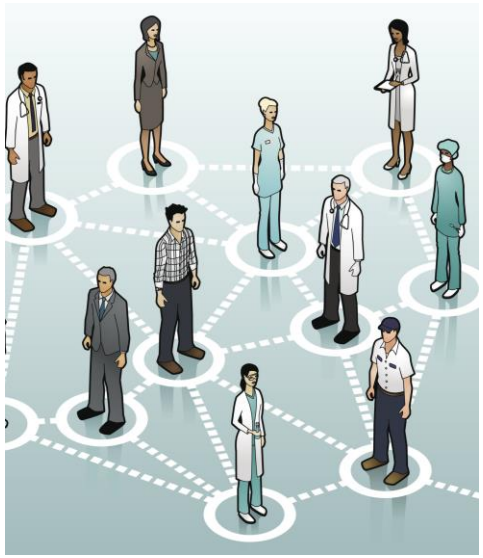
Help Me Grow®
National Center

Building Capacity:

Using Research and Data to Address the Needs of Substance-Exposed Infants and the Role of Help Me Grow



Connecticut Children's | Office for Community Child Health

Welcome from Help Me Grow National

Today's Speakers

Margaret Lloyd, PhD
Assistant Professor
University of Connecticut
School of Social Work

Stephanie Luczak, LMSW
Program Coordinator
Help Me Grow National Center

Sarah Catherine Williams, MSW
Research Scientist
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
Stephanie Luczak, LMSW, Help Me Grow National Center

June 5th, 2019

UCONN

Background

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Prenatal Substance Exposure (PSE)

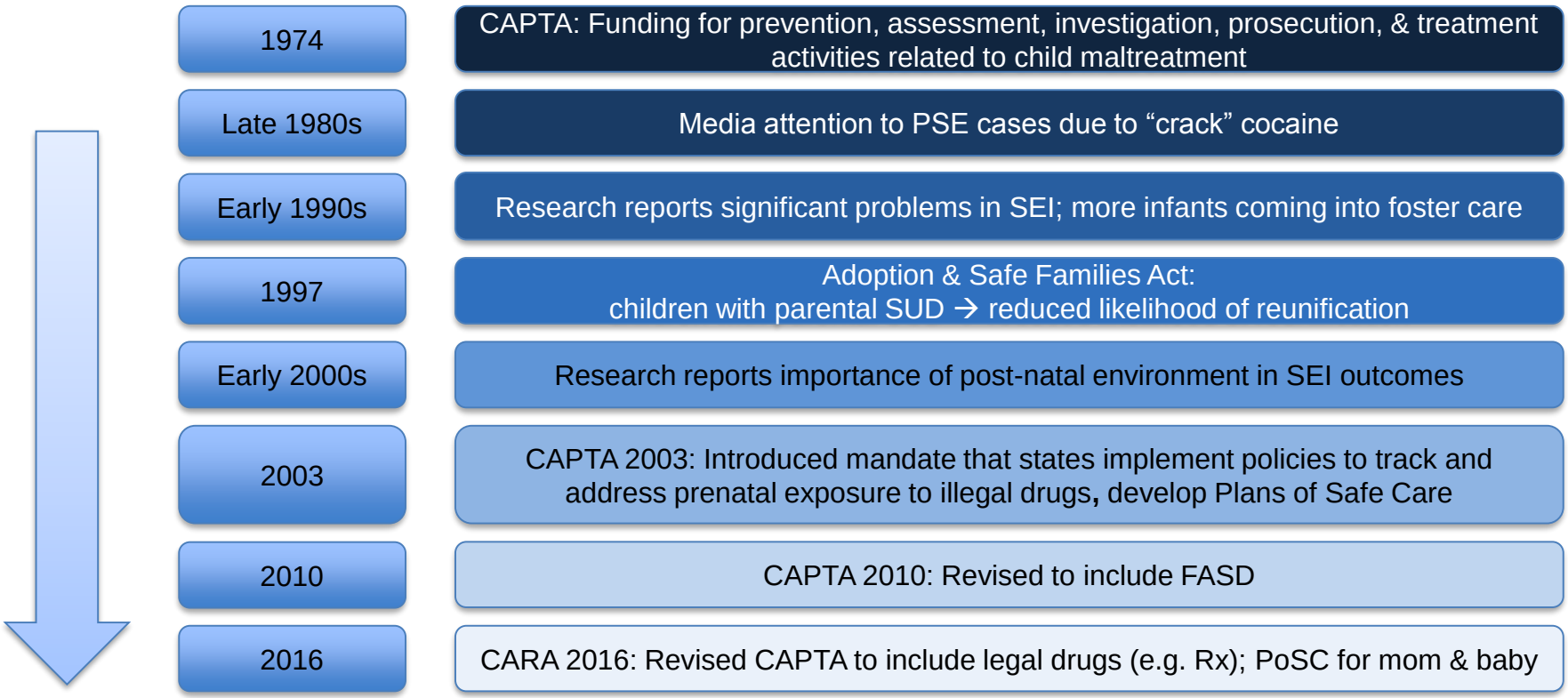
Prevalence (SAMHSA, 2018):

- 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 Adiction and Recovery Act (CARA)



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

UCONN

Data Collection

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

Parent Codes
1.) Substance Type
2.) Plan of Safe Care Development
3.) Plan of Safe Care Contents
4.) Notification Procedure
5.) Data and Monitoring Activities

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

Parent + Child Codes
1.) Substance Type
• Child code: illegal substances

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 κ statistics

Mean κ 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

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

Findings

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Who is fully compliant?

CAPTA/CARA Domains Compliant	States (n = 51)	
	N	%
0	19	**37.3**
1	17	**33.3**
2	10	**19.6**
3	3	**5.9**
4	0	**0**
5	2	**3.9**

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

State	Domains Compliant
Delaware	5
North Carolina	5
Kentucky	3
New York	3
West Virginia	3
Alaska	2
Iowa	2
Kansas	2
Maine	2
Missouri	2
Nevada	2
Oklahoma	2
Virginia	2
Washington	2
Wisconsin	2

Which mandates are most frequently addressed?

CAPTA/CARA Domain	States (n = 51)	
	N	%
Substance Type	14	27.5
Notification	7	13.7
Universal PoSC Development	16	31.4
PoSC Content	15	29.4
State Monitoring System	5	9.6

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 <u>notification</u>, 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

Focus on infant and mother safety, health, and substance use treatment may lead states or providers to believe that CAPTA/CARA fills a gap in therapeutic responses

- 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)

Discussion: Net-Widening

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

Full Publication

Children and Youth Services Review 99 (2019) 343–354

Contents lists available at ScienceDirect

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journal homepage: www.elsevier.com/locate/childyouth

Planning for safe care or widening the net?: A review and analysis of 51 states' CAPTA policies addressing substance-exposed infants

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Comprehensive Addiction and Recovery Act
Policy analysis
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 five domains of CAPTA/CARA. Results revealed extensive variability across states. Two states'

Lloyd, M., Luczak, S., Lew, S. (2019). Planning for safe care or widening the net? A review and analysis of 51 states' CAPTA policies addressing substance exposed infants. *Children and Youth Services Review*, 99, 343-354.

AFCARS Analysis

of infants and toddlers in foster care

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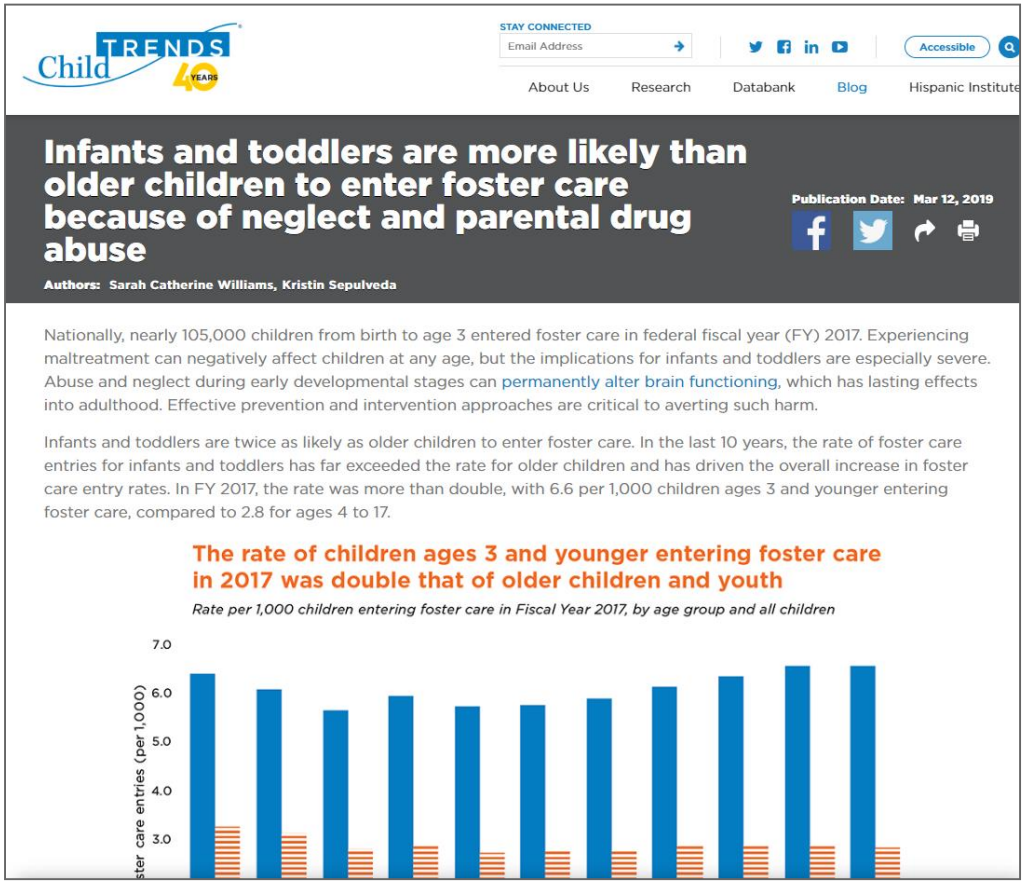
Child TRENDS

AFCARS Blog Series:

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



Child TRENDS 40 YEARS

STAY CONNECTED

Email Address

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About Us Research Databank Blog Hispanic Institute

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

Publication Date: Mar 12, 2019

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

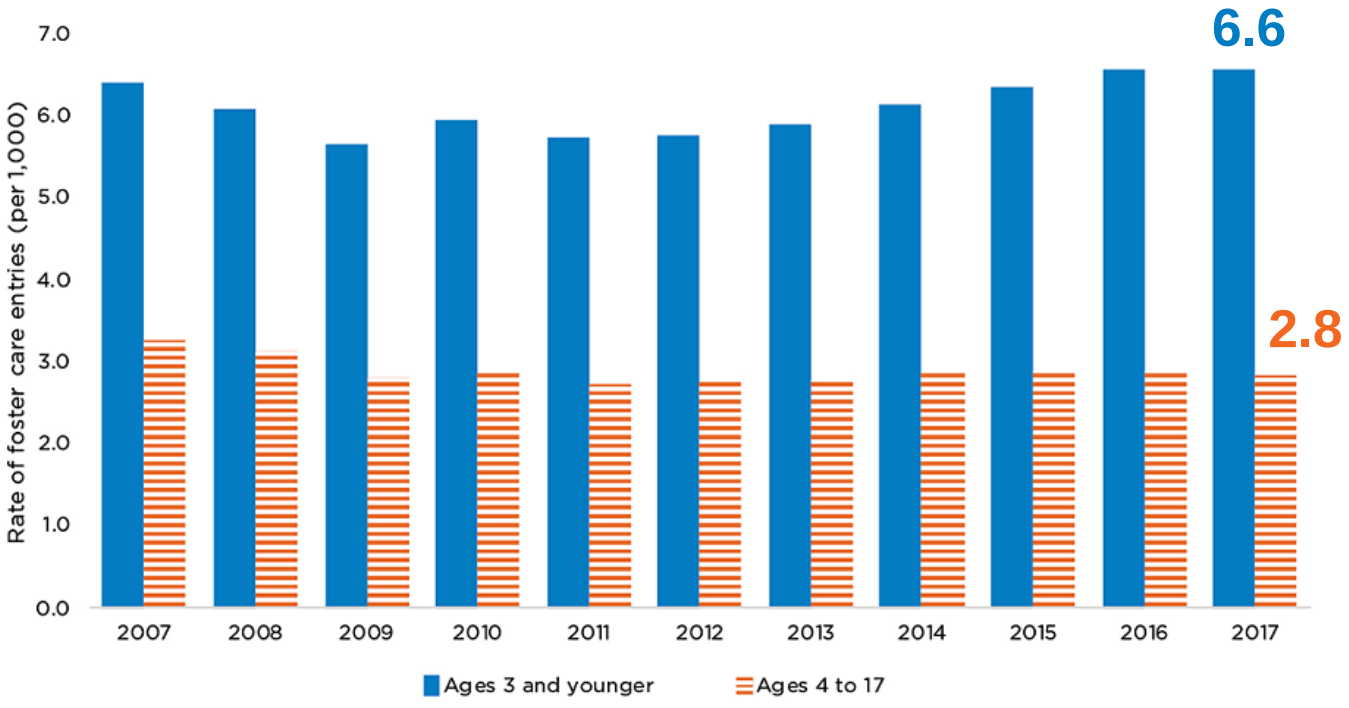
Rate per 1,000 children entering foster care in Fiscal Year 2017, by age group and all children

Child TRENDS

104,726

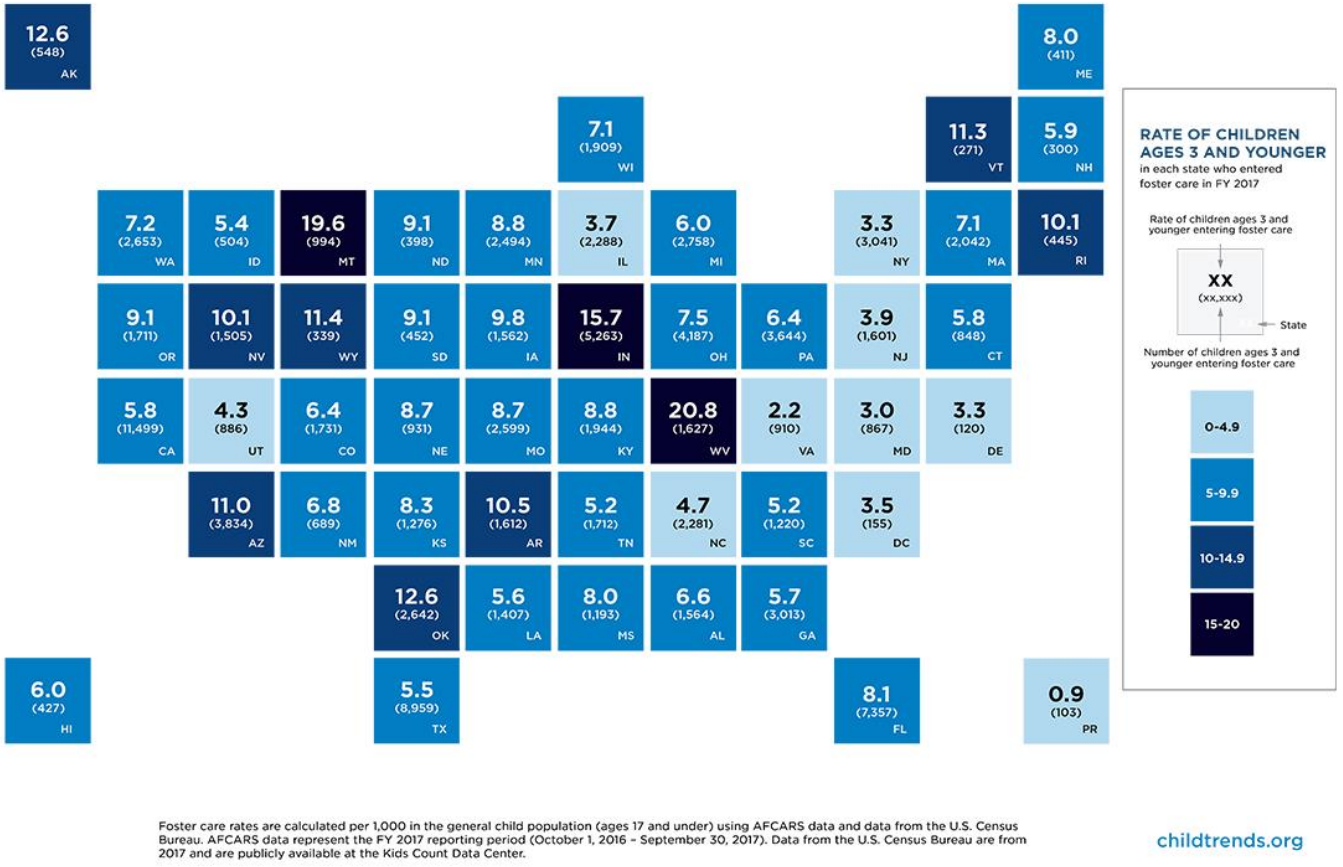
children ages 3 and younger entered foster care in 2017

Infants and toddlers are twice as likely than older children to enter foster care.



Foster care entry rates per 1,000 in the general child population (ages 17 and under) are calculated using the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) and data from the U.S. Census Bureau. AFCARS data pertain to the FY 2017 reporting period (October 1, 2016 – September 30, 2017). Data from the U.S. Census Bureau are from 2017 and are publicly available at the Kids Count Data Center.

The rate of children ages 3 and younger entering care in 2017 varied widely by state.



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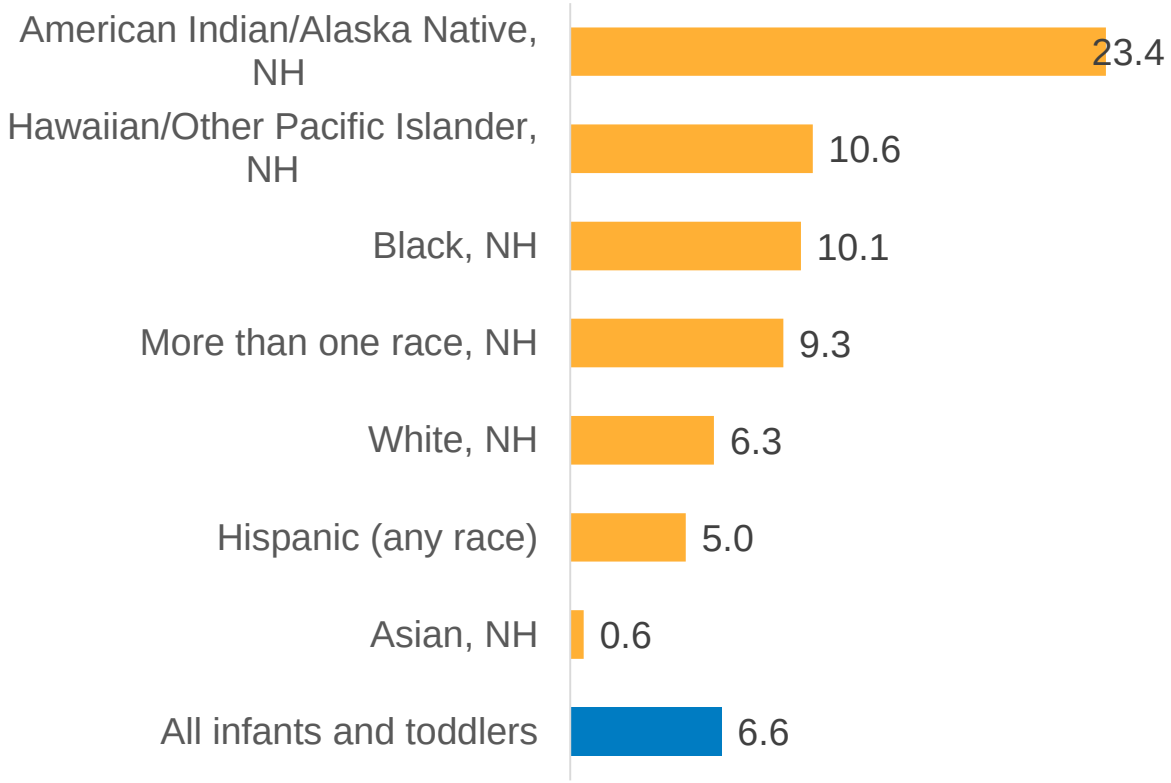
childtrends.org

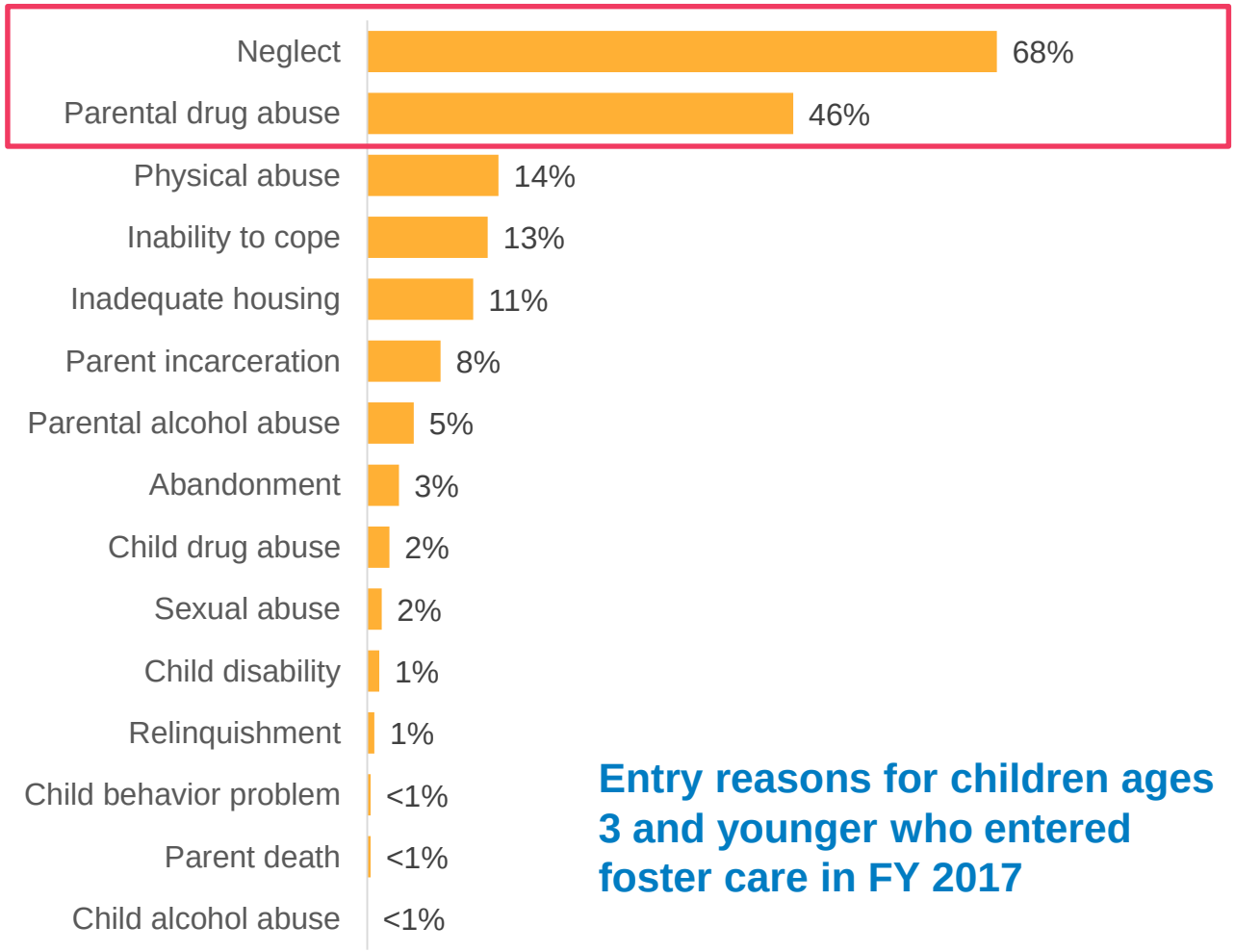
Child TRENDS

Rates of entry for infants and toddlers also vary by race/ethnicity.

Rate per 1,000 children ages 3 and younger who entered foster care in FY 2017, by race/ethnicity

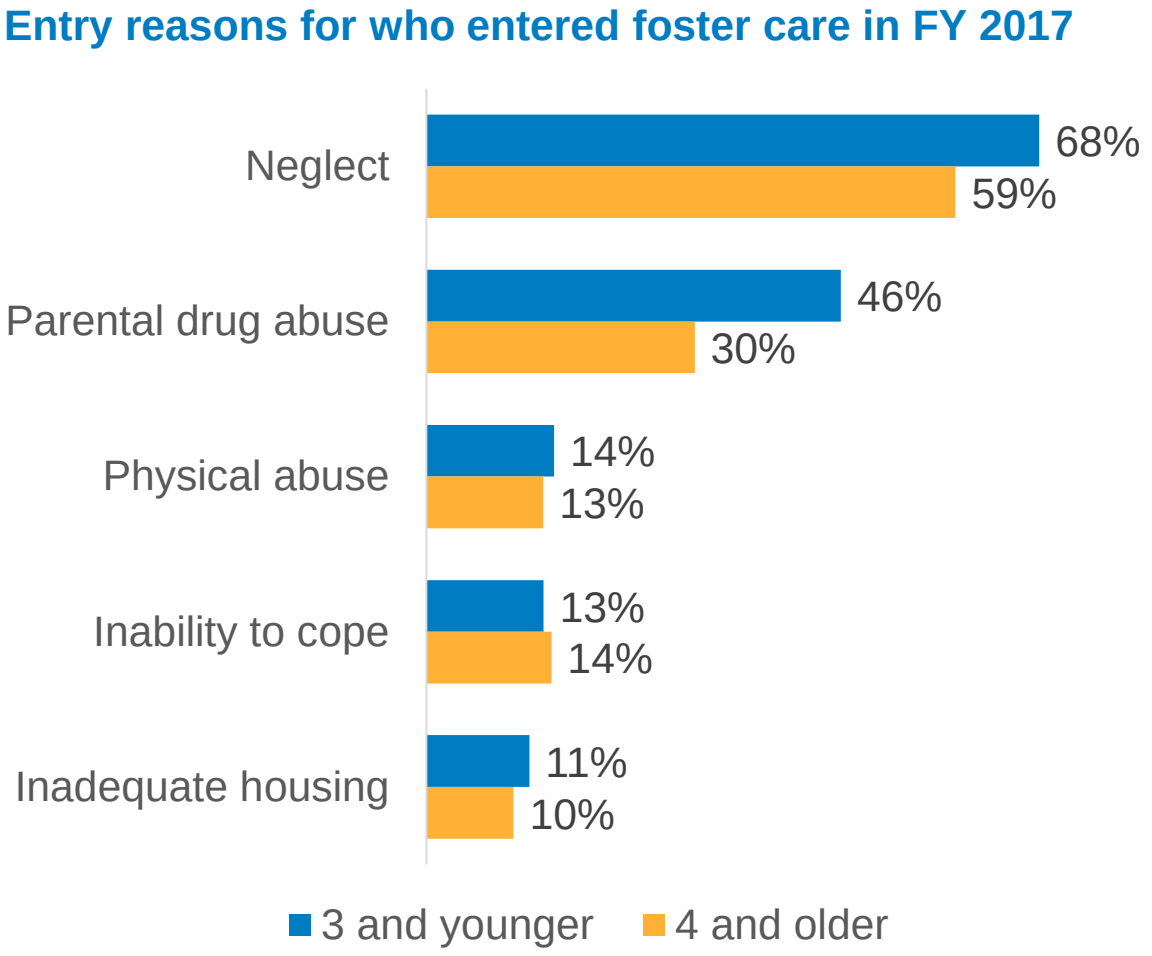


Neglect and parental drug abuse are the most common entry reasons for infants and toddlers.

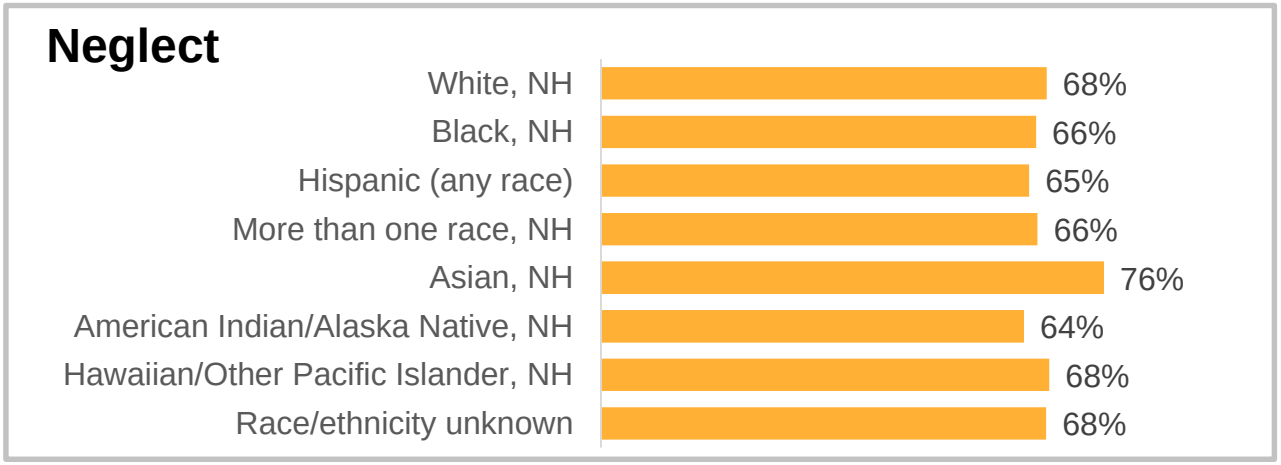


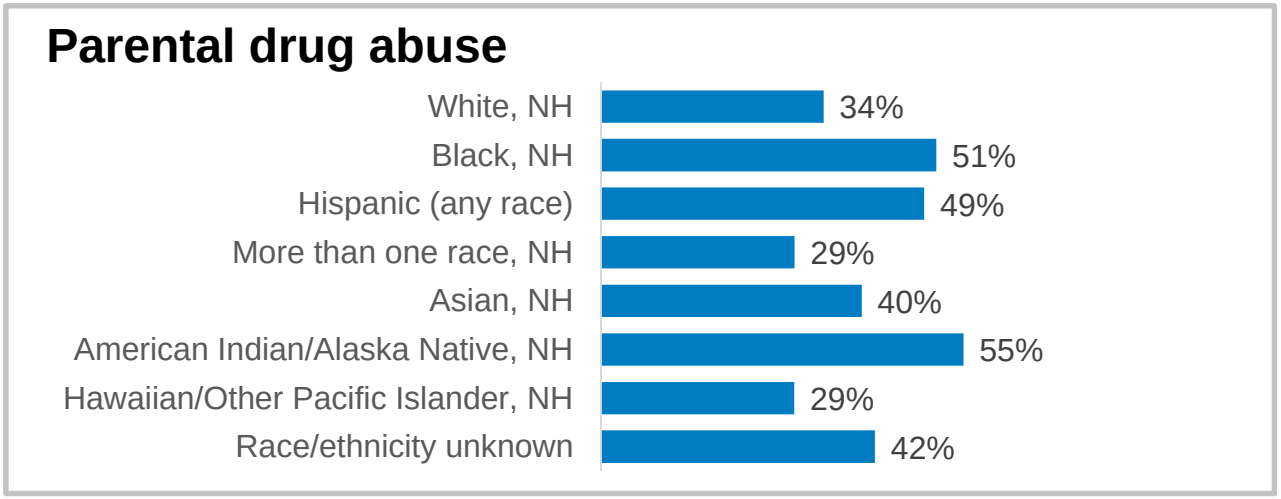
Entry reasons for children ages 3 and younger who entered foster care in FY 2017

Infants and toddlers are more likely than older children to enter care due to neglect or parental drug abuse.

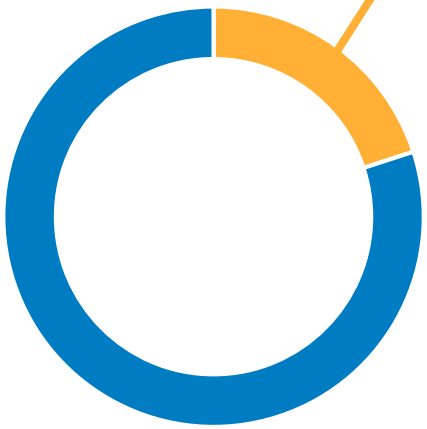


Percentage of **infants and toddlers** who enter care due to…





In 2017, **50,076 infants** entered foster care.

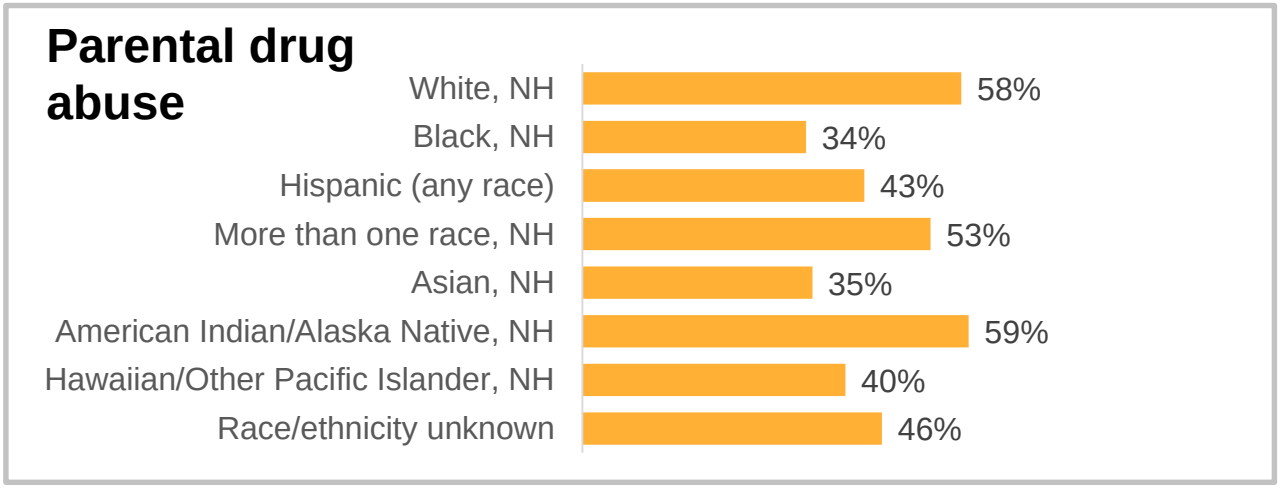


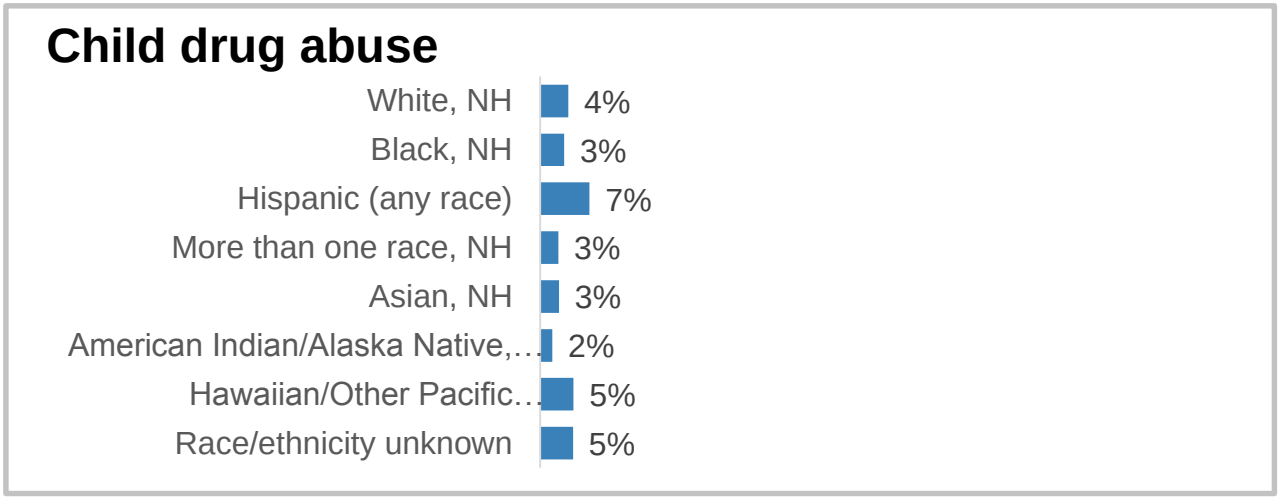
49% of infants enter care due to parental drug abuse

4% of infants enter care due to child drug abuse

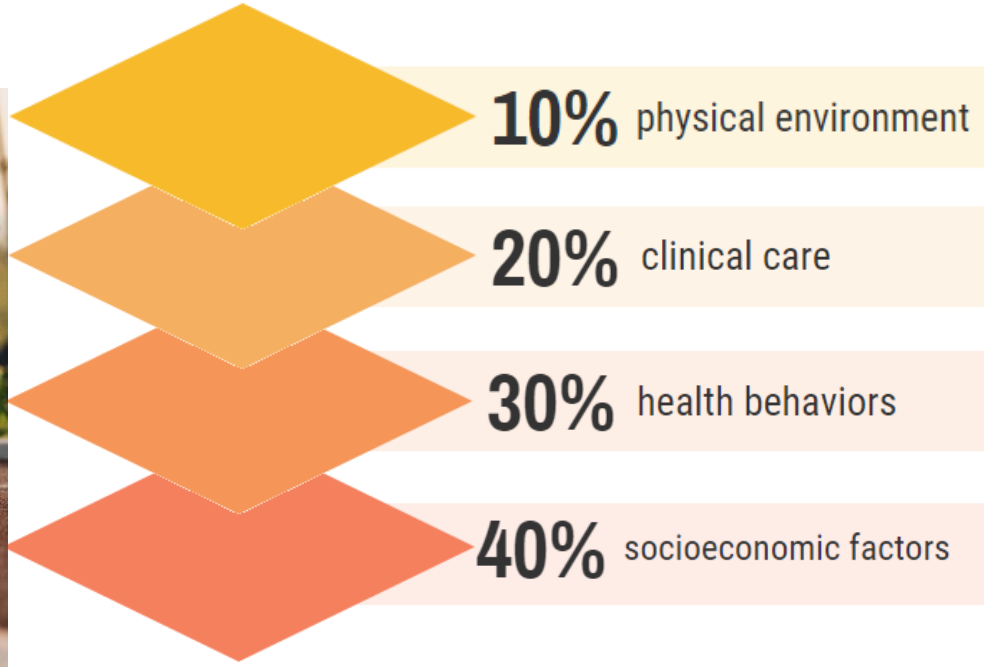
20% of all entries in 2017 were infants

Percentage of **infants** who enter care due to…





Social Determinants of Health



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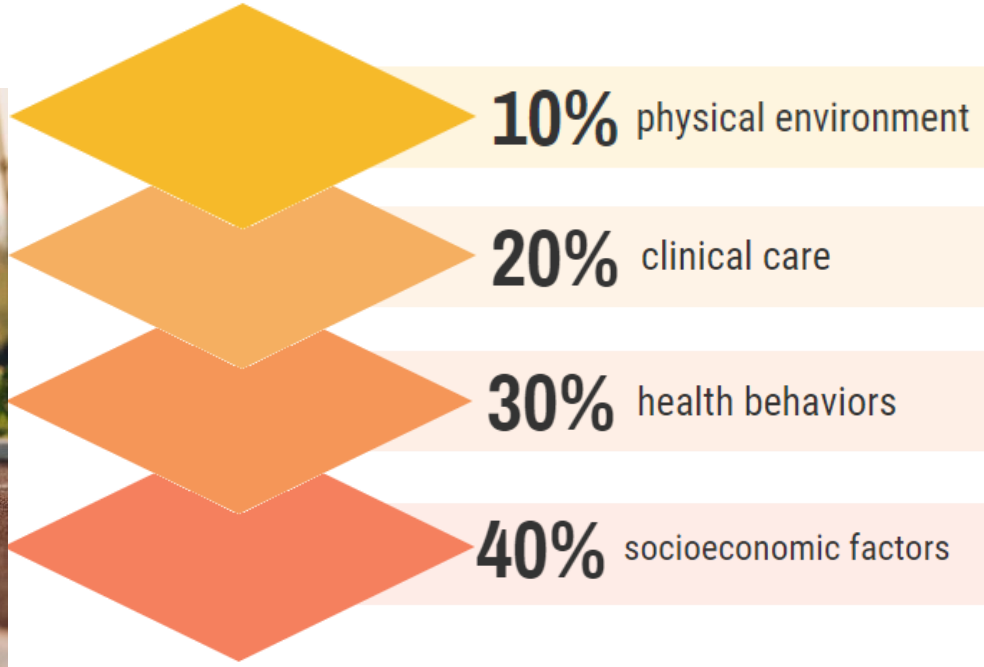


Surveillance & Screening for Vulnerability

Linkage to Community-Based Supports

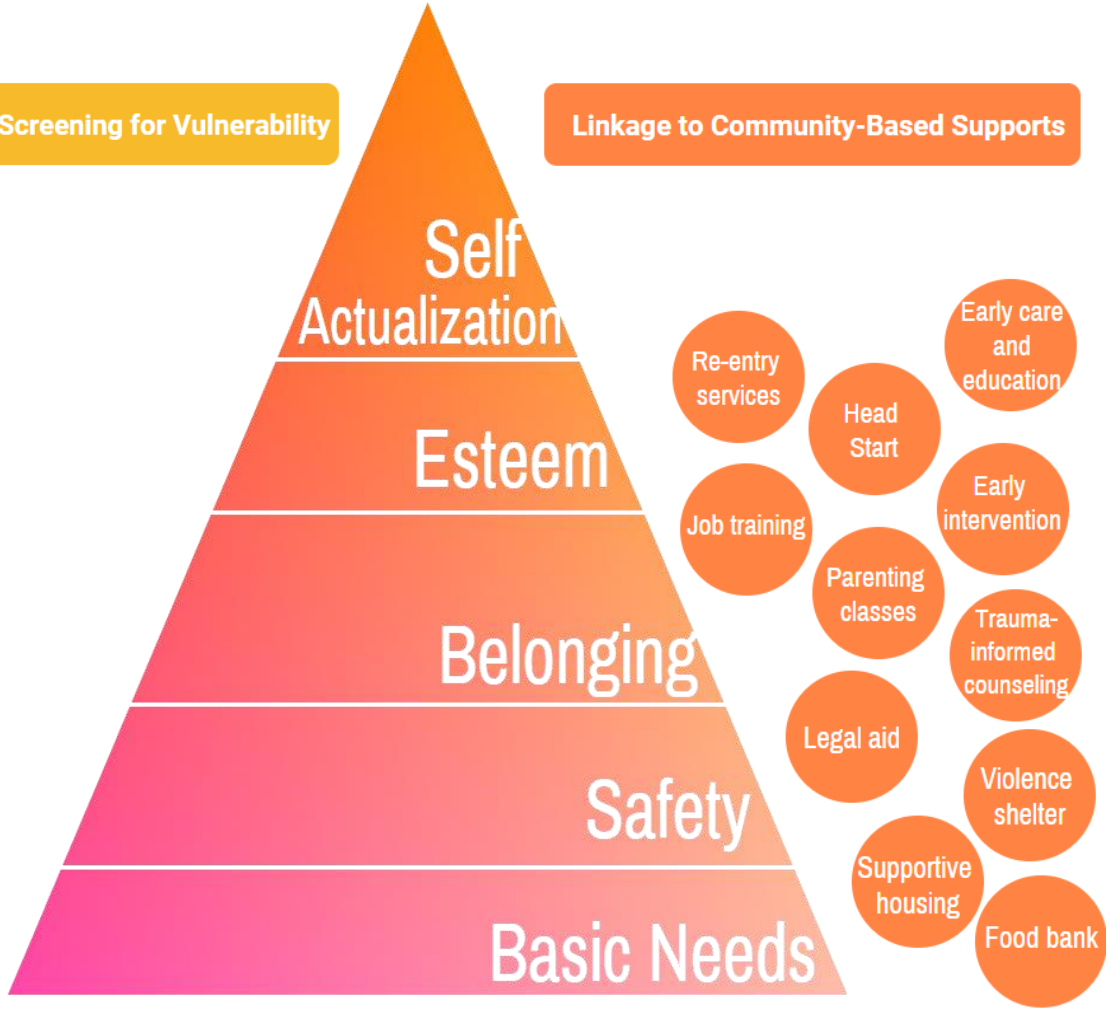
School readiness, all needed supports in place

Meaningful employment, social-emotional learning

Secure attachments, parents have support

Safe families, safe neighborhoods

Food security, stable housing, access to clean water



Re-entry services

Head Start

Early care and education

Job training

Early intervention

Parenting classes

Trauma-informed counseling

Legal aid

Violence shelter

Supportive housing

Food bank

MASLOW'S HIERARCHY OF NEEDS

Help Me Grow:
A Solution to Support All Children

- *Beyond developmental screening, beyond a program*
- Advancing developmental promotion, early detection & linkage to services

HELP ME GROW SYSTEM MODEL

Cooperation of Four Core Components

How is your Help Me Grow system supporting

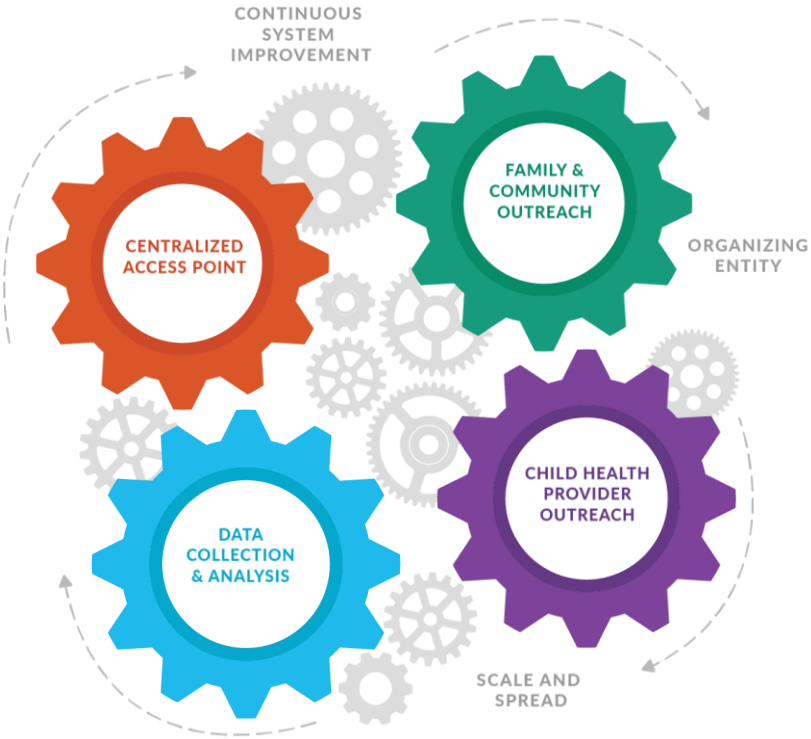
young children,

their caregivers,

service providers,

practices, processes, and policies

that are dealing with parental substance use and prenatal exposure?



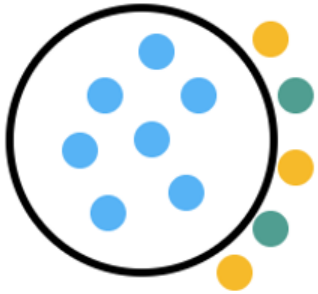
Assessing Help Me Grow within child serving sectors

Inclusion

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

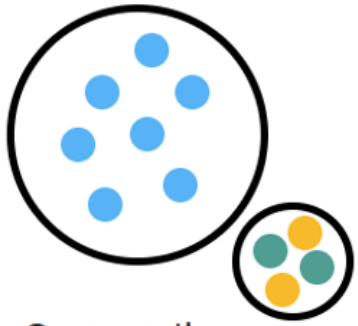
Integration

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



Exclusion

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

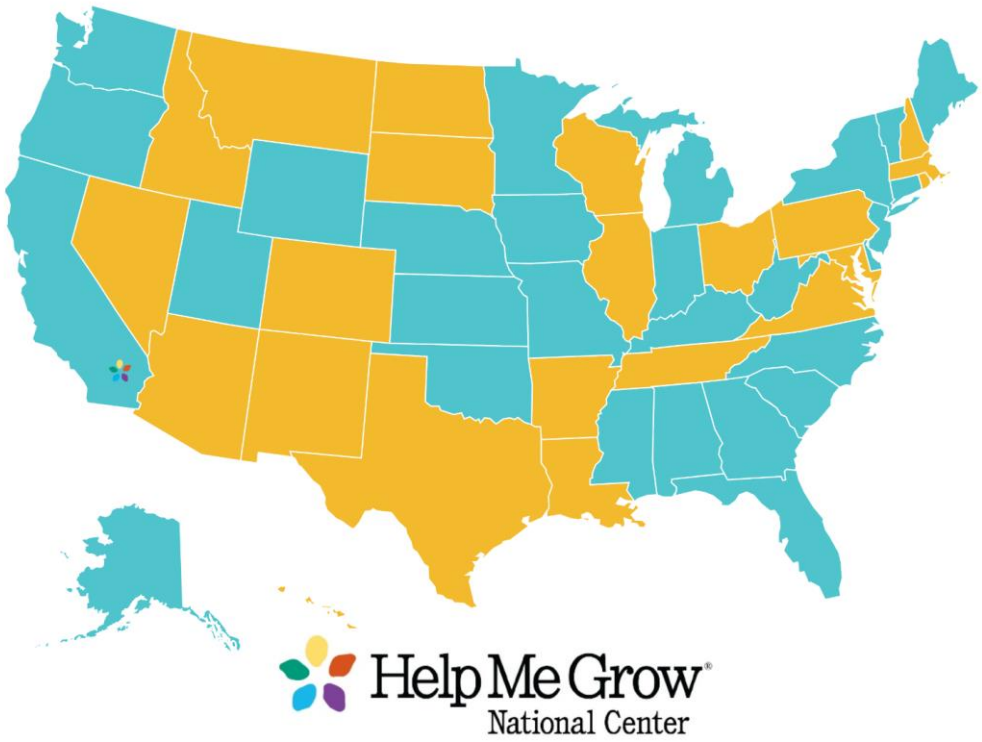


Segregation

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	
Alabama	Minnesota
Alaska	Mississippi
California	Missouri
Connecticut	New Jersey
District of Columbia	New York
Delaware	North Carolina
Florida	Oklahoma
Georgia	Oregon
Indiana	South Carolina
Iowa	Utah
Kansas	Vermont
Kentucky	Washington
Maine	West Virginia
Michigan	Wyoming

**based on 2018 data*

Q & A

Additional Questions?

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Thank You

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