# **A New Way:** Reimagining Substance Use Policies to Support Families and Reduce Infant and Toddler Entry into Child Welfare

Khanh Nguyen, Lisa McGarrie,
Mollyrose Schaffner, and Torey Silloway

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ZERO TO THREE
Early connections last a lifetime

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This report proposes 10 recommendations for transforming substance use policies and supports from a punitive and stigmatizing approach to a supportive, family-centered approach that promotes healing and helps all families thrive by preventing family separation and child welfare involvement.

# INTRODUCTION

The first three years of life are the most important years for ensuring all infants and toddlers have a bright future. Each baby's potential is unlimited, and their earliest relationships and experiences with their parents and caregivers dramatically influence brain development, social-emotional and cognitive skills, and future health and success. However, families with young children continue to face challenges, often stemming from economic insecurity, material hardship, and stressful experiences - which may all intersect with substance use disorder — that can undermine healthy development. Key to babies' healthy development is the well-being of the adults who care for them, and when parents and caregivers receive the support they need to foster close connections and healthy relationships with their babies, they are able to serve as a buffer against the impacts of trauma many families face every day.

Unfortunately, infants and toddlers are the largest age group in the child welfare system, representing one-third of all new entries.[1] Parental substance use is the leading driver of child welfare involvement for infants and toddlers, accounting for about 60% of entries into foster care among children from birth to age 5.[2] Lack of access to an appropriate array of health care, including mental health and substance use treatment, is resulting in more families entering the child welfare system. Punitive laws that further stigmatize and criminalize families who use substances and deem substance use without any other safety concerns as cause for removal of children have created additional harm without increasing child safety.

> *"Substance use disorder is a disease being treated with removal [of children from the home], which often leads to relapse and further disease."*
>
> —Dr. Mollie Nisen

The high proportion of family separation due to substance use is of particular concern for infants and toddlers because of the lasting impacts on child development and family stability. The parent-child relationship is the backbone of early development and sets the foundation for the mental health and well-being of infants and toddlers. Early relationships are the vehicle for repair of trauma, and for families in the child welfare system, these relationships have been disrupted. To respond most effectively, it is critical for policymakers and professionals working with families to center the urgent needs of young children, the needs of parents/caregivers with substance use disorders (SUDs), and the caregiver-child relationship. This approach rooted in supporting families and promoting healthy early childhood development aims to create environments where all families can thrive regardless of their circumstances.

> Substance use during 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 the risk of child abuse and neglect. Parents with a substance use disorder — a complex health condition requiring treatment and support — are often stigmatized or punished, which can have adverse impacts on the whole family, including the child. 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.[3]

Federal policy changes over time and unclear definitions of maltreatment contribute to wide variation in how states implement policies related to parental substance use. Federal laws such as the Child Abuse Prevention and Treatment Act (CAPTA) and the Comprehensive Addiction and Recovery Act (CARA) influence how states approach substance use in child protection policy. CAPTA includes a provision that suggests child abuse can include babies born affected by drug withdrawal, but it is up to each state to determine how this is interpreted, leading to varying definitions of child abuse and neglect. In the past decade, the use of opioids during pregnancy has grown rapidly. In response, several state governments have prosecuted and incarcerated pregnant people with SUDs. The 2010 reauthorization of CARA requires states to develop policies and procedures to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms. Federal guidance to states regarding CAPTA/CARA interpretation indicates that a notification to Child Protective Services (CPS) for prenatal substance exposure does not constitute a report of child abuse or neglect, but states have implemented policies of their own with varying degrees of harshness — from allowing de-identified notifications of substance exposure to requiring a report of abuse when drug use is suspected.[4] State policy, and its subsequent interpretation and implementation by health care and service providers, ultimately impacts outcomes for families on a day-to-day level. This also makes state-level policy a key lever for change.

The needs highlighted above are fundamental to the work and goals of Safe Babies, a program of ZERO TO THREE™. We propose 10 policy recommendations for states to adopt to transform substance use policies and improve outcomes for infants, toddlers, and families. Shifting from a punitive and stigmatizing approach to a supportive, family-centered approach would promote healing and help all families thrive.

While this resource will primarily focus on state-level substance use strategies, these policies are embedded in a broader system and principles that reduce the number of families that enter the child welfare system, including, but not limited to, the following cross-cutting strategies:

- Include in all stages of policy discussions and decisions those individuals and communities who have been historically harmed by policies and services.
- Invest in supports that alleviate family stress, such as economic and social stressors, to prevent substance use crises, including existing community resources that are trusted and culturally responsive sources of support for families experiencing poverty.
- To better meet the needs of American Indian and Alaska Native children and families, codify the Indian Child Welfare Act (ICWA) at the state level, collaborate with tribal governments, and ensure flexible and robust funding for Indian child welfare and family preservation services.
- Ensure accountability for outcomes through data collection across systems that respects data privacy and maintains families' autonomy over their data, and use a data-driven approach to reducing disparities.

Depending on their service delivery system and service array, some of these recommendations may also be applicable to American Indian and Alaska Native Tribal nations. Additionally, Tribal nations may have services and supports, especially culturally based services, for which their member Native families and children may be eligible. Tribal nation child welfare or social services can be an important partner in mobilizing resources for Native families.

# HOW TO USE THIS DOCUMENT

This document highlights a set of 10 recommendations to shift how we view substance use and how we can address SUD as a medical condition rather than a way to blame or stigmatize parents while also ensuring children are safe and thrive. Children do best when their families thrive, and we can help by supporting parents' recovery. This healing-centered approach focuses on the urgent developmental needs of infants and toddlers by promoting stable, strong, and safe families and protecting their crucial relationships in the earliest years. The 10 recommendations are grouped into two sections, with each section including background information, a brief explanation of what we mean and how the recommendation may help, and a few brief examples. The recommendations also span different levels of policy requiring action from various partners — from community service providers and clinicians to state agency leadership and state legislators — and call for partnership across these levels and sectors. There are specific recommendations that highlight actions child welfare agencies can take, but we also want to lift up the role of cross-sector collaboration in building an early childhood system that serves all families of babies and toddlers.

> 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.

The recommendations put forth here are the product of a group of individuals with expertise in many different areas, all of whom have a vested interest in improving the lives of families with very young children. Some of these recommendations may feel unattainable based on the current system, but they reflect the changes we believe are possible and have the potential to make a difference in how we support families. We recognize that context matters, and we encourage you to assess your community's and state's unique factors when considering these recommendations.

> All policies may have unintended consequences, and we encourage you to include parent voice and leadership in policy development and decision-making, as well as to assess each policy in the context of your environment before proceeding. Reflective questions may include the following:
>
> - How have the views of communities most impacted been considered in the policy development and implementation process (e.g., families, foster parents, service providers, community members, etc.)?
> - Are there any potential unintended consequences of this policy that have not been identified? Are there ways to mitigate such unintended consequences?
> - How might different communities be burdened by this policy (considering rurality, ability, race, ethnicity, language, wealth, income, etc.)?
> - How will we ensure that the policy change will balance your goals of supporting families, decriminalizing substance use disorder, and minimizing family separation while also ensuring child safety?

# POLICY RECOMMENDATIONS AT A GLANCE

**Policy Priority:** *Reducing infants and toddlers' unnecessary entry into the child welfare system by addressing stigma and promoting culturally responsive care for parental substance use disorder*


## SECTION 1:

### Shift from a system that views substance use categorically as child abuse to one that supports families and provides high-quality treatment services

#### POLICY RECOMMENDATIONS

1. To identify holistic social and health care needs, adopt universal screening in health visits. For identified needs, ensure connection to culturally responsive services that promote healing.

2. Create standards of practice for the treatment of patients screening positive for substance use for all providers, not just substance use disorder (SUD) treatment providers. Consider the following specific strategies:
   - Establish state-level policies for birthing hospitals to adopt best practices for cultural responsiveness for families with substance use issues.
   - Ensure that SUD treatment programs that receive state/federal funding follow the gold standard for evidence-based practices (EBPs), including medication for addiction treatment (MAT).
   - Ensure that SUD treatment is family-focused, culturally responsive, and inclusive of fathers and LGBTQ+ caregivers as well as family supports who are not biologically related (family is the unit of treatment).

3. Ensure public/private insurers cover the full continuum of SUD treatment based on EBPs and the following strategies:
   - Require public payor/regulatory alignment around the family as the unit of treatment.
   - Provide co-located mobile prenatal, postpartum, and SUD treatment to increase access to multiple services in one location.
   - Increase funding for residential SUD treatment and require that a percentage of SUD treatment beds is set aside for families with children, including fathers, and those who are pregnant who are covered under state insurance programs.

4. Within child welfare, embed executive- and frontline-level clinical expertise in SUDs and infant and early childhood mental health (IECMH), and establish trauma-responsive standards of care for families with SUD and/or IECMH needs.

5. Ensure IECMH expertise in contracted SUD and mental health providers who provide services to child welfare-involved families.

## SECTION 2:

### Shift away from mandatory reporting in favor of mandatory supporting

#### POLICY RECOMMENDATIONS

6. Revise state policy so that substance use alone is not automatic grounds for allegations/investigations of child abuse or neglect.

7. Build an alternate reporting pathway that is outside of child welfare with the structure of staffing including a multidisciplinary team that features peer mentors/peer support, community health workers, doulas, and access to evidence-based addiction treatment and/or connections to SUD clinicians.
    - Embed peer support across as many touchpoints as possible beyond traditional treatment settings.

8. Provide legal representation (consultation/advocacy) at the time of the initial report to CPS to support families as early as possible in the process.

9. Create a feedback loop so that reporters (doctors, teachers, etc.) know what happened after a report is made to CPS.

10. Identify funding to support research on parental outcomes resulting from child removal (e.g., SUD relapse, homelessness, overdose deaths).

# POLICY RECOMMENDATIONS

## SECTION 1:

### Shift from a system that views substance use categorically as child abuse to one that supports families and provides high-quality treatment services

**BACKGROUND:** As the leading driver of infants and toddlers entering the child welfare system, parental substance use is an issue that deserves more attention. Lack of access to an appropriate array of health care, including mental health and substance use treatment, is resulting in more families entering the child welfare system. In addition, punitive laws that further stigmatize and criminalize families who use substances and deem substance use without any other safety concerns as cause for removal of children have created additional harm without increasing child safety. As a result, many families are brought into the child welfare system who could have been supported through other systems within the community, resulting in unnecessary harm to that young child.

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 and babies the best chance to thrive in a stable caregiving environment.

Pregnancy is a critical time to ensure access to substance use treatment for parents who need it, but care must be taken to separate the use of substances from allegations of abuse or neglect. To ensure optimal outcomes for babies and their families, we should assess needs and provide services to achieve holistic health and well-being, including adopting a compassionate view of SUDs as complex health conditions requiring treatment and support. It is also critical for the field to understand that not all substance use is defined as a clinical disorder, and only a qualified health professional can make the diagnosis of an SUD. Supporting the caring adults who touch the lives of infants and toddlers can maximize the long-term impact in ensuring all infants and toddlers have a bright future.

Stigma is pervasive and is perpetuated by punitive policies toward parents; community culture and beliefs; individual feelings of shame surrounding disease and systems involvement; and inconsistent application of policies, which can result in additional barriers for families battling addiction. In addition to making parents fearful of seeking substance use treatment because of the risk of initiating a child welfare allegation, stigma has been shown to further traumatize those with SUDs.[5] 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.[6,7,8]

## POLICY RECOMMENDATIONS:

**1.** To identify holistic social and health care needs, adopt universal screening in health visits. For identified needs, ensure connection to culturally responsive services that promote healing.

### What do we mean?

- Adopt voluntary screening of all patients for social and health care needs, including mental health, nutrition, economic security, and substance use. This would be a verbal or written screening with a questionnaire or assessment, not a drug/toxicology test.
- While identifying holistic needs such as concrete supports and SUD treatment, center needs related to the parent-child relationship and ensure that babies' healthy development is at the forefront of services and supports.
- Embed parent peer support specialists who have navigated perinatal SUDs in prenatal and delivery care settings. Involve the peer support workforce in screening and have them support families through the process that follows.
- Screening entities should connect with and know their community's resources and services. This requires that community services are in place for connections to actually happen. Implementing universal screening without a system in place to make necessary referrals and follow through with accessible, culturally appropriate services may prove ineffective and erode trust.
- Ongoing support during and following health visits can also ensure that developmental monitoring and services are provided when children do experience effects of parental substance use, such as fetal alcohol spectrum disorders that may emerge later. Other developmental needs identified should lead directly to early intervention services.

### Why might this help?

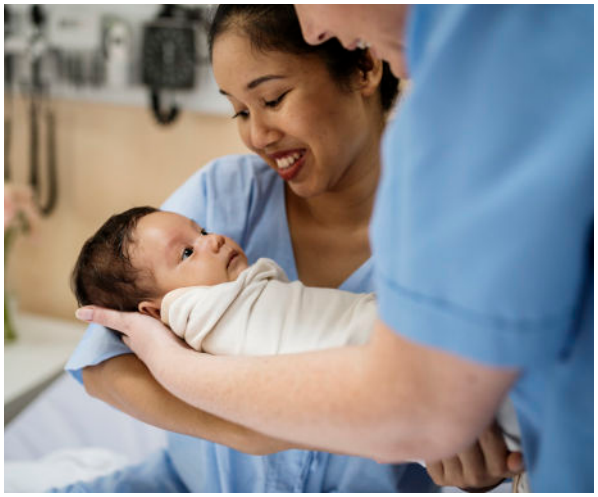
- Universal screening that connects families to treatment early (both before and during pregnancy) can keep families together (protecting crucial early caregiving bonds), reach more families, and greatly reduce biases toward different racial, ethnic, and socioeconomic groups.
- Without universal screening, the current practice often defaults to "selective" screening, which is when bias often happens. As a standard practice for all patients, the focus can shift to identifying needs and enabling access to comprehensive supports and treatment for all, avoiding an unconscious bias that often disproportionately leads to child welfare involvement for people of color and families experiencing poverty.
- 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.
- With the objective of identifying ways to support patients and families holistically and focusing on connection to services, embedding substance use screening into a comprehensive screening process destigmatizes substance use and recognizes it as part of a broader set of needs to be approached with care and compassion.

## 2. Create standards of practice for the treatment of patients screening positive for substance use for all providers, not just SUD treatment providers. Consider the following specific strategies:

- Establish state-level policies for birthing hospitals to adopt best practices for cultural responsiveness for families with substance use issues.
- Ensure that SUD treatment programs that receive state/federal funding follow the gold standard for EBPs,[a] including MAT.
- Ensure that SUD treatment is family-focused, culturally responsive, and inclusive of fathers and LGBTQ+ caregivers as well as family supports who are not biologically related (family is the unit of treatment).

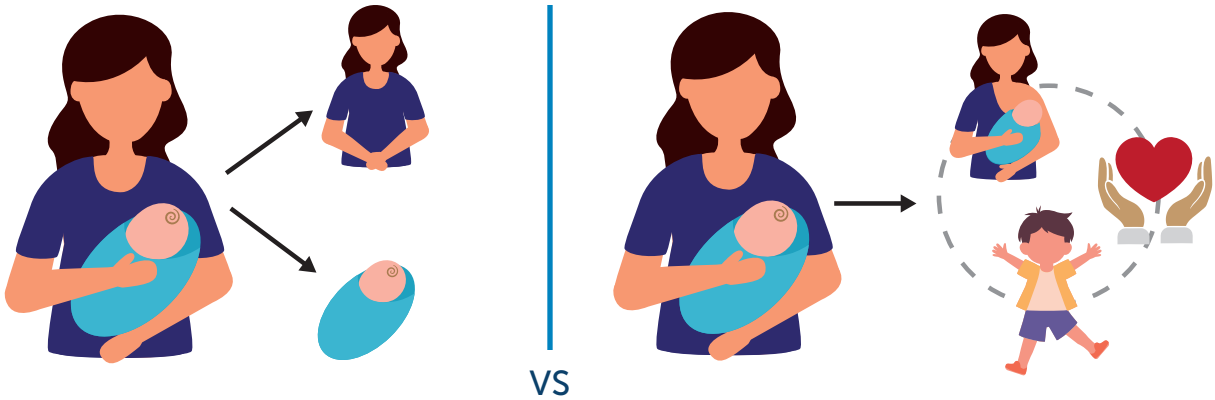
## What do we mean?

- Shift the model of care to focus on keeping the birthing person and baby together and out of the neonatal intensive care unit (NICU) when possible, including prioritizing skin-to-skin contact, rooming in, and breastfeeding (see Figure 1). Supports should focus on keeping babies' early development on track.
- Keep the focus on trauma-informed and culturally responsive care to improve outcomes for both the birthing person and baby.
- Implement standardized protocols to increase provider and patient satisfaction and reduce the length of hospitalization.
- Include training recognizing the disproportionate impact of surveillance and limited access to treatment and supports for families of color.
- Link state and federal funding to following the gold standard for EBPs, which should include MAT. Consider the criteria for EBPs to be inclusive of local cultural methods and avoid potential harm through requirements for communities of color to use narrowly defined practices only tested in white populations.
- Keep the family as the unit of treatment. Treatment should be family-focused, inclusive of fathers, LGBTQ+ caregivers, and all persons of support, whether biologically related or not.
- Connect families with peer support specialists/parent partners prenatally and postpartum and continue to support the family after a parent is discharged.



a EBPs are not always culturally tested or appropriate for every community. We recommend a broad approach to EBPs to make them more community-defined.

## FIGURE 1: SHIFTING MODELS OF CARE



VS

### Traditional (and Common):

Transfer to a tertiary care facility
*Separate mom & baby, place baby in NICU*

Treatment separate from mother
*Breastfeeding not allowed, or inconsistent*

Focus on correct medicine, instead of care process
*Burnout common, lack of trauma-informed processes*

Care not standardized
*Long lengths of treatment and stay*

### Newer Care Models:

Transfer to a tertiary care facility not necessary
*Keep dyad intact, out of NICU if possible*

Treatment inclusive of mother
*Breastfeeding encouraged and supported if safe*

Focus on care process, not just medications
*Engage staff in trauma-informed care*

Use of standardized protocols
*Greater provider/patient satisfaction, reduced stay*

Source: Wachman EM, Schiff DM, Silverstein M. Neonatal Abstinence Syndrome: Advances in Diagnosis and Treatment. JAMA. 2018 Apr 3;319(13):1362-1374. doi: 10.1001/jama.2018.2640. PMID: 29614184.

## Why might this help?

- Without shifting the model of care to focus on the family unit, there is increased likelihood that the birthing parent and baby will be separated, breastfeeding might not be fully explored or offered as an option, and care might not be standardized, all of which can strain the critical caregiver-baby relationship.
- Families should be treated in a way that is trauma-informed and culturally responsive (and be treated as a unit) to ensure the best outcomes. Infants and toddlers grow up within the context of their relationships with primary caregivers, so focusing on the family as the unit of care/treatment makes sense.
- Connecting families with peer support as a way of providing care coordination is another strategy to support families prenatally and postpartum. Peer support services that are culturally responsive can support families outside of a purely clinical environment. Peer support has been shown to reduce stigma, increase participant confidence, and enhance connectedness to others.[9] Parent partner programs, which offer peer support for those with child welfare involvement, have been shown to increase reunification rates and lower rates of repeat maltreatment.[10]

## 3. Ensure public/private insurers cover the full continuum of SUD treatment based on EBPs and the following strategies:

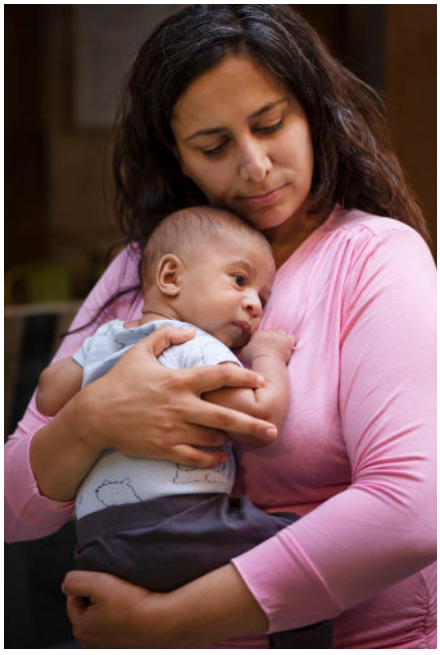
- Require public payor/regulatory alignment around the family as the unit of treatment.
- Provide co-located mobile prenatal, postpartum, and SUD treatment to increase access to multiple services in one location.
- Increase funding for residential SUD treatment and require that a percentage of SUD treatment beds is set aside for families with children, including fathers, and those who are pregnant who are covered under state insurance programs.

## What do we mean?

- Require public and private insurance programs to cover SUD treatments, including opioid treatment. There is a lack of mandates requiring insurers to cover a full continuum of SUD supports and treatments for both public and private insurance plans.
- Invest in mobile prenatal, postpartum, and SUD treatment, particularly in maternity care deserts. More than 5 million prenatal women live in counties with limited or no access to maternity care.[11]
- Support the development of specialized prenatal clinics that provide co-located care to women who are pregnant and using substances to reduce barriers to treatment.
- Increase access to family-based residential substance use treatment. Such programs rarely incorporate a component that allows parents to receive treatment and reside with their children, which offers an important opportunity to develop and heal the caregiver-child relationship. More residential programs should have a focus on including fathers and other caregivers, such as LGBTQ+ partners.
- Parents should have access to individualized SUD treatment and parenting support. These programs should be covered by Medicaid.

## Why might this help?

- Half of the country's states do not require a full continuum of SUD care in their Medicaid managed care contracts.[12] Mandating such coverage would help break down barriers and ensure greater access to comprehensive and effective treatment in a more cost-effective way. Medicaid is a critical lifeline for those it covers, and there is a great need across the Medicaid population for comprehensive SUD treatment services. Medicaid also provides an important sustainable funding source for providers.
- Pregnant people with SUDs have historically had limited access to treatment services and often face additional stigma from the health care system when they do seek care. Investment in specialized, co-located SUD clinics can support pregnant people within their own communities.



- A significant barrier to parents seeking residential treatment for SUDs is fear of separation if the program does not allow children. Parents may not have others to step in and care for a child while they attend inpatient/residential treatment, putting their children at risk of foster care. One of parents' greatest concerns when seeking treatment is the welfare of their children while they are in treatment. Programs that wrap around a family and support the unique needs of both children and parents are a critical resource for families seeking treatment. This approach also protects parent-child bonding that is critical during the early years rather than parents having to be separated for treatment.

## 4. Within child welfare, embed executive- and frontline-level clinical expertise in SUD and IECMH, and establish trauma-responsive standards of care for families with SUDs and/or IECMH needs.

### What do we mean?

- Child welfare systems can directly hire staff with substance use and IECMH expertise at various levels.
- At the executive level, experts can help shape policy and practices that are aligned with the fields of IECMH and substance use treatment and recovery. Both areas bring a unique lens to prevention, early intervention, and treatment — and are directly related to the families being served.
- At the frontline level, workers are encountering families in need of substance use and IECMH services. It makes sense to have roles within these teams with such expertise to help guide care plans, serve as a resource for colleagues, and inform policy choices.
- A foundational element to adopting an IECMH lens is the prioritization of reflective practice, which creates space for child welfare workers to reflect on their experiences in the field with families and other professionals, explore how their own beliefs and biases show up in this work, and discover ways to improve practice, including self-care.

*"We know each baby is different. Reflective practice encourages us to bring all of that wonderful nuance to the forefront of how we work with them."*

—Mike Sherman, PsyD, IECMH Clinical Consultation Manager, Safe Babies

## Why might this help?

- Families in child welfare would benefit from access to teams with expertise and knowledge that guide them to the right services at the right time. Internal expertise within the child welfare agency could provide additional focus on and prioritization of the needs of infants and toddlers. For example, IECMH experts can consult on care plans, support the development of policy and practices, and lead reflective practice. This could lead to additional capacity building across teams or departments.
- Embedding these areas of expertise within a child welfare agency has the potential to shift understanding and create changes in practice inside the agency culture. Working alongside experts in substance use and IECMH can transform how the system works with families and what services are prioritized to promote their healing. This level of internal expertise can lead to positive policy and practice changes that are trauma-responsive.
- Adoption of an IECMH-centered approach could positively influence how child welfare workers partner with families by centering infants/toddlers in every process and decision, including their need for strong early relationships and trauma-responsive, safe environments.
- Child welfare is a fast-paced, demanding atmosphere, where critical life-changing decisions are made daily. Ensuring reflective practice as a way for the workforce to process their experiences could help create a less reactive and more responsive environment. Reflective practice is about being present and aware.

# 5. Ensure IECMH expertise in contracted SUD and mental health providers who provide services to child welfare-involved families.

## What do we mean?

- The largest age group in foster care is children from birth to age 3, all of whom have experienced traumatic disruption in a primary caregiving relationship, with many also experiencing other traumas prior to entering foster care. Parents and caregivers of these children have also experienced extreme stress and trauma, and they are highly likely to have a traumatic history that precedes child welfare involvement. SUD and mental health providers need to be equipped with IECMH knowledge and have access to experts who can consult with and/or directly serve families using multigenerational approaches. Child welfare systems and their networks of contracted partners need to embed IECMH expertise to provide high-quality and effective care to families in child welfare with infants and toddlers.
- The field of IECMH offers a critical opportunity to understand the urgent mental health and developmental needs of infants and toddlers in the context of their relationships with parents and other caregivers—and to begin the work of healing. Providing training and mentorship in IECMH concepts and practices to substance use and mental health providers is critical to bridging these domains and encouraging holistic family care. Child welfare systems and their networks can ensure training and workforce development is centered around national workforce competencies from ZERO TO THREE's IECMH Guiding Principles and the Alliance for the Advancement of Infant Mental Health.

## Why might this help?

- Contracted substance use and mental health providers treat parents who have young children in foster care. It is therefore critical for these providers to value and elevate the role of parents in healing relationships with their infants/toddlers and to understand the urgent needs of their children, which can be a motivating factor in adult recovery.
- It is also important for providers to understand that these parents are experiencing extreme stress during the child welfare/dependency court process, which will impact the clinical treatment process for SUDs or other mental health concerns, as well as parental engagement in IECMH clinical services with children.
- As part of the clinical team, IECMH professionals can help parents understand the healing process, learn how to read their children's cues and respond appropriately, and value the importance of reciprocity in the parent-child relationship. As parents/caregivers work through their own recovery, they can also engage in IECMH treatment to repair the parent-child bond and support their children's mental health and development.
- The addition of an IECMH clinical expert can help the whole clinical team communicate across the needs of each family member, respond with interventions, and engage with families in a way that is coordinated and that centers the needs of their children. Working together, a trans-disciplinary team of providers can share the importance of engagement with the family from their perspective and help families and other professionals (e.g., attorneys, judicial officers, child welfare professionals) understand the clinical process and what to expect from the various types of treatments offered.

## What might recommendations from Section 1 look like?

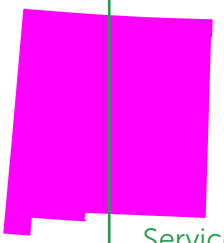
The American College of Obstetricians and Gynecologists recommends SUD screening during pregnancy. The New York State Department of Health's Plan to Transform the Empire State's Medicaid Program encompasses changes that align with these recommendations. West Virginia requires perinatal mental health screening that can be adapted for broader social and health care needs. Maryland's Chrysalis House, Inc. recovery housing keeps families together while providing treatment. New Jersey provides co-located prenatal and SUD treatment programs. Tribal initiatives like that of the Port Gamble S'Klallam Tribe provide holistic family services. The University of Washington's Parent-Child Assistance Program provides peer support for parents with SUDs. The University of Utah's SUPeRAD Clinic offers co-located clinical care to people who are pregnant and using substances. Illinois provides peer recovery doulas to pregnant people with SUDs and developmental specialists to support child welfare professionals working with very young children and their families.

**A STATE-LEVEL COLLABORATIVE IN GEORGIA** has developed the Two Generation Community of Practice for Family-Integrated Relationship-Based Care to support families experiencing hospitalization in NICUs by lifting up care that promotes both the emotional well-being of caregivers and the development of infants. The initiative, which has reached across early childhood systems (including NICUs and home visiting programs in the state), includes a cross-disciplinary group of professionals[b] supporting families and the workforce.

With a focus on staff who work with infants and families requiring neonatal intensive care, the community of practice facilitators emphasize the lived experiences of infants and families in the hospital as well as upon discharge to the home setting. The approach draws heavily on research demonstrating the importance of dynamic interactions between infants and caregivers and the critical period following birth.[13] Program participants engage in hands-on simulations via a six-step mentorship process. Facilitators teach evidence-based techniques, such as:

1. Gradual implementation of skin-to-skin contact;
2. Documenting and understanding the need of infants to have their signals met and answered; and
3. Supporting staff and families with the language necessary to enhance engagement and confidence.

Integrating developmentally responsive practices and providing empowering tools, the approach engages families as partners through mentorship and aims to reduce the stress associated with early separation and to enhance long-term developmental trajectories and family well-being.



NEW MEXICO'S CHILDREN, YOUTH AND FAMILIES DEPARTMENT has a state-level child welfare unit dedicated to IECMH. The unit's mission is to "ameliorate the transmission of intergenerational trauma between parents and infants through effective dyadic and triadic clinical work." A team led by the unit's infant mental health manager supports the integration of IECMH for families across the community not involved in child welfare, as well as for those who are involved in the foster care system. Embedded within the department's Behavioral Health Services division, the unit has expertise in IECMH and provides technical assistance for the child welfare system and to sister state agencies such as the Early Childhood Education and Care Department and the Department of Health. The team also focuses on building and maintaining the infrastructure for implementation of child-parent psychotherapy — through both workforce development and family treatment lenses.

b Coordinated by partners from Georgia THRIVe, Communication Crossroads, and Georgia Family Connection Partnership

## SECTION 2:
### Shift away from mandatory reporting in favor of mandatory supporting

**BACKGROUND:** For families who become involved in the child welfare system, where infants and toddlers represent the largest age group entering foster care, they often encounter a child welfare system that is not responsive to the developmental needs of infants, toddlers, and their families. We all have a shared responsibility to nurture and protect each child and to support communities and families in creating the safe, stable, nurturing environment children need. Mandatory reporting laws often trigger investigations of families by the child welfare system even when there are no safety concerns, resulting in unnecessary trauma for both children and their parents. State laws vary widely on mandatory reporting when infants are born exposed to substances. For example, some states focus on connection to treatment and do not require a report of child abuse while others require an automatic report when there is suspected substance use, even without confirmation (e.g., based on past removal due to substance use). From state to state, implementation of these laws can also vary considerably by hospital and other service providers.

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 child protective system, it does not establish a definition under federal law of what constitutes child abuse or neglect. This leaves a lot of room for states to define what triggers a notification or report (whether a simple notification without allegation of abuse is sufficient or a report of abuse is required), leading to a range of consequences for families.

Research has found that many states are not in compliance with CAPTA requirements, with only 14 (27.5%) appropriately identifying the type of substance exposure that warrants notification and the development of a plan of safe care (POSC). Just seven states (11.8%) use the term "notify" in their CAPTA/CARA policy, while most policies continue to require that states "report" or "refer" families, resulting in unnecessary investigations.[14]

Rates of child welfare investigations of infants stemming from the reports of medical professionals have increased dramatically over the past decade, with persistent and notable racial inequities. Health professional reporting has increased 400% during this time, driven by misuse of urine drug testing.[15,16] Between 2010 and 2019, Black, American Indian, and Alaska Native infants were more likely to be investigated following a medical professional's report than were white, Hispanic, or Asian/Pacific Islander children.[17]

Mandated reporting laws do not address the root causes of why a family enters the child welfare system (e.g., loss of a job, homelessness, SUD, or food insecurity), and they frequently fail to provide access to the types of resources that may help a family stay together. Conversely, states or localities that engage in "mandatory supporting" envision a new way of working with families to strengthen protective factors and help them stay together. This section elevates strategies that change the trajectory of families with infants and toddlers by avoiding the trauma of being system-involved solely due to the presence of substances or a treatable disorder, allowing babies to remain in stable and nurturing relationships.

## Policy Recommendations:

### 6. Revise state policy so that substance use alone is not automatic grounds for allegations/investigations of child abuse or neglect.

## What do we mean?

- Almost half of the country's states and the District of Columbia consider substance use during pregnancy to be evidence of child abuse or neglect.[18] States with this definition in place should revise their statutes to remove substance use alone as a reason for mandatory reporting.
- The criteria for reporting substance use and removing children from homes are often vague and can be applied inconsistently. To remove such ambiguity, states should clearly note that substance use without evidence of harm should not be a reason for reporting.
- States can also use legislation to reform the liability and penalties for mandated reporters to reduce fear that professionals could lose their job or license to practice. This could help foster a strengths-based system that rebuilds trust with communities.[19]

## Why might this help?

- Mandatory reporting requirements can prevent a parent from seeking care for substance use during pregnancy due to the fear of child welfare involvement. It is crucial that pregnant individuals be able to confide in their health care professionals without such concerns.
- Mandatory reporters often believe they are helping families by making referrals to CPS even if there are no objective safety concerns for a child. However, these systems often lack the resources to provide the support that families need.
- Separating the identification of substance use from child welfare reporting of abuse and neglect allows professionals to determine whether there are safety concerns for children rather than assuming that is always the case.
- Without objective criteria centered around safety concerns (rather than solely the presence of substances), infants and toddlers face significant harm from the trauma of unnecessary removal from their caregivers, which can impact how their brains develop and affect their emotional, mental, and physical health for years to come.

## 7. Build an alternate reporting pathway that is outside of child welfare, with the structure of staffing including a multidisciplinary team that features peer mentors/ peer support, community health workers, doulas, and access to evidence-based addiction treatment and/or connections to SUD clinicians.

### What do we mean?

- Families who are struggling with substance use are unlikely to reach out for support and are likely to miss important health and wellness check-ins if there is a possibility that they could lose custody of their children.
- The current structure, with child welfare as the default option for health providers to report concerns of child health and safety when a pregnant parent is using illegal substances, punishes parents for seeking help and often leads to unnecessary child welfare involvement, with negative consequences for young children and their parents.
- States can create alternative, non-investigative pathways for sharing low-risk concerns (such as helplines) and coordinate responses with non-child welfare entities as appropriate to enhance the ways in which mandated reporters can support families.
- Look for opportunities to strengthen and amplify existing trusted sources of community support.

### Why might this help?

- Creating alternative pathways outside of child welfare can increase engagement with parents with SUDs and more quickly match them with needed services and supports. This supportive pathway can provide both SUD treatment for parents and IECMH-focused supports for babies and the parent-child relationship while the family navigates SUD.
- This alternate pathway provides another approach to prevent families being brought into the child welfare system who could have been supported through other systems within the community.
- Embedding peer support across as many touchpoints as possible beyond traditional treatment settings can also increase engagement with parents who fear or distrust providers seen as being aligned with the child welfare system. Peer support includes parents who have lived experience dealing with SUDs and/or navigating the child welfare system.

## 8. Provide legal representation (consultation/advocacy) at the time of the initial report to CPS to support families as early as possible in the process.

### What do we mean?

- Many families that come to the attention of a child welfare agency are dealing with, or recovering from, familial, health, housing, or economic challenges. Research demonstrates that providing independent legal representation to parents and caregivers in civil legal proceedings can help prevent families from unnecessary contact with the child welfare system by helping resolve challenges that can otherwise become a crisis if not addressed.[20]
- Attorneys can contest removals, identify relatives to serve as respite care providers, advocate for safety plans, identify resources, and provide a range of services to address such family issues as housing, immigration, and domestic violence — all of which may help prevent unnecessary removal and placement.
- Preventive legal advocacy can also help avoid further trauma by reducing the number of unwarranted investigations.
- Multidisciplinary legal representation is one potential approach. Teams typically include attorneys, social workers, and parent mentors/advocates, as well as professionals with expertise in substance use treatment or legal matters related to domestic violence, education, delinquency, employment, or housing concerns.
- For American Indian and Alaska Native children placed in foster care, federal funds can pay for tribes' attorneys or representatives to provide the court with critical information about a child's tribe.

### Why might this help?

- Early appointment of parent counsel in child welfare cases can help prevent the unnecessary placement of children into foster care. For children already in foster care, it can improve the rate of reunification and permanency outcomes.[21] The less disruption infants and toddlers face in their environment and the quicker they can reunify with parents or caregivers, the quicker they can heal from the harms of separation.
- Providing a family at risk of entering the foster care system with legal representation may also help secure stable housing, access public benefits, or establish custody or guardianship to prevent the unnecessary removal of a child from the home.

## 9. Create a feedback loop so that reporters (doctors, teachers, etc.) know what happened after a report is made to CPS.

### What do we mean?

- Mandatory reporters, including health care providers, are often unable to learn what has happened after they refer a family to CPS, including whether a parent was able to access services or treatment following a report.
- While many reporters believe that their intervention will help a parent access treatment or other support, the reality is that a CPS report can lead to months or years of involvement in the child welfare and/or court system.
- Many mandatory reporters are unaware of the high rate of cases that are unsubstantiated (meaning no abuse or neglect was found) and that many of the families they report are not linked to services or treatment that may help them.
- Policy will need to address whether the information provided back to the individual who made the report can be case-specific or needs to be aggregated (e.g., by reporter category), depending on a state's confidentiality laws. If states opt for a case-specific feedback loop, parents must provide consent to release their information.

### Why might this help?

- This policy is similar to closed-loop referrals in the medical field where a patient's referral is tracked from the initial request to completion of the service or appointment, ensuring connection to services. If not sharing aggregated data only, consent for individual-level data sharing is critical.
- This could help doctors and other health care providers gain a better understanding of what happens when they make a report, including the status of a parent's treatment plan as well as their child's well-being. This is also an opportunity to educate and emphasize the importance of the parent-child relationship in the child's healthy growth and development.
- Doctors could also obtain information about alternative pathways they could use, rather than issuing a report if there are no concerns of abuse or neglect.

## 10. Identify funding to support research on parental outcomes resulting from child removal (e.g., SUD relapse, homelessness, overdose deaths).

### What do we mean?

- There is anecdotal evidence that parents experience significant trauma when a child is removed from their care and that such an experience can lead to additional loss, including a substance use relapse, loss of stable housing, or even a fatal overdose. Further, due to the intergenerational nature of trauma and addiction, this data can help inform efforts to prevent similar outcomes for future children and generations.
- Conduct additional research on the impact on parents who have a child removed from their care, including temporary placement in foster care and other situations in which parental rights are terminated.
- There is also opportunity to study the benefits of positive child experiences associated with keeping the family unit intact.

### Why might this help?

- Data that can highlight parental outcomes may be useful in designing policies and programs to strengthen families, prevent future child welfare involvement, and help families grieve and heal.
- This data may also be useful in economic analyses and cross-systems decision making around services for people with SUDs.

### What might recommendations from Section 2 look like?

Illinois' Family Recovery Plans Act removes substance exposure from automatic finding of abuse/neglect and focuses on recovery plans. Minnesota's African American Family Preservation and Child Welfare Disproportionality Act emphasizes supporting and strengthening African American families to prevent the unnecessary removal of children. Michigan's Stop Overreporting Our People (STOP) initiative works with medical professionals and others to address bias in mandated reporting. Nebraska distinguishes between a report and a de-identified CPS notification when there are no safety concerns.

**CONNECTICUT LAW** does not consider infant prenatal substance exposure to be a crime or child abuse. The law requires birthing hospitals to make a de-identified online notification (a CAPTA notification) to the state's Department of Child and Family Services at the time of birth for infants with prenatal substance exposure (IPSE) and/or those who experience withdrawal symptoms consistent with IPSE. The law also requires the reporter to conduct a brief risk assessment to determine if the case warrants a separate maltreatment report. A POSC must be developed using the state's template for all infants with prenatal substance exposure at or before the time of CAPTA notification.

A study found that this notification system diverted more than half of substance-exposed infants from the child welfare system, connecting families with community services instead.[22] However, the study also found that disproportionality was still prevalent, with Black families more likely to be identified as having an IPSE and subsequently reported to CPS. While some strides have been made to date, it will take multiple policy strategies to address the root causes of disproportionality, as well as systematic data collection and analysis to understand progress in or barriers to achieving equitable outcomes for all families.

# CONCLUSION & ACKNOWLEDGMENTS

The policy recommendations presented in this document capture a vision of a new way to approach substance use among families with very young children (supporting rather than reporting) and remove common practices that lead to trauma for babies and their families. While these 10 recommendations may only tackle part of the system that drives unnecessary entry into the child welfare system, we believe they are an important part of the change we would like to see. Policymakers, health care providers, and communities must collaborate to reform child welfare systems, and rethinking the way we view and act on substance use is one place to start.

The Safe Babies policy team is available to provide tailored technical assistance to partners and communities interested in implementing these recommendations, which were developed in partnership with the following experts:

Lindsay Calveri
Alexandra Citrin, MSW, MPP
Jamie Colvard, MPP
Christina Commons
Kiesha D. Crawford, MPA
Suzanne Farris
Melissa Gueller, MS
Janet Nickell Horras
Sarah Kastelic, PhD, MSW
Eva J. Klain, JD
Zoe Livengood, MA
Hilda Loria, MD, MPH, FAAP
Jennifer Boutin Mane, MSW
Kimberly Martini-Carvell, MA
Larisa Méndez-Peñate, EdM
Mollie Nisen, MD, FASAM
Joy Osofsky, PhD
Gordy Pyper
Kerrie L. Schnake, MA, IMH-E®
Dawn Stehle, DrPH, MPS
Cynthia L. Tate, PhD
Judge Joyce Williams Warren, Ret.

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The Safe Babies National Advisory Group for Parents' Voices
Gwen Doland, MS, LMHC, CADC, IMH-E®
Erinn Havig
Margaret Lloyd Sieger, PhD
Rebecca Grey Bull
Kristen Weber, JD
Tanya Gassenheimer, JD, MSW
Erin Ingoldsby, PhD
Tammy Richards, MEd
Kelly McGlothen-Bell, PhD, RN, IBCLC
Bayard Love, MBA, MPP
Sheri Brady, JD

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