ADRIANA KOHLER AND KATE MURPHY
SENIOR POLICY ASSOCIATES
AKOHLER@TXCHILDREN.ORG
KMUPRHY@TXCHILDREN.ORG
MARCH 20, 2018

Addressing Substance Use Among Pregnant Women and New Moms

Opportunities to Improve the Health and Well-Being of Texas Women and Their Young Children

Substance use disorders among pregnant women and new mothers play a significant role in the health and well-being of the mother and her child. Tragically, overdose is the most common cause of maternal death in Texas. Substance use is also the primary reason Child Protective Services (CPS) interacts with families in Texas. As policymakers consider ways to prevent and address substance use disorders, addiction, and tragic overdoses in Texas, this brief shows the connection between parental substance use and the short- and long-term consequences for maternal health and child well-being, particularly for families with children under age three. Effective substance use prevention, treatment, and recovery supports would not only help curb maternal mortality, but also improve parent and child well-being, keep more families together in safe homes, and reduce stress on Texas' foster care system. The end of this brief outlines the issues that policymakers should work on to address these issues.

The Challenge: Substance Use Disorders Play a Significant Role in Maternal Mortality, Children's Health, Child Maltreatment, and CPS Child Removals

Maternal Mortality and Maternal Health

Substance use disorders can have a devastating impact on women and their families. Texas is facing a maternal mortality crisis, with drug overdose as the most common cause of maternal death in Texas from 2012 to 2015.[1] While a handful of overdose deaths occurred within seven days of delivery, the vast majority occurred more than 60 days postpartum and within one year following birth.[2] Of the 382 maternal deaths in Texas between 2012 and 2015, drug overdose was the cause of 65 of them and five more were the result of

Texans Care for Children is a statewide, non-profit, non-partisan, multi-issue children's policy organization. We drive policy change to improve the lives of Texas children today for a stronger Texas tomorrow. We envision a Texas in which all children grow up to be healthy, safe, successful, and on a path to fulfill their promise.

Substance Use Sequelae (conditions that are a consequence of substance use, e.g., liver cirrhosis).[3] From these data, it is clear that risks may not disappear after mothers leave the delivery room. Prevention and health interventions throughout the year after the birth of a baby are critical for preventing tragic maternal deaths.

Health Risks to Babies and Children

Untreated substance use disorders during pregnancy can have damaging effects on the short- and long-term health and well-being of children. According to the American Academy of Pediatrics, in the short-term, prenatal substance exposure (including to nicotine, alcohol, opiates, and other drugs) can affect fetal growth, create congenital anomalies, risk complications related to withdrawal, and alter neurobehavior.[4] In the long term, prenatal substance exposure can lead to intellectual disabilities and affect a child's growth, behavior, cognition, language, and achievement.[5]

Child Maltreatment and Fatalities

The National Center on Addiction and Substance Abuse at Columbia University reports that children whose parents abuse alcohol and other drugs are four times more likely to be neglected and three times more likely to be sexually or physically assaulted.[6]

Substance use is also a significant risk factor in child fatalities in Texas. In FY2017, 52 percent of confirmed child fatalities caused by abuse or neglect included a parent or caregiver actively using a substance or under the influence of one or more substances that affected their ability to care for the child.[7]

CPS Investigations and Child Removals

For nearly half of all Texas families that interact with CPS in any way, substance use is one of the primary reasons CPS is involved.[8] Statewide in 2015:

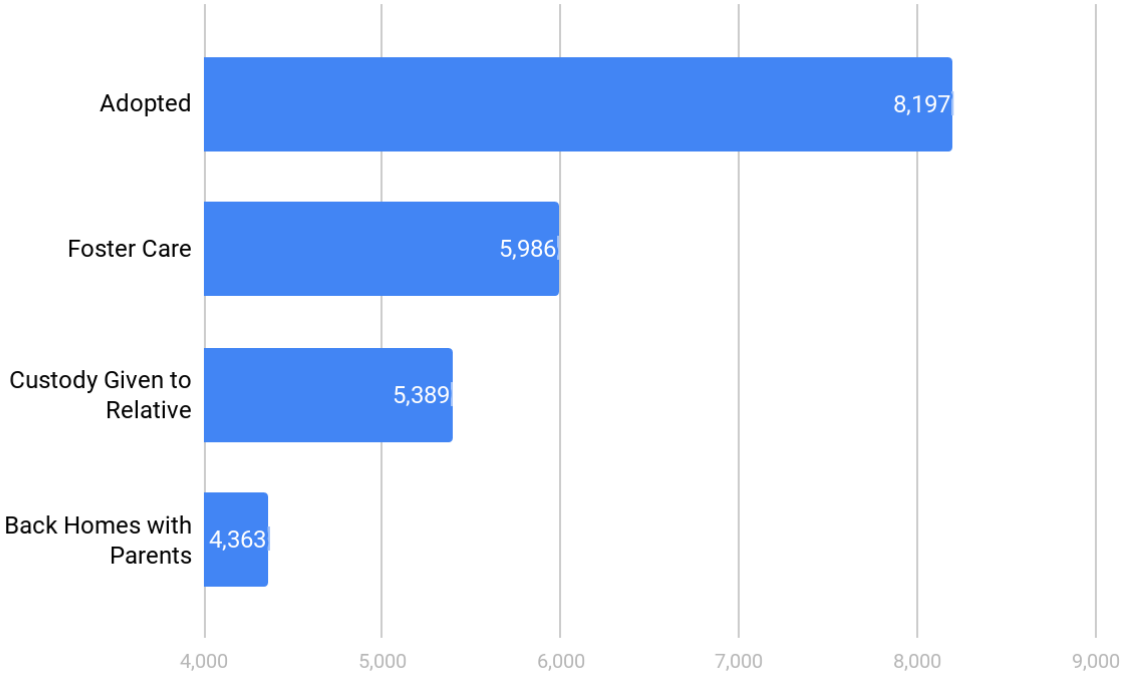
- 43 percent of CPS investigations were of families with substance use issues;
- 75 percent of family preservation cases involved families with substance use issues;
- **66 percent of Texas children removed from their homes and placed in foster care are there because of a parent or caregiver with substance use issues**.[9] This is almost *twice* the national average.[10]

Nationwide, parental alcohol or other drug use (AOD) as a cause for removal has nearly doubled (increasing from 18.5 percent of removals to 34.4 percent).[11] And although Texas has one of the lowest removal rates in the country (2.34 per 1000 children in 2015[12] and 2.64 now[13]), the main reason children enter foster care is because of parental substance use. Young children are particularly affected; 37 percent of all removals where substance use was identified as a factor in removal from 2010 to 2015 were of children under age three.[14]

Children in foster care because of parental substance use are less likely to be reunited with their families compared to children who were removed for other reasons. From 2010-2015, about one-third of children who exited foster care went home to their parents.[15] During those years, significantly fewer children who were removed due to parental substance were reunified with their parents (only 21.9 percent).[16] Looking specifically at children under three, only 18.2 percent returned home to their families.[17] Children who were removed from their parents because of substance use were nearly two times *less* likely to return home and have a safe, healthy relationship with their biological parents.

Further, many babies and toddlers who enter foster care because of parental substance use languish in care for months or years. Data from DFPS show that from 2010 to 2015, a total of 23,935 children under age three were removed because of parental substance use (in some cases there were additional reasons for removal). As shown below, a 2015 snapshot of the permanency outcomes for those 23,935 babies shows that *one quarter* were still in foster care, some after being in care for six years.[18]

A Snapshot of the 2015 Homes of the 23,935 Children under Age 3 Removed from their Families because of Substance Use from 2010 to 2015*[19]



* *In each of these cases substance use was identified as a factor in removal, but substance use may not be the sole reason for removal in every case.*

The Solutions: Improving Substance Use Services and Keeping Mother and Child Safely Together is Often Best for Both of Them

To support recovery and address the four consequences outlined above, it is important to improve access to substance use disorder services, especially female- and family-specialized services.

Though sometimes overlooked, another key to meeting those goals is promoting safe, stable nurturing home environments and parent-child relationships.

During the initial years of a child's life, if a mother has been using substances, keeping the mother and her child together -- if there is a way to do it safely -- is best practice for the mother's treatment and recovery because it promotes mother-child bonding and attachment, which are key to both infant health and parental success.[20]

Avoiding CPS child removal, when possible, is also best for children in these circumstances. In the short-term, when it comes to opioids, medical professionals recommend keeping the mom and baby together to alleviate the symptoms of Neonatal Abstinence Syndrome (NAS). Studies have shown that rooming in, breastfeeding, skin to skin contact, bonding, and attachment reduce the need for pharmacological interventions when infants are experiencing withdrawal symptoms after birth.[21] Looking further down the road, removing children from their families is a very traumatic experience. Many children may experience additional trauma in foster care. Multiple traumas affect brain development and can lead to negative long-term physical and behavioral health problems.[22]

Policy Issues to Address

Address Data Gaps

- **Track substances connected with CPS removals.** One glaring gap in information is that Texas currently does not track which substances are involved when children are removed from their families by CPS. Without knowing which substances are causing removals, it is difficult to truly assess community needs and tailor prevention and intervention services to meet the needs of children and parents in a region or local area.

Early Intervention

- **Enhance the ability of DFPS Prevention and Early Intervention (PEI) programs to support families facing substance use disorders.** PEI programs like Healthy Outcomes through Prevention and Early Support (HOPES), Helping through Intervention and Prevention (HIP), and Home Visiting play a vital role improving child well-being and families success. These programs help families build positive parenting

skills and are proven to reduce child abuse and neglect. In PEI's Five Year Strategic Plan, DFPS set a goal of addressing the underlying causes of child maltreatment including substance use. Some options to further this goal include:

  - Training PEI program staff on best practices for screening and referral to Texas' Outreach, Screening, Assessment, and Referral Centers (OSARs), which assess for level of need and serve as an entry point into substance use treatment and recovery. Currently there is one OSAR in each of the 11 Health and Human Service Regions.
  - As a parent completes treatment and heads towards long-term recovery, PEI programs can play a role helping families build parenting skills, create safe, nurturing homes for their kids, and offer supports that assist with relapse prevention.

- Increase targeted outreach and training for health providers on the available behavioral health resources in the community and evidence-based methods for screening and referral.
  - In their review of maternal deaths, DSHS and the Texas Maternal Mortality Task Force found there were numerous missed opportunities to screen for behavioral health issues and refer new mothers to treatment or services. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based process where providers can choose to screen, use motivational interviewing techniques to address issues early, and refer for follow-up. Training on SBIRT is needed to maximize effectiveness, yet the necessary training may be keeping many health professionals from using this best practice.
  - Moreover, health providers may not be aware of where to refer clients who screen positive for substance use issues. DSHS has developed helpful posters and documents with information on OSARs in each region. Greater distribution and additional outreach efforts would help ensure a broader range of health providers -- as well as other parent- and child-serving professionals -- are aware of the role of OSARs and how to refer to them.

- HHSC should provide behavioral health providers with additional education and training about local women's health services, including Healthy Texas Women (HTW) and Family Planning Program (FPP). Unintended pregnancy rates among women with substance use disorders are approximately 80 percent, considerably higher than in the general population. SAMHSA and the American College of Obstetricians and Gynecologists (ACOG) agree that women with substance use disorders should be able to easily access family planning and preventive health care. HTW and FPP offer critical health screenings and preventive care, including family planning -- and new mothers are auto-enrolled in HTW after Medicaid coverage ends 60 days postpartum. Yet, far too many community-based substance use treatment providers remain unaware of HTW and FPP and local women's health program providers to which they can refer. Effective screening and referral protocols are essential in both directions: from behavioral health providers to family planning providers, and vice-versa.

Alternative to CPS Removal

- **DFPS should expand eligibility criteria for Alternative Response (AR) to include families with children under age six to allow mothers in substance use treatment to stay with their child and avoid the need for foster care.** In the Texas child welfare system, Statewide Intake routes reports of abuse or neglect that present less immediate safety or risk issues are to AR, which is an alternative to traditional Child Protective Investigations (CPI). AR connects families to community organizations and service providers to address and resolve concerns as they arise. Currently cases with children under the age of six are ineligible for AR; this limitation precludes families with young children who are willing to seek treatment from taking advantage of this safe, successful foster care diversion.

Supportive Treatment and Recovery

- **Texas should leverage new opportunities in the Family First Prevention Services Act to use federal funding to engage parents in substance use treatment and prevent entry into foster care.** Under the new federal law, Title IV-E funding may be used to reimburse 50 percent of the amount states spend on substance use services for parents or caregivers when the services are directly related to the safety, permanency, or well-being of a child. The services may be reimbursed for 12 months. The reimbursement is contingent on the state having a well-designed, rigorously evaluated prevention plan for each child.

- **Increase state investment in family-specialized substance use treatment programs that allow parent and child to stay together during treatment.** Through state and federal funds, Texas supports only 10 women and children residential treatment providers that allow pregnant women/mothers and their children to stay together during the course of recovery. These programs -- in addition to early interventions like the Mommies Program that offers parenting education and counseling for parents with substance use issues -- are proven to decrease child maltreatment and improve maternal and infant health. However, if these programs are not available nearby, they may be inaccessible to CPS clients who need to stay close to their child to facilitate visitation and improve the chances of ultimately reunifying with their child.

Improved Coordination between Public Health and Child Welfare Systems

- **Promote training for CPS and Family Based Safety Services (FBSS) caseworkers, judges, and attorneys -- including training from external experts -- to improve knowledge around substance use disorders, maternal mortality, and referrals to treatment.** Emphasis should be promoting child safety and both child and parental well-being. Some examples of areas for improvement include:

- Training child welfare professionals on the role of OSARs in assessing for appropriate services. OSARs specialize in determining the level of treatment need and connecting individuals to services. If a caseworker, attorney, or judge is unfamiliar with behavioral health treatment and recovery providers in their area, they may not be able to help parents connect with the services they need, but an OSAR could. Unfortunately, parents often do not connect with an OSAR until after they have been in front of a judge. A caseworker, attorney, or judge who does not understand the function of an OSAR may recommend or order services that are inconsistent with the parent's actual need.
- Further, not all caseworkers, judges, and attorneys are aware that medication-assisted treatment (MAT, e.g., methadone or buprenorphine) is the best practice for many substance use disorders, especially for pregnant and postpartum mothers. More familiarity with best practice would help professionals working with CPS-involved families make better decisions that promote recovery and family reunification.

- **Improve coordination between HHSC and DFPS -- including Child Protective Investigations trainings -- on best practice protocols when a baby is substance-exposed or at risk of NAS.** For example, if a newborn experiences NAS, and CPS removes the child too soon, that removal contradicts best medical practice and undermines health outcomes for mom and baby. Many hospitals use standardized best practice protocols for NAS, which include evidence-based approaches that encourage breastfeeding, rooming-in (keeping mom and baby together as standard of care), and using low stimuli environments to reduce NAS. This shortens expensive hospital stays and reduces the need for costlier pharmacological interventions. CPS should not remove children from their mothers during this critical time.

******

[1] Overdose is classified as a pregnancy-associated death (i.e., a death that is not solely caused by pregnancy, but is connected to or aggravated by pregnancy).Texas Health and Human Services Commission. (2017). Legislative Brief: Investigating Maternal Mortality in Texas. Texas Department of State Health Services. Legislative Brief: Investigating Maternal Mortality in Texas (Sept. 2017). Available at https://hhs.texas.gov/sites/default/files//documents/about-hhs/communications-events/meetings-events/maternal-mortality-morbidity/m3tf-agenda7-170929.pdf.
[2] Ibid.
[3] Ibid.
[4] Behnke, M.D., & Smith, V.C.. (2013). Prenatal Substance Abuse: Short- and Long-Term Effects on the Exposed Fetus. American Academy of Pediatrics. Available at http://pediatrics.aappublications.org/content/pediatrics/131/3/e1009.full.pdf.
[5] Ibid.
[6] The National Center on Addiction and Substance Abuse. (1999). Available at https://www.centeronaddiction.org/addiction-research/reports/no-safe-haven-children-substance-abusing-parents.
[7] Texas Department of Family and Protective Services. (2018). Fiscal Year 2017 Child Maltreatment Fatalities and Near Fatalities Annual Report. Available at

https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/PEI/documents/2018/2018-03-01-Child_Fatality_Annual_Report-FY2017.pdf.

[8] Texas Department of Family Protective Services. (2015). CPS Families with Substance Abuse Issues.

[9] Ibid.

[10] National Center on Substance Abuse and Child Welfare. Child Welfare and Treatment Statistics. Retrieved March 2018 from https://ncsacw.samhsa.gov/resources/child-welfare-and-treatment-statistics.aspx.

[11] Ibid.

[12] Texas Department of Family Protective Services. (2015). Child Protective Services (CPS) Conservatorship: Removals. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Removals.asp.

[13] Texas Department of Family Protective Services. (2017). Child Protective Services (CPS) Conservatorship: Removals. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Removals.asp.

[14] Texas Department of Family Protective Services. (2015). Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2015, for children age 0-17; Texas Department of Family Protective Services. (2015). Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2014, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2013, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2012, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2011, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2010, for children age 0-17.

[15] Texas Department of Family Protective Services. (2018). CPS Conservatorship: Children Exiting DFPS Legal Custody. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Exits.asp.

[16] Texas Department of Family Protective Services. (2015). Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2015, for children age 0-17; Texas Department of Family Protective Services. (2015). Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2014, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2013, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2012, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2011, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2010, for children age 0-17.

[17] Ibid.

[18] Texas Department of Family Protective Services. (2015). Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2015, for children age 0-17; Texas Department of Family Protective Services. (2015). Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2014, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2013, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2012, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2011, for children age 0-17; Removals where Alcohol/Drug Abuse was identified as a factor in Removal for fiscal year 2010, for children age 0-17.

[19] Ibid.

[20] Substance Abuse and Mental Health Services Administration Center for Substance Use Treatment. (2007). Family Centered Treatment for Women with Substance Use Disorders: History, Key Elements, and Challenges. Available at https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf.

[21] Newman, A, Davies, G.A., Dow, K., Holmes, B., Macdonald, J., McKnight, S. & Newton, L. (2014). Rooming-in care for infants of opioid dependent mothers: Implementation and evaluation at a tertiary care hospital. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4677958/.

[22] Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. (2014). Chapter 3, Understanding the Impact of Trauma. Available at https://www.ncbi.nlm.nih.gov/books/NBK207191/.