, and it's strongly associated with poverty. Children of color are also disproportionately represented in this system.

Here's a quote from a report of the U.S. Advisory Board of Child Abuse and Neglect. It says, "The most serious shortcoming of the nation's system of intervention on behalf of children is that it depends upon the reporting and response process that has punitive connotations and requites massive resources dedicated to the investigation of allegations. However, the system acts in response to allegations not needs for help." So again, if you imagine resources going into this orange portion of the pie when need is represented is only by the gray portion of this pie.

The majority of reports are made by professionals. So what we know is that mostly professionals are reporting things that are not abuse or

neglect. This may be, at least partly, the result of a lack clarity about what mandatory reporters are supposed to report. And I use the image from that first slide to sort of underscore the gray area here, the kinds of qualities about what good parenting is that people have to face when they're figuring out what abuse and neglect may be. In most states, the standard is something like if you have a reasonable cause to suspect abuse or neglect, you have a duty to report it. Reasonable cause. Based on this data, it would be reasonable to suspect that most things are not abuse or neglect. You do not have to report things that are not clearly abuse or neglect. You do not have to report when you don't know if it's abuse or neglect, you really only have to report when you're pretty sure it is abuse or neglect. Nonetheless, this can still certainly be subjective in process.

The system is obviously built to err on the side of getting more reports. One way this happens is through penalties for failure to report. Forty-eight states have some sort of penalty ranging from a misdemeanor in fines to felony and jail time. But generally, the penalties are for knowing about abuse and failing to report. Many professionals, as our cartoon professional here on the left, guess because they're scared of not knowing, but what we know is that this can actually do more harm than good, especially when it comes to pregnant folks who, as we have discussed, will avoid care due to fear of Child Protective Services reports. In one study, physicians were shown to be internally inconsistent about when they make reports, which of course opens the door to bias and the over-reporting of black families that we see in the system. By definition, a doubt is not a reasonable cause to suspect, especially if it's in the context of establishing a trusting relationship with the pregnant women who is actively seeking services and care.

Prenatal care is strongly associated with improved outcomes for fetal development, even for women who are not able to overcome their addiction problem before their due date. For example, one study demonstrated that pregnant women who used illicit substance, but also received prenatal care significantly reduced their chances of delivering low birth weight or premature babies. So harm reduction really warrants protecting access to prenatal care over making reports.

There are new federal requirements through the Child Abuse Prevention and Treatment Act, but these do not create a new category of abuse. Instead, these requirements are premised on ensuring that infants and their parents have access to needed treatments. The government does want to know about infants born with symptoms of prenatal drug

exposure to ensure their care, but not necessarily to determine whether they're abuse or neglected. We definitely advocate for state systems that track this data separately from abuse and neglect registries. And that concludes the substantive overview that we have for you, but we hope at this point we can open it up to questions and conversation hoping that we've touched on many of these key issues.

Megan: Thank you so much, Indra, and to Aarin and to Amber for your thoughtful remarks. And folks, I do wanna to encourage to submit questions into the chat box or complicated cases that you've run into or other relevant things, comments that have come up. We really want you to utilize this time with the experts we have on the webinar. Here is a question for you all that was chatted into the chat box. If a pregnant mom seeks help for her addiction or substance use disorder, will they have charges brought on them by seeking help?

Aarin: I think that's a really good question, Sherry [SP], I believe it is. So I'm gonna start to answer that, and certainly Amber and Indra can jump in to cover anything I don't mention. And so, I mean, I'm sure many people have heard before from lawyers, most answers always start off with "it depends," and it really kind of can. All of these, and I'm sure most questions that will be asked, will kind of just depend on the state. I noticed that Sherry doesn't truly specify she needs criminal or civil charges brought at the time of a pregnant woman seeking help. And I think that is also important to know that there is a difference between criminal charges and civil child welfare or anything that can stem from civil child welfare accusations and can lead to civil child welfare charges. So most of my experience is with the criminal aspect, and I will attempt to answer it in that way.

Frankly, again, it's really not completely clear and it may depend on how the woman seeks help. For example, Alabama where there is a clear criminal statute or if you are a pregnant woman or pregnant person and you are drug using and maybe you go in to a doctor's office and you get tested and they say that you test positive even before you child is born and maybe at that point you want to seek help, right, maybe at that point you have a conversation with your doctor and they decide and you decide that you want to seek it voluntarily.

In Alabama, it can be a mitigating factor and even a defense considering you've actually gone and sought help, but when I use those words, "mitigating factor" and "defense," that means that there has been a criminal charge against you. So technically in Alabama whomever the

physician, the nurse, or what have you can report you, and the charge can be initiated not nearly just because you're seeking help in the moment, but literally the statute require them to report. So I hope that's a little clear. So if a woman just goes into a rehab center, for example, in Alabama, it's not apparent that she will have criminal charges against her just for seeking help. However, we haven't seen that, but frankly, because of the ways in which the law can be applied, I wouldn't even be surprised if something like that could potentially happy. So it is important to be mindful of that. Now, in other states, you know, other than Alabama, there are not clear criminal statutes that require anyone to report, but it can happen, and I will turn it over to Amber and Indra if they wanna answer the civil or add to the criminal part.

Amber: Thanks, Aarin. This is Amber speaking. In the civil child welfare world, Indra went over the example of Wisconsin and Wisconsin's Unborn Child Abuse Law. That was really is a rare exception in the United States. For the most part, most states define child neglect or abuse as it pertains to a live child. So, you know, think about this question, if a baby tests positive for a particular substance when it's born and that is basis of a report to a child welfare agency and a subsequent investigation, part of that investigation is going to be asking the parent if she has ever sought treatment and part of that investigation can be that the records from that treatment provider. So while the women isn't actually being punished for seeking treatment, all of that information can still be used against her. And that could include anything from what she was seeking treatment for to if she had a relapse to if she gave information that has nothing to do with substance use, but anything else, you know, personal inside it in her life, and all of that information can also become part of a larger child welfare investigation.

You know, the civil child welfare system is meant to be broad. It's meant to look into really private aspects of a person's family life to determine if that person is safely able to care for their child. So while a pregnant person is not likely in most states to be reported under a mandated reporting provision when receiving treatment, they certainly could be because a provider just may not know that they should or should not be reporting that person, or that person could end up being the subject of a report after the birth of a child, but still they can go backwards and look at all of that history of a person including their confidential medical records when trying to determine if a person is or is not a neglectful parent.

Megan: Thank you both so much for that response. Here's another

question that has come into the chat box. Have you seen increased criminalization or targeting of women or mothers who are undocumented immigrants in recent years? We've heard that participants in Healthy Start sites around the border fear seeking services for fear of deportation.

Indra: This is Indra. I think the first thing to consider with regard to that question is that with increased criminalization, in general, undocumented folks are even more vulnerable because any criminalization could significantly impact their ability to remain here, their ability to get documented in whatever way they may be seeking. So that factor would certainly impact undocumented folks. And then of course, in certain areas, there are immigration folks who are sort of breaking down what has been respected as barriers, places where they wouldn't go seeking people, and we know that that is happening in places like hospitals. I don't know that we've specifically tracked an increase in targeting of undocumented folks when it comes to these kinds of punitive responses to pregnancy outcomes.

So I think my take on this situation is just that the overall punishment and criminalization of pregnant folks additionally impacts undocumented folks. And then there's also the layer of what's happening to pregnant undocumented folks who are being detained. Prior to the recent administration, there were some protections for pregnant folks who were in immigration custody and those have broken down. So we are starting to see some worse treatment of folks who are undocumented and being detained and are pregnant. I hope that touches on all of the components of your question.

Megan: Thanks, Indra. Amber or Aarin, any additional thought on that question?

Amber: This is Amber. Just one addition, you know, one of the things that Indra mentioned is the treatment of pregnant people with respect to immigration detention. So as our immigration policies are changing and there's more push to detain people rather than releasing them into a community, including pregnant folks, more children are going to be born while under immigration custody and that has a direct connection to the child welfare system because depending on where that person is detained, they may not be living in a facility that allows their child to reside with them. So that child, even though the person is being detained under a federal immigration system, the child gets placed in a state or local-based child welfare system, and that child would then most

likely be placed in foster care unless there's a relative or a family member who can take custody.

So that has a direct connection because the ways civil child welfare systems and civil courts in general communicate with the federal system is really difficult. There isn't a great, easy communication. The parents were detained in federal facility often don't have access to a local civil court that their child is a subject in a preceding in. So in that way, you can also have some additional focus and attention, and certainly anytime that there is a government agent that is putting more focus and attention on a person, the more likely it is that, you know, the person could get accused of something else as well as it pertains to parenting.

Aarin: If I could just circle back. Go ahead, Indra.

Indra: No, go ahead, Aarin.

Aarin: I was gonna leave that question, so if you wanted to stay there, it's probably best.

Indra: Well, I was just going to also underscore Amber's point that whatever initiates scrutiny by the government can then lead to other things. So sometimes, a drug screen may be the first thing that leads people to be investigated or it could be some other thing. Again, it could be bias, it could be just...I've certainly had clients who were investigated because of their tattoos, whatever that, sort of, initiating thing is can then lead to further problems. Whether it be criminalization or whether it be further investigation in the child welfare system.

Megan: Thank you, Indra. Aarin, did you have something you wanted to add separate to that last question?

Aarin: Yes, just to go back to Sherry's question and my answer. I wanted to make it clear that in many states, going to seek treatment or to seek help, as she put it, not a basis for prosecution, but it could be in some, but in Alabama specifically, it is not. And even in Alabama, it depends on the county and I'm sure that's true of almost any and every state. The county and the district attorneys, the sheriff's officers, the hospitals, everyone comes into play all together in how all of this kind of plays out. And the prosecutors are the ones who have discretion, and they don't have to file charges, but once there's been a report, or once it gets on...you know, once it gets to potentially a law enforcement officer or even a child welfare agency, you know, it's going in a different direction.

So I wanted to make sure that was made clear too.

Megan: Well, and you bring up a good point, Aarin. Because Healthy Start is a national program, and your intro to that last Sherry's question was around it depends oftentimes based on the state. I know you all are an amazing resource, but if folks wanted to find out more specifically within their state around requirements or laws, do you have a recommendation for maybe different places in each state that someone could go to and look for more information? Not that you know all 50 or anything like, but is there an organization or...?

Dawn: I'll share a link here in the chat box, which at least gives you information about the states, how substance use in pregnancy is handled.

Megan: Perfect.

Amber: Beyond that, it can be hard even if we could give you a handy list of child welfare laws in each state, how those laws are interpreted are what is hard to convey. So there's a lot of nuance.

Together: Yes.

Aarin: I think also when it comes to mandated reporters, oftentimes, especially when thinking of healthcare settings or educational settings, a lot of folks do have the option of training regarding that since it is an obligation and part of a job responsibility, and part of that training certainly is going to be, you know, kind of the child welfare official version, but also just a copy of it. And I can say, mandated reporting statutes across the country are relatively short so they're not that hard to read, and one can certainly work through them, but they are also using more detailed policies and trainings and analysis of these rules to help professionals, certainly, that have an obligation under them.

Megan: Thank you.

Aarin: And in short, if you're not receiving the training, you know, demand the training because it's really important.

Megan: That's great advice. And folks, I'll pull together any resources that have been shared here and send that out in an email to everybody following the webinar. So a couple other questions have come into the chat box here. This person asked, what about as we an increased

legalization of marijuana, how has legalization of marijuana in states versus the federal laws affected criminalization of pregnant women who use marijuana?

Amber: Hi. Indra, who happens to be working in Colorado, I think, could be a great person to give that answer.

Indra: Well, I mean, I think as a net effect, we see the disparity, kind of increasing so that we are definitely still seeing states that are criminalizing pregnant folks for marijuana use during pregnancy, and we're now seeing states that aren't. So in Colorado, marijuana legalization coincided with laws that really explicitly protected pregnant folks. So we have a law here in Colorado that says, "You can't use a drug screen of a pregnant person criminally," and it was really out of the legalization process that people were thinking about, what do we wanna do to protect pregnant folks? Nonetheless, marijuana is still used in the child welfare system even in legal states, even in Colorado. So that was an area that was kind of neglected during legalization. And I think the penalties for that, at least in Colorado, have shifted, but a positive drug screen for marijuana may be one of those incidents that just starts the wheels turning and gets the child welfare system into a family's life. So it still is, sort of, a point of vulnerability.

Megan: Thank you, Indra, for that. So another question for you all, what is one is key takeaway or piece of advice for Healthy Start sites to remember or know about what they can do with their participants on this topic? Advice on if you're not getting mandatory reporting/training to request it, to ask for it. What are some other takeaways?

Aarin: Also a really good question, and honestly, we were mute in this room, and we immediately said the same thing, which is to treat your patients with respect and to center them and their interests. It seems really baseline, but that is what is what frankly works. What came to mind of many of us was Jennie Joseph's model, she's a midwife in Florida who runs a birthing center, Commonsense Birthing, which really means as it says, which is commonsense birthing, which is treating every person, every pregnant person with respect and making sure that they understand that mothering and pregnancy does not have to be a complicated and, frankly, institutionalized as it has become.

And her outcomes, her birthing outcomes are much better than they are in many, many hospitals because it is that woman or people who have the capacity to be pregnant are not entering these space feeling as if,

you know, they could be arrested, or that they're going to be judged, or for any of the options that they have or any choices that they potentially make. It is a reality that many people feel that way. And for all the examples that we provided, it's grounded in facts that people feel that they could lose their children whether it's the child that they are pregnant with or the children they have at home. Or they could lose, you know, three days to three years or more of their life based upon just going in and disclosing something to the people that they trust with their health and the health of the fetus growing inside of them. So commonsense birthing and just really respecting your patient, and centering them and understanding them that that relationship has to come first before all other relationships.

Indra: Yes, this is Indra. I would say Healthy Start's site could make a commitment to being a safe place to encourage access to care no matter what, to just keep that focus on being accessible no matter what, which I think what also means you don't have to report unless you think somebody is being abused, and having a substance use disorder does not necessarily mean that somebody is being abused, especially if they are seeking help for it. You can have confidence in taking that stand, and can even, I think, influence other folks and other providers in communicating that your priority is in getting folks into prenatal care, ensuring that they go, ensuring that they feel safe and supported, that your job isn't to provide surveillance for the state, to really just clarify that that's your priority, that Healthy Start, in fact, is your priority.

Megan: Thank you so much Indra and Aarin for that. Amber, I don't want to put you on the spot, I don't think you had spoke on that key takeaway piece, any additional thoughts to share?

Amber: I think part of respecting a patient is also to remember, especially when thinking about pregnant folks that, you know, the patient care is probably the most when it comes to the health of their pregnancy and the outcome of their pregnancy more so than probably any healthcare provider and certainly law enforcement official that the person is gonna come into contact with. So, you know, in thinking about that, people are, you know, coming to a healthcare facility because they want help, because they wanna know that they're okay, that their pregnancy is okay, they want advice that's supportive, and I think remembering that and giving people information even if what they are disclosing is substance use, and even if the medical opinion is, you know, you should not use that particular substance, but giving options in a respectful way so that person can think about what is the best way to

reduce that substance if it considered to be problematic or go to treatment if that's helpful or just to maybe even reduce the amount use. You know, Indra had used the term "harm reduction" earlier and that's an important thing to remember in these situations that treating somebody with respect and promoting an honest relationship, if nothing else, could just reduce some of the harms that even medical professionals may be genuinely concerned about.

Megan: Thank you so much for that. Oh, go ahead. Please continue.

Indra: Here's another takeaway. Aarin mentioned some of the cases that we've seen have to with how people have acted following a stillbirth or a miscarriage. And I think what we've seen in those cases, even when folks have sought medical help in those circumstance, if they didn't handle the remains or the tissue following the miscarriage or stillbirth in a particular way, it was viewed as questionable, kind of alerting suspension, and that then led to the investigation and charges in some of these cases. And I think what Healthy Start folks can keep in mind is that the more people feel like they have a trusting relationship with somebody, the more that we can help decrease those situations where folks are in a position of being scared and not knowing what to do, perhaps being traumatized having often experienced the stillbirth or miscarriage by themselves. And if they have someone trusting that they can turn to, maybe that can help reduce some of these instances where how they behave in those is moments is seen as suspicious and then investigated. And Healthy Start sites can just keep in mind that this is one of the things that happens during pregnancy, miscarriages are particularly common. So having that be a part of what folks talk about and think about as the range of normal and just making it a safe space to include that potential outcome I think is a way that folks can directly help.

Megan: Thank you all so much. So folks, we still have a little bit more time for question, so we'll leave the chat box open, but let's revisit some of the questions we asked at the beginning of the webinar to see if your responses have changed at all. So the first question we are posting here is newborn babies exposed to opioids or the medication for opioid use disorder should not breastfeed, true or false? And folks are chiming in here. All right, and we're gonna skip to the results. If you remember at the beginning, we were split down to middle 50-50. Now the majority of folks are responding that it's false. And the answer is false. NAPW team, do you wanna say more at all about that? I know you did during your remarks, but any more you wanna add?

Amber: Just one of the slides that we had put up regarding NAS had quotes including from U.S. federal government that it recommends breastfeeding including for opioid-exposed babies and for women who are receiving medication-assisted treatment. So just something to remember, that's not just our opinion, but it is actually the universal advice of medical providers and of the U.S. federal government.

Megan: Great, thank you. Okay, so then next question we asked at the beginning, must you, without a court order, turn over your patient's confidential medical records to child protective services when they ask, yes or no? And folks are responding. We'll give it another second or two here. And let's skip to the results, and 100% of you say no, and that is correct answer. It is no. So I don't know if there's more that folks wanna say on that, but I know you've spent some time talking about that.

Indra: I'll just note additionally that at least the American Medical Association has clear ethical guidelines about the limits of medical provider's participation in investigations that the medical provider's priority needs to be their patient and that they are expected to maintain the confidentiality of their patient and not to become a proxy for the investigators. So folks can, you know, feel confident that their sense of wanting to protect the confidential patient information is grounded in ethics.

Megan: Thanks, Indra. Okay, so then the last of the questions we asked at the beginning was can women who use drugs during pregnancy ever be prosecuted for crimes related to their drug use, yes or no? So folks, take a moment and chime in here.

Dawn: Hey, Megan, you're on mute, I think. Megan, can you hear me? You're on mute. We can't hear you speaking. Okay, hang on with us folks, but we need to get Megan dialed back in. Give us just a minute. Okay, sorry, well, we lost Megan here for a second. I'll just kind of wrap this one up. So it looks like the majority of you said yes. Again, do our speakers wanna add anything on this?

Amber: For the one person who answered no, please visit National Advocates for Pregnant Women's website, there are plenty of examples there.

Dawn: Okay, fantastic. I'm gonna go ahead and take us into our wrap up and reminders slide. So as...

Amber: Can I pause just before you totally wrap up?

Dawn: Certainly.

Amber: I'm wondering if we could ask what folks who are out there may be seeing or experiencing as barriers that the pregnant folks they work with are facing? You know, if there's something that we haven't touched on, or if there's some place or way that they're finding that pregnant folks are not being able to access care, we would be interested in knowing.

Dawn: Perfect. So if folks wanna chat into the box...Megan, do we have you back yet?

Megan: I'm back, yeah. Sorry about that. Sorry, folks. So I'll just give you all a few wrap-ups and reminders, and like I said, if anybody...I'll chat out or email out all of the resources that have been shared throughout this webinar. But we have an upcoming webinar on May 17th. It's a conversation with the division webinar where they give some updates on both programmatic and any resources that are available. That is from 1:00 to 2:30.

And then it might be a nice follow up to this webinar, it's through our A [SP] Step Initiative, a webinar on building your referral network. That will be a "Hear from your Peer" webinar where we'll give an overview of, sort of, a landscape perspective of what a referral network may look like from the context of a Healthy Start. But then to give a couple examples from a Healthy Start grantee and how they're operationalizing their referral network for both mental health and substance use disorders supports. I've included a couple of links here both the general Healthy Start EPIC Center website, which is where we post all of our webinar slides and transcripts. So if any of your colleagues that missed today's webinar but may wanna review or listen to it or look at the slides, we'll be posting that information there as well as any past webinars. There's also a web page on the website devoted to behavioral health resources on the A Step page and I will chat that link in here. So thank you all for joining today. Go ahead. Anybody else...

Dawn: Sorry, I just wanted to let you know that our speakers were also asking if there were any additional questions. Let me turn it back over to them. Just as you had fallen off the call and rejoined. So I don't know if there were some other folks who had chatted anything into the box for

our presenters. Thank you.

Megan: No one has right now, but you know, we still have moment, folks. So if you do have any questions please do chat them in. I did just get a comment to thank you all for the information. So with that, I just wanna extend a huge thank you to the division for supporting this webinar, but to our expert speakers at the National Advocates for Pregnant Women, thank you all for providing such an informative webinar and so many great resources and guidance and suggestions on this kind of sensitive topic. I just chatted in the link for the resources specific to behavioral health and alcohol and substance-exposed pregnancy prevention website into the chat box, but thanks to you all also for your time that you took out of your schedule to listen to the webinar. This concludes our event for the day, and I hope you enjoy the rest of your afternoon and evening.