On the Ethics of Mandatory Reporting of Positive Drug Tests in Newborns and Pregnant Parents at the Time of Delivery

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ABSTRACT

The opioid epidemic has renewed debate about how to structure laws, agency policies and hospital protocols for mandatory reporting of illicit substances during pregnancy. This paper analyzes the ethics of Rhode Island's approach to mandatory reporting – in particular, reporting of positive maternal and newborn drug tests at time of delivery. Given that state intervention is generally perceived by pregnant people as punitive and threatening to their family, we consider how four elements often used to justify punitive action by the state – retribution, deterrence, rehabilitation, and incapacitation (societal protection) – apply to Rhode Island's policy and approach to prenatal substance use. In addition, the paper considers the equity implications of Rhode Island's approach. It concludes that, given the potential for the policy to do more harm than good, investment of resources would be better spent on clinical and community services that support substance using parents and their newborns.

KEYWORDS: public health ethics, substance use, pregnancy, mandatory reporting law, hospital policies, child protective services

INTRODUCTION

A 22-year-old woman arrives at her obstetrician's office for her first prenatal visit. During the appointment, she is asked if she uses tobacco products, drinks alcohol, or uses illicit substances; she reports twice weekly cannabis use. This positive verbal drug screen triggers a urine drug test with a repeat test during the third trimester. The patient is informed that if the test in the third trimester is positive, she and her newborn will be tested at the time of birth. Rather than consent to this testing, the woman leaves the office and is lost to follow-up.

According to the Centers for Disease Control and Prevention (CDC), an estimated 48.2 million people used cannabis at least once in 2019, while the American College of Obstetricians and Gynecologists (ACOG) reports cannabis use during 2–5% of pregnancies.[1] This percentage increases to 15–28% of pregnancies among urban, young, and low-socioeconomic status populations.[2] In addition to cannabis use during pregnancy, there are an estimated 750,000 cocaine-exposed pregnancies each year, and maternal opioid use is found in 0.82% of deliveries.[3,4]

An intricate web of interacting federal laws, state laws,[5] government agency guidelines, and healthcare institution policies govern the response to substance use in pregnancy. An exploration of this complex landscape is beyond the scope of this paper; here we focus on how Rhode Island's state law, R.I. Gen. Law § 40-11-6, governing health care provider reporting of suspected abuse and neglect, is applied, implemented and enforced in cases involving substance use by pregnant patients.[6] While we focus on this specific law, the ethical and clinical questions raised by the case above apply to other state laws, agency policies and institutional practices surrounding mandatory reporting of positive drug tests in pregnant individuals and neonates.

This article assesses some ethical questions associated with the potential benefits and harms of Rhode Island's law and policy governing mandatory reporting of pregnant parents and newborns with positive drug tests to the Department of Children, Youth and Families (DCYF), the state's child protective services agency. We consider the potential ethical justifications and evidence for state intervention based on drug testing at birth. Given that DCYF involvement is generally perceived by pregnant people as punitive and threatening to their family, we consider how four elements often used to justify punitive action by the state – retribution, deterrence, rehabilitation, and incapacitation (societal protection)[7] – apply to Rhode Island's policy and approach to prenatal substance use. We also discuss the equity implications of the policy.

RHODE ISLAND LAW AND POLICY REGARDING PRENATAL DRUG EXPOSURE

RI Gen. Law § 40-11-6 mandates that whenever a "health-care provider is involved in the delivery or care of infants born with, or identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder" they must report it to DCYF. DCYF guidance interprets the law to require that a provider must make a report when "a mother of a newborn tests positive for an illegal or non-prescribed controlled substance and/or misused prescribed controlled substance and the infant has not tested positive or when a neonate tests

positive."[8] At Women & Infants Hospital (WIH), RI's largest delivery hospital, neonatal drug tests are pursued for any newborn whose mother either tests positive for illegal substance use or refuses testing at the time of presentation to the hospital for delivery.[9]

Once a report is made to DCYF, it may open an investigation into whether the newborn is in danger of child abuse or neglect as defined by state law. In some cases, based on that investigation, a newborn may be temporarily removed from the care of parents. Although certainly removal is not the only outcome of an investigation, according to DCYF, 126 newborns less than 60 days old were removed from their parents' care in 2020.[10] The data does not indicate the reason for report or removal. Nonetheless, the possibility of removal resulting from a health care provider's report based on a positive drug screen induces fear among pregnant people. Thus, fear of removal may affect their decisions about their own health care, most importantly, obtaining regular prenatal care.[11] Given these potential consequences, it is important to assess the benefits and harms of the state's policy of mandating the reporting of all positive maternal and neonatal drug tests to DCYF at the time of delivery.

CURRENT POLICY MOTIVATIONS

To fairly assess the current policy, we first assess policymakers' motivations. In-utero exposure to many substances – both licit and illicit – can have significant health consequences for infants. Exposure to alcohol may cause fetal alcohol syndrome, characterized by cognitive deficits, changes in face structure, and impaired growth. Increasing evidence suggests that marijuana is associated with several adverse effects for fetuses.[12] Opioid exposure can cause neonatal abstinence, which involves symptoms of withdrawal, impaired growth, and seizures. And cigarette smoking is the largest known risk factor for low birth weight in developed countries.[13] Not only do these health conditions have severe and lasting impacts, but their burden falls on individuals who had no agency in bringing them about. It is understandable, then, that policy makers seek to protect infants from these outcomes. Well-intentioned though these policies may be, they must still be evaluated critically to understand if they are achieving their goals and promoting maternal and neonatal health and well-being.

Importantly, DCYF wears many hats after being contacted regarding a newborn with neonatal abstinence syndrome or a positive drug screening. DCYF's *Infant Plans of Safe Care Guidance Document 14*8 describes three goals: 1) identify infants at risk of child abuse and neglect as a result of prenatal substance exposure, 2) ensure that a Plan of Safe Care (POSC) is developed for these infants, and 3) ensure the referral of these infants and affected caregivers to appropriate services. Here, we focus on the first of these efforts by DCYF – identification of infants at risk of child abuse and neglect – for two reasons. First, identifying risk of abuse and neglect depends on discretionary decision-making by DCYF staff that may lead to the separation of parents and children as well as potentially inequitable outcomes based on socioeconomic status, race and ethnicity. Second, because DCYF involvement is perceived as punitive, requiring reporting in every case in which there is a positive maternal or neonatal drug test at birth undermines potentially more beneficial therapeutic options that could be undertaken in clinical settings. We describe these options later in this article.

JUSTIFICATIONS FOR DCYF INVOLVEMENT

Is DCYF intervention a Punishment for Drug Use?

While the consequences of the current policy (i.e., healthcare provider mandatory reporting of illicit substance use by pregnant people to DCYF) may not be intended as punitive, the policy constitutes a punishment by meeting the criteria set out by philosophers such as Bean:[15] it is a sanction handed out in response to an actual or alleged offense by an agency (in this case the clinician or hospital) and it is generally perceived as unpleasant by the victim (the patient). Indeed, subjective research supports the view that pregnant patients usually view DCYF involvement as unpleasant and as a punishment.[16] Given the evidence that pregnant people perceive intervention by child protective services agencies based on their use of substances as punitive, we analyze four ethical justifications for punishment – retribution, deterrence, rehabilitation, and incapacitation – to consider how these justifications function to address illicit substance use by pregnant people.

Retribution

Is illicit substance use during pregnancy something for which 'just desserts' must be served? More specifically, does use of substances potentially affecting the health of a fetus constitute abuse or another type of morally relevant harm? One of the problems with retribution based on potential harm to a fetus is that it opens up a slippery slope of government interventions based on a person's behavior during pregnancy. This is evident from proposed fetal protection laws that criminalize certain behaviors of pregnant people.[17] There are a panoply of other behaviors that state policymakers and state actors may deem less morally objectionable than illicit substance use that may still confer risk to fetal and neonatal well-being during pregnancy. For instance, should healthcare providers report and DCYF investigate every pregnant parent who smokes cigarettes, eats soft cheeses, drinks caffeine, works with pesticides, takes teratogenic medications they were prescribed, has unprotected sex with multiple partners, poorly controls their blood sugar or blood pressure, remains unvaccinated to infections, or goes without a mask or other COVID-19 precautions? Would choices made early in life among those who plan to have children, such as

working jobs that increase the risk of spermatogonia irradiation, be responded to with such investigations? Since none of these cases are deemed moral wrongdoings deserving of punishment, we therefore ask what justifications beyond social stigma earn illicit substance use during pregnancy its current unique status? Here we echo ACOG's committee opinion on this matter, in which they encouraged obstetrician-gynecologists to work to "retract legislation that punishes women for substance abuse during pregnancy."[18]

Deterrence

Another justification for punitive policies is deterrence. One might hypothesize that the threat of DCYF involvement reduces the likelihood of prenatal substance use. Most current literature, however, does not find evidence supporting a deterrence effect for substance use related punishments.[19,20] Further research suggests a possible explanation: while crime that involves conscious planning may be impacted by deterrence, substance use and addiction are rarely impacted by this sort of cost-benefit analysis.[21] Substance use disorder is now understood as a disease that requires proper therapeutic intervention, not a willful behavior that can be scared out of people.

Deterrence as a policy motivation is also potentially risky, as fear of losing one's newborn may deter help-seeking rather than deterring substance use. Some individuals, particularly those who are unable to abstain due to addiction, may be less likely to attend prenatal appointments or use the birthing hospital if they fear reporting to the state. Such potential loss of patients to prenatal care is particularly concerning given evidence that prenatal care reduces the impact of illicit drug use on perinatal outcomes.[22] Apprehension about reporting may prevent patients from speaking with their healthcare providers about their substance use during pregnancy, reducing the benefits conferred by prenatal care. Fear of state involvement might also drive those with addiction to go through withdrawal unaided, without critical supports and information about what to do in the event they relapse. Indeed, most people who use substances attempt to reduce their use or abstain when they discover they are pregnant, highlighting the opportunity for medical professionals to aid these individuals and raising the question of whether state involvement is the best means to promote deterrence.[23]

Rehabilitation

While the evidence does not support deterrence through punitive actions, and in fact suggests that there is the potential for more harm than benefit, other policies such as screening, brief intervention, and referral to treatment (SBIRT) protocols have been shown to effectively reduce substance use during pregnancy.[24] If the goal of requiring healthcare providers to report substance-using pregnant people to DCYF is to connect them to rehabilitative services and protect the health and safety of the newborn, then the question becomes: is a punitive policy (or at least one that is perceived as such) the best road to rehabilitation? Many pregnant persons are motivated to reduce or eliminate their substance use, often for the same reason that they fear DCYF involvement: a desire to be present in the life of and promote the well-being of their future child. This motivation can therefore likely be leveraged without the threat of family separation which looms over families when DCYF becomes involved. As discussed above, while DCYF currently does important work in trying to connect parents with rehabilitative programs and services, these same goals may be achieved through healthcare providers and their community partners (e.g., recovery programs, social service agencies, etc.), without families experiencing the strains that come with state involvement. Alternatively, if DCYF is to be involved, it's role should be to work collaboratively with clinicians, without the looming threat of removal, as early as possible in pregnancy. In situations in which healthcare providers – obstetric, pediatric, primary care – suspect that substance use is leading to abuse and neglect, they always have the option of reporting this to DCYF; indeed, they are mandated to do so.

Incapacitation

Perhaps it is incapacitation, then, that justifies reporting all positive screens for illicit drugs to DCYF at birth; allowing individuals to continue without intervention may increase the risk of substantial future harms. Notably however, there are no incapacitation benefits related to fetal development conferred by the current policy since DCYF involvement based on positive drug testing at birth only occurs after the end of the prenatal period. Apart from incarcerating a pregnant parent to restrict their use of illicit substances, incapacitation (preventing the unwanted behavior) can only occur after the delivery of the newborn. In order to satisfy incapacitation goals, therefore, illicit substance use during pregnancy would need to predict future (postnatal) mistreatment of a child, and DCYF involvement would seek to prevent this mistreatment.

Predicting future harm based on drug screening has not been well-studied; thus, there is not strong evidence for policy based on this justification for reporting. Further, if present substance use does indeed predict future child abuse and/or neglect, should any clinician caring for a parent who uses substances (e.g., in internal medicine and family medicine) assume such and report that parent to DCYF, even when they have no suspicion that the substance use endangers the patient's children? Policy governing mandatory reporting of parents to DCYF based on substance use is only justified if a strong nexus between use of illicit substances and potential for abuse and/or neglect is demonstrated.

EQUITY CONCERNS

The policy of mandatory reporting of all maternal or newborn positive drug screens at birth to DCYF is partly

justified as a way to remove discretion from healthcare providers whose decision-making may be driven by biases based on race, ethnicity and/or socioeconomic status. But as noted above, discretionary decision-making by DCYF officials still leaves room for inequitable outcomes (such as which parents have children removed from their care) based on bias. The reservation of mandatory reporting based solely on substance use of pregnant parents, but not that of other parents, also raises gender equity concerns. If the goal is to protect a child from the harms of parental drug use, then substance-using fathers and other partners would be just as relevant to potential future harm as a pregnant parent. Holding pregnant people, especially those from historically marginalized communities, uniquely accountable through a punitive approach for the societal problem of substance misuse is inequitable.

CONCLUSION

While we do not question that illicit substance use may, in certain circumstances, cause harm to a developing fetus, the current Rhode Island policy of mandatory reporting of all positive maternal and newborn drug tests at birth to DCYF does more harm than good. Because reporting to DCYF is generally understood by parents as punitive and because a positive drug test is not known to predict future child abuse and/or neglect, this response to substance use during pregnancy is counterproductive and lacks justification under any consideration of retribution, deterrence, rehabilitation, and/or incapacitation. Importantly, it tends to undermine, rather than support, treatment for maternal substance use disorders.

Instead, we support an equitable, evidence-based, and therapeutic approach which aims to prevent and reduce the harms caused by illicit substance use during pregnancy. This approach reinforces a trusting provider-patient relationship rather than penalizing patients for disclosing their substance use history. Limited resources now spent on testing, reporting and investigation would be better employed developing and implementing an evidence-based[23] rehabilitative and non-punitive approach that enables providers to develop and maintain therapeutic patient relationships and to connect patients to recovery and supportive social services. Most importantly, resources should be redeployed toward addiction treatment services tailored to pregnant people. These services are currently in short supply in Rhode Island.

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