SJ 29 Preliminary Report

STATE-TRIBAL RELATIONS COMMITTEE
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SUMMARY

Prenatal exposure to substances such as methamphetamine and fentanyl has become a growing concern in the United States, leading to the passage of Senate Joint Resolution 29 (SJ 29) at the 2025 Montana legislative session. However, state education systems face significant challenges when attempting to identify and support children affected by prenatal substance exposure.

Key barriers include:
• inconsistent tracking of prenatal substance exposure in healthcare systems,
• privacy protections limiting data sharing across agencies,
• polysubstance exposure complicating identification of specific drugs, and
• the fact that developmental outcomes are often influenced by environmental conditions rather than specific drug exposure.

Because of these limitations, many states have moved away from policies focused on identifying specific prenatal drug exposures and instead emphasize developmental screening, early intervention, and trauma-informed educational supports.

1. PRENATAL EXPOSURE TO METHAMPHETAMINE AND FENTANYL

Many substances used during pregnancy cross the placenta and may affect fetal development. Research indicates that prenatal substance exposure can influence birth outcomes and neurological development (Behnke & Smith, 2013).

Methamphetamine
Prenatal methamphetamine exposure has been associated with:
• preterm birth
• low birth weight
• placental complications
• increased likelihood of neonatal intensive care unit admission

The Infant Development, Environment, and Lifestyle (IDEAL) Study found that infants exposed to methamphetamine prenatally may demonstrate increased stress responses and neurobehavioral differences during infancy (Smith et al., 2008).

However, long-term developmental outcomes remain difficult to isolate because children exposed prenatally often experience other environmental risk factors including poverty, trauma, and caregiver substance use (Lester et al., 2010).

Fentanyl and Opioid Exposure

Fentanyl is a synthetic opioid increasingly present in the illicit drug supply. Infants exposed to opioids during pregnancy may develop Neonatal Abstinence Syndrome (NAS) or Neonatal Opioid Withdrawal Syndrome (NOWS).

Symptoms may include:

- tremors
- feeding difficulties
- respiratory complications
- irritability and sleep disturbances

Rates of NAS increased significantly in the United States during the opioid epidemic (Patrick et al., 2020). Long-term outcomes vary widely depending on environmental conditions and access to supportive services.

2. CHALLENGES IN IDENTIFYING PRENATAL SUBSTANCE EXPOSURE

A major challenge in developing policy responses is that prenatal exposure to specific substances is not consistently tracked in statewide datasets.

Limited Clinical Tracking

Hospitals may document substance exposure but do not always identify the specific drug involved. Drug testing during pregnancy or after birth is not universal and may depend on hospital policies, physician discretion, or patient consent (Guttmacher Institute, 2023).

Polysubstance Use

Substance use during pregnancy frequently involves multiple substances, making it difficult to attribute developmental outcomes to a single drug (SAMHSA, 2018).

Privacy Restrictions

Federal privacy laws limit the sharing of maternal substance use information across systems, including HIPAA, FERPA, and 42 CFR Part 2. These protections mean prenatal medical information rarely follows a child into the education system.

3. FEDERAL POLICY CONTEXT

Federal policy addressing prenatal substance exposure primarily stems from the Child Abuse Prevention and Treatment Act (CAPTA).

CAPTA requires states to develop procedures to address the needs of infants affected by substance abuse and withdrawal symptoms and to develop Plans of Safe Care for these infants and their families (U.S. Department of Health and Human Services, 2019).

However, CAPTA does not require long-term tracking of exposed children in education systems.

4. STATE POLICY APPROACHES

States have adopted several strategies to address prenatal substance exposure.

Mandatory Reporting

Many states require healthcare providers to report prenatal substance exposure to child welfare agencies (Guttmacher Institute, 2023). In Montana, a healthcare provider involved in the delivery or care of an infant must report to the state (DPHHS) if the infant is known to be affected by a dangerous drug. There is no standalone requirement to report a pregnant person for substance use during pregnancy.

Plans of Safe Care

Plans of Safe Care coordinate services among healthcare providers, child welfare agencies, substance use treatment programs, and early childhood services.

Neonatal Abstinence Syndrome Monitoring

Some states track Neonatal Abstinence Syndrome as a public health indicator rather than attempting to identify specific substances. States including Kentucky, Tennessee, and Vermont have implemented NAS surveillance systems.

Early Intervention

Programs under IDEA Part C provide developmental services for infants and toddlers with delays.

Trauma-Informed Education

Several states have adopted trauma-informed education strategies to support students affected by early adversity.

5. IDENTIFICATION CHALLENGES FOR EDUCATION SYSTEMS

Education systems face significant challenges in identifying students affected by prenatal drug exposure.

Limited Access to Medical Records
School systems generally do not have access to prenatal medical records due to federal privacy protections.

Education Privacy Protections
Education records are protected by FERPA, which further restricts cross-system data sharing.

Identification Based on Educational Needs
Schools typically identify students based on observable developmental needs rather than prenatal medical history. Students may receive services through Individualized Education Programs (IEPs), Section 504 accommodations, and behavioral support systems.

6. POLICY CONSIDERATIONS

Based on current research and state policy approaches, several policy considerations may be relevant.

- Focus on developmental outcomes rather than exposure identification.
- Strengthen early childhood screening.
- Improve coordination between health and early childhood systems.
- Support trauma-informed educational practices.

7. KEY FINDINGS

1. Prenatal exposure to methamphetamine and fentanyl is not consistently tracked in statewide health or education datasets.

2. Privacy protections limit the ability to share prenatal medical information across health, child welfare, and education systems.

3. Education systems generally identify student needs based on developmental outcomes rather than prenatal exposure history.

4. Many states address prenatal substance exposure through early intervention, developmental screening, and trauma-informed educational supports rather than substance-specific programs.

REFERENCES

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