Building Capacity: Using Research and Data to Address the Needs of Substance-Exposed Infants and the Role of Help Me Grow
Welcome from Help Me Grow National
Today’s Speakers

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Child Trends
Planning for Safe Care or Widening the Net?:
A Review and Analysis of 51 States’ CAPTA Policies Addressing Substance-Exposed Infants

Margaret H. Lloyd, PhD, MS, University of Connecticut
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June 5th, 2019
Background
Prenatal Substance Exposure (PSE)

Prevalence (SAMHSA, 2018):
• 12.9% of pregnant women used illegal drugs or alcohol during pregnancy in 2017
  – 8.5% of pregnant women used illegal drugs during pregnancy
  – 1.4% of pregnant women used opioids (heroin or Rx misuse) during pregnancy
  – 11.5% of pregnant women used alcohol during pregnancy

Estimated 600,000 infants born substance exposed in 2017
# PSE Policy Timeline

## Child Abuse Prevention Treatment Act (CAPTA) and Comprehensive Addiction and Recovery Act (CARA)

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1974</td>
<td>CAPTA: Funding for prevention, assessment, investigation, prosecution, &amp; treatment activities related to child maltreatment</td>
</tr>
<tr>
<td>Late 1980s</td>
<td>Media attention to PSE cases due to “crack” cocaine</td>
</tr>
<tr>
<td>Early 1990s</td>
<td>Research reports significant problems in SEI; more infants coming into foster care</td>
</tr>
<tr>
<td>1997</td>
<td>Adoption &amp; Safe Families Act: children with parental SUD → reduced likelihood of reunification</td>
</tr>
<tr>
<td>Early 2000s</td>
<td>Research reports importance of post-natal environment in SEI outcomes</td>
</tr>
<tr>
<td>2003</td>
<td>CAPTA 2003: Introduced mandate that states implement policies to track and address prenatal exposure to illegal drugs, develop Plans of Safe Care</td>
</tr>
<tr>
<td>2010</td>
<td>CAPTA 2010: Revised to include FASD</td>
</tr>
<tr>
<td>2016</td>
<td>CARA 2016: Revised CAPTA to include legal drugs (e.g. Rx); PoSC for mom &amp; baby</td>
</tr>
</tbody>
</table>
Changes to CAPTA Resulting from CARA

- Substance use identification: removed the term “illegal”;
- Plan of safe care (PoSC) expanded to address the needs for both the infant and family/caregiver.
- Added the mandate that states collect data including:
  - # of infants identified,
  - whether the identified infants received a PoSC,
  - types of service referrals included in the PoSC,
  - whether infant and affected caregiver received the referred services.

CAPTA now comprises 5 domains related to PSE:

1. Substance type
2. Notification procedure
3. Plan of safe care development
4. Plan of safe care content
5. Data and monitoring activities
Research Questions

To address the gap in the literature, the current study answered the following research questions:

1. What proportion of states’ State Plans is fully compliant with CAPTA/CARA?

2. Which CAPTA/CARA mandates do non-compliant states most frequently address?

3. For each CAPTA/CARA mandate, what themes characterize deviations from the federal legislation among non-compliant states?
Current Study
Because a lack of repository or summary cataloging all states’ CAPTA/CARA policies, we used multiple approaches to obtain copies of relevant documents.

As a result, we:

- Accessed states’ publicly available child welfare websites
- Submitted individual requests to state child welfare professionals from all 50 states, Washington D.C., and Puerto Rico
  - Annual Progress and Services Report (ASPR)
  - Relevant legislation, statutes, or administrative policies
- Obtained 194 total documents from 51 states
  - Unable to obtain any materials from 1 state
Coding Guide

- Five parent codes
- Language verbatim to policy
- Coded for compliance

- Open coding to create child codes
  Ex.) *Illegal substances*

### Parent Codes

<table>
<thead>
<tr>
<th>1.) Substance Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.) Plan of Safe Care Development</td>
</tr>
<tr>
<td>3.) Plan of Safe Care Contents</td>
</tr>
<tr>
<td>4.) Notification Procedure</td>
</tr>
<tr>
<td>5.) Data and Monitoring Activities</td>
</tr>
</tbody>
</table>

### Parent + Child Codes

<table>
<thead>
<tr>
<th>1.) Substance Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child code: illegal substances</td>
</tr>
</tbody>
</table>
Sample & Inter-Rater Reliability

Final Sample
• N = 179 documents
  – 15 documents excluded

Inter-Rater Reliability
• Second author & research assistant coded by state
• Third author independently coded to assess reliability
• Calculated % agreement and $\kappa$ statistics

Mean $\kappa$ range: .824 - .897

Mean raw agreement range: 98.4% - 99.7%
Analysis

- Analyzed child codes
- Generated themes for each parent code
- Calculated frequencies and percentages to gauge non-compliance

<table>
<thead>
<tr>
<th>CAPTA/CARA Compliance Parent Code</th>
<th>Policy Definition</th>
<th>N Child Code Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Type</td>
<td>Substance abuse or withdrawal or Fetal Alcohol Spectrum Disorder</td>
<td>4</td>
</tr>
<tr>
<td>Notification</td>
<td>Healthcare provider notifies CPS of the occurrence</td>
<td>5</td>
</tr>
<tr>
<td>Universal Plan of Safe Care (PoSC) Development</td>
<td>PoSC developed for [all] infants identified</td>
<td>3</td>
</tr>
<tr>
<td>PoSC Content</td>
<td>PoSC addresses health and Substance Use Disorder treatment needs of infant and affected caregiver</td>
<td>4</td>
</tr>
<tr>
<td>State Monitoring System</td>
<td>State monitoring system regarding implementation of plans</td>
<td>3</td>
</tr>
</tbody>
</table>
Findings
Who is fully compliant?

<table>
<thead>
<tr>
<th>CAPTA/CARA Domains Compliant</th>
<th>States (n = 51)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>N</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>37.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>17</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>19.6</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>3.9</td>
<td></td>
</tr>
</tbody>
</table>

- Only 2 states fully CAPTA/CARA compliant
- 71% of states compliant with one or zero domains

<table>
<thead>
<tr>
<th>State</th>
<th>Domains Compliant</th>
</tr>
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<tbody>
<tr>
<td>Delaware</td>
<td>5</td>
</tr>
<tr>
<td>North Carolina</td>
<td>5</td>
</tr>
<tr>
<td>Kentucky</td>
<td>3</td>
</tr>
<tr>
<td>New York</td>
<td>3</td>
</tr>
<tr>
<td>West Virginia</td>
<td>3</td>
</tr>
<tr>
<td>Alaska</td>
<td>2</td>
</tr>
<tr>
<td>Iowa</td>
<td>2</td>
</tr>
<tr>
<td>Kansas</td>
<td>2</td>
</tr>
<tr>
<td>Maine</td>
<td>2</td>
</tr>
<tr>
<td>Missouri</td>
<td>2</td>
</tr>
<tr>
<td>Nevada</td>
<td>2</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>2</td>
</tr>
<tr>
<td>Virginia</td>
<td>2</td>
</tr>
<tr>
<td>Washington</td>
<td>2</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>2</td>
</tr>
</tbody>
</table>
Which mandates are most frequently addressed?

<table>
<thead>
<tr>
<th>CAPTA/CARA Domain</th>
<th>States (n = 51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Type</td>
<td>N: 14, %: 27.5</td>
</tr>
<tr>
<td>Notification</td>
<td>N: 7 , %: 13.7</td>
</tr>
<tr>
<td>Universal PoSC Development</td>
<td>N: 16, %: 31.4</td>
</tr>
<tr>
<td>PoSC Content</td>
<td>N: 15, %: 29.4</td>
</tr>
<tr>
<td>State Monitoring System</td>
<td>N: 5, %: 9.6</td>
</tr>
</tbody>
</table>
How do states deviate from the federal legislation?

For each of the 5 CAPTA/CARA domains:

• **No** state or administrative level policy

• **Expanded** the scope of federal legislation  
  Ex.) Expanding definition of PSE to include a diagnosis through the first year of life

• **Narrowed** the scope of federal legislation  
  Ex.) Creating a plan of safe care only after a CPS case is opened
Key Limitations

1. States’ administrative documents may not reflect current policy

2. Written policy may not reflect actual practice

3. Conservatively defined compliance using language verbatim to the federal policy

4. Although we amassed and reviewed 194 documents, it is likely that we overlooked, or lacked access to, certain internal policies or laws that influence CAPTA/CARA implementation
Discussion: Policy Analysis

Policy requires identification of infants affected by prenatal exposure to any substance type, legal or illegal

- 14 states excluded FASD from policy, 10 states limit policy to illegal drugs

Mandate is for notification, not report

- May protect families from unnecessary CPS involvement
  - Particularly babies exposed to certain types of substances and babies of color (Prindle, Hammond, & Putnam-Hortnstein, 2018; Chasnoff, Landress, & Barrett, 1990)
  - 40 states use the term report instead of notify

Plan of Safe Care for all identified families that addresses health and substance use treatment needs of infant and mother

- Different from a “safety plan” or “case plan”
- Developed for all identified infants
  - Priority is health and well-being, not just safety (National Center on Substance Abuse and Child Welfare, 2018)
Discussion: Net-Widening

Net widening is an unintended consequence

Results when professionals consider the diversionary program a vital community resource

Leads to increase arrests or case initiation (McElrath, Taylor, & Tran, 2016; Gross, 2010; Geller, 2006)
Discussion: Net-Widening

Problems with net-widening for this population

- Mothers using medication-assisted treatment, an evidence-based practice for treating opioid use disorders, will deliver infants with withdrawal symptoms (Beckwith & Burke, 2015; Binder & Vavrinková, 2008; Desai et al., 2015)

- Mothers/infants of color with PSE risk higher-intensity child welfare involvement than white counterparts (Kerker, Horwitz, & Leventhal, 2004; MacMahon, 1997)

- Infants with substance removals are the group least likely to achieve permanency compared to infants without substance removals and all groups of older children (with and without substance removals) (Lloyd, Akin, & Brook, 2017)
Is net-widening due to CAPTA/CARA happening?

- No existing research

- However, in CA, a state that *bars reporting for substance exposure alone*, 61% of infants diagnosed with PSE were reported to CPS before age 1, and 30% were placed into foster care (Prindle, Hammond, & Putnam-Hornstein, 2018)

- For **16 states** that expand scope of policy and mandate reporting of any PSE, or **40 states** that mandate reporting, *likely to involve substantially greater numbers of infants*
Barriers to CAPTA/CARA Implementation

Why do so few states’ plans suggest appropriate implementation of this policy?

1. PSE mandates constitute **two of 39 CAPTA State Plan requirements**
2. TA only recently available and provided to certain states (2017 Policy Academy for **15 states**)
3. CWS policy implemented at **frontlines of hospital practice**
   - In one earlier study, <18% of hospital workers were aware of CAPTA 2010 (Chasnoff, Barber, Brook, & Akin, 2018)
Moving Forward

- Impact of Family First Act
- Unfortunately, no interventions on the FFA Registry for PSE
- Possible EBPs:
  - Early Intervention Family Drug Court in CA
  - Family-Based Recovery in CT
  - Home visiting programs
Planning for safe care or widening the net?: A review and analysis of 51 states’ CAPTA policies addressing substance-exposed infants

Margaret H. Lloyd⁎, Stephanie Luczak, Samantha Lew

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Connecticut Children's Medical Center, USA

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Prenatal substance exposure
Child protective services

ABSTRACT
The Comprehensive Addiction and Recovery Act of 2016 (CARA) amended the Child Abuse Prevention and Treatment Act Reauthorization of 2010 (CAPTA) to include mandates that states’ child protection systems implement policy for identification and safety planning in cases of prenatal substance exposure (“State Plans”). These amendments have implications for hospital, child welfare, and early intervention systems. However, no accounting of states’ CAPTA/CARA State Plans exists in the literature. The purpose of this study was to analyze State Plans for consistency with the federal legislation and document common types of inconsistencies.

We obtained copies of 51 states and territories most recent Annual Progress and Services Reports (APSR) and any related administrative policy or state legislation. States’ documents were uploaded into NVivo for content analysis across four domains of CAPTA/CARA goals, noting emerging variability across states. Two states…

AFCARS Analysis

of infants and toddlers in foster care

Sarah Catherine Williams, MSW
swilliams@childtrends.org
AFCARS Blog Series:

- Rate of children in care
- Entries due to parental drug abuse
- Infants and toddlers
- Older youth
- Placement with relatives

Infants and toddlers are more likely than older children to enter foster care because of neglect and parental drug abuse

Authors: Sarah Catherine Williams, Kristin Sepulveda

Nationally, nearly 105,000 children from birth to age 3 entered foster care in federal fiscal year (FY) 2017. Experiencing maltreatment can negatively affect children at any age, but the implications for infants and toddlers are especially severe. Abuse and neglect during early developmental stages can permanently alter brain functioning, which has lasting effects into adulthood. Effective prevention and intervention approaches are critical to averting such harm.

Infants and toddlers are twice as likely as older children to enter foster care. In the last 10 years, the rate of foster care entries for infants and toddlers has far exceeded the rate for older children and has driven the overall increase in foster care entry rates. In FY 2017, the rate was more than double, with 6.6 per 1,000 children ages 3 and younger entering foster care, compared to 2.8 for ages 4 to 17.

The rate of children ages 3 and younger entering foster care in 2017 was double that of older children and youth

Rate per 1,000 children entering foster care in Fiscal Year 2017, by age group and all children
104,726 children ages 3 and younger entered foster care in 2017
Infants and toddlers are twice as likely than older children to enter foster care.
The rate of children ages 3 and younger entering care in 2017 varied widely by state.
Rates of entry for infants and toddlers also vary by race/ethnicity.

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Rate per 1,000 children ages 3 and younger who entered foster care in FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native, NH</td>
<td>23.4</td>
</tr>
<tr>
<td>Hawaiian/Other Pacific Islander, NH</td>
<td>10.6</td>
</tr>
<tr>
<td>Black, NH</td>
<td>10.1</td>
</tr>
<tr>
<td>More than one race, NH</td>
<td>9.3</td>
</tr>
<tr>
<td>White, NH</td>
<td>6.3</td>
</tr>
<tr>
<td>Hispanic (any race)</td>
<td>5.0</td>
</tr>
<tr>
<td>Asian, NH</td>
<td>0.6</td>
</tr>
<tr>
<td>All infants and toddlers</td>
<td>6.6</td>
</tr>
</tbody>
</table>
Neglect and parental drug abuse are the most common entry reasons for infants and toddlers.

Entry reasons for children ages 3 and younger who entered foster care in FY 2017
Infants and toddlers are more likely than older children to enter care due to neglect or parental drug abuse.

Entry reasons for who entered foster care in FY 2017

- **Neglect**: 68% (blue) and 59% (yellow)
- **Parental drug abuse**: 46% (blue) and 30% (yellow)
- **Physical abuse**: 14% (blue) and 13% (yellow)
- **Inability to cope**: 13% (blue) and 14% (yellow)
- **Inadequate housing**: 11% (blue) and 10% (yellow)

Legend: **3 and younger** (blue) and **4 and older** (yellow)
Percentage of *infants and toddlers* who enter care due to...

### Neglect

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, NH</td>
<td>68%</td>
</tr>
<tr>
<td>Black, NH</td>
<td>66%</td>
</tr>
<tr>
<td>Hispanic (any race)</td>
<td>65%</td>
</tr>
<tr>
<td>More than one race, NH</td>
<td>66%</td>
</tr>
<tr>
<td>Asian, NH</td>
<td>76%</td>
</tr>
<tr>
<td>American Indian/Alaska Native, NH</td>
<td>64%</td>
</tr>
<tr>
<td>Hawaiian/Other Pacific Islander, NH</td>
<td>68%</td>
</tr>
<tr>
<td>Race/ethnicity unknown</td>
<td>68%</td>
</tr>
</tbody>
</table>

### Parental drug abuse

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, NH</td>
<td>34%</td>
</tr>
<tr>
<td>Black, NH</td>
<td>51%</td>
</tr>
<tr>
<td>Hispanic (any race)</td>
<td>49%</td>
</tr>
<tr>
<td>More than one race, NH</td>
<td>29%</td>
</tr>
<tr>
<td>Asian, NH</td>
<td>40%</td>
</tr>
<tr>
<td>American Indian/Alaska Native, NH</td>
<td>55%</td>
</tr>
<tr>
<td>Hawaiian/Other Pacific Islander, NH</td>
<td>29%</td>
</tr>
<tr>
<td>Race/ethnicity unknown</td>
<td>42%</td>
</tr>
</tbody>
</table>
In 2017, 50,076 infants entered foster care.

20% of all entries in 2017 were infants.

49% of infants enter care due to parental drug abuse.
4% of infants enter care due to child drug abuse.
Percentage of infants who enter care due to...

### Parental drug abuse

- **White, NH**: 58%
- **Black, NH**: 34%
- **Hispanic (any race)**: 43%
- **More than one race, NH**: 53%
- **Asian, NH**: 35%
- **American Indian/Alaska Native, NH**: 59%
- **Hawaiian/Other Pacific Islander, NH**: 40%
- **Race/ethnicity unknown**: 46%

### Child drug abuse

- **White, NH**: 4%
- **Black, NH**: 3%
- **Hispanic (any race)**: 7%
- **More than one race, NH**: 3%
- **Asian, NH**: 3%
- **American Indian/Alaska Native, NH**: 2%
- **Hawaiian/Other Pacific Islander, NH**: 5%
- **Race/ethnicity unknown**: 5%
Social Determinants of Health

- 10% physical environment
- 20% clinical care
- 30% health behaviors
- 40% socioeconomic factors
Social Determinants of Health

- 10% physical environment
- 20% clinical care
- 30% health behaviors
- 40% socioeconomic factors
MASLOW'S HIERARCHY OF NEEDS

- Basic Needs
  - Food security, stable housing, access to clean water
  - Safe families, safe neighborhoods
- Safety
- Belonging
- Esteem
- Self-Actualization

Surveillance & Screening for Vulnerability

- School readiness, all needed supports in place
- Meaningful employment, social-emotional learning
- Secure attachments, parents have support

Linkage to Community-Based Supports

- Re-entry services
- Head Start
- Early care and education
- Job training
- Parenting classes
- Early intervention
- Legal aid
- Trauma-informed counseling
- Violence shelter
- Supportive housing
- Food bank
Help Me Grow: 
A Solution to Support All Children

• Beyond developmental screening, beyond a program
• Advancing developmental promotion, early detection & linkage to services
How is your Help Me Grow system supporting young children, their caregivers, service providers, practices, processes, and policies that are dealing with parental substance use and prenatal exposure?
Assessing Help Me Grow within child serving sectors

Help Me Grow is situated **inside** of child serving sectors, influencing the system.

Help Me Grow is situated **outside** of child serving sectors, not a part of the system.

Help Me Grow is situated **inside** of child serving sectors, as a separate system.

Help Me Grow is situated **outside** of child serving sectors, as a separate system.
Help Me Grow National Network

28 states, 92 systems*

Help Me Grow Affiliate States

<table>
<thead>
<tr>
<th>Alabama</th>
<th>Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
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<td>California</td>
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<td>New Jersey</td>
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<td>West Virginia</td>
</tr>
<tr>
<td>Michigan</td>
<td>Wyoming</td>
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</tbody>
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*based on 2018 data
Additional Questions?

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sluczak@connecticutchildrens.org
swilliams@childtrends.org
Thank You