



What The Data on Infants and Toddlers Tell Us: The Intersection of Parental Substance Use and Child Welfare



ZERO TO THREE
Early connections last a lifetime

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An effective public health approach to family strengthening requires partners in early childhood systems to address the factors and conditions that affect families as early as possible to prevent more significant, negative long-term outcomes. An early childhood system brings together health (holistically defined and for all members of the family), child welfare including the dependency court, early care and education, other human services, and family support program partners - as well as community leaders, families, and other partners - to achieve agreed-upon goals for thriving children and families. When infants, toddlers, and parents have the supports and skills they need to succeed, families are stronger and more stable. The National Resource Center for the Infant-Toddler Court Program (NRC) works with states and communities to build their capacity to address the adversity families face and prevent the removal of infants and toddlers from their parents.

The impacts of parental substance use¹ on very young children are well-documented, including the numerous negative effects on health, development, and overall well-being. Parental substance use is the leading driver of child welfare involvement for infants and toddlers. Substance use in pregnancy or in families is not maltreatment in and of itself, but it is associated with other factors that may negatively influence caregiving and increase risk for child abuse and neglect. Parents with substance use disorders (SUD) are often stigmatized or punished, which can have adverse impacts on the whole family. Implementing policies and practices that support recovery and heal trauma, strengthen parent-child relationships, and provide concrete wraparound support will give families the best opportunities for success.



Multiple policy options exist for states and systems to support families impacted by parental substance use addressing the needs of the whole family and prioritize the safety and well-being of the children. The policies highlighted in this brief disrupt stigma and promote non-punitive responses to substance use that can otherwise harm the parent-child bond and create barriers to appropriate services.

Oftentimes, for families at risk of child welfare involvement, parental substance use is co-occurring with mental health issues, histories of trauma, chronic medical conditions and/or intellectual disabilities. Many families are unable to access critical health services, including mental health and substance use treatment, potentially increasing the risk of child welfare placement and prolonging the time their children spend in out-of-home care. Research shows that cases of child neglect are frequently tied to lack of access to appropriate treatment or supports for the parent and that increasing access to a continuum of preventive services can help keep the family together.¹

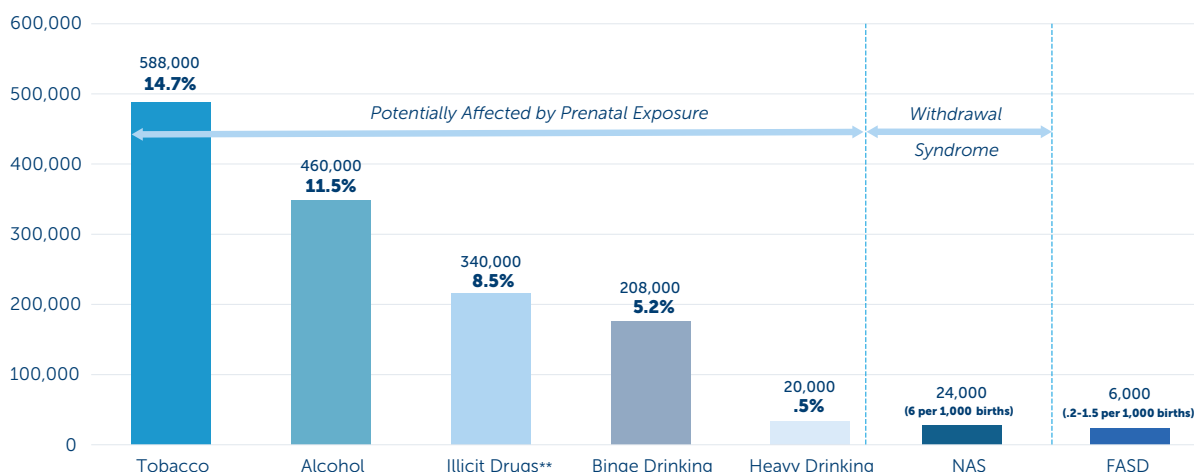
¹ Throughout this brief, substance use primarily refers to the use of illicit substances, including non-medical use of prescriptions; however, the use of legal substances (e.g., alcohol, tobacco) remains a critical public health concern that affects family and child well-being.

This data brief highlights the prevalence and impacts of parental substance use on the lives of very young children, which if unaddressed, can lead to child welfare involvement. Children ages birth to three-years-old are overrepresented in child welfare systems compared to older children and youth, and the data tell us that actionable policy solutions are needed. This brief offers a selection of policy opportunities from *Strengthening Families with Infants and Toddlers: A Policy Framework for States* for systems leaders to consider.

Prenatal substance exposure to both illicit drugs and legal substances can have significant effects on fetal development and remains a critical public health concern. The data below are compiled from published research, including studies of federal datasets, to provide a snapshot of trends in prenatal substance exposure.

- Of children under age 3 in U.S. households, 12.8 percent—or 1.5 million—had a parent with a substance use disorder, and 7.5 million lived in households with at least one parent who had an alcohol use disorder. (based on data collected from 2009-2014)ⁱⁱ
- Consuming alcohol during pregnancy is linked with an increased risk that the baby will develop Fetal Alcohol Spectrum Disorders (FASD).ⁱⁱⁱ 1 in 20 pregnant people reported binge drinking (consuming 4 or more drinks on one occasion at least once in the past 30 days).
- It is likely that FASDs are under-diagnosed across age groups because of factors like complexity in diagnostic formulation and stigma.^{iv} Estimates of the prevalence of Fetal Alcohol Syndrome and FASDs are higher among children in child welfare— 6% and 17% respectively.^v
- Neonatal Abstinence Syndrome (NAS), which affects infants exposed to opioids and other substances in utero, has increased by 82% between 2010 -2017.^{vi, vii, viii} More research is needed to understand the short- and long-term impacts of NAS on babies. Some research has shown an association between poorer neurodevelopmental outcomes from one year of age through adolescence for children born with NAS.^{ix}
- Research shows that polysubstance use, or the use of multiple substances, is common among pregnant people. More research is needed to fully understand the impacts of polysubstance use on the health, growth, and well-being of infants.^x

Estimated Number of Infants* Affected by Prenatal Exposure, by Type of Substance and Infant Disorder, 2017



*Approximately 4 million (3,855,500) live births in 2017; National Vital Statistics Report, Vol.67 No. 8; https://www.cdc.gov/nchs/data/nvsr67/nvsr67_08-508.pdf
 Estimates based on rates of past month drug use: National Survey on Drug Use and Health, 2017; <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUH-DetailedTabs2017.pdf>

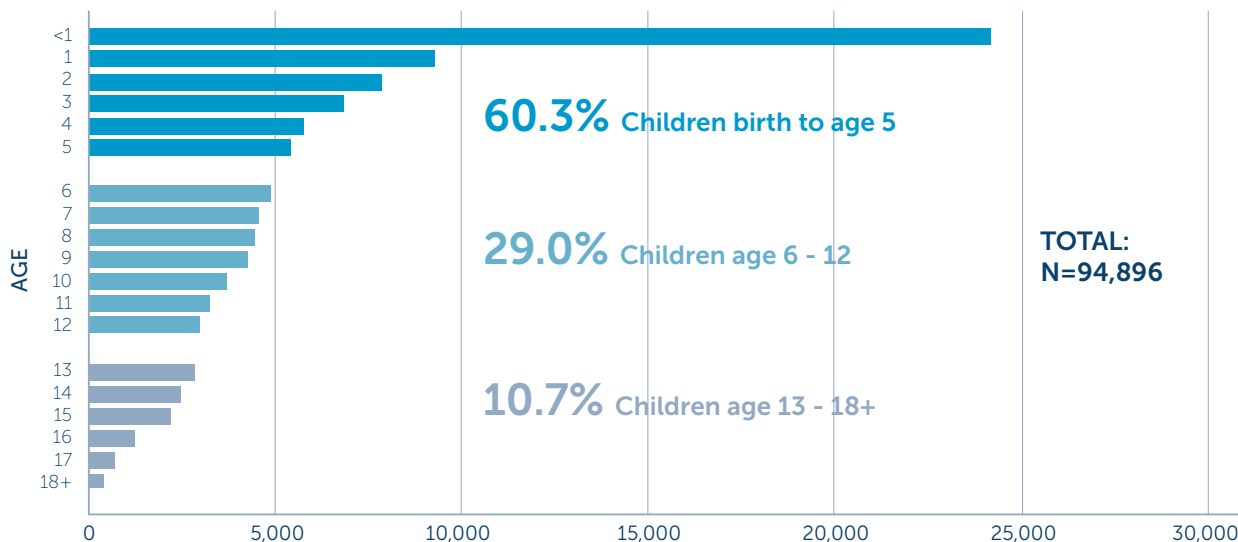
**Includes nine categories of illicit drug use: use of marijuana, cocaine, heroin, hallucinogens, inhalants, and methamphetamine, as well as the non-medical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives

(U.S. Department of Health and Human Services, 2018; Center for Behavioral Health Statistics and Quality, 2018; Patrick et. al., 2015; Milliren et. al., 2017; CDC, 2002)

While parental substance use continues to be a major driver of child welfare involvement for children of all ages, young children ages birth to five are the most likely to come into the child welfare system as a result of parental substance use.

- Children ages birth to five are entering foster care more often (60%) because of a parent’s drug or alcohol use when compared to older children and youth (ages 6-12 - 29%; ages 13-18 - 10%)^{xi}
- Infants under the age of 1 are the fastest growing age group of children entering foster care. Between 2011 and 2018, there was a 24% increase in infants being placed in foster care (~50,000 infants in 2018).^{xiii}
- Prenatal exposure to substances is linked with higher rates of child welfare involvement for babies under one year of age. More than 61% of infants with substance exposure at birth are reported to child protective services before they turn one year old, which is much higher than babies who are not substance exposed (4.5% referred to child welfare).^{xiv}
- The Health Resources and Services Administration projects demand for behavioral health treatment services to outpace growth in the workforce. In fact, a shortage of over 11,000 addiction counselors is forecasted between 2017-2030, which implies increasing challenges for families in finding the care they need.^{xv} Many rural areas already experience a shortage of services due in part to the lack of qualified professionals, including providers of medication for addiction treatment (MAT) for opioid users.^{xvi}
- As of 2018, just 23% of substance use disorder treatment facilities offered programs focused on supporting pregnant and postpartum people.^{xvii}

Number of Children who Entered Out-of-Home Care with Incidence of Parental Alcohol or Drug Abuse as an Identified Condition of Removal, by Age at Removal in the United States, 2019



Child welfare and alcohol and drug use statistics. (n.d.). National Center on Substance Abuse and Child Welfare. Retrieved January 6, 2023, from <https://ncsacw.acf.hhs.gov/research/child-welfare-and-treatment-statistics.aspx>.

Note: Estimate based on children who entered out-of-home care during Fiscal Year

Source: AFCARS Data 2019 v1



OPPORTUNITIES

A continuum of supports— from prevention to early intervention to treatment— is key to addressing substance use among parents, preventing or minimizing the involvement of child welfare, and reducing stigma surrounding the need for help. Child welfare agencies should partner with community and state systems and work together to identify parental substance use as early as possible and build a continuum of care that can meet the child and family’s needs. State leadership can make positive impacts on family well-being through policy change across multiple areas where families may seek help, including adult- and child-serving systems.

While there is tremendous stigma around both parental substance use and child welfare involvement, there are also many opportunities to disrupt stigma and partner with parents in meaningful and trauma-responsive ways that can help improve the health and well-being of the child. Stigma is pervasive and is perpetuated by punitive policies toward parents, community culture and beliefs, and systemic racism, which can result in additional barriers for families of color, and an individual’s feelings of shame surrounding their disease and systems involvement. Not only can stigma make parents fearful of seeking substance use treatment because of the risk of initiating a child welfare allegation, but stigma also has been shown to further traumatize those with substance use disorders.^{xviii} In fact, in some states, seeking substance use treatment while pregnant can result in automatic involvement of child welfare and/or criminal charges, which can deter parents from getting the help they need as early as possible during pregnancy or postpartum.^{xix, xx, xxi}

Multiple policy options exist for systems leaders to disrupt stigma and promote non-punitive responses to substance use that can otherwise harm the parent-child bond and create barriers to appropriate services. The policy strategies outlined below, while not exhaustive, provide potential solutions for states to identify issues early and keep families together while also ensuring children are safe and their needs are met. Additional strategies can be found in [*Strengthening Families with Infants and Toddlers: A Policy Framework for States*](#).

Adopt universal screening. Provide universal screening during pregnancy to increase detection of prenatal substance use, increase awareness among pregnant people of the risks of substance use, and increase prevention and early intervention opportunities. Ideally, the screening would occur during the first prenatal visit, with a validated verbal screening tool. Universal screening that connects families to treatment early, both before and during pregnancy, can keep families together, reach more families, and greatly reduce biases toward different racial, ethnic, and socioeconomic groups.

Improve policies and practices related to reporting and investigating child maltreatment. State child welfare agencies can reevaluate their maltreatment definitions with a focus on distinguishing low-risk, poverty-related neglect and using non-punitive approaches to provide supports to impacted families. States can also create alternative, non-investigative pathways for reporting low-risk concerns (such as helplines) and coordinate responses with non-child welfare entities as appropriate to enhance the ways in which mandated reports can support families.

Provide a comprehensive array of screening, diagnostic, treatment, and support services to families with very young children.

States have an opportunity through Plans of Safe Care (POSC) to implement a comprehensive and multi-disciplinary planning approach with families during pregnancy and postpartum if the infant has had prenatal substance use exposure.^{xxii} The process is typically facilitated by a health care provider or the child welfare agency, with the aim of putting the needed supports/services in place that will follow the family and protect the health and well-being of the infant. Some states have gone beyond the minimum federal requirements and expanded their POSC programs to include infants and families not yet involved in child welfare. States have also made strides in aligning other initiatives with shared goals (e.g., Perinatal Quality Collaboratives²). The teams that support POSC include a range of professionals and paraprofessionals, and increasingly, teams are expanding to include parents/individuals with lived experience as supports/resources for the parents. Promising outcomes from some states have shown that POSC and Family Care Plans have reduced child welfare involvement and led to increased engagement of the parent in recovery/treatment services.^{xxiii}

States can also build the capacity of providers by supporting the adoption of evidence-based treatment strategies such as MAT, and in some instances, states may be able to encourage the uptake of evidenced treatments through state or federal funding opportunities. Capacity for this can be bolstered at the federal level by supporting legislation that increases access to medications for addiction treatment and medications to treat opioid use disorder. Evidence-based treatment, including long term MAT, has been shown to decrease substance use rates and decrease the risk of overdose death.^{xxiv} MAT is essential and lifesaving for families struggling with substance use and is clinically proven as safe and effective for women who are pregnant and postpartum.^{xxv}

Increase availability of family-based substance use disorder treatment services.

This would include residential treatment programs for parents with very young children where the child is allowed to stay in the residential facility with the parent. A family-centered approach to SUD treatment provides a comprehensive array of clinical treatment and related support services that meet the needs of each member in the family, not just of the individual requesting care. Providing timely referrals to substance use treatment services for parents, particularly those approaches that are family focused and oriented toward the parent–child relationship, can help prevent maltreatment, reduce the need for child removals, and increase the likelihood of reunification of children with their families.



² State-based teams that focus on improving the quality of care for mothers and babies with an emphasis on health care outcomes, including maternal and infant mortality/morbidity.

Use Family First Prevention Services Act and other federal funding to support a continuum of services for families at risk of entering the child welfare system, including addressing housing needs and other social determinants of health.

States with approved Title IV-E Prevention Program Plans can utilize funding to help ensure families receive evidence-based mental health, substance use, and parenting services as part of an array of supports focused on keeping children’s early development on track. The Title IV-E Prevention Services Clearinghouse has identified multiple evidence-based early childhood interventions to support children and families and prevent foster care placement that states can include in their Title IV-E plans.^{xxvi} States can opt to include infants with prenatal exposure as ‘candidates for foster care’ as an eligible at-risk population for Title IV-E Prevention Services. Title IV-E Prevention Services can be provided to children at-risk for foster care entry and their families as per the state’s approved Title IV-E Prevention Plan.

State Medicaid programs also provide an avenue to support the social determinants of health, as seen in recently approved state Medicaid waivers.^{xxvii} Policies for continuous eligibility allow people to keep their Medicaid coverage without disruption and ensure that Medicaid members can access care on an ongoing basis for a variety of needs, including health, mental health and substance use, or other supports. Absent universal, federal Medicaid expansion, states are leading the way in creating mechanisms for ongoing access to these services and supports. For instance, Oregon is offering continuous Medicaid eligibility for children from birth to 6 years old and two years of continuous coverage for Medicaid enrollees ages 6 and older. Oregon’s 1115 Demonstration Waiver also adds benefits for housing supports (e.g., rental assistance), nutrition assistance, and protection from climate events (e.g., upgrades to heating/air conditioning).^{xxviii}

Create a network of family support partners and mentors to help parents successfully navigate the child welfare and court processes.

States have options to develop programs and related policies to include parent partners and parent mentors as support for families in the child welfare system, including during the investigation process. Parent partners and mentors bridge connections to additional supports, and for instance, could support families in linking across multiple service systems, including prenatal and postpartum services, behavioral health, courts, and child welfare. The emerging research shows that families who work with parent partners have a higher likelihood of reunification.^{xxix} In developing a new program, or adapting an existing approach, consider available research and evidence on effectiveness, including how the program incorporates cultural competency in working with families of color.



CONCLUSION

The NRC strives to support families affected by substance use, trauma, and mental health challenges. Through our work with states, we focus on cross-system collaboration and integration between all early childhood systems that support families affected by substance use. We envision that states will develop a continuum of services and increase timely and equitable access to those services. We provide technical assistance to states to support a shared understanding of the stressors and needs young families with infants and toddlers face as well as the stigma that is constantly present for them.

States have an opportunity to transform the way that families with substance use experience the child welfare system. Our hope is that by implementing the policies and practices discussed here, infants, toddlers and their families can experience healing and recovery and less risk of involvement with the courts and child welfare system.

ACKNOWLEDGMENTS

This program was made possible through the support of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$5,000,000 with 0 percent financed from non-governmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government. For more information, please visit [HRSA.gov](https://www.hrsa.gov).

ZERO TO THREE deeply appreciates Ballmer Group for its generous support of our work to scale the Safe Babies approach. We'd like to especially thank Connie Ballmer for her vision and commitment to transforming the child welfare system so that all babies thrive. Ballmer Group is committed to improving economic mobility for children and families in the United States, funding leaders and organizations that have demonstrated the ability to reshape opportunity and reduce systemic inequities.

ENDNOTES

- i Rostad, W., Rogers, T., & Chaffin, M. (2016). The influence of concrete support on child welfare program engagement, progress, and recurrence. *Children and Youth Services Review*; 72: 26–33. doi: 10.1016/j.chilyouth.2016.10.014.
- ii Lipari, R. & Van Horn, S. (2017). Children living with parents who have a substance use disorder. Retrieved December 19, 2022, from https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html
- iii Fetal alcohol spectrum disorders: Alcohol use and binge drinking among pregnant people in the United States. (2022). <https://www.cdc.gov/ncbddd/fasd/features/alcohol-use-and-binge-drinking.html#:~:text=About%201%20in%20%20pregnant,those%20aged%2035%E2%80%9349%20years>.
- iv Wozniak, J. Riley, E. & Charness, M. (2019). Diagnosis, epidemiology, assessment, pathophysiology, and management of fetal alcohol spectrum disorders. *Lancet Neurol*. 2019 Aug; 18(8): 760–770. Retrieved January 6, 2023, from, [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6995665/#:~:text=Although%20FASD%20is%20as%20common,Deficit%20Hyperactivity%20Disorder%20\(ADHD\)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6995665/#:~:text=Although%20FASD%20is%20as%20common,Deficit%20Hyperactivity%20Disorder%20(ADHD)).
- v Understanding fetal alcohol spectrum disorders: Child welfare practice tips. (n.d.). National Center on Substance and Child Welfare. Retrieved November 7, 2022, from <https://ncsacw.acf.hhs.gov/files/fasd-tip-sheet-cw.pdf>
- vi Pregnancy data and statistics. (2021). Centers for Disease Control and Prevention. Retrieved from <https://www.cdc.gov/pregnancy/opioids/data.html#:~:text=Neonatal%20Abstinence%20Syndrome&text=That%20is%20approximately%20one%20baby,80%20newborns%20diagnosed%20every%20day>.
- vii Anbalagan, S., & Mendez, D. (2022). Neonatal abstinence syndrome. StatPearls. Retrieved September 29, 2022, from <https://www.ncbi.nlm.nih.gov/books/NBK551498/#:~:text=During%20pregnancy%2C%20substance%20abuse%20is,minutes%20in%20the%20United%20States>.
- viii Hirai, A, Ko, J., & Owens, P. (2021). Neonatal abstinence syndrome and maternal opioid-related diagnoses in the US, 2010–2017. *JAMA*; 325(2): 146–155. doi:10.1001/jama.2020.24991
- ix Ibid.
- x Polysubstance use in pregnancy. (2020). Centers for Disease Control & Prevention. Retrieved September 29, 2022, from <https://www.cdc.gov/pregnancy/polysubstance-use-in-pregnancy.html>
- xi Child welfare and alcohol and drug use statistics. (2019). National Center for Substance Use and Child Welfare. Retrieved September 29, 2022, from <https://ncsacw.acf.hhs.gov/research/child-welfare-and-treatment-statistics.aspx>
- xii Substance use disorder in pregnancy: Improving outcomes for families. (2022). The White House Executive Office of the President, Office of National Drug Control Policy. Retrieved October 31, 2022, from https://www.whitehouse.gov/wp-content/uploads/2021/10/ONDCP_Report-Substance-Use-Disorder-and-Pregnancy.pdf
- xiii Crouse, G., Ghertner, R., Madden, E., and Radcl, L. (2021). Foster care entry rates grew faster for infants than children of other ages, 2011–2018. Retrieved October 31, 2022, from <https://aspe.hhs.gov/index.php/reports/foster-care-entry-rates-2011-2018>
- xiv Prindle, J. J., Hammond, I., & Putnam-Hornstein, E. (2018). Prenatal substance exposure diagnosed at birth and infant involvement with child protective services. *Child Abuse & Neglect*, 76, 75–83.
- xv Behavioral health workforce projections, 2017–2030. (n.d.). Retrieved September 29, 2022, from <https://bhwhrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf>
- xvi Lister, J. et al. (2019). A systematic review of rural-specific barriers to medication treatment for opioid use disorder in the United States. *The American Journal of Drug and Alcohol Abuse*, 46:3, 273–288, DOI: 10.1080/00952990.2019.1694536
- xvii Meinhofer A., Hinde J., Ali M. (2020). Substance use disorder treatment services for pregnant and postpartum women in residential and outpatient settings. *Journal of Substance Abuse Treatment*. 2020;110:9–17. doi:10.1016/j.jsat.2019.12.005

-
- xviii Disrupting stigma: How understanding, empathy and connection can improve outcomes for families affected by substance use and mental disorders. (n.d.) National Center for Substance Abuse and Child Welfare. Retrieved September 29, 2022, from <https://ncsacw.acf.hhs.gov/files/disrupting-stigma-brief.pdf>
- xix Criminalizing pregnancy: policing pregnant women who use drugs in the USA. (2017). Retrieved September 29, 2022, from <https://www.amnestyusa.org/reports/criminalizing-pregnancy-policing-pregnant-women-use-drugs-usa/>
- xx Parental substance use as child abuse. (2019). Children’s Bureau. Retrieved September 29, 2022, from <https://www.childwelfare.gov/pubPDFs/parentalsubstanceuse.pdf>
- xxi Public policy statement on substance use and substance use disorder among pregnant and postpartum people. (2022). American Society of Addiction Medicine. Retrieved October 31, 2022, from <https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/10/12/substance-use-and-substance-use-disorder-among-pregnant-and-postpartum-people>
- xxii Plans of Safe Care for infants with prenatal substance exposure and their families. (2019). Retrieved January 6, 2023, from <https://www.childwelfare.gov/pubPDFs/safecare.pdf>
- xxiii How states serve infants and their families affected by prenatal substance exposure: Brief 3 – lessons from implementation of plans of safe care. (n.d.). Retrieved January 6, 2023, from <https://ncsacw.acf.hhs.gov/files/prenatal-substance-exposure-brief3.pdf>
- xxiv Wakeman S., et al. (2020). Comparative effectiveness of different treatment pathways for opioid use disorder. *JAMA Network Open*. 3(2):e1920622. doi: 10.1001/jamanetworkopen.2019.20622.
- xxv Ibid.
- xxvi Title IV-E prevention services clearinghouse. (2022). Retrieved October, 31, 2022, from <https://preventionser-vices.acf.hhs.gov/program>
- xxvii Hinton, E. & Stolyar, L. (2021). Medicaid authorities and options to address social determinants of health. Retrieved January 26, 2023, from: <https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/>
- xxviii What’s changing in the 2022 – 2027 1115 Demonstration Waiver. (2022). Retrieved November 1, 2022, from <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Changes.aspx>
- xxix How do parent partner programs instill hope and support prevention and reunification? (2021). Retrieved January 6, 2023, from <https://www.casey.org/Appendix-A-Research-Parent-Partner-Programs/>