

# SUBSTANCE USE DURING PREGNANCY AND FAMILY CARE PLANS

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## INTRODUCTION

Substance use disorders (SUDs), including alcohol use disorder (AUD), opioid use disorder (OUD), and stimulant use disorder, affect people from all walks of life, including individuals who are or may become pregnant. The American Society of Addiction Medicine defines addiction as “a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences.”<sup>1</sup> Individuals with an SUD or other substance-related disorder, including those who are or may become pregnant, “use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.”<sup>2</sup> Those harmful consequences all too often culminate in an unintentional overdose. For the 12-month period ending May 2022, an estimated 108,000 individuals lost their lives to drug overdose.<sup>3</sup> Further, in 2020 (the most recent year for which there is data), an estimated 1.8 million individuals appeared in the emergency room with an unintentional, non-fatal poisoning, a category that includes drug overdoses.<sup>4</sup>

In that same year, an estimated 169,000 pregnant people in the United States aged 15 to 44 reported illicit drug use, with the vast majority (164,000) reporting cannabis use.<sup>5</sup> An additional 8,000 reported use of opioids, while 215,000 reported any alcohol use.<sup>6</sup> While those who are pregnant are more likely to stop using drugs during the pregnancy, they are also more likely to die of an overdose within one year following giving birth.<sup>7</sup> In a number of states, drug overdose is the leading cause of pregnancy-associated death (defined as “the death of a woman during pregnancy or within one year of the end of pregnancy from any cause”<sup>8</sup>) in the one-year postpartum period following the birth of a child.<sup>9</sup> In Tennessee, for example, a 2022 report detailing maternal mortality found that, for the period 2017-2020, SUD contributed to 26 percent of pregnancy-related deaths where death occurred within one year of pregnancy and the pregnancy was an aggravating factor.<sup>10</sup> Overdose was the leading cause of death for that same time period for pregnancy-associated deaths where the pregnancy was not related to the death.<sup>11</sup>



In addition to health concerns for the pregnant or postpartum individual, untreated SUD during pregnancy can lead to serious health issues for the newborn infant including premature birth and low birth weight. It can even result in fetal loss. Prenatal substance exposure can cause the infant to experience withdrawal and, potentially, be diagnosed with neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS).<sup>12</sup> Nationally, during the period 2010 to 2017, there was a relative 82 percent increase in the incidence of NAS.<sup>13</sup> Finally, having an untreated SUD while pregnant can result in family separations, child removals, and even criminal actions against the pregnant individual.<sup>14</sup>

There are a number of expert recommendations regarding how to identify, work with, and treat pregnant and postpartum individuals with SUD to ensure the best outcomes for both parent and child. There are also legal requirements regarding notification to state child welfare agencies of infants born affected by prenatal substance exposure or experiencing withdrawal and the creation of family care plans (also known as plans of safe care). This fact sheet provides readers with an overview of those recommendations and requirements.

## EARLY DIAGNOSIS AND TREATMENT

Experts agree that the key to improving outcomes for both the pregnant individual and the infant is through early diagnosis and treatment. The American College of Obstetricians and Gynecologists (ACOG) recommends, “early universal screening, brief intervention..., and referral for treatment.”<sup>15</sup> ACOG further recommends that screening “should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant” individual.<sup>16</sup> Screening involves the use of a validated screening tool, such as a questionnaire, to determine if it is likely that the individual has an SUD. Screening is distinct from testing, which involves taking a urine, hair follicle, or blood sample from the individual and testing that sample for the presence of controlled substance metabolites.

If a pregnant individual screens as likely having an SUD, the screening should be followed up by an assessment conducted by an individual with the experience and training necessary to conduct the assessment to determine whether and what type of treatment and other services (*e.g.*, education, employment, housing, or legal assistance) the individual may need. Further, if the individual has an OUD, “opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse outcomes.”<sup>17</sup> Medications for addiction treatment include not just medications to treat OUD but also medications to treat AUD and should be the first line of treatment for pregnant individuals with an SUD where possible. However, pregnant individuals are less likely to be accepted for SUD treatment than non-pregnant individuals,<sup>18</sup> and they also “face substantial systemic and cultural barriers in accessing this care.”<sup>19</sup> For example, studies suggest that other factors contribute to an individual being less likely to be able to access medications for addiction treatment, including, but not limited to, “being a person of color, living in a rural community, and not speaking English.”<sup>20</sup>

Another barrier to accessing treatment is the fear among pregnant individuals with SUD that their child will be removed from their care once born due to their substance use. One of the “five key values” set forth in the Biden-Harris Administration Plan is that “having SUD in pregnancy is not, by itself, child abuse or neglect.”<sup>21</sup> The Plan further provides that, “[c]riminalizing SUD in pregnancy is ineffective and harmful as it prevents pregnant women with SUD from seeking and receiving the help they need.”<sup>22</sup> Unfortunately, however, 23 states and the District of Columbia consider substance use during pregnancy to be evidence of child abuse or neglect.<sup>23</sup> Further, the application of those laws appears to be inconsistent.

**Data indicate that Black pregnant women are more likely to be referred to child welfare systems compared to White pregnant women, Black children are over represented (*sic.*) in the US child welfare system, and Black parents whose infants were placed in foster care are less likely than White parents to be reunified with their children. Further, American Indian/Alaska Native children are overrepresented in foster care at a rate that is nearly 3 times greater than the general population. Given that more than half of infant foster care placements are associated with parental substance use, there are often missed opportunities to prevent unnecessary foster care placements through connecting pregnant and postpartum women to treatment and other resources.<sup>24</sup>**

One way in which these connections to treatment and other services can be made is through the use of a family care plan (also known as a plan of safe care). The federal Child Abuse Prevention and Treatment Act (CAPTA) includes a requirement for states that receive CAPTA funds that those states have policies and procedures in place mandating that any healthcare professional involved in the care or delivery of an infant “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 their state or local child welfare agency of the birth of such infant.<sup>25</sup> This notification is not an allegation of child abuse or neglect, and CAPTA does not require the submission of any identifying information with the notification.<sup>26</sup> CAPTA does, however, require that a family care plan be created for each infant for whom a notification is submitted.<sup>27</sup>

## FAMILY CARE PLANS

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The purpose of the family care plan is to “ensure the safety and well-being of an infant with prenatal substance exposure following his or her release from the care of a healthcare provider by addressing” the health needs of the infant and any affected family members, including the birthing individual.<sup>28</sup> However, experts recommend that family care plans be created as early in the pregnancy as possible so that the pregnant individual is supported and engaged in the receipt of any treatment or other services, including, but not limited to, education, employment, housing, SUD treatment, and early intervention services, prior to the birth of the child. They further recommend that the individual continue to receive such support and services during the postpartum period.<sup>29</sup>

The creation of a family care plan should involve the pregnant or postpartum individual and a multidisciplinary team that includes the individual’s healthcare provider. The multidisciplinary team may include one or more other individuals or entities including, but not limited to, public health agencies, home visitation programs, SUD treatment providers, mental health treatment providers, representatives from courts of law, housing agencies, child welfare agencies, and any other individuals or entities that might be able to provide services, or connections to services, for the pregnant or postpartum person, based upon the individual’s specific needs. Family care plans should be tailored to the individual or family that is the subject of the plan to ensure the best outcomes for the family. As stated in the Biden-Harris Administration Plan, “[c]lear coordination of health care and early childhood systems, including public health, early learning, courts, child welfare systems, and family economic supports will optimize the outcomes for infants and pregnant women with SUD.”<sup>30</sup>

## CONCLUSION

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Substance use during pregnancy can result in poor outcomes for both the pregnant individual and the newborn infant. Moreover, adverse legal consequences, including family separation and criminal sanctions, have a deleterious effect on outcomes for the pregnant individual and infant. Therefore, pregnant individuals should be engaged in treatment and participate in a family care plan as early in the pregnancy as possible in order to ensure the best outcomes for the individual, infant, and any other affected family members or caregivers.

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<sup>1</sup> *Definition of Addiction*, AM. SOC’Y OF ADDICTION MED. (Sept. 15, 2019), [asam's-2019-definition-of-addiction-\(1\).pdf](#).

<sup>2</sup> *Id.*

<sup>3</sup> FB Ahmad et al., *Provisional Drug Overdose Death Counts*, NAT’L CTR. FOR HEALTH STATS., CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 12, 2022), <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#citation>.

<sup>4</sup> *WISQARS™ - Web-based Injury Statistics Query and Reporting System*, CTRS. FOR DISEASE CONTROL & PREVENTION (accessed Oct. 27, 2022), [WISQARS \(Web-based Injury Statistics Query and Reporting System\)|Injury Center|CDC](#). Poisoning was the third most commonly reported unintentional, non-fatal injury, representing 8.6 percent of all reports, with falls (32.7 percent) and being struck by/against or crushed by something other than a motor vehicle (10.8 percent) coming first and second, respectively.

<sup>5</sup> *2019-2020 National Survey on Drug Use and Health, Table 6.20A*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), U.S. DEP’T OF HEALTH & HUM. SERVS. (Jan. 2022), [2020 NSDUH Detailed Tables | CBHSQ Data \(samhsa.gov\)](#).

<sup>6</sup> *Id.*

<sup>7</sup> See, e.g., *Maternal Mortality in Tennessee 2017-2020, 2022 Report to the Tennessee General Assembly*, TENN. DEP’T OF HEALTH 9 (April 13, 2022), [MMR-2022-Annual-Report.pdf \(tn.gov\)](#).

<sup>8</sup> *Maternal Mortality in Tennessee 2017-2020, 2022 Report to the Tennessee General Assembly*, TENN. DEP’T OF HEALTH 9 (April 13, 2022), [MMR-2022-Annual-Report.pdf \(tn.gov\)](#).

<sup>9</sup> See *Substance Use Disorder in Pregnancy: Improving Outcomes for Families*, OFF. OF NAT'L DRUG CONTROL POL'Y, EXEC. OFF. OF THE PRESIDENT (Oct. 2022), [ONDCP Report-Substance-Use-Disorder-and-Pregnancy.pdf \(whitehouse.gov\)](#); *A Report on Pregnancy-associated Deaths in Ohio 2008-2016*, OHIO DEP'T OF HEALTH (2019), [A\\_Report\\_on\\_Pregnancy-Associated\\_Deaths\\_in\\_Ohio\\_2008-2016+website+version.pdf](#).

<sup>10</sup> TENN. DEP'T OF HEALTH, *supra* note 8, at 13.

<sup>11</sup> *Id.* at 18.

<sup>12</sup> See Stephen W. Patrick et al., *Neonatal Opioid Withdrawal Syndrome*, 146(5) PEDIATRICS, Nov. 2020, [Neonatal Opioid Withdrawal Syndrome | Pediatrics | American Academy of Pediatrics \(aap.org\)](#).

<sup>13</sup> Ashley H. Hirai et al., *Neonatal Abstinence Syndrome and Maternal Opioid-related Diagnoses in the US, 2010-2017*, 325(2) JAMA NETWORK 146-155 (Jan. 12, 2021), [Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the US, 2010-2017 | Neonatology | JAMA | JAMA Network](#).

<sup>14</sup> See *Substance Use during Pregnancy and Child Abuse or Neglect: Summary of State Laws*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Oct. 2022).

<sup>15</sup> *Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy*, 130(2) OBSTETRICS & GYNECOLOGY e84-e85 (Aug. 2017), [Committee Opinion No. 711: Opioid Use and Opioid Use Disorder... : Obstetrics & Gynecology \(lww.com\)](#).

<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> See Stephen W. Patrick et al., *Association of Pregnancy and Insurance Status with Treatment Access for Opioid Use Disorder*, JAMA NETWORK OPEN (Aug. 14, 2020), [Association of Pregnancy and Insurance Status With Treatment Access for Opioid Use Disorder - PMC \(nih.gov\)](#).

<sup>19</sup> OFF. OF NAT'L DRUG CONTROL POL'Y, *supra* note 9, at 2.

<sup>20</sup> *Id.*

<sup>21</sup> *Id.* at 3.

<sup>22</sup> *Id.*

<sup>23</sup> See *Substance Use during Pregnancy and Child Abuse or Neglect: Summary of State Laws*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Oct. 2022).

<sup>24</sup> OFF. OF NAT'L DRUG CONTROL POL'Y, *supra* note 9, at 2.

<sup>25</sup> 42 U.S.C.A. § 5106a.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> *Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families: State Statutes*, CHILDREN'S BUREAU, ADMIN. FOR CHILD. & FAM., U.S. DEP'T OF HEALTH & HUM. SERVS. 2 (Aug. 2019), [Plans of Safe Care for Infants With Prenatal Substance Exposure and Their Families \(childwelfare.gov\)](#).

<sup>29</sup> See *Model Substance Use during Pregnancy and Family Care Plans Act*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Oct. 2022).

<sup>30</sup> OFF. OF NAT'L DRUG CONTROL POL'Y, *supra* note 9, at 3.

## ABOUT LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

The Legislative Analysis and Public Policy Association (LAPPA) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

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