

Substance Use Disorder: Pregnancy, Parenting and Prevention

September 19, 2023

Child Welfare Fellows Program

Legislative Examples

Colorado ([HB22-1278](#), 2022) created a pilot program that will co-locate services for substance use disorder, including medication for opioid use disorder and obstetric and gynecological health services.

West Virginia ([HB 2266](#), 2021) extended postpartum Medicaid coverage to 12 months.

Illinois ([HB 0005](#), 2019) requires the Department of Human Services to ensure access to substance use and mental health services statewide for pregnant and postpartum women.



Access to Treatment and Services



Legislative Examples

Florida ([SB 768](#), 2022) established an outreach program for high-risk pregnant women who suffer from substance misuse or mental health challenges and who may not seek prenatal care.

New York ([SB 7194](#), 2022) provides programs for pregnant women and new parents who currently or formerly have had a substance use disorder and newborns with neonatal abstinence syndrome.

In **Oregon** ([HB 4098](#), 2022) opioid settlement funds can be used towards programs that use evidence-based or evidence-informed strategies to address the needs of pregnant or parenting women with opioid use disorders.



Targeted Programs for Pregnant and Postpartum Women



Legislative Examples

Washington's [Parent Child Assistance Program](#) is a home visiting program for pregnant and parenting women with substance use disorders and their children. It is funded through client rates and through the state's dedicated marijuana account ([SB 5693](#), 2022).

Kentucky ([SB 90](#), 2022) established the Behavioral Health Conditional Dismissal Pilot Program. Program requirements include access to medical treatment, counseling, education and vocational training.

Colorado ([HB 1193](#), 2019) created the Child Care Services and Substance Use Disorder Treatment Pilot Program. The program awards grants to existing child care programs that serve pregnant and parenting women who participate in substance use disorder treatment.



Supports for Families in Treatment



Legislative Examples

Montana ([SB 150](#), 2023) prohibits drug testing requirements in treatment plans during a child abuse or neglect proceeding unless the court finds substance use contributed to the removal of the child from the home or contributes to the child remaining out of the home.

In **Ohio** ([HB 265](#), 2022), infants are eligible for placement into care facilities if they are born with substance use exposure and require additional care.

Pennsylvania ([HB 253](#), 2021) created a task force on the impact of the opioid abuse epidemic on children to focus on improving the safety, well being and permanency of substance exposed infants.



Substance Use, Child Well-being and System Involvement



Pregnancy, Substance Use, and Child Welfare: Evidence and Consequence

Mishka Terplan MD MPH
Medical Director, Friends Research Institute
Substance Use Warmline Clinician, UCSF



Assumptions

Addiction is a chronic condition, treatment works, and recovery happens all the time

Child abuse (physical, sexual, emotional) is real, rare, and within health professional responsibility to assess and respond

Substance exposure is not in-and-of-itself child abuse

From the Comprehensive Child Development Act to CAPTA (Child Abuse Prevention and Treatment Act):

PRESIDENT VETOES CHILD CARE PLAN AS IRRESPONSIBLE

He Terms Bill Unworkable and Voices Fear It Would Weaken Role of Family
DEC 10 1971
PERKINS PLEDGES FIGHT
SEC 10
 But Overriding of Nixon's Step Is Doubtful—Javits May Seek Compromise

NY Times
 By JACK ROSENTHAL
 Special to the New York Times
 WASHINGTON, Dec. 9.—In a stinging message, President Nixon vetoed today a Congressionally initiated bill to establish a national system of comprehensive child development and day care.
 The proposal, he said, was characterized by "fiscal irresponsibility, administrative unworkability and family-weakening implications."
 The President said that he objected to committing, without wide national debate, "the vast moral authority of the national Government to the side of communal approaches to child-rearing over against the family-centered approach."

The veto message, which had been expected, was unusually strong in its language. Mr. Nixon also criticized two other measures included in the same legislation—general of the Office of Economic Opportunity, the Federal antipoverty agency, and the spinning off of the Federal legal services program as an independent corporation.

Congress Reacts Quickly
 The veto brought quick, sharp reaction from Congress. "We'll fight it all the way," said Representative Carl D. Perkins, Democrat of Kentucky, chairman of the House Education and Labor Committee.
 It was extremely doubtful, however, that Congress could muster enough votes to override the veto. While the Senate passed the measure by a 63-to-17 vote last week, the House vote on Tuesday was only 210 to 186.

Senator Jacob K. Javits, Republican of New York, co-sponsor of the bill, expressed disappointment and said that if the veto was not overridden he would seek a quick compromise bill. Senator Walter F. Mondale, Democrat of Minnesota, the other Senate co-sponsor, said that the veto was "a cruel blow to children and working parents."

The child development proposal had attracted unusually broad support from labor, reli-

Continued on Page 39, Column 1

PRESIDENT VETOES CHILD CARE PLAN

Continued From Page 1, Col. 1

gious, women's liberation and public interest groups. They and Congressional advocates argued that it was a necessary response to a change in society as large numbers of mothers have gone to work.
 Ronald L. Ziegler, the White House press secretary, told reporters that the President was not opposed to day care, Mr. Nixon's opposition, rather, is to the particular program set out in the bill, Mr. Ziegler said.

However, in his message, Mr. Nixon said: "Neither the immediate need, nor the desirability of a national child development program of this character has been demonstrated."
 The President called attention to other Administration proposals concerning child development. He cited particular-\$2-billion in its first full year by the \$750-million day care component of his welfare re-formation plan. This is to provide

service to welfare mothers who would go to work under the Administration's plan.
 Repeatedly in the message, Mr. Nixon raised strong reservations about the principle of child development.
 "We cannot and will not ignore the challenge to do more for America's children in their all-important early years," the message said.

Asks Measured Response
 "But our response to this challenge must be a measured, evolutionary, painstakingly considered one," consciously designed to cement the family in its rightful position as the keystone of our civilization.
 "Good public policy requires that we enhance rather than diminish both parental authority and parental involvement with children."

The Congressional proposal called for a broad system ranging from nutrition aids for pregnant mothers to after-school programs for teen-agers. The plan would have cost \$2-billion in its first full year. It would have operated through Federal grants to communities of down to

5,000 population that applied for funds and gave assurance of high standards of quality.
 The Congressional proposal, Mr. Nixon said, would create a new army of bureaucrats without answering where qualified personnel would come from and without justifying costs that he estimated could reach \$40-billion a year.
 Two Other Segments Scored
 The President also applied sharp language to two other components of the bill, which began last winter as simply a two-year extension of O.E.O. As to the extension of the poverty agency, Mr. Nixon criticized mandatory funding levels set by Congress for 15 projects. Such earmarking, he said, most importantly because it restricts the amount of funds available for innovative projects.
 The earmarking would mean, he said, that "O.E.O. would rapidly degenerate into just another outdated bureaucracy."
 The President said that his

would have vetoed this proposal even if it had come to him separately.
 The final component of the bill, the proposal to create an independent national legal services corporation, was supported in principle by the Administration. But once again Mr. Nixon said that the restrictions that Congress imposed in the final bill were "an affront to the principle of accountability to the American people as a whole."
 Mr. Nixon expressed strong objections to the machinery for choosing this corporation's board. Six of the members would be appointed by the President, and the 11 others would be chosen by him from lists provided by professional groups.
 The universal aim of the corporation, proposal was to insulate the controversial poverty law program from political pressures. But Mr. Nixon said today "it would be better to have no legal services corporation than one so irresponsible structure."



FACTSHEET
 August 2017

About CAPTA: A Legislative History

The key federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted on January 31, 1974 (P.L. 93-247). This act has been amended several times and was last reauthorized on December 20, 2010, by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). Most recently, certain provisions of the act were amended on May 29, 2015, by the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22) and on July 22, 2016, by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198).

CAPTA provides federal funding and guidance to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations, including Indian tribes and tribal organizations, for demonstration programs and projects. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and establishes a national clearinghouse of information relating to child abuse and neglect.¹ CAPTA also sets forth a federal definition of child abuse and neglect. In 2015, the federal definitions of "child abuse and neglect" and "sexual abuse" were expanded by the Justice for Victims of Trafficking Act to include a child who is identified as a victim of sex trafficking or severe forms of trafficking in persons.

The complete text of the law (U.S. Code title 42, chapter 67) can be downloaded from the Cornell University Legal Information Institute website at <https://www.law.cornell.edu/uscode/text/42/chapter-67>. The text of CAPTA as amended, including the Adoption Opportunities program and Abandoned Infants Assistance Act, as amended, is available on the Children's Bureau website at <https://www.acf.hhs.gov/cb/resource/capta2016>.

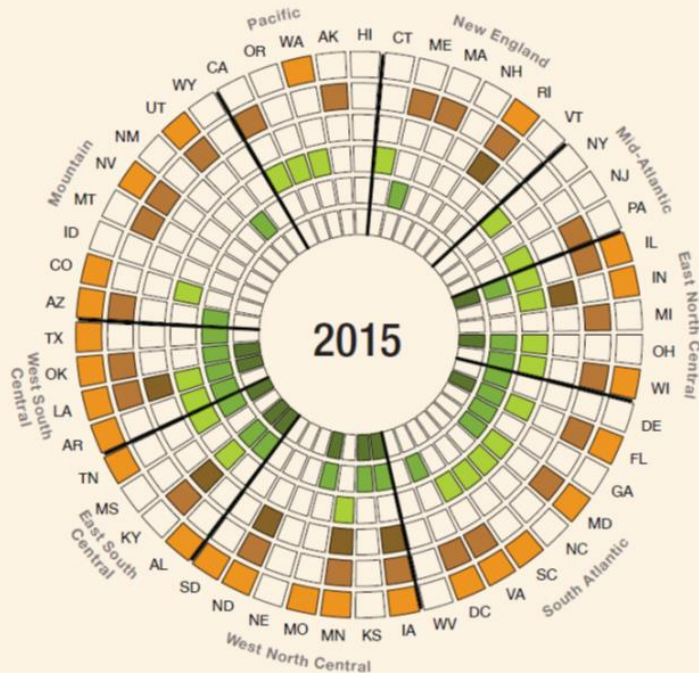
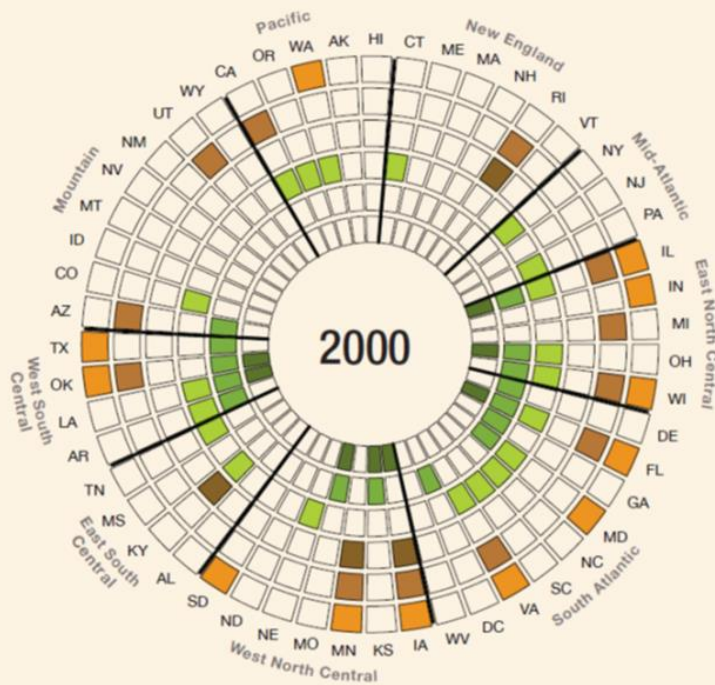
¹ This clearinghouse operates as Child Welfare Information Gateway.



Children's Bureau/ACYF/ACF/HHS
 800.394.3366 | Email: info@childwelfare.gov | <https://www.childwelfare.gov>



State Policies on Substance Use in Pregnancy



- 25 states and DC consider substance use during pregnancy to be child abuse under civil child-welfare statute
- 5 consider it grounds for civil commitment
- 26 states and DC require health care professionals to report suspected prenatal drug use
- 8 states require health care professionals to test for prenatal drug exposure if they suspect drug use

Punitive Policies Associated with:

- No Improvement in Birth Outcomes
- Increased Odds of Neonatal Abstinence Syndrome
- Increased Odds of Low Birth Weight
- Increased Odds of Preterm Delivery
- Decreased Odds of any Prenatal Care
- Decreased Odds of APGAR 7+

Mandatory Reporting Does Not Improve Population Health Outcomes

FAHERTY, ET AL., ASSOCIATION BETWEEN PUNITIVE POLICIES AND NEONATAL ABSTINENCE SYNDROME AMONG MEDICAID-INSURED INFANTS IN COMPLEX POLICY ENVIRONMENTS. ADDICTION, 2022

THOMAS, ET AL., DRUG USE DURING PREGNANCY POLICIES IN THE UNITED STATES FROM 1970 TO 2016. CONTEMPORARY DRUG PROBLEMS, 2018

CARROLL, THE HARMS OF PUNISHING SUBSTANCE USE DURING PREGNANCY. IJDP, 2021

ROBERTS, ET AL., FORTY YEARS OF STATE ALCOHOL AND PREGNANCY POLICIES IN THE USA: BEST PRACTICES FOR PUBLIC HEALTH OR EFFORTS TO RESTRICT WOMEN'S REPRODUCTIVE RIGHTS? ALCOHOL AND ALCOHOLISM, 2017

Child Welfare: What happens after a report



Figure Courtesy of Yuan He MD

SAMHSA's WORKING DEFINITION OF RECOVERY



10 GUIDING PRINCIPLES

Recovery is “a dynamic process of self-directed action, it is the movement toward wellness, rather than any single outcome state... “recovery” [is] a process rather than an outcome. Abstinence, as one of many outcomes that may or may not fully occur across multiple domains of individual wellness, is thus a potential product of the process of recovery.”

Ashford, Robert D., et al. "Defining and operationalizing the phenomena of recovery: a working definition from the recovery science research collaborative." *Addiction Research & Theory* 27.3 (2019): 179-188.

Screening vs.
Testing:
Professional
Society and Public
Health Agency
Recommendations

Universal Screening:

Recommended (ACOG, ASAM, SMFM, AAP, SAMHSA, CDC)

- **Voluntary** (ACOG, SAMHSA, CDC)

Testing:

Not Recommended - Not an appropriate measurement of addiction (ACOG, ASAM, SAMHSA)

AAP: positive test = exposure, NOT indication of health or ill-health, not injury or harm, not mentioned in discharge criteria

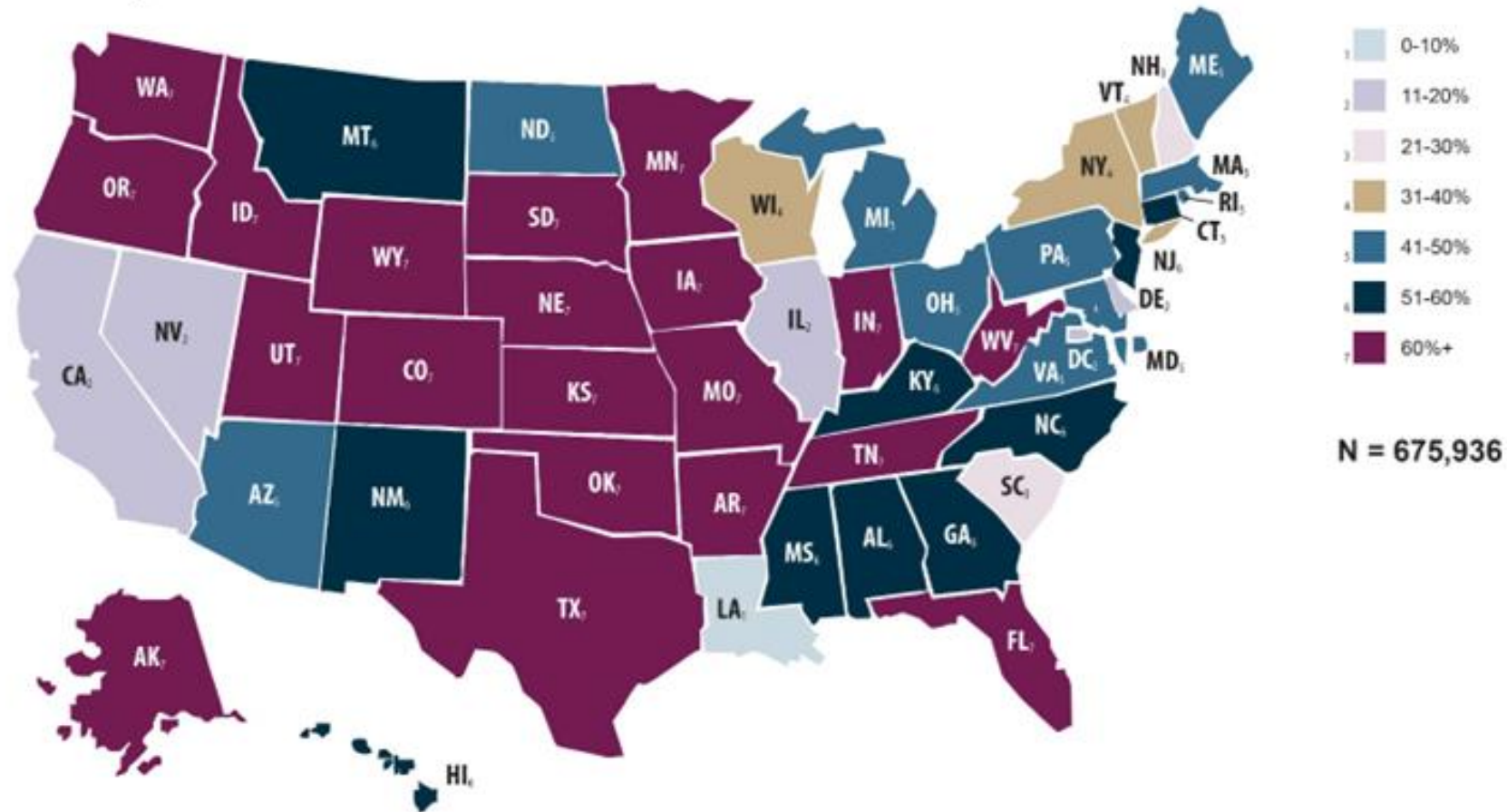
ASAM: Definitive testing required “when the results of inform decisions with major clinical or non-clinical implications for the patient”

- **Consent required** (ACOG, ASAM, SMFM, SAMHSA)

Percent of Children Removed with Parental Alcohol or Drug Abuse as an Identified Condition of Removal by Age, 2019

Under Age 1

National Average 50.7%



Child Maltreatment 2020



3,476,000 children received child welfare investigation

94,067 child welfare involved infants <1yr age (rate 25/1000)

42,821 infants (46%) reported to child welfare by healthcare professional due to prenatal substance exposure

Overall, 31% of infants who are reported to child welfare <1yr are placed in foster care (29,105)

35% of foster children experience more than 2 placements per year



U.S. Department of Health & Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

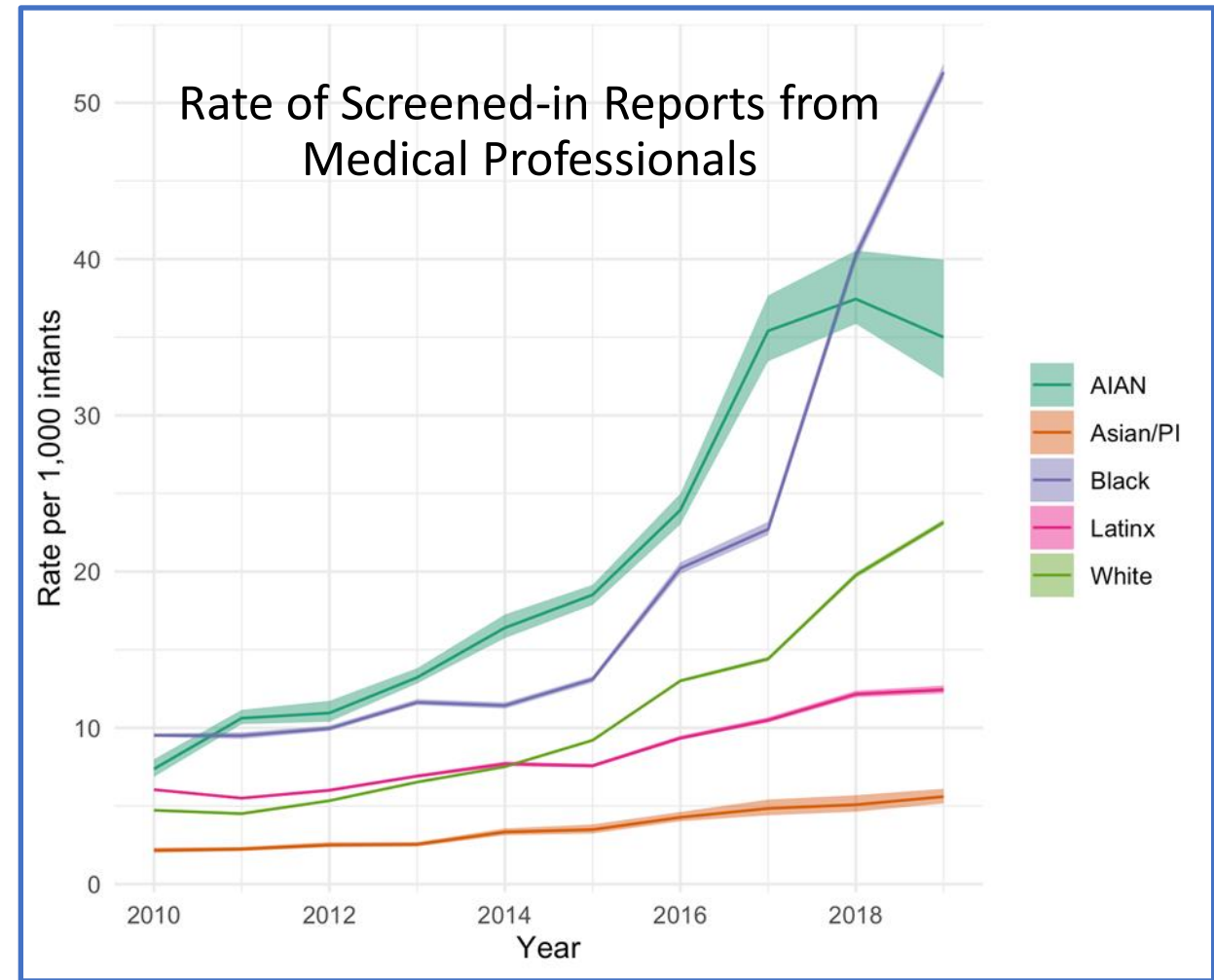


Most child welfare reports (<1yr) originate from health professionals during birthing hospitalization

Health Professional Reporting increased 400% in past decade

Driven by (misuse of) urine drug testing

Compounds racial inequities



Manuscript in preparation by Edwards F, Terplan M, Roberts S, Raz M Data from the NCANDS

HHS 2020 <https://www.childwelfare.gov/pubs/factsheets/cpswork/>

AAP 2015 <https://pediatrics.aappublications.org/content/135/5/948>

Racial Disparities in Drug Testing and Selection Bias in Child Welfare Reporting

1202 THE NEW ENGLAND JOURNAL OF MEDICINE April 26, 1990

SPECIAL ARTICLE

THE PREVALENCE OF ILLICIT-DRUG OR ALCOHOL USE DURING PREGNANCY AND DISCREPANCIES IN MANDATORY REPORTING IN PINELLAS COUNTY, FLORIDA

Ira J. Chasnoff, M.D., Harvey J. Landress, A.C.S.W., and Mark E. Barrett, Ph.D.

Abstract Florida is one of several states that have sought to protect newborns by requiring that mothers known to have used alcohol or illicit drugs during pregnancy be reported to health authorities. To estimate the prevalence of substance abuse by pregnant women, we collected urine samples from all pregnant women who enrolled for prenatal care at any of the five public health clinics in Pinellas County, Florida (n = 380), or at any of 12 private obstetrical offices in the county (n = 335); each center was studied for a one-month period during the first half of 1989. Toxicologic screening for alcohol, opiates, cocaine and its metabolites, and cannabinoids was performed blindly with the use of an enzyme-multiplied immunoassay technique; all positive results were confirmed.

Among the 715 pregnant women we screened, the overall prevalence of a positive result on the toxicologic tests of urine was 14.8 percent; there was little difference in prevalence between the women seen at the public clinics (16.3 percent) and those seen at the private offices (13.1 percent). The frequency of a positive result was also similar among white women (15.4 percent) and black women (14.1 percent). Black women more frequently had evidence of cocaine use (7.5 percent vs. 1.8 percent for white women), whereas white women more frequently had evidence of the use of cannabinoids (14.4 percent vs. 6.0 percent for black women).

During the six-month period in which we collected the urine samples, 133 women in Pinellas County were reported to health authorities after delivery for substance abuse during pregnancy. Despite the similar rates of substance abuse among black and white women in our study, black women were reported at approximately 10 times the rate for white women (P < 0.0001), and poor women were more likely than others to be reported.

We conclude that the use of illicit drugs is common among pregnant women regardless of race and socioeconomic status. If legally mandated reporting is to be free of racial or economic bias, it must be based on objective medical criteria. (N Engl J Med 1990; 322: 1202-6.)

Journal of Behavioral Health Services & Research, 2011, © 2011 National Council for Community Behavioral Healthcare. DOI 10.1007/s11414-011-9247-x

Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting

Sarah C. M. Roberts, DrPH
Amani Nuru-Jeter, PhD, MPH

	Chasnoff (1990)	Roberts (2011)
Positive Urine Drug Test		
Black Women	14.1%	14%
White Women	15.4%	14%
Child Welfare Report		
Black Women	10.7%	13.5%
White Women	1.1%	7.6%

Racial Disparities in Separation and Parental Rights Termination

Racial Disparities in Child Removal (2000-2011):

- 1 in 17 White children
- 1 in 9 Black children
- 1 in 7 American Indian children

Wildeman et al.

39

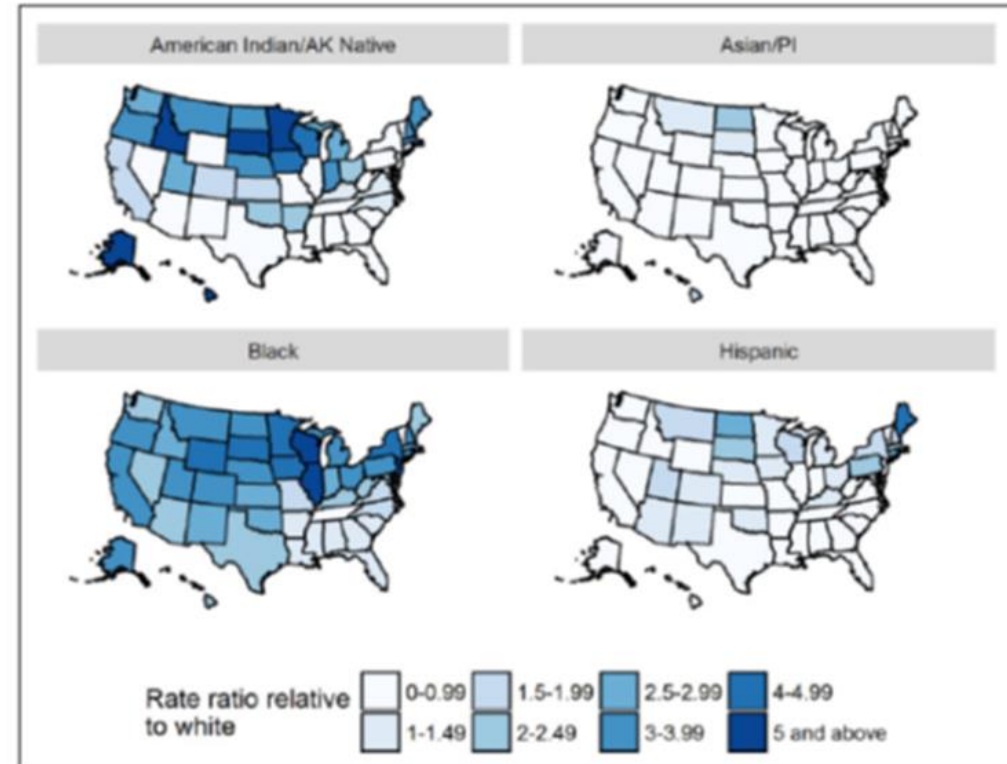


Figure 4. Inequality in cumulative prevalence of termination of both parents' rights by race/ethnicity relative to White children, 2000–2016 synthetic cohort.

MFP 2020

Wildeman C, 2020 *Child Maltreatment*

“Better Safe Than Sorry”? Child Welfare Report and Consequence for Drug Exposure

20% children experience abuse or neglect in out-of-home placement

Mental health and somatic conditions greater among children in foster care compared to general population

Toxic stress: The physiologic result of physical or dangerous, recurrent, or prolonged experience of trauma caused by the initiation of the stress response without the protective existence of a compassionate adult

Non-death Loss and Grief in Foster Care

Ideology and Misinformation

**Provider Assumptions:
Social/Legal Distinctions = Biological/Public Health**



Known Teratogens: ACE-Inhibitors, Alcohol, Carbamazepine, Diethylstilbetrol (DES), Isotretinoin, Phenytoin, Tobacco, Valproic Acid (partial list)

Substance Use in Pregnancy and Subsequent Child Maltreatment: Where is the Evidence?

- ❑ Substance-exposed infants have increased likelihood of child welfare involvement
- ❑ No strong evidence of substantiated maltreatment
- ❑ Overall literature is of poor methodological quality

Review Article

Prenatal Substance Exposure and Child Maltreatment: A Systematic Review

Anna E. Austin^{1,2}, Caitlin Gest¹, Alexandra Atkeson¹, Molly C. Berkoff³, Henry T. Puls⁴, and Meghan E. Shanahan^{1,2}

Abstract

State and federal policies regarding substance use in pregnancy, specifically whether a notification to child protective services is required, continue to evolve. To inform practice, policy, and future research, we sought to synthesize and critically evaluate the existing literature regarding the association of prenatal substance exposure with child maltreatment. We conducted a comprehensive electronic search of PubMed, Web of Science, PsycInfo, CHINAL, Social Work Abstracts, Sociological Abstracts, and Social Services Abstracts. We identified 30 studies that examined the association of exposure to any/multiple substances, cocaine, alcohol, opioids, marijuana, and amphetamine/methamphetamine with child maltreatment. Overall, results indicated that substance exposed infants have an increased likelihood of child protective services involvement, maternal self-reported risk of maltreatment behaviors, hospitalizations and clinic visits for suspected maltreatment, and adolescent retrospective self-report of maltreatment compared to unexposed infants. While study results suggest an association of prenatal substance exposure with child maltreatment, there are several methodological considerations that have implications for results and interpretation, including definitions of prenatal substance exposure and maltreatment, study populations used, and potential unmeasured confounding. As each may bias study results, careful interpretation and further research are warranted to appropriately inform programs and policy.

Keywords

child maltreatment, infants, substance abuse

Child Maltreatment
1-26
© The Author(s) 2021
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/1077559521990116
journals.sagepub.com/home/cmj



Drugs and Development: Measurement and Context

Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 85, No. 6
doi:10.1007/s11524-008-9315-6
© 2008 The New York Academy of Medicine

Illicit Drug Use and Adverse Birth Outcomes: Is It Drugs or Context?

Ashley H. Schempf and Donna M. Strobino

ABSTRACT Prenatal drug use is commonly associated with adverse birth outcomes, yet no studies have controlled for a comprehensive set of associated social, psychosocial, behavioral, and biomedical risk factors. We examined the degree to which adverse birth outcomes associated with drug use are due to the drugs versus surrounding factors. Data are from a clinical sample of low-income women who delivered at Johns Hopkins Hospital between 1995 and 1996 (n=808). Use of marijuana, cocaine, and opiates was determined by self-report, medical record, and urine toxicology screens at delivery. Information on various social, psychosocial, behavioral, and biomedical risk factors was gathered from a postpartum interview or the medical record. Multivariable regression models of birth outcomes (continuous birth weight and low birth weight ([LBW] <2,500 g)) were used to assess the effect of drug use independent of associated factors. In unadjusted results, all types of drug use were related to birth weight decrements and increased odds of LBW. However, only the effect of cocaine on continuous birth weight remained significant after adjusting for all associated factors (-142 g, p=0.05). No drug was significantly related to LBW in fully adjusted models. About 70% of the unadjusted effect of cocaine use on continuous birth weight was explained by surrounding psychosocial and behavioral factors, particularly smoking and stress. Most of the unadjusted effects of opiate use were explained by smoking and lack of early prenatal care. Thus, prevention efforts that aim to improve newborn health must also address the surrounding context in which drug use frequently occurs.

KEYWORDS Illicit drugs, Psychosocial factors, Pregnancy, Birth weight, Low birth weight

TABLE 3 Linear regression results of birth weight and drug use

	Marijuana coefficient (95%CI)	Cocaine coefficient (95%CI)	Opiates coefficient (95%CI)	Heavy smoking 10+ cigarettes per day coefficient (95%CI)	Heavy drinking daily/weekly coefficient (95%CI)
Unadjusted	-250.0 (-384.0, -116.0)***	-475.1 (-584.6, -367.7)***	-462.3 (-582.0, -342.5)***	-543.8 (-674.3, -413.3)***	-438.3 (-629.1, -247.5)***
Adjusted for other drug use	-0.2 (-140.6, 140.2)	-219.7 (-369.4, -70.0)**	-165.1 (-324.6, -5.5)*	-307.7 (-470.1, -145.3)***	-120.5 (-319.8, 78.8)
Social factors	12.7 (-127.6, 152.9)	-225.0 (-377.4, -72.8)*	-170.2 (-330.3, -10.1)*	-278.8 (-445.1, -112.6)**	-83.7 (-284.6, 117.1)
Social and psychosocial factors	7.7 (-131.5, 146.9)	-187.2 (-339.0, -35.5)*	-162.1 (-321.0, -3.1)*	-232.2 (-398.2, -66.2)**	-68.1 (-267.7, 131.5)
Social, psychosocial, and behavioral factors	10.1 (-128.2, 148.5)	-171.3 (-322.5, -20.1)*	-129.9 (-289.2, 29.5)	-225.9 (-391.0, -60.8)**	-46.3 (-245.3, 152.6)
Social, psychosocial, behavioral, and biomedical factors	-24.6 (-155.8, 106.5)	-142.0 (-285.8, 1.8)	-85.6 (-237.7, 66.4)	-158.2 (-315.9, -0.5)*	-30.6 (-219.4, 158.2)

Social factors include maternal age, money for necessities, and housing. Psychosocial factors include stress and pregnancy locus of control. Behavioral factors include early prenatal care. Biomedical factors include hypertensive disorders, other medical risk factors, prepregnancy weight, and net weight gain.

*p<0.05; **p<0.01; ***p<0.001

The assessment of substance use during the birthing hospitalization is not clinical care, not diagnosis, not treatment, and not prevention

“Equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons’ engagement with healthcare services.”

ASAM Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People, 10, 2022

“The laws, regulations, and policies that require health care practitioners and human service workers to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement.”

ACOG, Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period: Statement of Policy, 11, 2020

What do Pregnant and Parenting People with Substance Use Disorder Need; i.e. What Works?

- 1) Non-judgmental voluntary screening/assessment with immediate provision of treatment for those with substance use disorder
- 2) Better access to medication for opioid use disorder (methadone and buprenorphine)
 - Provision of split dosing for methadone
- 3) Chronic disease management for chronic conditions: Health insurance is not health care
 - Care continuation postpartum is critical
- 4) “Test and Report”: Child welfare policies should be based in science and center on those most affected



Thank you

Legislative Respondents



Speaker Pro Tempore Meade

Kentucky



Senator Plumb

Utah



Questions?



NCSL Resources

[Policy Levers for Preventing Child Maltreatment](#)

[Supporting Moms' Health in the Postpartum Period](#)

[Child Welfare Database](#)

[Opioid Abuse Prevention Database](#)

[Maternal and Child Health Database](#)



Next session starts: **2:45 pm**

- Grand Hyatt Conference Center—2nd Floor, Mt. Evans



Up Next!

