HELPING BABIES AND FAMILIES:

How states address the needs of opiate-exposed infants

A CSCH Brief by Margaret H. Lloyd and Helene M. Marcy

Background

National organizations estimate that 15% of newborns are born with prenatal substance exposure (PSE) and in 2017, an estimated 600,000 babies were born with PSE in the United States.[1] These high percentages of PSE infants have a substantial impact on the child welfare system; one 2006 study found that 61% of infants born with PSE were reported to child protective services before age one, and 30% were placed into foster care.[2]

In 2010, Congress reauthorized the Child Abuse Prevention and Treatment Act (CAPTA) and amended the act in 2016 through the Comprehensive Addiction and Recovery Act (CARA). CAPTA mandated that states enact policies to develop plans of safe care for babies born with PSE but focused on illegal substances and alcohol. The CARA amendment recognized the negative impact of legal drugs as well as the health and treatment needs of the mother. In addition, it required that states track the number of infants identified with PSE, the plans made to ensure their safety, and what services they received.[3] Though the 2010 act required that healthcare providers *notify* child protective services of infants with PSE, the 2019 Child Welfare Manual states that “such notification need not be in the form of a report of suspected child abuse or neglect.”[4]

Because these amendments could impact so many infants and families and because of the potential impact on many different systems of care, researchers at the University of Connecticut and Connecticut Children’s Medical Center recently analyzed 51 State Plans for compliance with CAPTA/CARA’s five primary PSE mandates.[5]

Key Findings

- **Most states (70%) were only compliant with either zero (37%) or one (33%) of the five CAPTA/CARA PSE mandates**. Three states (6%) were compliant with three mandates. Ten states (20%) were compliant with two mandates. Only two states (4%) have policies that comply with CAPTA/CARA across all five mandates.
- **Over three-fourths (78%) of states** use of the term “report” instead of “notify” and **require investigations for identified families**.
- **Many states do not correctly identify substances.** Over one-fourth (28%) of states fail to use the term “Fetal Alcohol Spectrum Disorder” or even mention alcohol exposure. Around one-fifth (20%) use the term “illegal” drugs, without also mentioning legal drugs.
- **Less than one-third of states (29%) correctly require that plans of safe care address the needs of both infants and mothers**.
- **Only 10% of states describe the required data collection or monitoring system**, though thirteen states mention that they are in the process of developing such a system.

Implications

The study findings demonstrate that states have much work to do to fulfill the true intent of the CAPTA/CARA legislation.

If states ignore the CAPTA/CARA requirement that healthcare workers identify infants with PSE no matter the form of form of substance (including legal and illegal drugs and alcohol), they ignore recent research that suggests that prescription drugs or alcohol can be just as, if not more, harmful.[6]

State deviation from the federal legislation requiring notification instead of reporting of babies with PSE, could result in an increase in babies entering the child welfare system and in continued reporting disparities with regard to race and ethnicity. Notification rather than reporting cases of PSE "could limit CPS contact for lower-risk PSE cases, and therefore reduce the proportion of babies of color in the child welfare system."[3]

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The federal requirements that all PSE-identified infants receive a plan of safe care, and that the plan includes the needs of mothers prioritizes their health and substance use treatment needs.

The new CAPTA/CARA mandate on data collection will track all identified children over time and across service systems, enabling policy-makers and direct care providers to learn more about what is happening overall.

Additional Resources

Resources from the National Center on Substance Abuse and Child Welfare:

In-Depth Technical Assistance: Infants with Prenatal Substance Exposure (2019)

A Planning Guide: Steps to Support a Comprehensive Approach to Plans of Safe Care (2018)

Understanding Prenatal Substance Exposure and Child Welfare Implications Child Welfare Training Toolkit (PowerPoint Presentation, 2019)

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[1]Center for Disease Control and Prevention (2018). Births, Final Data for 2017. National Vital Statistics Report, 67(1) and National Center on Substance Abuse and Child Welfare [NCSACW] (2018). A Planning Guide: Steps to Support a Comprehensive Approach to Plans of Safe Care.
[2] Prindle, J., Hammond, I., & Putnam-Hornstein, E. (2018). Prenatal substance exposure diagnosed at birth and infant involvement with child protective services. Child Abuse & Neglect, 76, 75.
[3] Lloyd, M.H., Luczak, S., & Lew, S. (2019). Planning for Safe Care or Widening the Net?: A Review and Analysis of 51 States' CAPTA Policies Addressing Substance-Exposed Infants. Children and Youth Services Review, 99 (April 2019), 343-354.
[4] Children's Bureau, 2019, Sec. 2.1F https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/index.jsp
[5] CARA/CAPTA covers the 50 states, Washington DC, and Puerto Rico. Despite repeated contact attempts and web searches, the authors were unable to obtain information from New Jersey.
[6] Behnke, M., & Smith, V. C. (2013). Prenatal substance abuse: short-and long-term effects on the exposed fetus. Pediatrics, 131(3), e1009–e1024.

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