Should Maternal Illicit Drug Use During Pregnancy Be Considered Child Abuse?

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National Center on Substance Abuse and Child Welfare

Acknowledgment

National Center on Substance Abuse and Child Welfare

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Children's Bureau

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Timeline of U.S. Drug Epidemics

- **1860's, The Civil War**: Morphine introduced to soldiers for pain relief. Morphine use disorder spread to the general public
  - 400,000 individuals with morphine use disorder, particularly women and "elixir use"
- **1880's**: Cocaine introduced to counter morphine use disorders
- **1910's**: Cocaine use associated with criminality and race. Southern black workers forced to consume cocaine to increase productivity
- **1920's**: Dangerous Drug Act Criminalized cocaine use and heroin criminalized in 1924

- **1960’s: Massive social change and increased use of criminalized substances**
  - 1970: Drug Abuse and Prevention Act
  - 1971: War on Drugs
  - 1972: Drug Enforcement Agency established

- **1980's: Cocaine epidemic**
  - Anti-Drug Abuse Act of 1988: Different penalties based on type of cocaine
    - 100-to-1 ratio and mandatory minimum sentencing for simple possession
    - Black individuals served virtually as much time in prison for non-violent drug offenses as whites did for violent offenses
  - 2010 Fair Sentencing Act: Reduced cocaine 100-to-1 ratio to 18-to-1 and repealed mandatory minimum sentencing for simple possession
  - 2014: *Report to Congress, Impact of the Fair Sentencing Act of 2010*— In 2014, approximately half as many 100-to-1 offenders were sentenced in the federal system as had been sentenced in 2010

United States Sentencing Commission. (2015). Report to Congress, Impact of the Fair Sentencing Act of 2010. https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/drug-topics/201507_RtC_Fair-Sentencing-Act.pdf#page=7

American Civil Liberties Union. (n.d.). Fair Sentencing Act. https://www.aclu.org/issues/criminal-law-reform/drug-law-reform/fair-sentencing-act

- **1980's: Cocaine epidemic**
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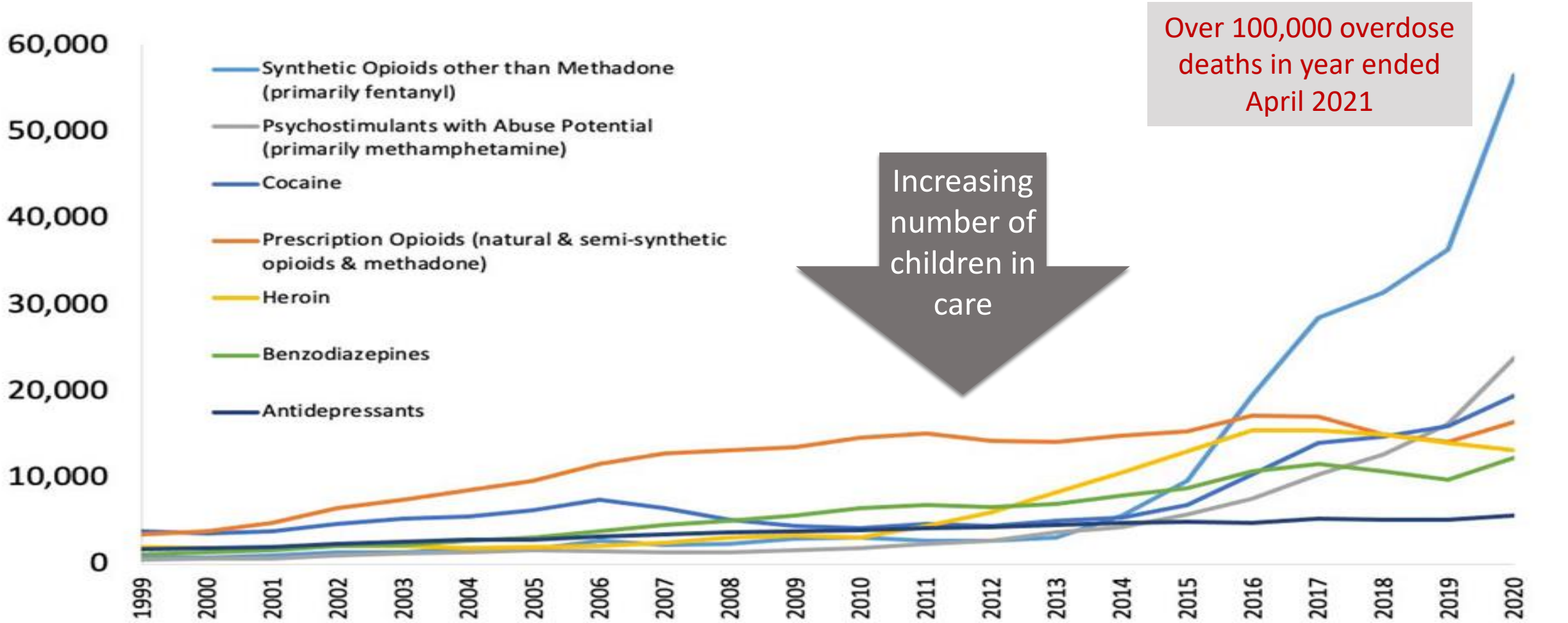
    - Black indi… non-vi… …ses
  - …00-to-1 ratio to 18-to-1 and …ing for simple possession
  - …*mpact of the Fair Sentencing Act of 2010*— I… …ly half as many 100-to-1 offenders were sentenced in … system as had been sentenced in 2010

Throughout US history, we have had disparities based on race/ethnicity, economics, and social class in how laws regarding drug use are implemented and we have operated bifurcated systems of criminal justice and health care responses

United States Sentencing Commission. (2015). Report to Congress, Impact of the Fair Sentencing Act of 2010. https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/drug-topics/201507_RtC_Fair-Sentencing-Act.pdf#page=7

American Civil Liberties Union. (n.d.). Fair Sentencing Act. https://www.aclu.org/issues/criminal-law-reform/drug-law-reform/fair-sentencing-act

The Opioid Epidemic: 4 Waves and Overdose Deaths



Over 100,000 overdose deaths in year ended April 2021

Increasing number of children in care

Wave 1, 1999: Rise in Prescription Opioid Deaths

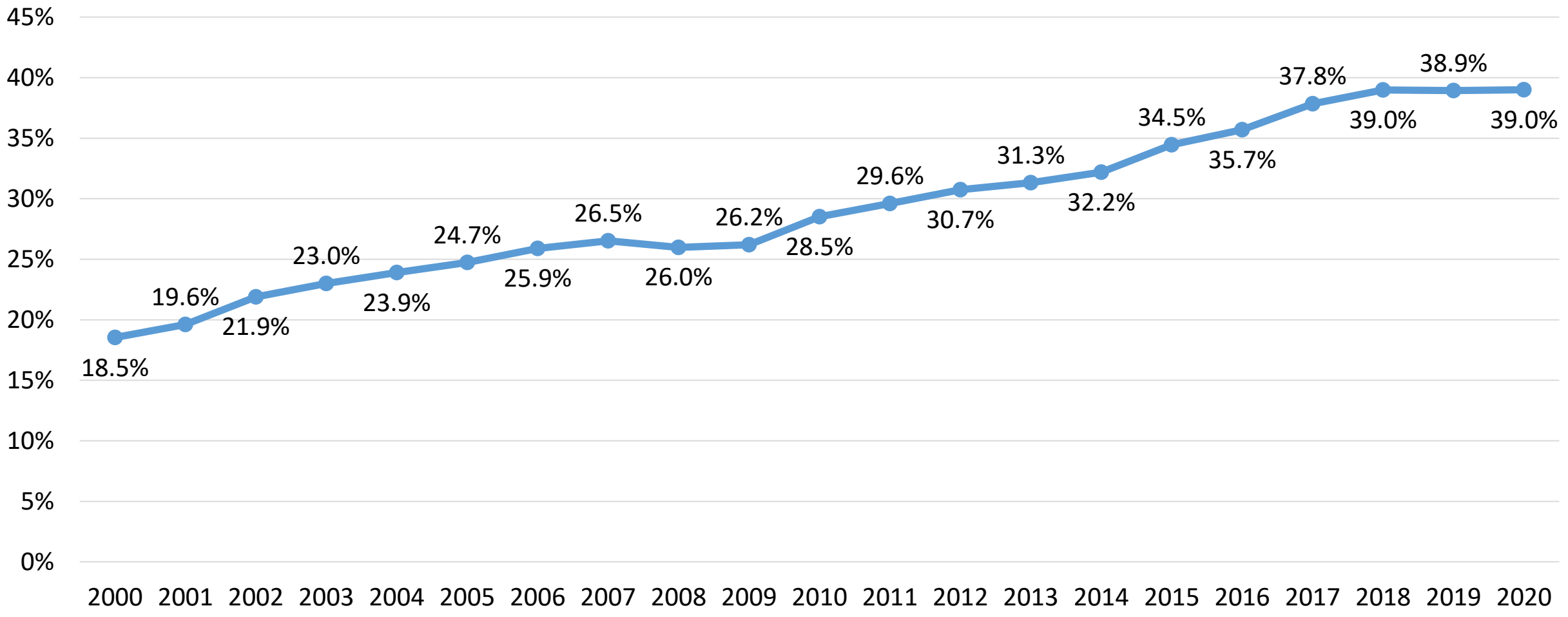
Wave 2, 2010: Rise in Heroin Deaths

Wave 3, 2013: Rise in Fentanyl Deaths

Wave 4, 2015: Rise in Fentanyl & Stimulant Deaths

(National Institute on Drug Abuse. (2022). Overdose Death Rates)

Prevalence of Parental Alcohol or Drug Abuse as an Identified Condition of Removal in the United States, 2000 to 2020

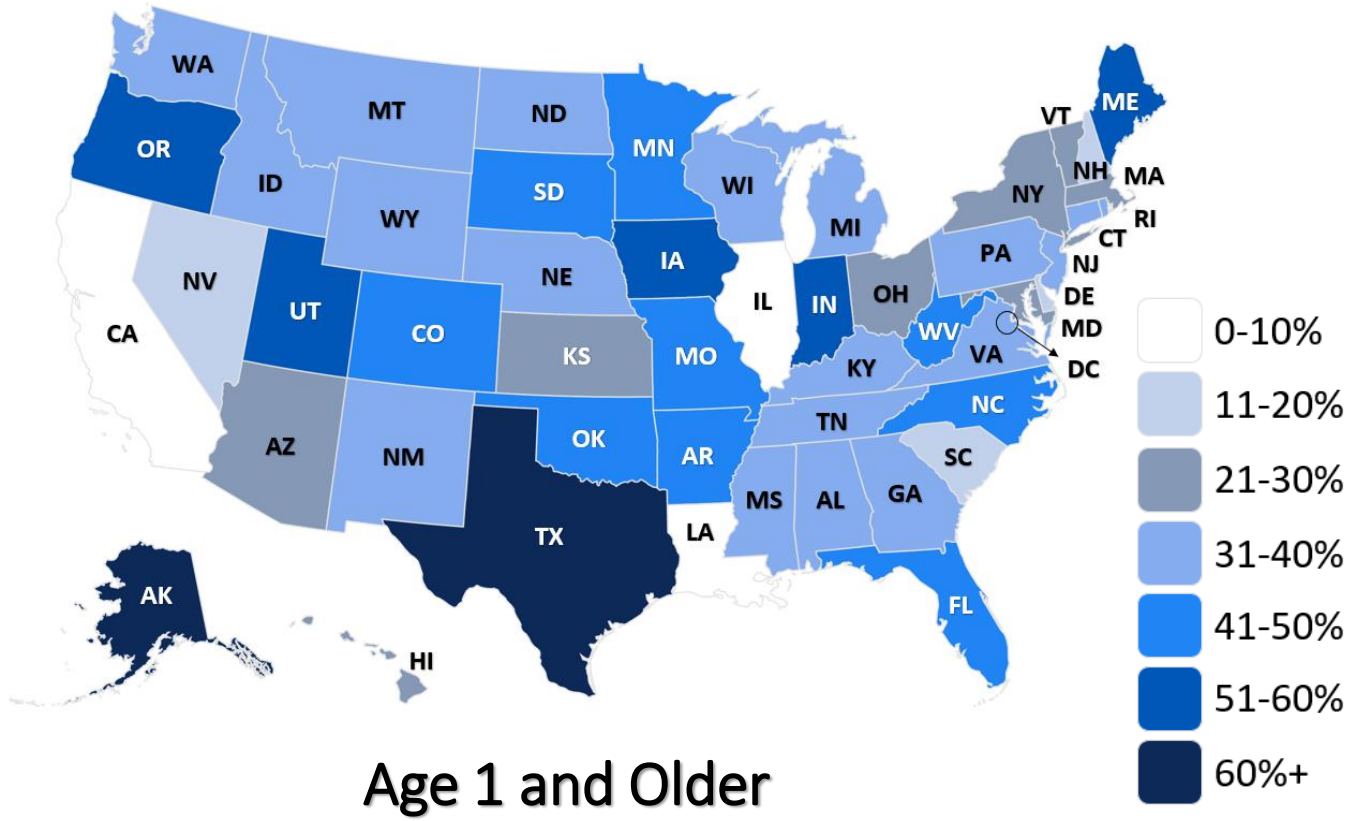


*Note: Estimates based on **<u>all children in out of home care at some point</u>** during Fiscal Year*

Source: AFCARS Data, 2000-2020

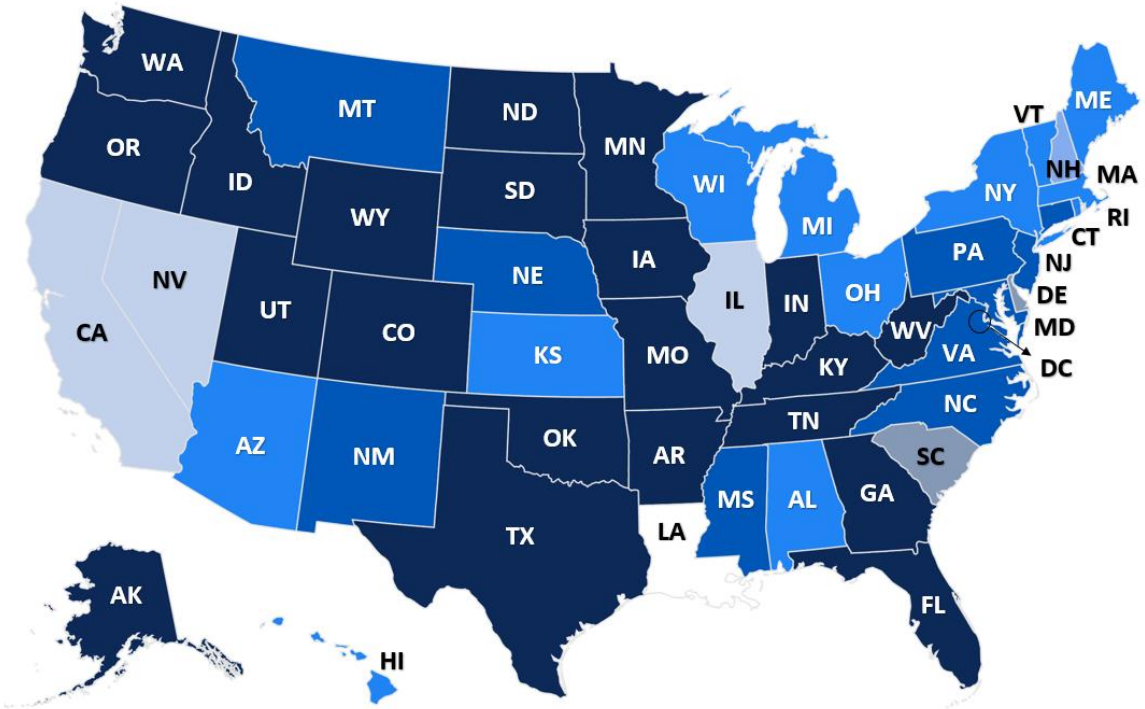
Incidence of Parental Alcohol and Drug Abuse as an Identified Condition of Removal for Children by Age, 2020*

Total Number of Removed Children with Parental Alcohol and Drug Abuse = 83,516



Age 1 and Older

National Average: 35.6%



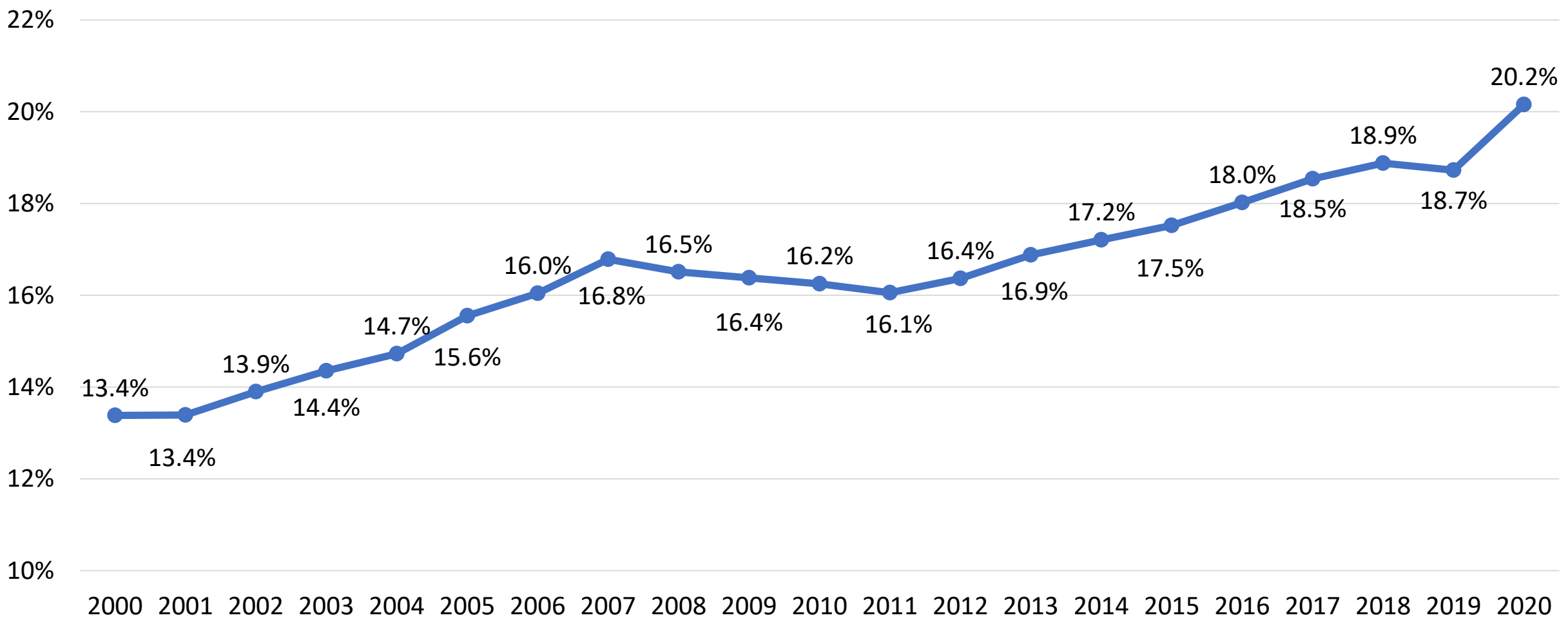
Under Age 1

National Average: 51.4%

Note: Estimates based on ***children who entered out-of-home care*** during the Fiscal Year

Source: AFCARS Data, 2020 v1

Of Children who Entered Out of Home Care in the United States, Percent Under Age 1 (2000 to 2020)*

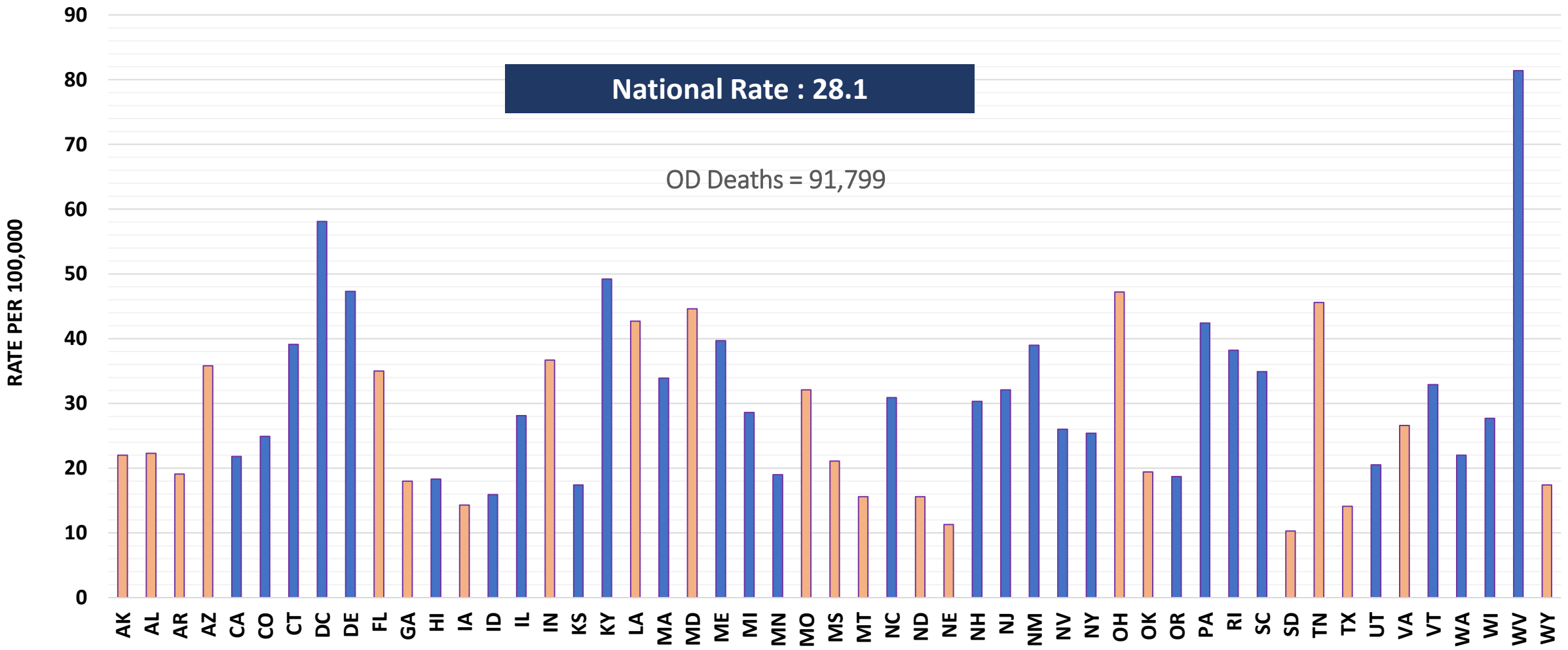


*Note: Estimates based on **children who entered out of home care** during Fiscal Year*

**2020 Estimates may be influenced by the COVID-19 pandemic*

Source: AFCARS Data, 2000-2020

Age-Adjusted Drug Overdose Death Rates Per 100,000 by State, 2020



States attending or will be in attendance at Secretary's Innovation Group Meeting since 2017

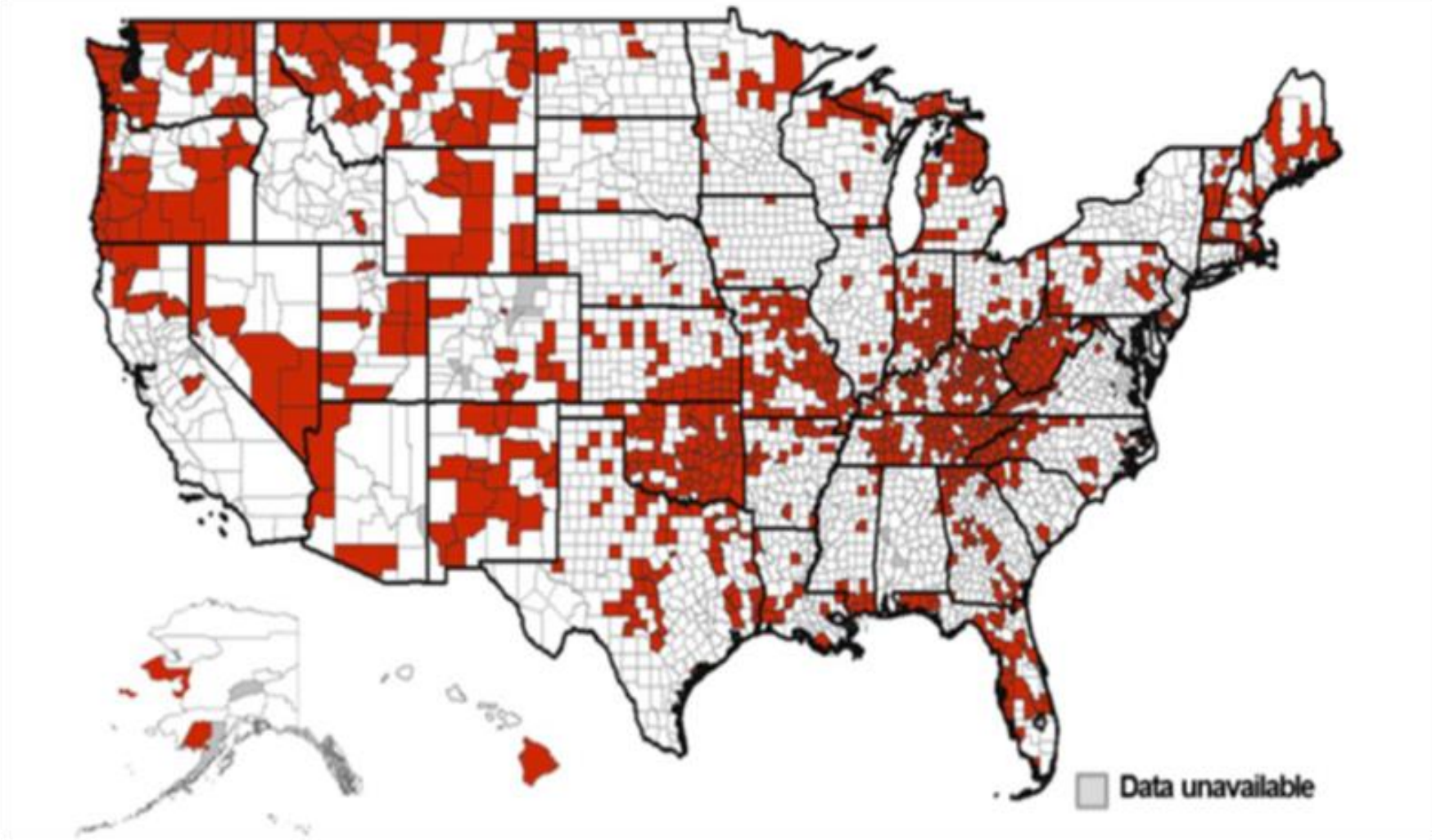
***Source**: CDC*

Office of the Assistant Secretary for Planning and Evaluation (ASPE) 2018 Study: Substance Use, the Opioid Epidemic, and the Child Welfare System, Key Findings from a Mixed Methods Study

- Mixed-methods study examining effects of the opioid epidemic on child welfare systems
  - *Qualitative*: 188 key informant interviews with child welfare and substance use disorder treatment agencies, judges and court personnel, and others. Represented counties with high rates of opioid sales and drug overdose deaths
  - *Quantitative*: County level statistical modeling of drug overdose death rates, and drug emergency department visits and hospital stays on child welfare case loads
  - Findings:
    - Child welfare systems are having difficulty meeting families' needs. Contributing factors include:
      - Limited options for family-centered substance use disorder treatment
      - Child welfare, legal, and other professionals often misunderstand how substance use disorder treatment works
      - Barriers to collaboration among service providers

Radel, L., Baldwin, M., Crouse, G., Ghertner, R. & Waters, A. (2018). Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study. Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Retrieved March 9, 2019, from: https://aspe.hhs.gov/system/files/pdf/258836/SubstanceUseChildWelfareOverview.pdf

Counties with Rates of Drug Overdose Deaths and Foster Care Entries Both Above the National Median in 2016



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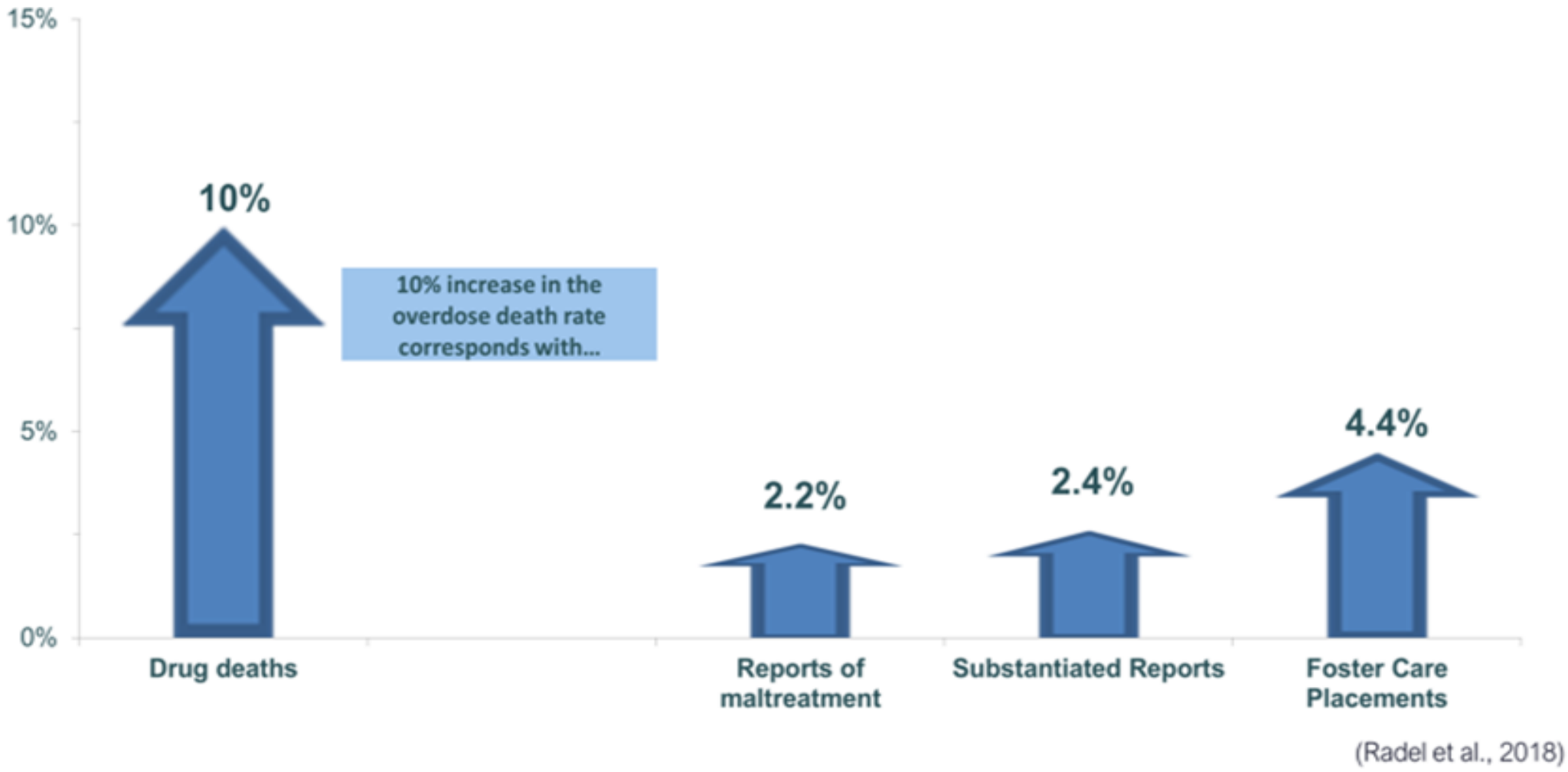
Rates of Opioid Overdose Deaths Correspond with Increases in Child Welfare Cases



Radel, L., Baldwin, M., Crouse, G., Ghertner, R. & Waters, A. (2018). Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study. Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Retrieved March 9, 2019, from: https://aspe.hhs.gov/system/files/pdf/258836/SubstanceUseChildWelfareOverview.pdf

What we've learned from previous drug epidemics




Summary of Effects of Prenatal Drug Exposure

	Nicotine	Alcohol	Marijuana	Opiates	Cocaine	Metham-phetamine
Short-term Effects/Birth Outcome						
Fetal Growth	Effect	Strong Effect	No Effect	Effect	Effect	Effect
Anomalies	No Consensus	Strong Effect	No Effect	No Effect	No Effect	No effect
Withdrawal	No Effect	No Effect	No Effect	Strong Effect	No Effect	--
Neuro-behavior	Effect	Effect	Effect	Effect	Effect	Effect
Long-term Effects						
Growth	No Consensus	Strong Effect			ensus	--
Behavior	Effect	Strong Effect	Effect	Effect	Effect	--
Cognition	Effect	Strong Effect	Effect	No Consensus	Effect	--
Language	Effect	Effect	No Effect	--	Effect	--
Academic Achievement	Effect	Strong Effect	Effect	*	No Consensus[5]	--

No Safe Amount of Alcohol During Pregnancy

--: Limited or no data available

**Data subsequent to the AAP review suggest significant academic effects in both the Tennessee study by Fill et al., in 2018 and a large study of children in Australia published by Oei, et al (2017) who found significant academic achievement effects for children who receive a NAS diagnosis and that disparities in their achievement increase as the child ages.*

American Academy of Pediatrics Review, Behnke, M. & Smith, V. C. (2013). Technical Report. Prenatal substance abuse: Short and long-term effects on the exposed fetus. *American Academy of Pediatrics, 131*(3), e1009-e1024.

Research Update:
Long-term Effects of Prenatal Opioid Exposure

- **2017-2019**: Publication of various studies examining the long-term effects of prenatal opioid exposure.

  Among school-aged children with an NAS diagnosis or prenatal opioid exposure, findings include:

  - Significant academic achievement effects
  - An increased need for special education services

Oei, J.L., Melhuish, E., Uebel, H., Azzam, N., Breen, C., Burns, L., Hilder, L., Bajuk, B., Abdel-Latif, M.E., Ward, M., Feller, J.M., Falconer, J., Clews, S., Eastwood, J., Li, A. & Wright, I.M. (2017). Neonatal Abstinence Syndrome and High School Performance. Pediatrics, 139(2):e20162651.

Fill, M-M.A., Miller, A.M., Wilkinson, R.H., Warren, M.D., Dunn, W.S. & Jones, T.F. (2018). Educational Disabilities Among Children Born With Neonatal Abstinence Syndrome. Pediatrics: 142(3).

Lee, S.J., Woodward, L.J., Henderson, J.M.T. (2019). Educational achievement at age 9.5 years of children born to parents maintained on methadone during pregnancy. PLoS One, 14(10): e0223685. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6786534/citedby/

Early Intervention: Screening and Engagement into Substance Use Disorder Treatment

- Unbiased Prenatal Universal Screening (Not Drug Testing)
  - Intent: Identify pregnant women with substance use disorders (SUD) *to engage in treatment*
  - Promotes equitable identification and access to SUD treatment

- Risk-Based Screening
  - Based on risk factors such as lack of prenatal care or previous adverse pregnancy outcomes
  - Can result in missed cases and disproportionalities
  - Does not account for structural inequities: Barriers to prenatal care, including socio-economic considerations including inability to take time off work

American College of Obstetricians and Gynecologist, Committee Obstetric Practice. (2017). Opioid use and opioid use disorder in pregnancy. ACOG Committee Opinion 711. Obstetrics and Gynecology,130, 81-94. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

Fryer, K., Munoz, M., Rahangdale, L., & Stuebe, A. (2020). Multiparous Black and Latinx Women Face More Barriers to Prenatal Care than White Women. Journal of Racial and Ethnic Health Disparities, 8(1), 80-87.

- Toxicology Based Screening
  - Negative results do not rule out substance use
  - Results do not indicate the presence of
  - Kits are limited to identifying
  - False-positives can
  - Different bio
    Delay
  - . Black women and their infants
    be tested for substance use, *despite*
    positive toxicology results among Black women and
    racial/ethnic background

Appropriate use of drug test is an adjunct to treatment to adjust structure of program as needed

ASAM: increase program structure if a person cannot maintain abstinence

Farst, K. J., Valentine, J. Hall, R.W. (2011). Drug Testing for Newborn Exposure to Illicit Substances in Pregnancy: Pitfalls and Pearls. International Journal of Pediatrics, Volume 2011. doi:10.1155/2011/951616

Hudak, M.L. and Tan, R.C. American Academy of Pediatrics, The Committee on Drugs, The Committee on Fetus and Newborn, Frattarelli, D.A.C., Galinkin, J.L., Green, T.P., Neville, K.A., Paul, I.M., Van Den Anker, J.N., Papile, L., Baley, J.E., Bhutani, V.K., Carlo, W.A., Cummings, C., Kumar, P., Polin, R.A., Wang, K.S., & Watterberg, K.L. (2012). Clinical Report: Neonatal Drug Withdrawal. American Academy of Pediatrics. 129(2): e540-e560.

Kunins, H. V., Bellin, E., Chazotte, C., Du, E., & Arnsten, J. H. (2007). The effect of race on provider decisions to test for illicit drug use in the peripartum setting. Journal of Women's Health,16(2), 245– 255.

Implications for Infants, Children, and Families

- Majority of infants with prenatal substance exposure who are removed from parental care are disadvantaged and Black
- Infants and young children are at greatest risk for termination of parental rights—a permanent severance
- Native American and Black families experience the highest rates of parental termination among all racial and ethnic groups

Adams, C.M. (2013). Criminalization in shades of color: Prosecuting pregnant drug-addicted women. Cardozo Journal of Law & Gender 20: 89–110.

Mohapatra, S. (2011). Unshackling addiction: A public health approach to drug use during pregnancy. Wisconsin Journal of Law, Gender & Society 26: 241

Needell, B., Brookhart, M. A., & Lee, S. (2003). Black children and foster care placement in California. Children and Youth Services Review, 25(5-6), 393-408.

Wildeman, C., Edwards, F. R., & Wakefield, S. (2020). The cumulative prevalence of termination of parental rights for U.S. children, 2000–2016. Child Maltreatment, 25(1), 32–42.

Engagement of Pregnant Women in Substance Use Disorder Treatment Yields Cost-Savings

- Study of treatment costs for pregnant women with substance use disorders (SUD):
  - *Control group*: Women with SUDs who did not receive treatment prior to the birth of their infants
  - *Intervention group*: Women who received prenatal SUD treatment

Svikis, D.S., Golden, A.S., Huggins, G.R., Pickens, R.W., McCaul, M.E., Velez, M.L., Rosendale, C.T., Brooner, R.K., Gazaway, P.M., Stitzer, M.L., & Ball, C.E. (1997). Cost-effectiveness of treatment for drug-abusing pregnant women, Drug and Alcohol Dependence, Volume 45, Issues 1–2, 105-113.

- Findings:
  - Total treatment costs, including maternal SUD treatment and infant NICU stays, were conservatively **~$5,000 less** per mother-infant pair in the intervention group
  - Infants in the control group were **twice as likely to require a NICU** stay, compared to infants in the intervention group
  - Infants in the control group required **significantly lengthier NICU stays** (~40 days), compared to intervention group infants who required the NICU (~7 days)
  - Infants in the control group likely to **require intensive pediatric care** following NICU discharge

Current approaches to families Affected by prenatal substance exposure




Child Abuse Statutes and Policies Affect *Rates of Infant Removal* and *Entry to Out-of-Home Care*

- Four broad categories of state statutes and child welfare policies:
  - *Define* prenatal substance exposure as child maltreatment
  - Require a *report* to child protective services
  - Require a *notification* to child protective services
  - Child welfare response to allegations of prenatal substance exposure

Implications of Defining Prenatal Substance Exposure as *Child Maltreatment and Mandating a Report or Notification*

- Existing statutes and policies *defining* prenatal substance exposure—particularly among pregnant women with a substance use disorder and participating in treatment—as child maltreatment are raising increased concern among healthcare, substance use disorder treatment and other community providers that identifying affected women and infants too often result in:
  - **Automatic removal** of the infant without an assessment of safety and risk factors
  - Un-warranted **substantiation of child maltreatment allegations** being maintained in states' central registries and affect persons employment background checks as well as prospective foster and adoptive parents

Child Welfare Information Gateway. (2018). Establishment and maintenance of central registries for child abuse or neglect reports. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway. (2018). Review and expunction of central registries and reporting records. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

- In states in which a *report* is mandated, there may also be concern that a report to child welfare will initiate un-warranted removal of the infant or substantiation of the allegations

- Although a *notification* is not to be construed to establish a definition of child abuse, there may be concern that the notification will be treated as a report and result in un-warranted infant removal or allegation substantiation. This may be particularly concerning for states that **have not yet developed separate *reporting* and *notification* pathways**

Four Categories of U.S. States and D.C. Identified based on State Statutes and Child Welfare Policies

- Methodology
  - 51 states and D.C.: Review of state statutes as compiled by Legislative Analysis and Public Policy Association from the Westlaw database (October 2022)
  - 48 states and D.C.: Review of child welfare policies that are available in the public domain (November 2022)

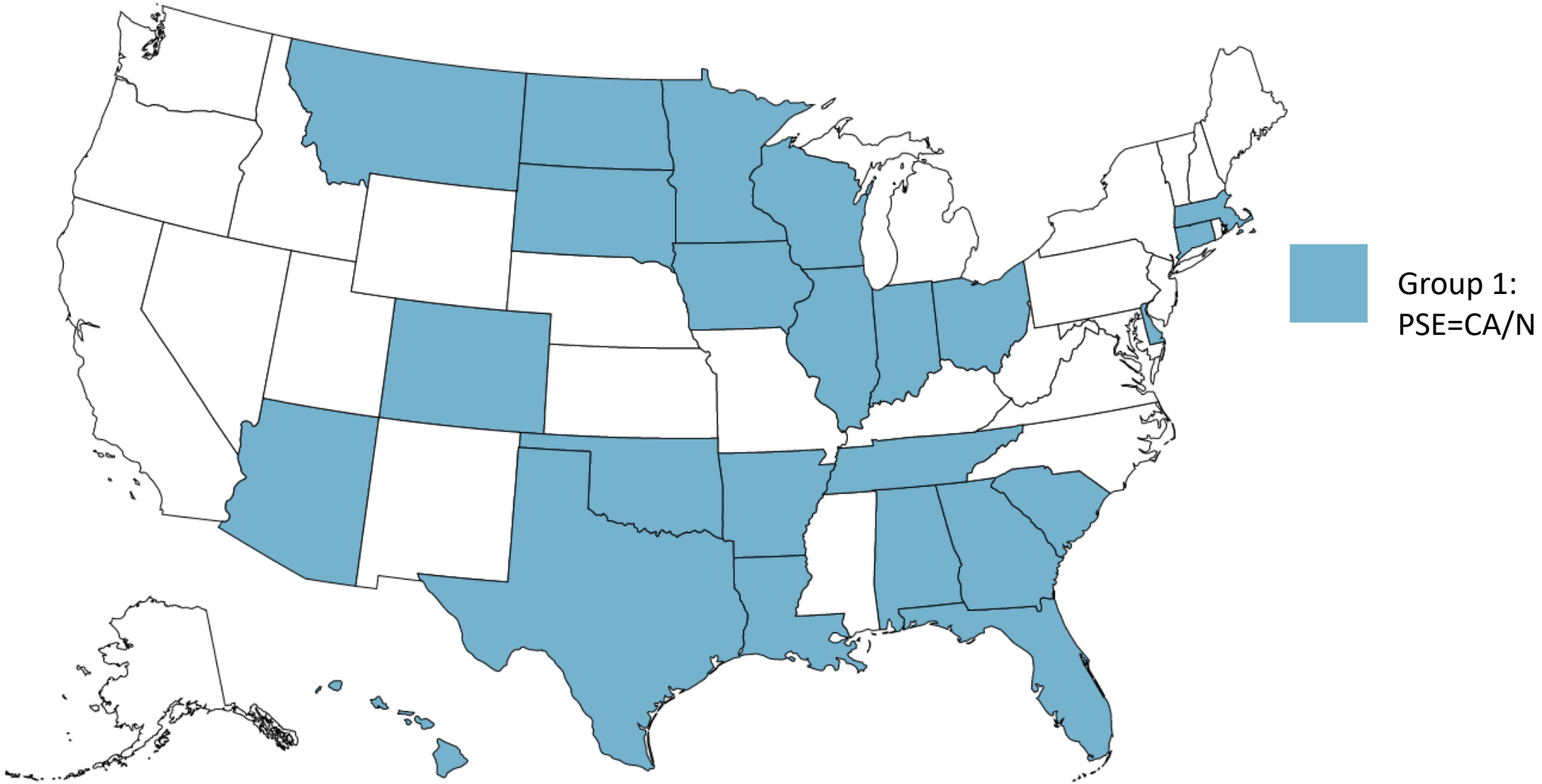
Based on Review of State Statutes and Child Welfare Policies Four Categories Developed

- **Group 1 (n=24): Prenatal substance exposure is defined as child maltreatment (PSE=CA/N)**

  AL AR AZ CO CT DC DE FL GA HI IA IL IN LA MA MN ND OH OK SC SD TN TX WI

  - A subset of 11 states also require a child maltreatment report
    - AZ, AR, DC, FL, IA, LA, MN, ND, OK, SD, WI
  - CT also requires a notification to child welfare

Group 1: PSE=CA/N (n=24)
Prenatal Exposure defined as child abuse or neglect



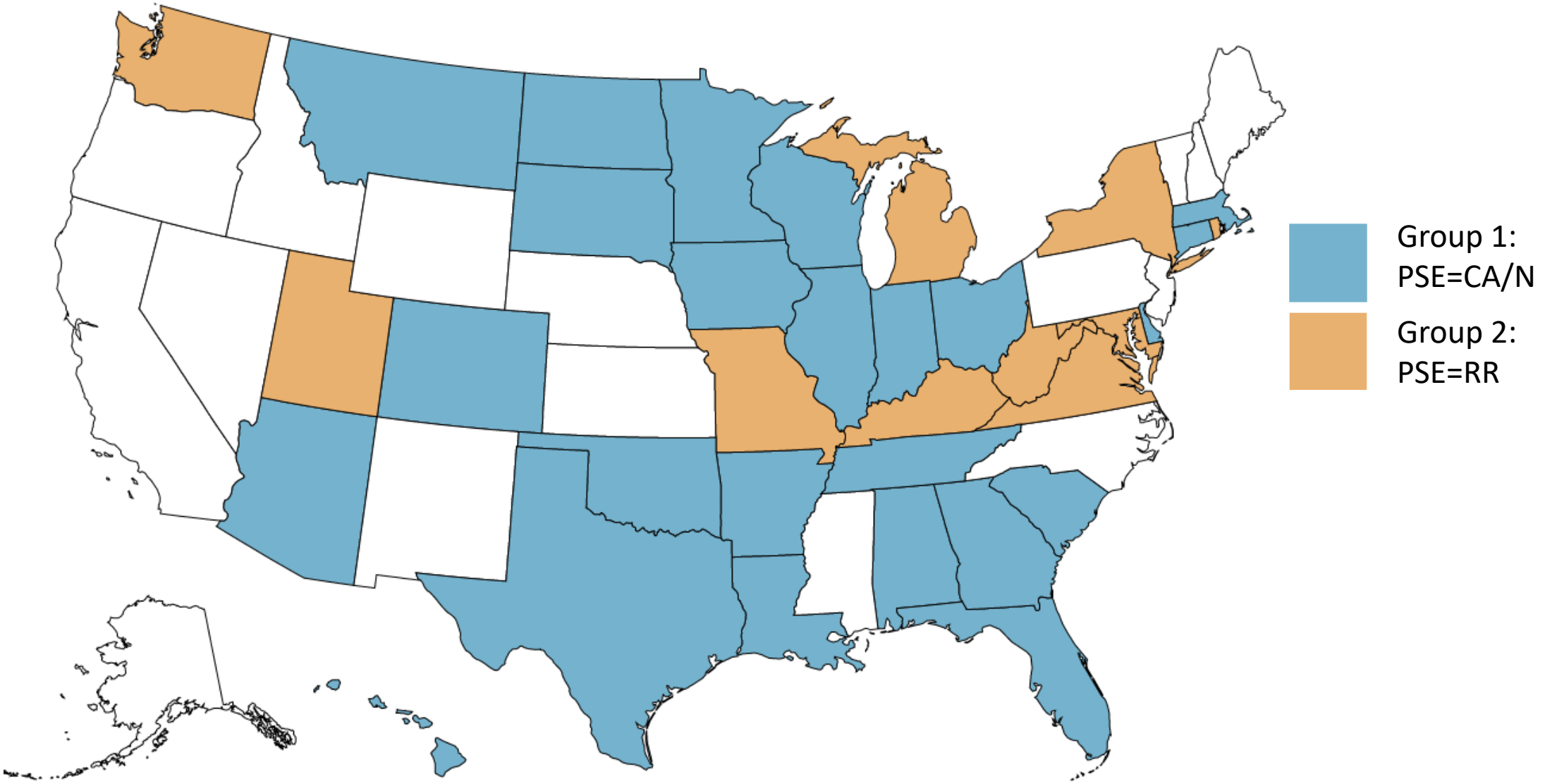
Preliminary Results, Not for Distribution

- **Group 2 (n=11): Prenatal substance exposure requires a child maltreatment *report* (PSE=RR)**

  KY MD MI MO MT NY RI UT VA WA WV

  - Do not have statutes or child welfare policies defining prenatal exposure as child maltreatment but require a report to child welfare services
    - *Michigan and Maryland*: Exempt report requirement if exposure is prescribed medication
    - *Maryland and Virginia*: Report is not presumption of child maltreatment
    - *New York*: Report requirement when there are concerns of child maltreatment

Group 2: PSE=RR (n=11)
Requires child maltreatment report



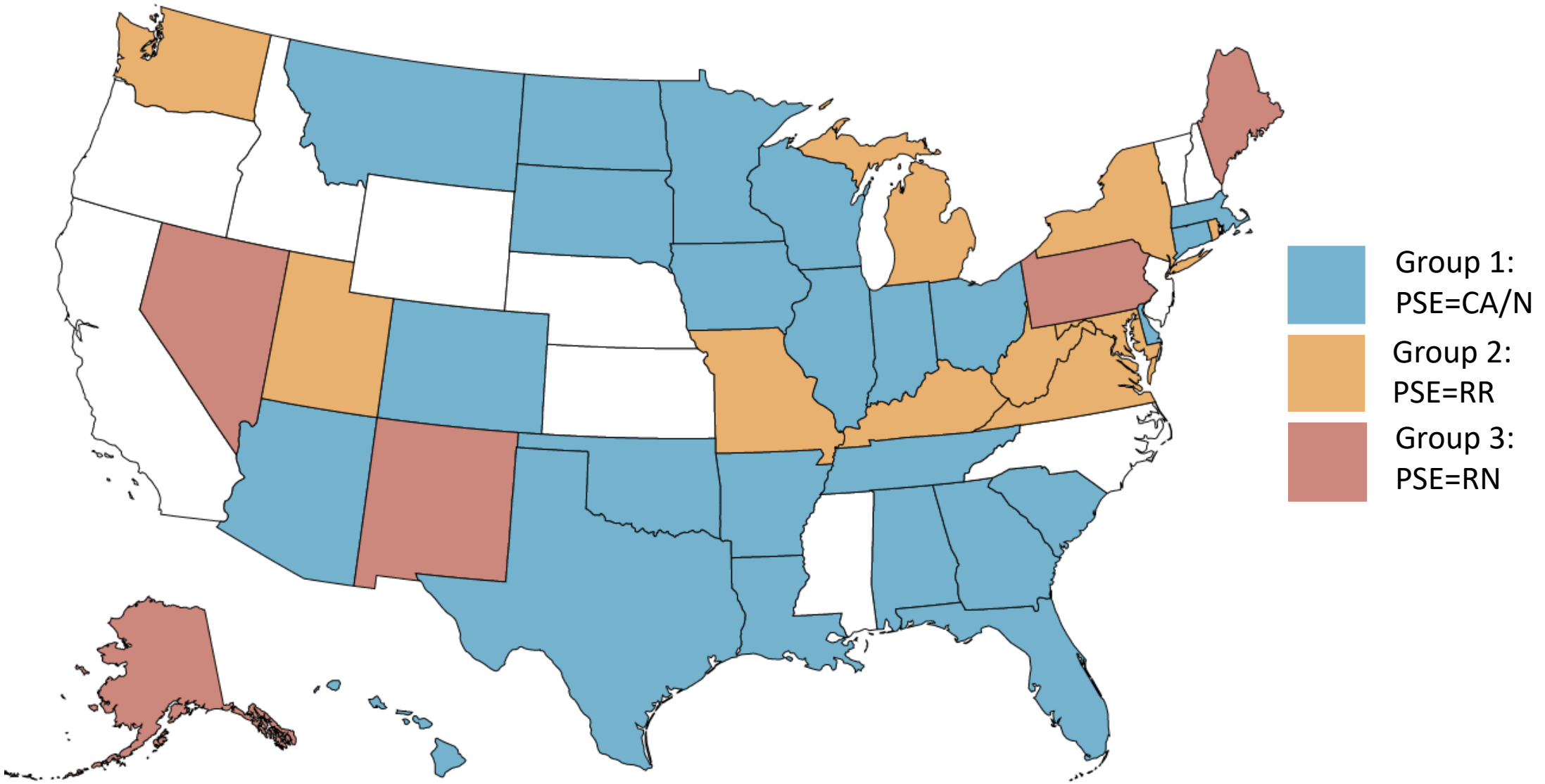
Preliminary Results, Not for Distribution

- **Group 3 (n=5): Prenatal substance exposure requires a *notification* to child welfare (PSE=RN)**

  AK ME NV NM PA

  - Do not have statutes or child welfare policies defining prenatal exposure as child maltreatment but require a notification to child welfare services
    - *Maine*: Notification not presumption of child maltreatment or criminal prosecution
    - *Nevada*: Child welfare investigation in response to notification not required when concerns are mitigated with referral and engagement in services
    - *Pennsylvania*: Notification not construed as child maltreatment report

Group 3: PSE=RN (n=5)
Requires notification to child welfare



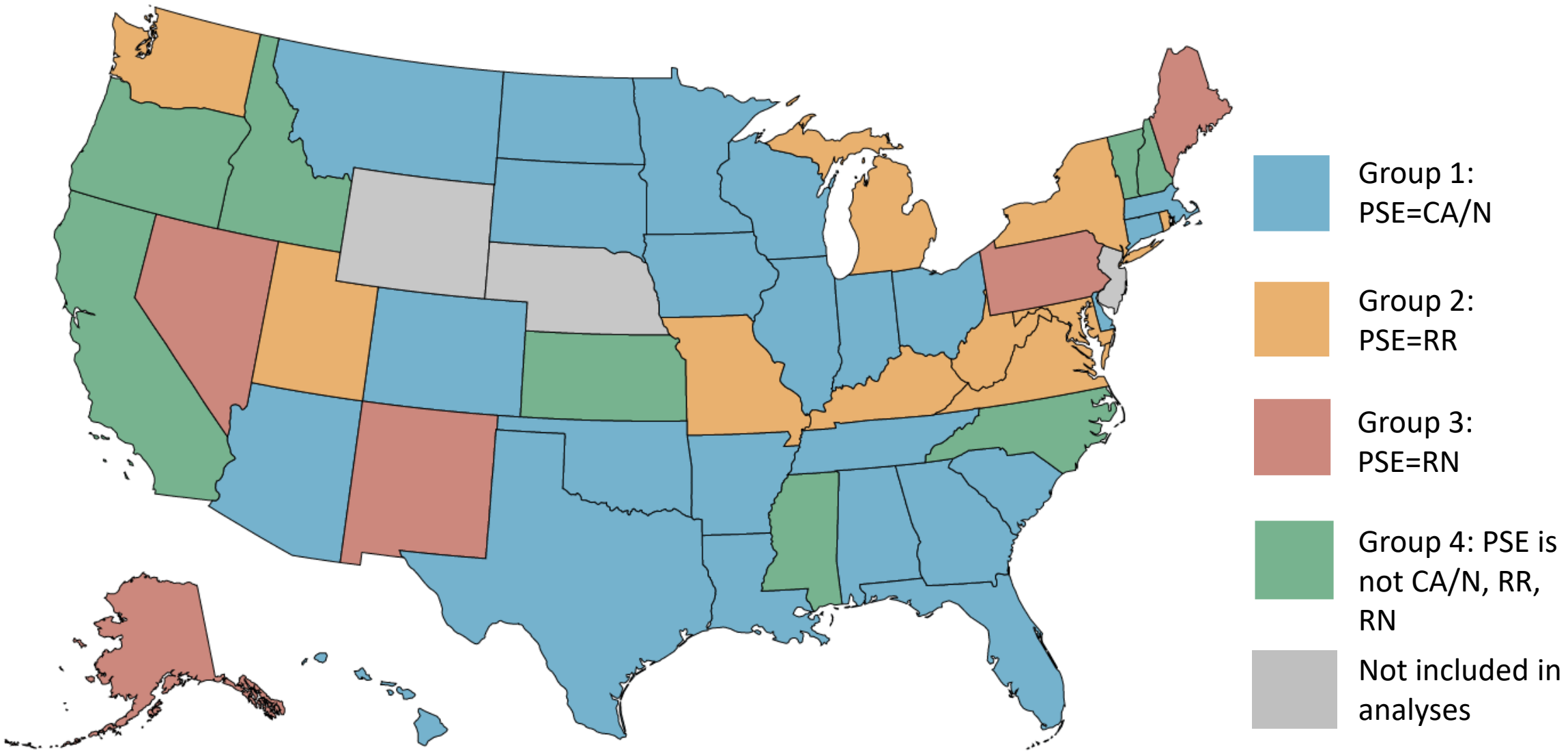
Preliminary Results, Not for Distribution

- **Group 4 (n=11): Prenatal substance exposure is not defined as child maltreatment; a report or notification is not mandated (PSE is not CA/N, RR, RN)**

  CA ID KS MS NH NC OR VT (CW Policy not reviewed in NE NJ WY)

  - Do not have statutes or child welfare policies defining prenatal exposure as child maltreatment or mandating a report or notification to child welfare
  - Have other child welfare policies that guide child welfare procedures in responding to allegations involving prenatal exposure
    - Examples include determining whether allegations involving prenatal exposure should be screened-in for a child welfare response or referred to alternative/differential response programs for non-child welfare intervention
  - *Nebraska, New Jersey, Wyoming*: Not included in the 4 categories. The three states do not have statutes defining or mandating a report or notification. Their child welfare policies were not available for review

Group 4: PSE is not CA/N, RR, RN (n=8)
Not defined as child maltreatment; report or notification not mandated



Preliminary Results, Not for Distribution

Examples of States' Child Welfare Policies and Procedures In Response to Allegations of Prenatal Substance Exposure

- California: Positive infant toxicology screen not by itself a basis for a child maltreatment report. Presence of child maltreatment concerns require a report to child welfare.
  - State infant removal rate: 12.7
- Kansas: Structured Decision Making to guide child welfare screen-in. CW policy includes information on CARA/CAPTA with the focus on Plan of Safe Care, doesn't specify notification
  - State infant removal rate: 12.8
- Mississippi: Positive maternal and infant toxicology tests screened-in for child welfare response. Allegations involving prenatal exposure without toxicology results not addressed. CW policy includes general CAPTA/CARA language but doesn't specify a notification
  - State infant removal rate: 10.4

Examples of States' Child Welfare Policies and Procedures In Response to Allegations of Prenatal Substance Exposure

- New Hampshire: Describes prenatal exposure protocols, including an enhanced response and plan of safe care development.
  - LAPPA found statute in which healthcare provider is to determine if CA/N report is warranted based on suspicion that infant has been abused or neglected
  - State infant removal rate: 8.7
- Oregon: Child welfare hotline screener must determine whether plan of safe care developed and code cases as Notifications in the data system. Child welfare to ensure families engaged in plan of safe care services.
  - State infant removal rate: 14.1
- Vermont: Child welfare conducts assessment for allegations involving concerns for child maltreatment
  - State infant removal rate: 19.9

Collaborative Policy Efforts
Example: **North Carolina**

North Carolina Child Welfare Resources for Substance Affected Infants & Plan of Safe Care, March 2021

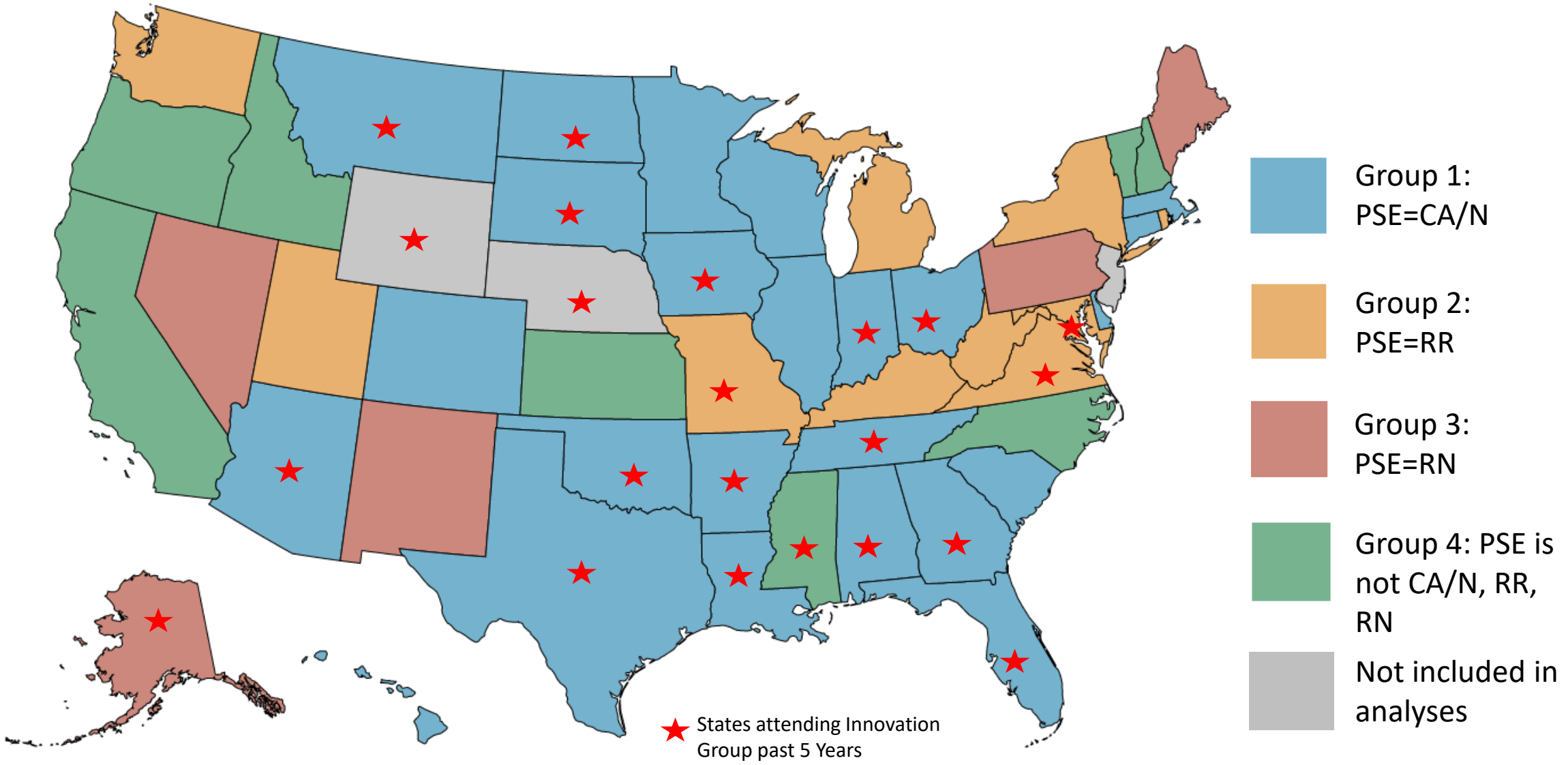
- "CAPTA and the Comprehensive Addiction and Recovery Act (CARA) requires healthcare providers to notify CPS of all substance affected infants. The notification itself is not an allegation of maltreatment and requires the assigned intake worker to complete a thorough screening to determine whether the notice meets the definition of abuse, neglect, and/or dependency."

State of North Carolina Department of Health and Human Services, Infant Plan of Safe Care – Executive Summary, n.d.

- "In North Carolina, our intent in developing the needed policies and procedures is to support the infant and mother, increase access to treatment for all women with substance use disorders and their children, and not to penalize the mother or family…"
- "… health care providers involved in the delivery and care of such infants must notify the county child welfare agency upon identification of the infant as "substance affected"…"

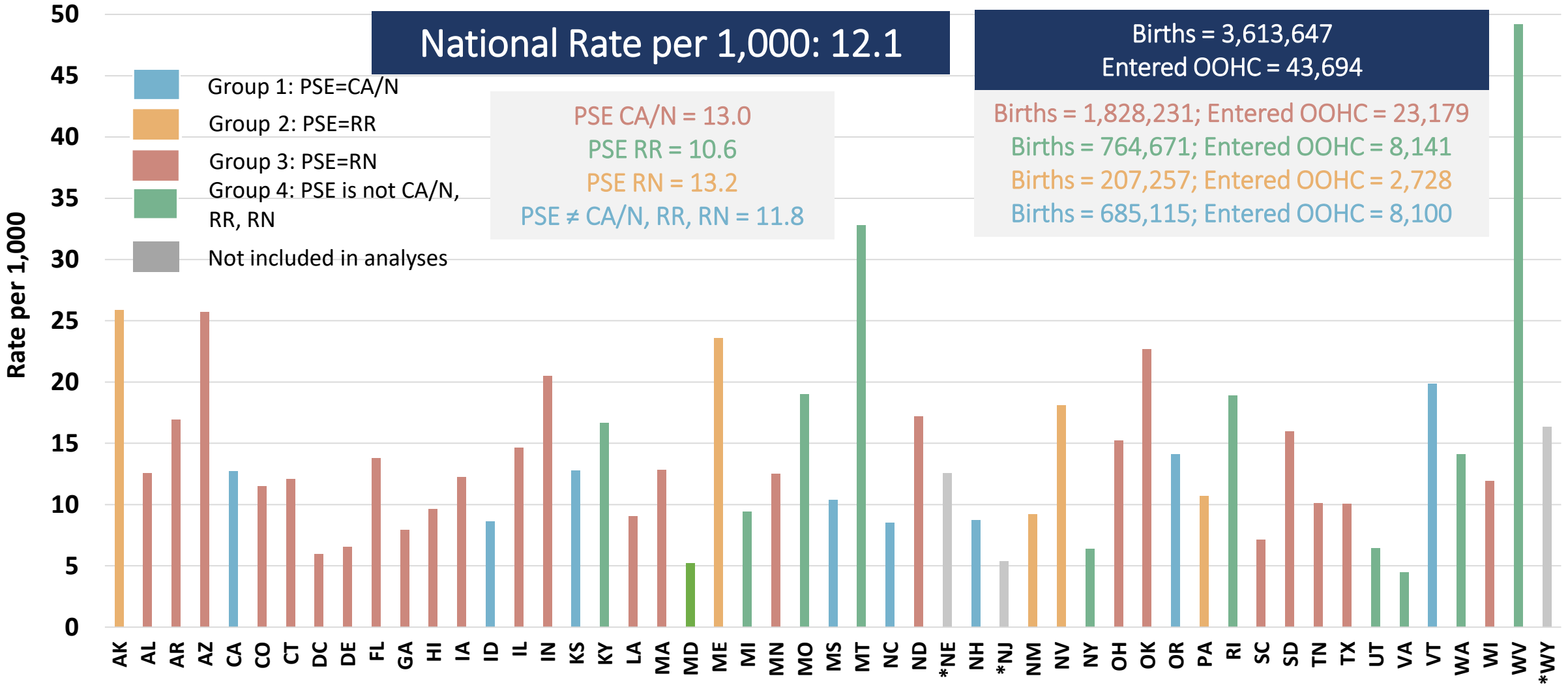
- State infant removal rate: 8.5

States Attending Secretaries Innovation Group Past Five Years



Preliminary Results, Not for Distribution

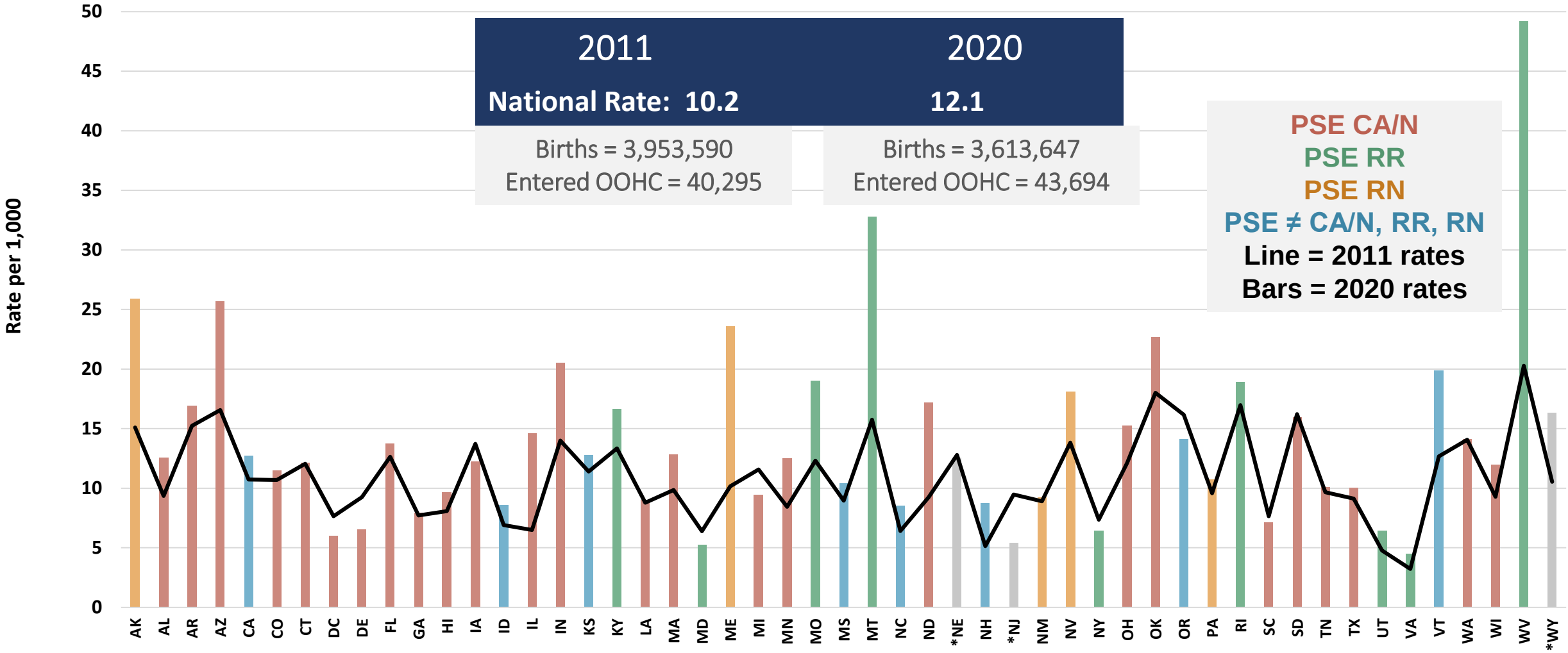
Rates of Children Under Age 1 Who Entered Out of Home Care Per 1,000 Births by State, 2020



*Note: Estimates based on **<u>all children who entered out of home care</u>** during Fiscal Year*
**Not included in the analyses*

Source: AFCARS Data, 2020 v1
CDC Wonder

Rates for Children Under Age 1 Who Entered Out of Home Care Per 1,000 Births by State, 2011 and 2020



*Note: Estimates based on **<u>all children who entered out of home care</u>** during Fiscal Year*

***Source**: AFCARS Data, 2011 v6 and 2020 v1; CDC Wonder*

Summary of Rates of Children under One Placed in Care by State Policy Grouping

Group	Rate of Removals Under One by Total Births	States Above National Rate of 12.1
PSE CA/N	13.0	13 of 24 – 54%
PSE RR = 10.6	10.6	6 of 11 – 54%
PSE RN = 13.2	13.2	3 of 5 – 60%
PSE ≠ CA/N, RR, RN	11.8	5 of 11 – 45%
SIG Attendee States	13.2	16 of 22 – 72%

- **2022**: 23 state analyses of states with child abuse policies that substance use in pregnancy is child maltreatment and mandating reporting of substance use in pregnancy to child welfare.
- In states with one or both policies, pregnant women with substance use disorders (SUDs):
  - Initiated prenatal care later
  - Less likely to access prenatal or postpartum care
  - While pregnant and postpartum women with SUDs are less likely to engage in prenatal and postpartum care, compared to women without SUDs, the study confirmed that these policies further decreased rates of engagement

"These results suggest that programmatic and policy strategies that emphasize supportive, non-stigmatizing approaches to substance use during pregnancy are needed."

Austin, A.E., Naumann, R.B., & Simmons, E. (2022). Association of State Child Abuse Policies and Mandated Reporting Policies With Prenatal and Postpartum Care Among Women Who Engaged in Substance Use During Pregnancy. JAMA Pediatr. 2022;176(11):1123–1130. doi:10.1001/jamapediatrics.2022.3396

What's Required?




Child Abuse Prevention and Treatment Act

1974: Child Abuse Prevention and Treatment Act (CAPTA)

2003: The Keeping Children and Families Safe Act
Requires Plan of Safe Care

2010: The CAPTA Reauthorization Act
Adds Fetal Alcohol Spectrum Disorder

2015: Reuters Investigation
Infants and families who "fell through the cracks"

2016: Comprehensive Addiction and Recovery Act (CARA)
Made several modifications to CAPTA

Summary: CAPTA Prenatal Substance Exposure Requirements

Governor assures that the State is operating statewide policy or procedures to address the needs of infants affected by prenatal substance use, withdrawal or FASD and that there is

- A notification to child welfare by medical professionals of infants:

  "born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder"

  "except that such notification shall not be construed to establish a definition under federal law of what constitutes child abuse or require prosecution for any illegal action"

- Development of a Plan of Safe Care/Family Care Plan for both the affected infant and affected family/caregiver
- State monitoring and oversight to ensure that Plans of Safe Care are implemented and that families have access to appropriate services

WHO COULD DEVELOP FAMILY WELLNESS PLAN CARE?

	POTENTIAL AGENCY/SYSTEM TO OVERSEE A FAMILY WELLNESS PLAN	
POPULATION OF PREGNANT AND POSTPARTUM WOMEN	**POSSIBLE DEVELOPERS IN THE PRENATAL PERIOD**	**POSSIBLE DEVELOPERS AT BIRTH**
• Mothers who use opioid (or other legal) medications (e.g., benzodiazepines) for chronic pain as prescribed by the healthcare provider. **These mothers do not have a SUD.**	• Prenatal care provider, along with pain specialist or other physician; or a family mentor/family navigator.	• Maternal and child health (MCH) service providers (e.g., home visiting programs and Healthy Start), agencies providing substance use prevention services, or a family mentor/navigator.

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• Mothers who receive MAT (e.g., buprenorphine or methadone) for an OUD or are already engaged in treatment for a SUD.	• Prenatal care provider, along with MAT program provider, therapeutic SUD treatment provider, or a family mentor or family navigator.	• MAT program provider or therapeutic SUD treatment provider—with MCH partners or child welfare agencies—or a family mentor or family navigator.

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• Mothers misusing prescription or legal drugs (or using illegal drugs); mothers who meet criteria for a SUD and are not engaged in a treatment program.	• Prenatal care provider or high-risk pregnancy clinic, along with SUD treatment agency or a family mentor or family navigator.	• CPS and other child welfare service agencies.

5 POINTS FOR FAMILY INTERVENTION: Pre- and Post-Natal Intervention

https://ncsacw.acf.hhs.gov/files/five-points-family-intervention-infants-with-prenatal-substance-exposure-and-their-families.pdf

PRE-PREGNANCY

Focus on preventing substance use disorders before a woman becomes pregnant through promoting public awareness of the effects of substance use, including alcohol and tobacco, during pregnancy and encouraging access to appropriate substance use disorder treatment

PRENATAL

Focus on identifying substance use disorders among pregnant women through screening and assessment, engaging women into effective treatment services, and providing ongoing services to support recovery

BIRTH

Focus on identifying and addressing the needs of infants affected by prenatal substance exposure, withdrawal symptoms, and Fetal Alcohol Spectrum Disorder including the immediate need for bonding and attachment with a safe, stable, consistent caregiver

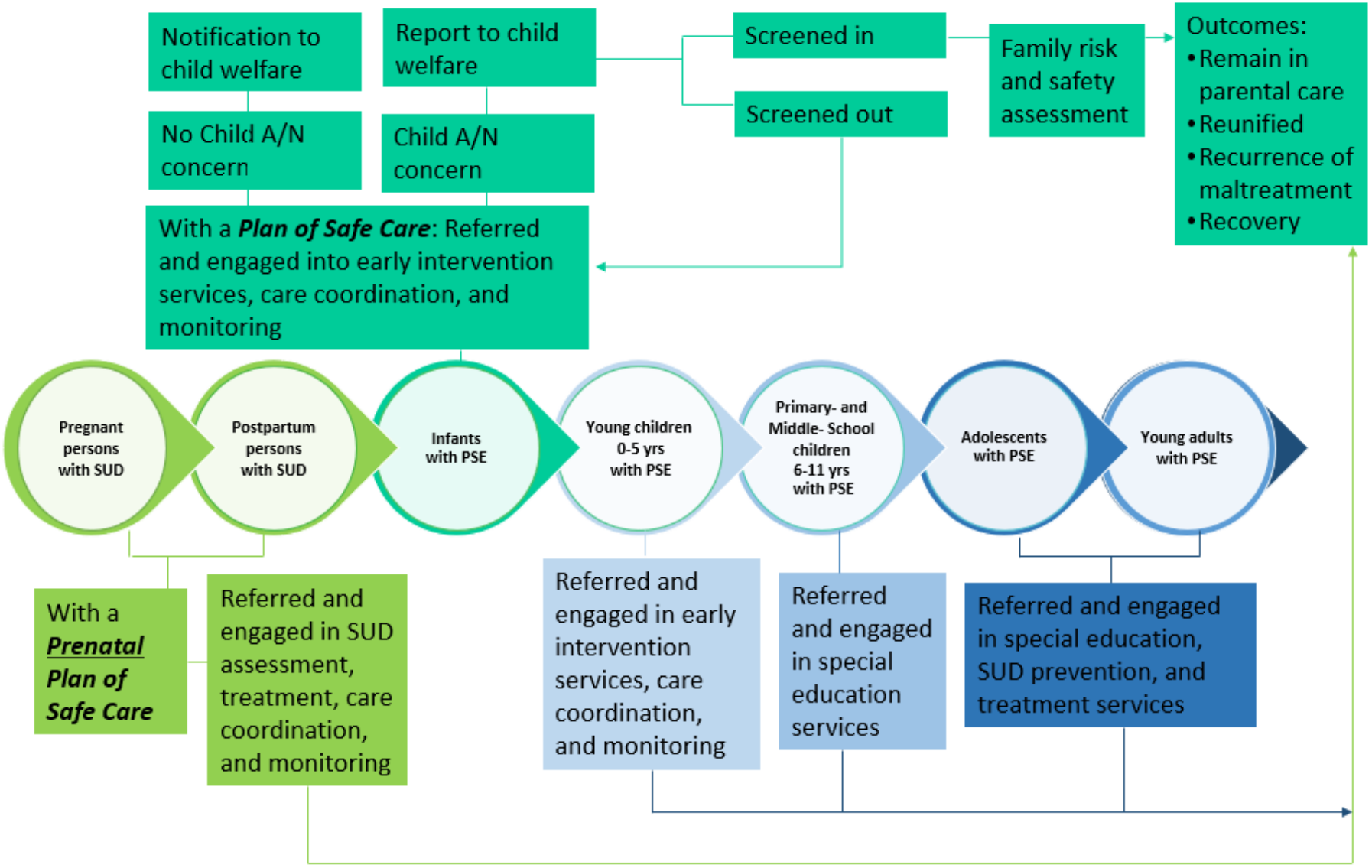
NEONATAL, INFANCY, & POSTPARTUM

Focus on ensuring the infant's safety and responding to the needs of the infant, parent, and family through a comprehensive approach that ensures consistent access to a safe, stable caregiver and a supportive early care environment

CHILDHOOD & ADOLESCENCE

Focus on identifying and responding to the unique developmental and service needs of the toddler, preschooler, child, and adolescent who was prenatally exposed through a comprehensive family-centered approach

What does it look like?



Child A/N: Child abuse/neglect

PSE: Prenatal Substance Exposure

SUD: Substance Use Disorder

- **Public Health, Prenatal Interventions—Screening and Plan of Safe Care/Family Care Plan**: Engagement into SUD treatment and other supportive services by public health and medical care
- **Closed-Loop Referrals**: For families determined not in need of child welfare intervention, ensure ongoing engagement in SUD treatment and other supportive services
- **Comprehensive Services**: Array of interventions to mitigate effects of prenatal substance exposure for the family and across developmental stages

Innovation Sites




Early Intervention

- **Jefferson County, Alabama**: SAFE CARE Program for pregnant and parenting women with substance use disorders
  - A Care Coordinator develops a plan of safe care/family care plan and provides integrated intensive case management and support in navigating child welfare services and family court requirements
  - The Coordinator helps families access a variety of services including substance use disorder treatment, therapeutic parent education, mental health support, housing, and maternal and child health
  - SAFE CARE services are available from pregnancy through 3 years postpartum. Program outcomes: 81% of children were able to remain in home or relative placement. 62% of participating families did not require child welfare services
- **Minnesota:** Both pregnant women with SUDs and their infants require a report to child welfare. Upon receipt of the report, allegations involving pregnant women are screened-out for a child welfare investigation while voluntarily engaged into supportive services

Coordinated, Cross-Sector Response

- **Delaware**: Aiden's Law, mandating a coordinated response among child welfare, SUD treatment, and other systems to ensure the safety and well-being of infants with prenatal substance exposure
  - Child welfare staff work at birth hospitals to engage families and support development of plans of safe care/family care plan
  - Medication-assisted treatment providers lead the development and monitoring of prenatal plans of safe care/family care plans
  - For cases determined low-risk, through a contract with child welfare, a SUD treatment provider develops, implements, and monitors the plan of safe care/family care plans. The provider also reports on family status and progress to child welfare

Distinct Reporting and Notification Pathways

- **Connecticut:** Online portal for hospital health care providers to enter information on all infants identified as affected by substance abuse, withdrawal symptoms, or an FASD

  Information about the family and risk to the infant is entered into the portal

  - The portal system generates information on whether a notification or report of potential child abuse or neglect is necessary
  - If the family requires a child abuse or neglect report, the portal system first directs the user to a demographic page and then to an online child maltreatment report
  - If the family requires a notification, the health care provider develops a plan of safe care/family care plan with the parents
  - The Department of Children and Families' Careline receives de-identified information on the notification form, which includes ZIP code, community type (e.g., urban, rural, suburban), and notifications/reports and Plans of Safe Care by race/ethnicity

Statute Modification

- **New Mexico: House Bill 230, Plans of Care for Substance-Exposed Newborns:** Healthcare professionals develop plans of safe care/family care plans and refer to services, for all substance-exposed newborns. The bill also modified the state's Children's Code to specify that substance use on its own is not considered child abuse or neglect

- **Arkansas**: Garret's Law expanded definition of child maltreatment to include prenatal substance exposure and mandates child welfare to screen-in allegations involving infants with prenatal exposure. Prenatal substance exposure allegations are to be found as "true but exempted" and parents will *not* be placed on the child maltreatment registry

Key Policy Levers




CAPTA
Prenatal Substance Exposure Requirements

- A notification to child welfare by medical professionals of infants:

  "born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder"

  "except that such notification shall not be construed to establish a definition under federal law of what constitutes child abuse or require prosecution for any illegal action"

- Development of a Plan of Safe Care/Family Care Plan for both the affected infant and affected family/caregiver

- State monitoring and oversight to ensure that Plans of Safe Care are implemented and that families have access to appropriate services

Prioritize Substance Use Disorder Treatment for Child Welfare Involved Families

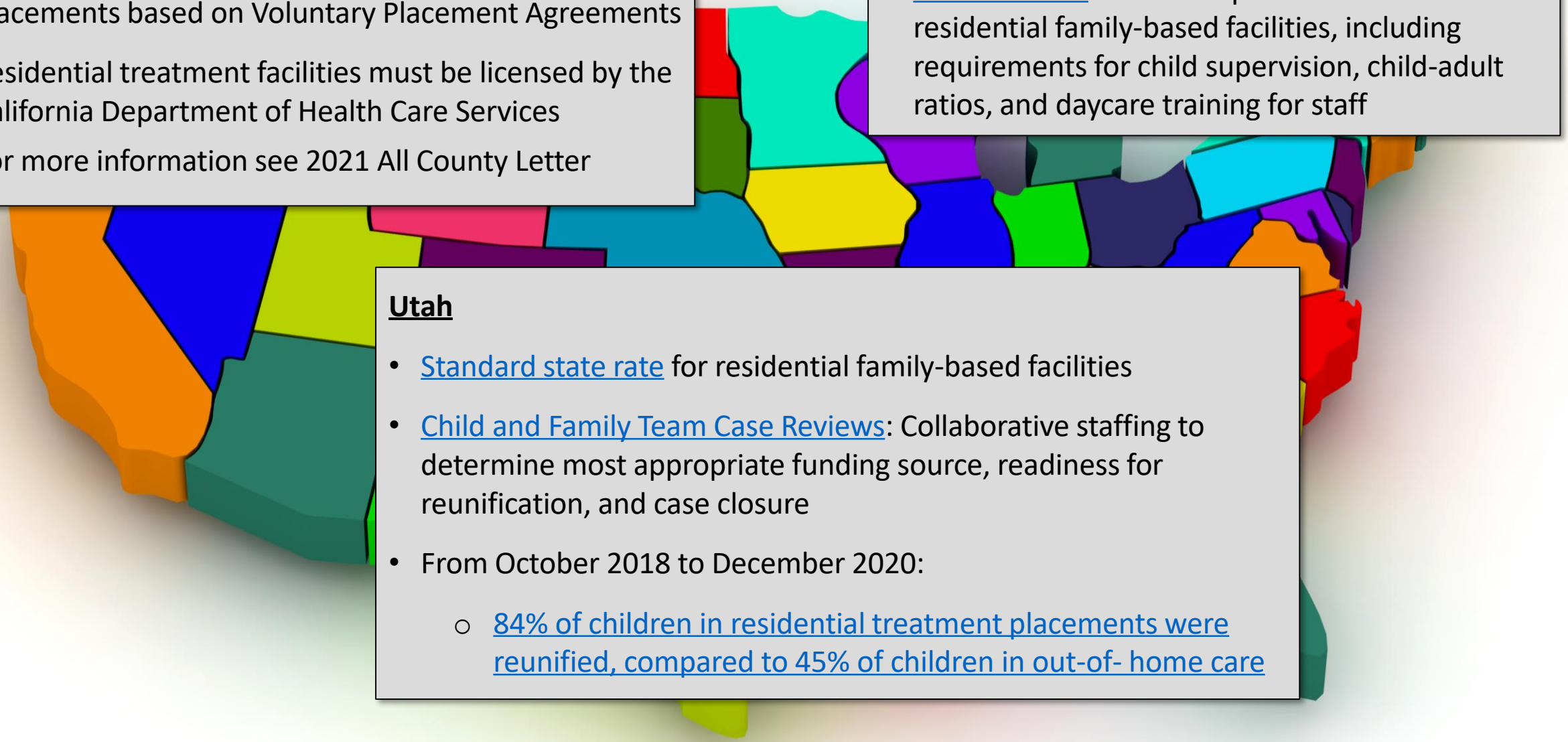
- Substance Abuse and Prevention Treatment Block Grant (SAPTBG)
  - Pregnant and parenting women's set-aside
  - Priority populations: Pregnant women and IV drug users
- Medicaid
  - Substance use and mental health treatment
  - Targeted case management
- Opioid Litigation Settlements: Key opportunity to build systems and infrastructure

Family First Prevention Services Act (FFPSA) Two Major Components for Families Affected by Substance Use Disorders

1. **Residential Family-Based Substance Use Disorder (SUD) Treatment**
   - Allows states to claim Title IV-E foster care maintenance payments for a ***child who is placed with a parent in a licensed residential family-based treatment facility for SUDs***
   - Covers the child's room and board
   - Effective October 01, 2018, up to 12 months of maintenance payments
   - Requirements
     - Placement must be recommended in the child welfare case plan
     - Facility must provide: Parenting skills training; individual and family counseling; and trauma-informed services

Administration on Children, Youth and Families, Program Instruction ACYF-CB-IM-18-02

FFPSA Residential Services: Implementers



California

- Placements based on Voluntary Placement Agreements
- Residential treatment facilities must be licensed by the California Department of Health Care Services
- For more information see 2021 All County Letter

Minnesota

- State statutes include requirements for residential family-based facilities, including requirements for child supervision, child-adult ratios, and daycare training for staff

Utah

- Standard state rate for residential family-based facilities
- Child and Family Team Case Reviews: Collaborative staffing to determine most appropriate funding source, readiness for reunification, and case closure
- From October 2018 to December 2020:
  - 84% of children in residential treatment placements were reunified, compared to 45% of children in out-of- home care

2. Prevention Services

- New Title IV-E funds for ***prevention services for families who are at risk for out-of-home care***. Eligible groups:
  - Children at risk for out-of-home care
  - Pregnant and/or parenting youth in foster care
  - Parents and kin caregivers of children and youth
- Prevent out-of-home care among "candidates" for placement
- Requirements
  - States must submit and receive approval on their 5-Year Title IV-E Prevention Services Plan. The plan must specify the interventions that will be implemented and quality assurance efforts. For more information see Administration on Children, Youth and Families, Program Instruction ACYF-CB-PI-18-09
  - Prevention services must meet evidentiary standards established by the ***Title IV-E Prevention Services Clearinghouse***

Medicaid

- Prenatal SUD screening, assessment and treatment
- Peer support specialists
- Early and Periodic Screening, Diagnostic, and Treatment: Up to age of 21 years. Other pathways to early intervention and special education services
  - *IDEA Parts B and C*: Ages 0-3 and up to 21 yrs—Prenatal substance exposure as an automatic qualifier for services (OH, KY, GA)
  - *IDEA Part C*: Ages 0-3—Substantiated victims of child maltreatment must be referred to early intervention

National Center on Substance Abuse and Child Welfare

CONTACT US

NCSACW

(714) 505-3525

ncsacw@cffutures.org

Technical Assistance Tools and Resources

National Center on Substance Abuse and Child Welfare

Available Now!

Download your copy @

https://ncsacw.acf.hhs.gov/files/five-points-family-intervention-infants-with-prenatal-substance-exposure-and-their-families.pdf

National Center on Substance Abuse and Child Welfare

Understanding Fetal Alcohol Spectrum Disorders

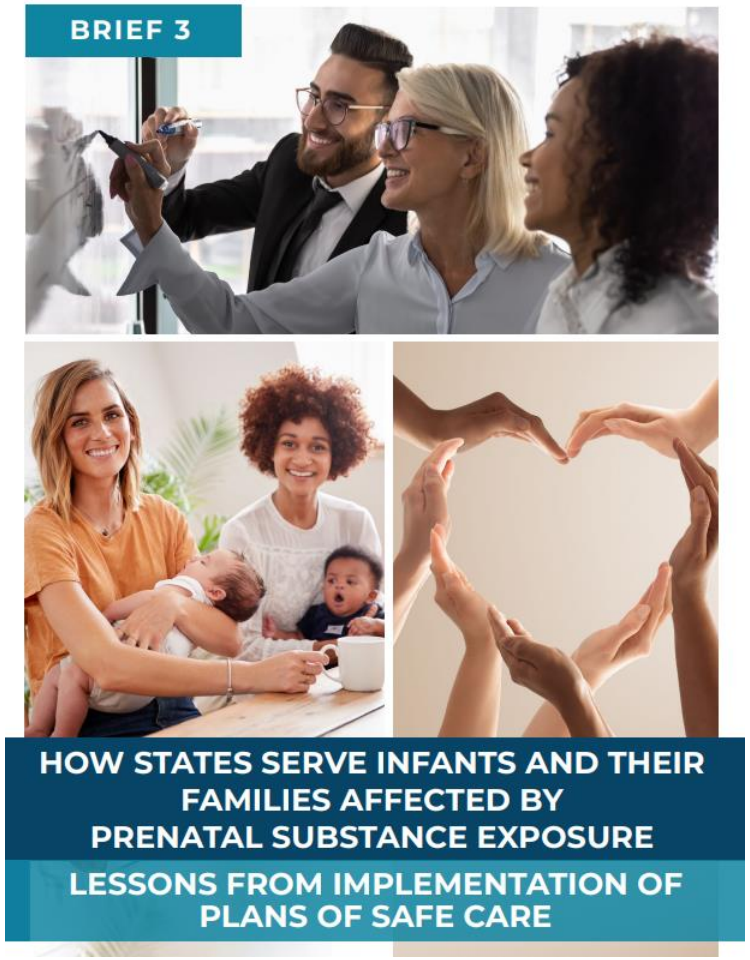
For child welfare and substance use treatment professionals

- Overview of fetal alcohol spectrum disorders (FASD)
- Effect of FASD on child development
- Treatment for FASD
- Practice strategies to support infants, children, and families with a family-centered approach
- Indicators of FASD among adults in SUD treatment

Now Available!

Download @ https://ncsacw.acf.hhs.gov/topics/parental-substance-use-disorder.aspx

How States Serve Infants and Their Families Affected by Prenatal Substance Exposure



Available @:

https://ncsacw.acf.hhs.gov/topics/plans-of-safe-care.aspx

Plan of Safe Care Learning Modules

To access the Plan of Safe Care Learning Modules, visit:
https://ncsacw.acf.hhs.gov/topics/plans-of-safe-care-learning-modules.aspx

Five Learning Modules:

- ***Brief 1:*** *Preparing for Plan of Safe Care Implementation*
- ***Brief 2:*** *Establishing Collaborative Partnerships*
- ***Brief 3*****:** *Determining Who Needs a Plan of Safe Care*
- ***Brief 4:*** *Implementing and Monitoring Plans of Safe Care*
- ***Brief 5:*** *Overseeing State Systems and Reporting Data on Plans of Safe Care*

National Center on Substance Abuse and Child Welfare

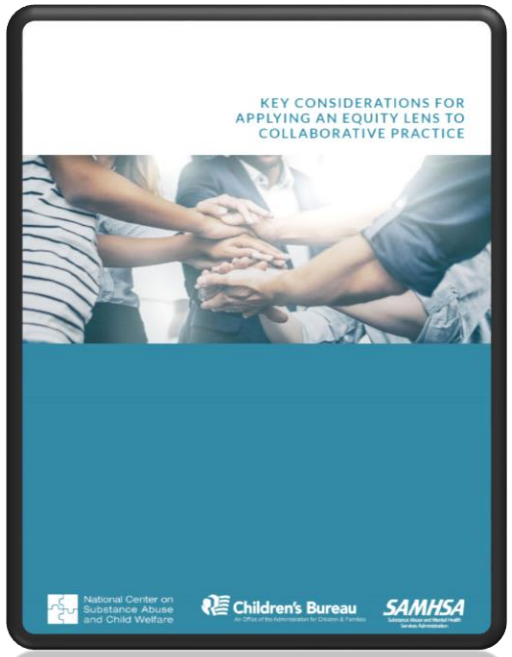
Disproportionalities and Disparities in Child Welfare

A resource for child welfare workers to help

- Understand the link between disproportionalities, disparities, and the child welfare system
- Recognize disproportionalities and disparities when working with families affected by SUD
- Implement strategies to increase engagement with families and reduce inequities.

Available @ https://ncsacw.acf.hhs.gov/files/cw-tutorial-supplement-equity.pdf

Key Considerations for Applying an Equity Lens to Collaborative Practice



This brief helps collaborative teams formally ***assess existing policies*** to determine if and how they ***contribute to disproportionate and disparate outcomes for families*** being served.

By working through the "Questions to Consider", teams begin applying an ***equity lens*** to collaborative policies and practices.

Available @ https://ncsacw.acf.hhs.gov/files/equity-lens-brief.pdf

NEW RESOURCE



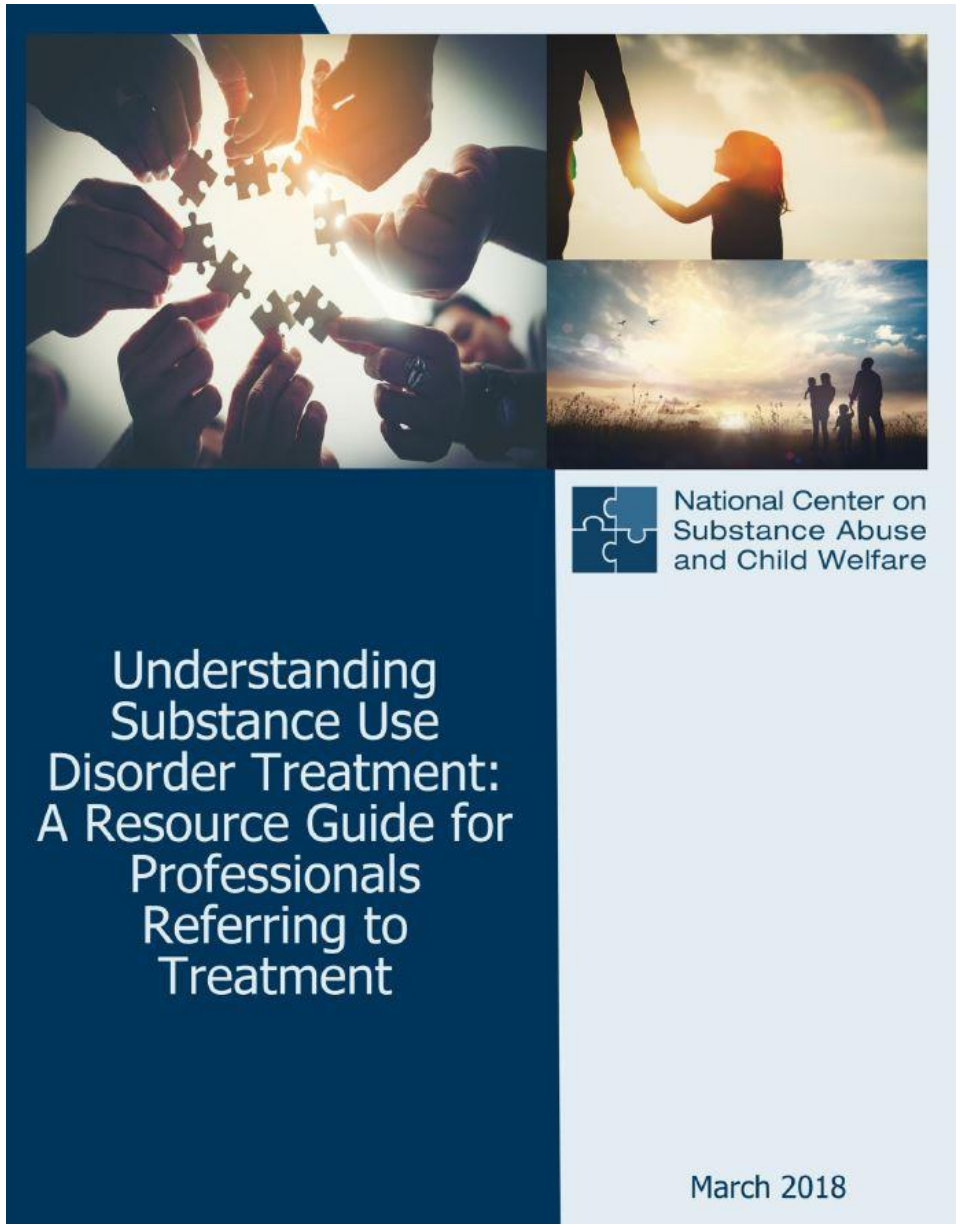


Tribal Family Wellness Plan Learning Modules

The Quality Improvement Center for Collaborative Community Court Team's Tribal Family Wellness Plan Learning Modules, prepared in collaboration with the Tribal Law and Policy Institute (TLPI), are designed to guide tribally driven collaboratives seeking to:

- Reduce the impact of substance abuse on pregnant and parenting families
- Improve systems and services to reduce prenatal substance exposure
- Prevent the separation of families
- Support infant and family wellness

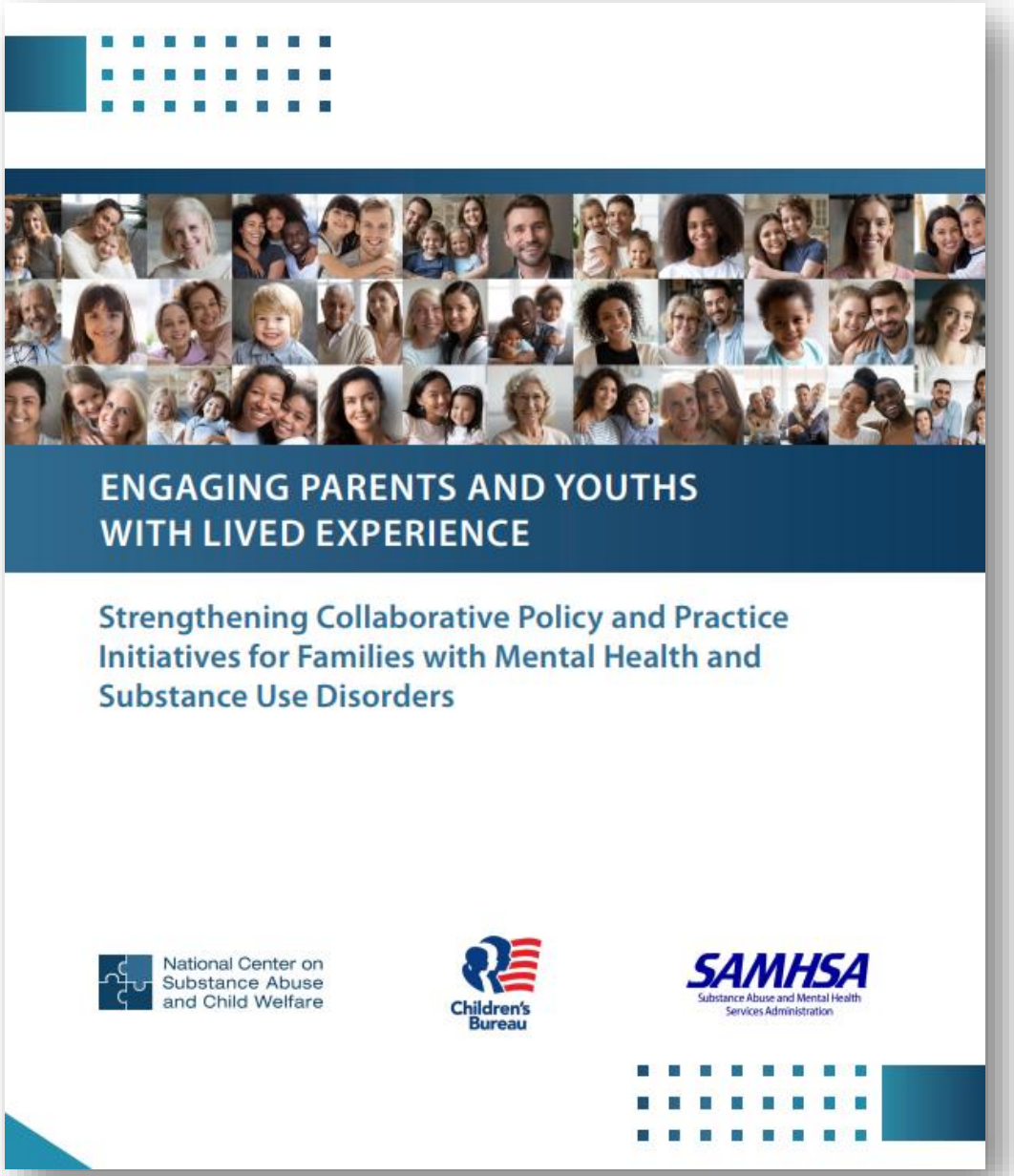
Available @
https://www.cffutures.org/home-page/qic-ccct-tribal-posc-modules/



- This TA tool is designed to equip professionals who refer parents to SUD treatment with a fundamental understanding of treatment.
- The tool includes a list of questions child welfare or court staff can ask treatment providers to ensure that effective linkages are made.
- With the knowledge gained, professionals will be able to make informed referral decisions for services that are a good fit to meet the parent and family's needs.

Available for download here: https://ncsacw.acf.hhs.gov/files/understanding-treatment-508.pdf

Engaging Parents and Youths With Lived Experience



- Provides key considerations for collaboratives that are trying to engage parents who have been involved with the child welfare system due to substance use disorder or other mental health challenges.

- Highlights considerations for those collaboratives trying to engage youth who have been in the foster care system.

Available @ https://ncsacw.acf.hhs.gov/files/live-experience.pdf

BUILDING COLLABORATIVE CAPACITY SERIES

Offers effective strategies to create cross-systems collaborative teams, communication protocols, and practice innovations. These strategies aim to improve screening, assessment, and engagement for families affected by substance use disorders and child welfare involvement.

AVAILABLE @ https://ncsacw.acf.hhs.gov/collaborative/building-capacity.aspx

Exploring Civil Rights Protections for Individuals in Recovery from an Opioid Use Disorder

NEW RESOURCE!

Five-Part Video and Webinar Series

- *Medication-Assisted Treatment and Common Misconceptions*
- *Civil Rights Protections for Individuals with a Disability: The Basics*
- *Civil Rights Protections for Individuals with an Opioid Use Disorder*
- *Child Welfare Case Staffing: Social Worker and Supervisor*
- *Child Welfare Case Staffing: Child Welfare Court Case*

Available @ https://ncsacw.acf.hhs.gov/topics/medication-assisted-treatment.aspx

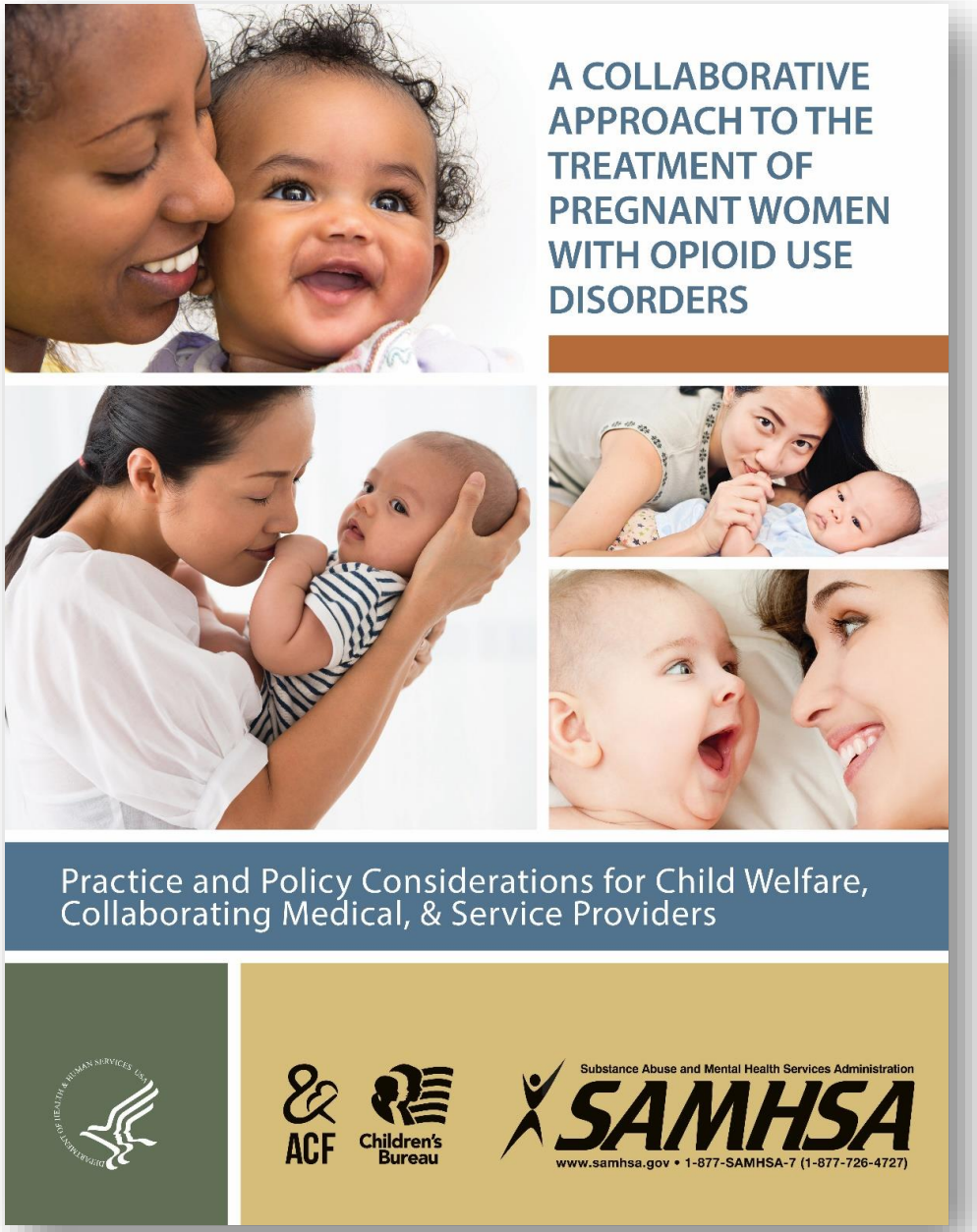
Free Online Tutorials for Cross-Systems Learning

Understanding Substance Use Disorders and Facilitating Recovery: A Guide for Child Welfare Workers

Understanding Child Welfare and the Dependency Court: A Guide for Substance Use Treatment Professionals

Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals

https://ncsacw.acf.hhs.gov/training/default.aspx



Purpose: Support the efforts of States, Tribes and local communities in addressing the needs of pregnant women with opioid use disorders and their infants and families

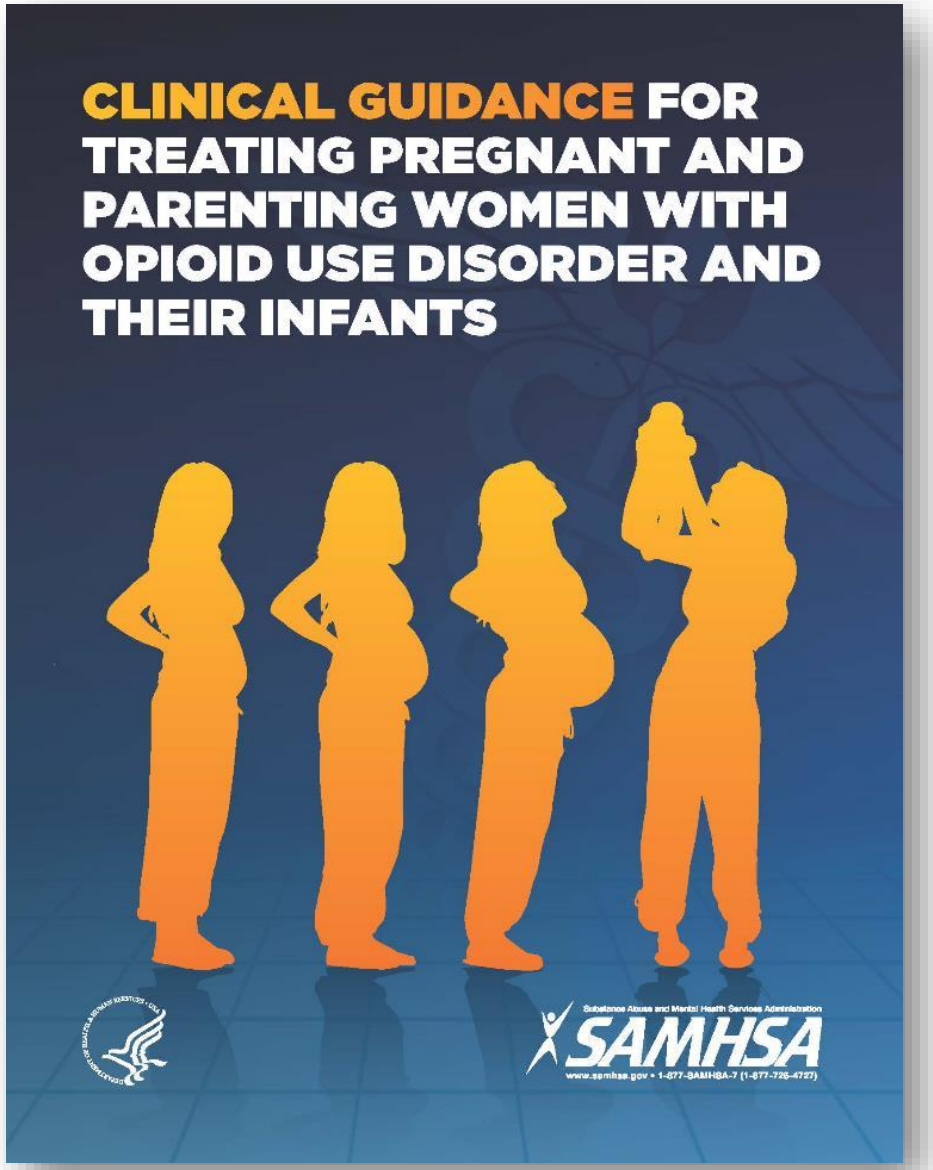
Audience

- Child Welfare
- Substance Use Treatment
- Medication Assisted Treatment Providers
- OB/GYN
- Pediatricians
- Neonatologists

National Workgroup

- 40 professionals across disciplines
- Provided promising and best practices; input and feedback over 24 months

Available for download here: https://ncsacw.acf.hhs.gov/files/Collaborative_Approach_508.pdf



Comprehensive, national guidance for optimal management of pregnant and parenting women with opioid use disorders and their infants.

The Clinical Guide helps healthcare professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions.

Available for download here: https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054