

BRIEF 1



HOW STATES SERVE INFANTS AND THEIR FAMILIES AFFECTED BY PRENATAL SUBSTANCE EXPOSURE

IDENTIFICATION AND NOTIFICATION

OVERVIEW

The National Center on Substance Abuse and Child Welfare (NCSACW), with support from the Administration on Children, Youth and Families (ACYF) Children’s Bureau (CB), has developed a series of briefs highlighting states’ approaches to serving infants and their families affected by prenatal substance exposure. These briefs derive from NCSACW’s review of states’ Annual Progress and Services Reports (APSRs) pertaining to Section 503 “Infant Plan of Safe Care” of the Child Abuse and Prevention Treatment Act (CAPTA) and years of practice-based experience providing technical assistance (TA) to support systems-level policy efforts and practice-level innovations to improve outcomes for these infants and families.

NCSACW HELPS STATES AND COMMUNITIES IMPROVE OUTCOMES FOR INFANTS AND THEIR FAMILIES AFFECTED BY PRENATAL SUBSTANCE EXPOSURE

Since the passage of the Comprehensive Addiction and Recovery Act (CARA) amendments to CAPTA in 2016, NCSACW has

- Responded to over 3,000 TA requests related to the prenatal substance exposure provisions in CAPTA, Plans of Safe Care, and neonatal abstinence syndrome
- Engaged 17 sites—including five Tribes and one county—in its In-Depth Technical Assistance program to support their efforts to implement the CARA amendments to CAPTA
- Convened two Policy and Practice Academies (2017, 2020) with 18 state teams and one county team to provide consultation on collaborative strategies to improve outcomes for infants and their families affected by prenatal substance exposure
- Supported two regional convenings—along with the Department of Health and Human Services regions 4, 6, 7, and 9, and their respective state teams—to advance their capacity to improve the safety, permanency, recovery, and well-being of infants and their families
- Visited eight state child welfare agencies in 2018 and 2019 to gain a greater understanding of the states’ policies and practices related to the CARA amendments to CAPTA. The site visits provided a forum to: 1) identify promising and best practices (as well as the challenges and barriers to the implementation of Plans of Safe Care), 2) learn about multidisciplinary efforts by the state to support implementation, and 3) identify TA needs
- Conducted 40 virtual and in-person interviews with child welfare, substance use treatment, healthcare, and legal professionals to gather information on how states and localities are serving infants and their families affected by prenatal substance exposure



BRIEFS IN THIS SERIES

BRIEF 01 • *Identification and Notification*

BRIEF 02 • Plans of Safe Care Data and Monitoring

BRIEF 03 • Lessons from Implementation of Plans of Safe Care

INTRODUCTION

CAPTA was amended by the [Comprehensive Addiction and Recovery Act \(CARA\)](#) in 2016. The legislation changed some requirements of states' assurances related to Plans of Safe Care. Families falling under the new requirements included infants born with, and identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder, and their affected family or caregivers.¹ There is also a provision that health care providers involved in the delivery or care of such infants notify their local Child Protective Services (CPS) system.

Brief #1: Identification and Notification summarizes steps states took to implement the CARA amendments to CAPTA. This brief focuses on modifications to state statutes of child abuse and neglect, establishing a difference between notifying and reporting to CPS, and developing shared definitions to identify and serve infants and their families affected by prenatal substance exposure.

STATUTE MODIFICATIONS

States have a wide range of experiences implementing the CARA amendments to CAPTA as specific child maltreatment statutes guide agency policies, procedures, and strategies that states operationalize.

Since 2018, 28 states have described modifications to their state statutes in their APSRs. Most of these modifications took place in 2017 following the passage of the CARA amendments to CAPTA. For many states, statute modifications were an initial step toward achieving compliance with CARA. The most common changes related to

- Modifying the statutory definition of child maltreatment to include aspects of prenatal substance exposure
- Changing the process for notifying CPS about infants identified as affected by prenatal substance abuse

From NCSACW's work providing technical assistance, stakeholders have reported that child maltreatment statutes can deter pregnant women from seeking health care, including early prenatal care and substance use disorder treatment, to avoid a maltreatment report to CPS at the time of delivery.



Some states have modified their statutes to clarify identification, notification, and reporting; and to achieve broader engagement of other systems to meet the CARA amendments to CAPTA, including designating other systems beyond child welfare to develop a Plan of Safe Care.

NCSACW has found that a distinction between a report and notification to CPS can support parental engagement in services and increase provider engagement in the development of Plans of Safe Care. Implementing Plans of Safe Care for infants and their families or caregivers not involved in the child welfare system through partnerships with community-based agencies can provide access to needed services and supports while preventing future child welfare involvement.

STATE HIGHLIGHT: NEW MEXICO

In July 2019 New Mexico implemented [House Bill 230: Plans of Care for Substance-Exposed Newborns](#). The law requires health care professionals to assess whether an infant has been exposed to substances at birth. Plans of Care are required for any newborn identified as having been exposed to any substance at any time during the pregnancy. Once the health care professional creates a Plan of Care, they must make a referral to the Medicaid managed care organization or children’s medical services for care coordination and monitoring.



This law also changed New Mexico’s Children’s Code to specify that substance use on its own is not considered abuse or neglect. Health care professionals concerned about a parent’s ability to care for the infant still make referrals to New Mexico’s Children, Youth and Families Department (CYFD). The change in the statute is designed to help families remain together, mitigate safety concerns, and provide individualized support and services.

New Mexico is currently gathering data directly from families who participated in a Plan of Care to understand what worked well and identify opportunities for improvement. New Mexico is also examining its child welfare data for families with a Plan of Care to understand how many had CYFD involvement and where the infants currently reside (in state custody, with biological parents, or other placements). In the future, New Mexico plans to do a comparison study using a cohort of families that had an infant with prenatal substance exposure and CYFD involvement prior to the state law change to determine any differences in child welfare outcomes.

STATE HIGHLIGHT: LOUISIANA

In 2017 Louisiana passed [House Bill 678, Act 359](#) to establish “if a newborn exhibits symptoms of withdrawal or other observable and harmful effects in his physical appearance or functioning that a physician believes are due to the use of a controlled dangerous substance, as defined by R.S. 40:961 et seq., in a lawfully prescribed manner by the mother during pregnancy, the physician shall make a notification to the Department of Children and Family Services (DCFS) on a form developed by the department. Such notification shall not constitute a report of child abuse or prenatal neglect, nor shall it require prosecution for any illegal action.”



The state’s *Physician Notification of Substance Exposed Newborns, No Prenatal Neglect Suspected* form is for data-gathering purposes and provides DCFS with the following essential information:

- Substances to which the newborn was exposed, if known
- Whether or not a neonatal abstinence screening was completed
- Pertinent discharge referral information and educational resources provided to the mother, if applicable.

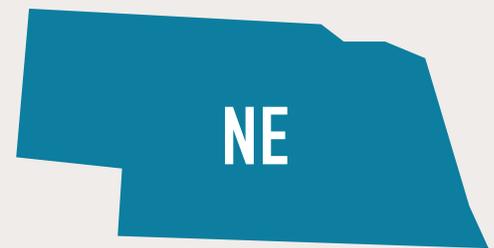
THE DIFFERENCE BETWEEN NOTIFICATION AND REPORT TO CHILD PROTECTIVE SERVICES

Although CAPTA includes a requirement that health care providers involved in the delivery or care of “infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder” notify the CPS system, it does not establish a definition under federal law of what constitutes child abuse or neglect. The ACYF Program Instruction from January 2017 ([ACYF-CB-PI-17-02](#)) notes that “the focus of the provision is on identifying infants at risk due to prenatal substance exposure and on developing a plan to keep the infant safe and address the needs of the child and caretakers. Further, the development of a Plan of Safe Care is required whether or not the circumstances constitute child maltreatment under state law.”

States have reported stakeholder engagement has improved, including with health care providers, when notification and reporting pathways are clear. Lessons from states engaged with NCSACW show that standardization and clarity: 1) alleviate provider concerns about reporting infants and their families to CPS when they have not identified child maltreatment concerns; and 2) mitigate potential negative consequences for the infant and family, such as removing the infant from the mother when there are no immediate safety concerns for the infant.

STATE HIGHLIGHT: NEBRASKA

Nebraska’s Department of Health and Human Services created two pathways for health care providers involved in the delivery or care of substance-affected infants to notify CPS.



- If health care providers identify an infant either unsafe or at risk of abuse or neglect, they must report their concerns to the Nebraska Child Abuse and Neglect Hotline.
- If health care providers do not have child safety concerns, they can notify CPS using a form that does not provide identifying information. The following are criteria for a notification to CPS:
 - Mother is stable and engaged in opioid medication-assisted treatment with a licensed physician
 - Mother is receiving treatment with opioids for chronic pain by a licensed physician
 - Mother is stable and engaged in treatment for other non-opioid substance use—including alcohol—with a licensed provider or physician, or she is considered stable in a recovery program
 - Infant is at risk for fetal alcohol spectrum disorder
 - Mother is engaged in substance use or misuse (including marijuana), but the situation does not present a concern about abuse or neglect, which would require filing a report. This determination requires a physician’s judgment.

Most states do not have a notification process separate from their reporting process for child abuse and neglect. States with a distinct notification pathway for infants not at risk of child abuse or neglect (but which still require a Plan of Safe Care) have achieved this in a variety of ways. In some states, the health care provider makes the initial notification to the CPS hotline and the staff at the hotline refers the family to a contracted agency to develop and implement a Plan of Safe Care. Other states have opted to have health care providers either develop the Plan of Safe Care or refer families directly to the contracted agency.

NCSACW found that the collaborative development of notification pathways enhanced partnerships between local hospitals and child welfare departments while supporting increased information sharing and care coordination for families. Developing a distinct notification process can clarify the difference between a family in need of services and supports, and a family with child maltreatment concerns that requires oversight and support from child welfare agencies.

Without a distinct notification process, some health care providers may opt to only make reports under mandated reporting requirements, missing the opportunity to support infants and their families or caregivers with Plans of Safe Care that do not present with child maltreatment concerns.



States use multiple approaches, in addition to developing notification pathways, to respond to notifications. These include:

- Using existing alternative response pathways in which an assigned caseworker assesses family needs and connects the families to services. Child welfare caseworkers typically develop and oversee the Plan of Safe Care in this model.
- Contracting with an agency outside the child welfare system for low-risk cases. A community provider supports families typically screened out and not provided additional CPS services or referrals. For example, when infants have exposure to legally prescribed medications such as methadone, buprenorphine, benzodiazepines, or opioids for pain management, certain states will not open a CPS case if there are no other abuse or neglect concerns. This pathway offers continued support through community providers without increasing the number of families involved in CPS.

STATE HIGHLIGHT: CONNECTICUT

In 2019 Connecticut launched an online portal for hospital health care providers to enter information for all infants identified as affected by substance abuse, withdrawal symptoms, or a fetal alcohol spectrum disorder. The health care provider enters information about the family and the risk to the child, and the portal system generates information on whether the health care provider needs to make a report of potential child abuse or neglect—or a notification of the identification of an affected infant—and that a Plan of Safe Care was developed.



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 CPS report. If the family requires a notification, the health care provider develops a Plan of Safe Care with the parents. Child welfare receives and de-identifies personal information on the notification form, which includes zip code and demographics. The child welfare system then aggregates the data to better assess needs, allocate resources, and identify differences in notifications and Plans of Safe Care. The portal also provides this data reports for the state to report on the number of infants affected by prenatal substance exposure, for whom a plan of safe care was developed, and for whom a referral for services was made.

DEFINITIONS OF INFANTS “AFFECTED BY” PRENATAL SUBSTANCE EXPOSURE

CAPTA does not define or provide a list of diagnostic criteria for “infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder.”² States have flexibility to define this group, and the definition each state develops has implications for which infants and their families or caregivers receive a Plan of Safe Care.ACYF notes that states have flexibility “so long as the state’s policies and procedures address the needs of infants born affected by both legal (e.g., prescribed drugs) and illegal substance abuse.”³

Defining terminology is another step some states undertook to implement the CARA amendments to CAPTA as they reviewed their statutes and updated their policies and practice guidance. Since 2018 a total of 19 states have described in their APSR a definition of “affected by” prenatal substance exposure as part of either state statute or operating procedures.

States have a range of detail and complexity in their definitions. The strategies states use to create their definitions have varied. Some have used their collaborative teams including hospitals and other health care providers to develop shared definitions across systems while others have had CPS create the definitions and disseminate them to health care providers. Engaging health care providers in developing definitions provides credibility to the process and may identify champions who can provide leadership and support for statewide implementation.

Some states define “affected by” based on results of a toxicology screen of the infant, the mother, or both during pregnancy (and at the time of birth) to identify exposure. Other states rely on health care practitioner assessments based on the mother’s health care, substance use, and mental health history, along with observation of the infant and prenatal care history. Stakeholders involved in the care of infants and families affected by prenatal substance exposure note that inconsistencies and bias in hospital screening practices can result in differences in notifications to CPS and subsequent child welfare system involvement.

States report that having a clear definition of “affected by” offers an important starting point to determine which infants require a notification (or report) to CPS—and a Plan of Safe Care—to understand and resolve the health, social, and developmental needs of the infant and affected family or caregiver.

The definition of “affected by” influences both families and the multiple providers and agencies they interact with—including prenatal care providers, birthing hospital staff, public health nurses, child welfare agencies, and substance use disorder treatment providers. Each system provides a unique and important perspective:

- Health care focuses on the physiological effects of exposure on the infant and mother
- Substance use disorder treatment focuses on parental substance use and recovery
- Child welfare focuses on risk, safety, and the well-being of children

State collaborative teams that developed definitions of “affected by” achieved consensus from stakeholders by including perspectives of representatives from these multiple systems, as well as from individuals with direct experience. Bringing stakeholders together early and often helped increase cross-system buy-in of the final definitions while supporting implementation and practice changes.



DEFINITIONS OF “AFFECTED BY” VARY ACROSS STATES:

Ohio



“**Substance affected infant**” means a child under the age of 12 months who has any detectable physical, developmental, cognitive, or emotional delay or harm associated with a parent, guardian, or custodian’s abuse of a legal or illegal substance, excluding the use of a substance by the parent, guardian, or custodian as prescribed.

“**Substance exposed infant**” means a child under the age of 12 months who has been subjected to legal or illegal substance abuse while in utero.

Rhode Island



“**Affected by substance abuse**” means either the mother has misused a legal substance or used an illicit substance.

“**Affected by withdrawal**” means a group of behavioral and physiological features in the infant that follow the abrupt discontinuation of a substance that has the capability of producing physical dependence. No clinical signs of withdrawal in the neonate should be attributed to in utero exposure to alcohol or other drugs without appropriate assessment and diagnostic testing to rule out other causes.

“**Fetal alcohol spectrum disorders**” means the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

“**Substance-exposed newborn**” means a newborn who was exposed to alcohol and/or a controlled substance (illicit or prescribed) ingested by the mother in utero. This exposure may be detected at birth through a drug screen or through withdrawal symptoms.

“**Neonatal abstinence syndrome**” means a group of signs and symptoms that sometimes occur in a newborn who was exposed to opiate drugs while in utero.

New Jersey



A substance-exposed infant is an infant:

- Whose mother had a positive toxicology screen for a controlled substance or a metabolite thereof during pregnancy or at the time of delivery
- Who has a positive toxicology screen for a controlled substance after birth, which is reasonably attributable to maternal controlled substance use during pregnancy
- Who displays the effects of prenatal controlled substance exposure or symptoms of withdrawal resulting from prenatal controlled substance exposure

POLICY AND PRACTICE IMPLICATIONS

Stakeholder engagement and buy-in across systems, including from infant and maternal health care providers, are needed to develop distinct pathways for notification and reporting to CPS. Health care providers are more consistent with both notification and reporting to CPS when they: 1) engage in discussions about notification procedures and Plans of Safe Care; 2) offer input to statute modifications, policy, practice, and protocol development; and 3) clearly understand the child welfare response.

Child welfare agencies that distinguish between a notification and report can help communities see a distinction between prenatal substance exposure alone and prenatal substance exposure accompanied by child safety concerns and risk factors. They can also target services and supports more precisely to prevent child welfare involvement and meet families' needs. When various community partners share responsibility with child welfare for developing and providing oversight of Plans of Safe Care, families are likely to have more timely access to a broader array of services and supports.

- [*Plans of Safe Care Learning Modules*](#): This series of five modules provides state, Tribal, and local decision makers and practitioners with information, considerations, and tools to create cross-systems collaboration and implement policies and practices meeting the complex needs of infants affected by substance abuse, withdrawal symptoms, or a fetal alcohol spectrum disorder. Collectively, the five modules describe a comprehensive, collaborative approach to ensure the safety and well-being of these infants and their families. Each module describes important considerations and effective practices on the topic and provides brief examples of practice and policy from successful collaborative partnerships.

REFERENCES

- 1 Administration on Children, Youth and Families. Children's Bureau (2017). Program Instruction: ACYF-CB-PI-17-02. <https://www.acf.hhs.gov/sites/default/files/documents/cb/pi1702.pdf>.
- 2 CAPTA as amended by P.L. 115-271, including the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act: <https://www.acf.hhs.gov/sites/default/files/documents/cb/capta.pdf>.
- 3 Administration on Children, Youth and Families. Children's Bureau (2017). Program Instruction: ACYF-CB-PI-17-02. <https://www.acf.hhs.gov/sites/default/files/documents/cb/pi1702.pdf>.



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