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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Learning objectives:

(1) Participants will learn about changes to federal child welfare policy stemming from the Comprehensive Addiction and Recovery Act of 2016 (CARA).

(2) Participants will observe the variability among states’ policies in compliance with the federal legislation.

(3) Participants will understand the most common ways states are failing to comply with CARA, including the status of their own state and the potential impact of these discrepancies.
Background
Prenatal Substance Exposure

% Pregnant Women Past Month Substance Use
(NSDUH, 2018)

Estimated 600,000 infants born substance exposed in 2017

Drugs or Alcohol
Alcohol Use
Binge Alcohol Use
Illicit Drugs
Marijuana
Opioid

2016
2017
Prenatal Substance Exposure

- Rates of PSE are increasing, particularly rates of opiate exposure (Patrick et al., 2014; Ko et al., 2016)

![Graph showing incidence of NAS in 28 states per 1000 births from 1999 to 2013.](image)
PSE Policy Timeline

1974
CAPTA: Funding for prevention, assessment, investigation, prosecution, & treatment activities related to child maltreatment

Late 1980s
Media attention to PSE cases due to “crack” cocaine

Early 1990s
Research reports significant problems in SEI; more infants coming into foster care

1997
ASFA: children with parental SUD → reduced likelihood of reunification

Early 2000s
Research reports importance of post-natal environment in SEI outcomes

2003
CAPTA 2003: Introduced mandate that states implement policies to track and address prenatal exposure to illegal drugs, develop Plans of Safe Care

2010
CAPTA 2010: Revised to include FASD

2016
CARA 2016: Revised CAPTA to include legal drugs (e.g. Rx); PoSC for mom & baby
CAPTA PSE Domains

CAPTA now includes 5 domains related to prenatal substance exposure:

- No earlier documentation or analysis of states’ CAPTA/CARA plans
- No earlier evaluation of states’ plans for compliance with the federal legislation
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
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 requests to state child welfare professionals from all 50 states, Washington D.C., and Puerto Rico
  – Annual Progress and Services Report (APSR)
  – Relevant legislation, statutes, or administrative policies
• Obtained 194 total documents from 51 states
  – Unable to obtain any materials from 1 state
### Coding Guide

**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

**Parent + Child Codes**

1. Substance Type

   - Child code: illegal substances

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

- Open coding to create child codes
  Ex.) *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 raw agreement range: 98.4% - 99.7%
Mean κ range: .824 - .897
### 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>
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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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.
Who is fully compliant?

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

- Only 2 states fully CAPTA/CARA compliant
- 36 (71%) of states compliant with one or zero domains
Which mandates are most frequently addressed?

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

<table>
<thead>
<tr>
<th>State (N = 51)</th>
<th>CARA Compliant</th>
<th>Non-Compliant (n = 37)</th>
<th>Narrowed Scope (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Scope more broad</td>
<td>Scope more narrow</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Limited to &quot;illegal&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Excludes FASD</td>
</tr>
<tr>
<td>Total n</td>
<td>14</td>
<td>21</td>
<td>14</td>
</tr>
<tr>
<td>% of N</td>
<td>27.5</td>
<td>41.2</td>
<td>27.5</td>
</tr>
</tbody>
</table>
| North Dakota’s Century Code 50.51.1 defines prenatal substance exposure as: Use of a controlled substance...during pregnancy as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery of the child at birth, or medical effects or developmental delays during the child’s first year of life that medically indicate prenatal exposure to controlled substance (p. 2).
| Oregon’s policy applies to infants with Fetal Alcohol Spectrum Disorder or experiencing withdrawal symptoms (OR Department of Human Services, 2017). |
How do states deviate from the federal legislation?

### Notification Procedure

<table>
<thead>
<tr>
<th>State (N = 51)</th>
<th>CARA Compliant</th>
<th>Non-Compliant (n = 44)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mandated Report (n = 40)</td>
</tr>
<tr>
<td>Total n</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>% of N</td>
<td>13.7</td>
<td>37.3</td>
</tr>
</tbody>
</table>

**Montana**’s 2018 APSR describes that medical professionals are mandated reporters of substance-exposed newborns, but that “the criterion for reporting is the impact on the safety of the child” (p. 73).

**Texas**’s 2017 APSR indicates that cases of PSE “are staffed on an individual case-by case basis and safety decisions are made with regards to placement, supervision, and appropriate referrals to substance abuse [sic] treatment services” (p. 631).
How do states deviate from the federal legislation?

*Universal Plan of Safe Care*

<table>
<thead>
<tr>
<th>State (N = 51)</th>
<th>CARA Compliant</th>
<th>Non-Compliant (n = 35)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For safety concern only</td>
<td>For NO safety concern only</td>
</tr>
<tr>
<td><strong>Total n</strong></td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td><strong>% of N</strong></td>
<td>31.4</td>
<td>33.3</td>
</tr>
</tbody>
</table>

**Idaho’s 2018 APSR** indicates that plans of safe care are developed *only if an infant is determined to be unsafe* during initial child welfare assessment.

**Washington D.C.’s 2018 APSR** indicates that plans of safe care are developed for infants *“who are neither neglected...nor at risk of neglect”* (p. 131)
How do states deviate from the federal legislation?

Plan of Safe Care Content

<table>
<thead>
<tr>
<th>State (N = 51)</th>
<th>CARA Compliant</th>
<th>CARA-Compliant in Development</th>
<th>No Policy</th>
<th>Same as Safety Plan</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total n</td>
<td>15</td>
<td>6</td>
<td>13</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>% of N</td>
<td>29.4</td>
<td>11.8</td>
<td>25.5</td>
<td>31.4</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Connecticut’s 2018 APSR indicates that the state is in receipt of extensive technical assistance, has developed a working group and seeks input from providers across the state in order to develop a statewide policy on plans of safe care.

Michigan’s 2017 APSR indicates infants receive “plans of safe care” only after a CPS case is opened; in a manner consistent with routine safety planning.
How do states deviate from the federal legislation?

**Plan of Safe Care Development & Content**

- 9 states (17.56%) are compliant on both domains of Plan of Safe Care policy
- 13 states (25.5%) are compliant with either domain
- 29 states (56.86%) are non-compliant on both domains

**States' Compliance with CAPTA/CARA PoSC Policy**

- Neither: 56.86%
- Both: 17.65%
- Development Only: 13.73%
- Content Only: 11.76%
How do states deviate from the federal legislation?

**Data Collection & Monitoring**

<table>
<thead>
<tr>
<th>State (N = 51)</th>
<th>CARA-Compliant</th>
<th>Non-Compliant (n = 46)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Developing CAPTA/CARA system</td>
</tr>
<tr>
<td>Total n</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>% of N</td>
<td>9.8</td>
<td>25.5</td>
</tr>
</tbody>
</table>

New Mexico’s 2017 state plan mentions that data collection infrastructure is being reviewed to determine the *types of changes that will be needed to fully comply* with CAPTA/CARA mandates.

Alabama’s 2018 APSR includes the number of infants who **tested positive for drugs/drug withdrawals** at birth, the number of infants **who tested positive for alcohol at birth or exhibited FASD symptoms**, and the number of infants determined to be “chemically endangered”, meaning they were **exposed to methamphetamine** in utero.
Limitations & Discussion
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 197 documents, it is likely that we overlooked, or lacked access to, certain internal policies or laws that influence CAPTA/CARA implementation
Why are so few states compliant?

Barriers to Implementation:

1. PSE mandates constitute **two of 39 CAPTA State Plan requirements**
   - Compliance leveraged via CWS grants; **funds released without full compliance**
   - CAPTA state grants increased from **$25B to $85B** with 2018 budget appropriations; **more money, more oversight?**
Why are so few states compliant?

Barriers to Implementation:

2. CWS policy implemented at frontlines of hospital practice
   - Hospitals are used to “mandated reports”; can “notifications” be mandated?
   - Compliance leveraged with CWS funding; hospitals do not benefit
   - In one earlier study, <18% of hospital workers were aware of CAPTA 2010 (Chasnoff, Barber, Brook, & Akin, 2018)
Why are so few states compliant?

Barriers to Implementation:

3. TA only recently available and provided to certain states
   - 2017 Policy Academy for 15 states
   - Focus on plans of safe care & data/monitoring
   - Less emphasis on substances identified in policy, defining “affected by”, or differentiating between “notification” and “report”
What happens if states are non-compliant?

40 states mandate reporting instead of notification

16 states expand scope of policy and mandate reporting

Is this because states believe that CAPTA/CARA fills a gap in therapeutic responses?

Possibility for “net-widening”
What happens if states are non-compliant?

Results of net-widening:

- California, which bars reporting for substance exposure alone, 61% reported before age 1, and 30% placed into foster care (Prindle, Hammond, & Putnam-Hornstein, 2018)

- Mothers using Medication Assisted Treatment may face CWS intervention because infants are born with withdrawal symptoms (Beckwith & Burke, 2015; Binder & Vavrinková, 2008; Desai et al., 2015)

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

- Infants with substance removals are at high risk of failure to achieve permanency (Lloyd, Akin, & Brook, 2017)
Moving Forward

Practice
• Need for continued technical assistance and stakeholder engagement
• Training for hospital social workers on best practices for treating PSE in infants (e.g., Rooming In)
• Plan of Safe Care policies and processes that differ from traditional safety planning

Research
• Research on possible net-widening effects of CAPTA/CARA
Moving Forward

Policy

- Need for implementation oversight
- Role 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
QUESTIONS & DISCUSSION
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