

PLANS OF SAFE CARE: POLICY TO PRACTICE

Nurturing Healthy Families:
Promoting Effective Safe Care
Plans for Substance-affected
Families

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LEARNING OBJECTIVES

Upon completion of this session, participants will improve their competence and performance by being able to:

1. Examine historical and current issues in policy and practice for infants with prenatal substance exposure (IPSE) and their caregivers;
2. Compare and contrast states' implementations of a landmark federal policy change pertinent to IPSE; and
3. Conceptualize a range of best-case scenarios and clarify how providers and policymakers can work towards these preferred outcomes using plans of safe care.

Today's Session



Overview of Substance Use in Pregnancy



History & Research on Child Welfare Policy Responses to IPSE

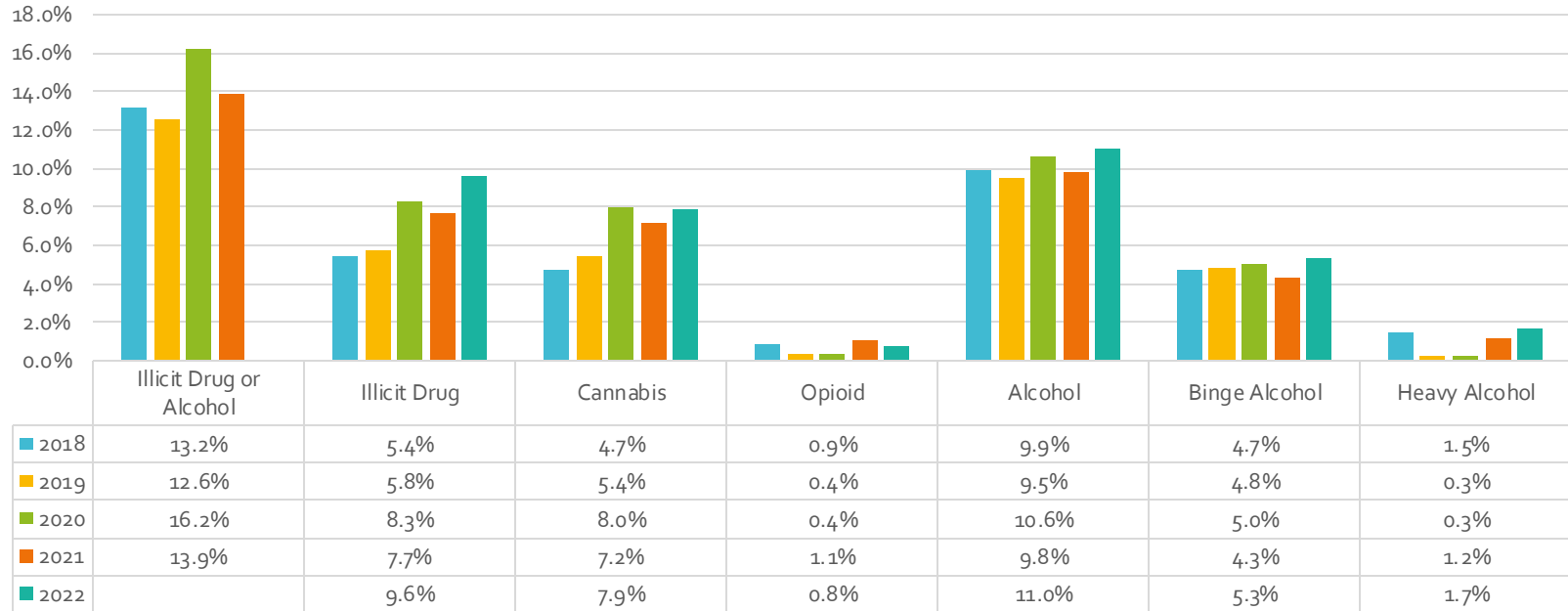


Plans of Safe Care in Connecticut



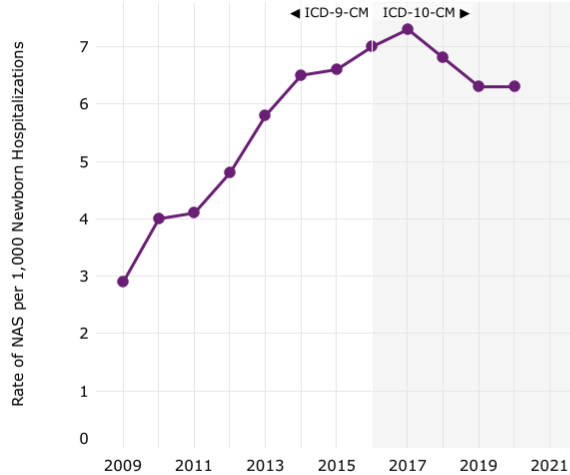
Discussion & Implications for Practice and Policy

Self-Reported Substance Use in Pregnancy, NSDUH 2018-2022



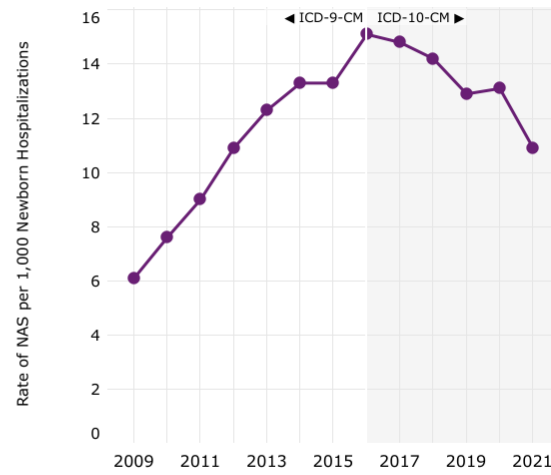
■ 2018
 ■ 2019
 ■ 2020
 ■ 2021
 ■ 2022

U.S. National: Rate of NAS per 1,000 Newborn Hospitalizations by All NAS, 2009 to 2020



Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), National (Nationwide) Inpatient Sample (NIS) 2009 to 2020 (all available data as of 10/18/2022). Abbreviation: NAS, neonatal abstinence syndrome.

Pennsylvania: Rate of NAS per 1,000 Newborn Hospitalizations by All NAS, 2009 to 2021



Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID) 2009 to 2021 (all available data as of 10/18/2022). Abbreviation: NAS, neonatal abstinence syndrome.

US VS. PA NAS RATES

NAS VS. NOWS

- Both characterize early withdrawal and neurobehavioral difficulties in substance-exposed newborns
 - Nicotine
 - Alcohol
 - Cannabis
 - Cocaine
 - Methamphetamines
 - PCP
 - Opioids (including Rx medications)
- Only NOWS can be treated pharmacologically

NOWS
ISN'T A
BAD
THING!

Very pre-term infants with opioid exposure do not demonstrate NOWS symptoms

Thus, MOUD-exposed infants may demonstrate more symptoms than infants with illicit opioid exposure

Full-term gestation predicts long-term health & development to a much greater degree than NOWS symptoms at birth!

Child Maltreatment Risk among IPSE

Parent's SUD may contribute to decreased stress tolerance and executive functioning, reduced bonding and attachment, disrupted sleep patterns, and risk of postpartum depression

(Cataldo et al, 2019; Håkansson et al., 2018; McLafferty et al., 2016)



Intense needs and behaviors of substance-exposed newborns often contributes to increased caregiver stress among families

(Patrick et al., 2015; Wallin et al., 2021)



Systemic marginalization, including economic, housing, and relational instability disproportionately affect perinatal people with substance use disorders and are associated with referrals for maltreatment

(Hubberstey et al., 2019; Canfield et al., 2017)

IPSE & CPS INVOLVEMENT

42% of infants diagnosed with PSE at birth reported by the hospital at time of birth (Rebbe et al., 2019)

60% of infants diagnosed with PSE at birth reported before **1st birthday** (Prindle et al., 2018)

30% of infants diagnosed with PSE at birth **placed into foster care** (Prindle et al., 2018)

Racism & Substance Use in Pregnancy

1870s

First published case study on narcotics withdrawal in a neonate (Cobrinik et al., 1959)

1960s

Drugs cross the placental barrier & cause birth defects and behavioral/ developmental abnormalities (Lester et al., 2004)

1970s

Description of FAS (Lester et al., 2004)
First substance use in pregnancy policy

1980s

Crack cocaine epidemic; intensified concern around other substance types in pregnancy (Lester et al., 2004)

1990

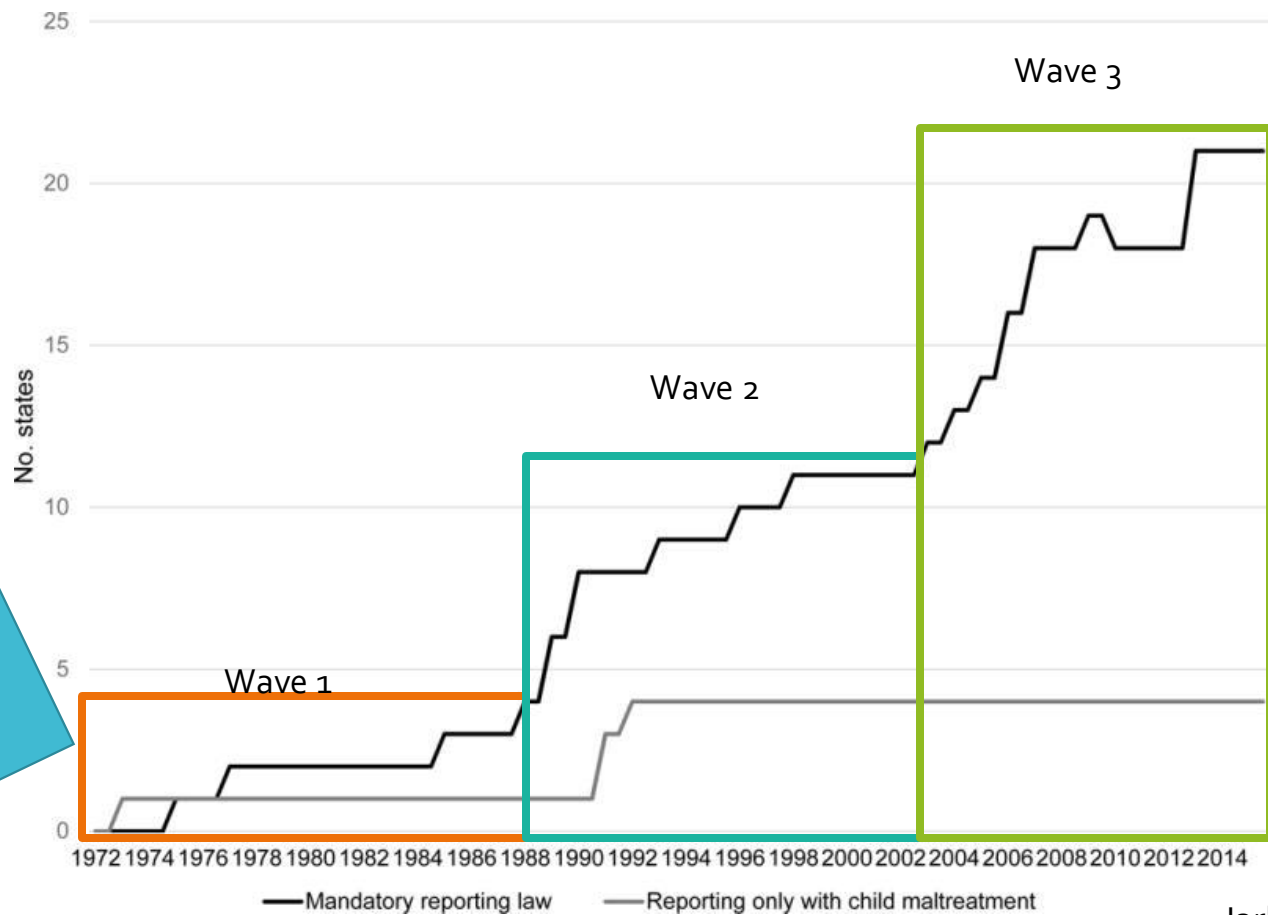
Pinellas County study: Black mothers 10x more likely to be reported to CPS (Chasnoff et al., 1990)

2012

Medi-Cal study: Universal screening resulted in 14% of white & Black mothers identified; Black mothers 2.5x more likely to be reported to CPS (Roberts et al., 2012)

2019

WA State study: Indigenous infants identified at 3-5x higher rate than white infants & 41% increased odds of report vs. white; no Black-white disparity (Rebbe et al., 2019)



MA enacted 1st
mandated report law
for PSE in 1974



1974

Massachusetts enacts the first IPSE mandated reporting policy & defines substance use in pregnancy as CAN

2003

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

2010

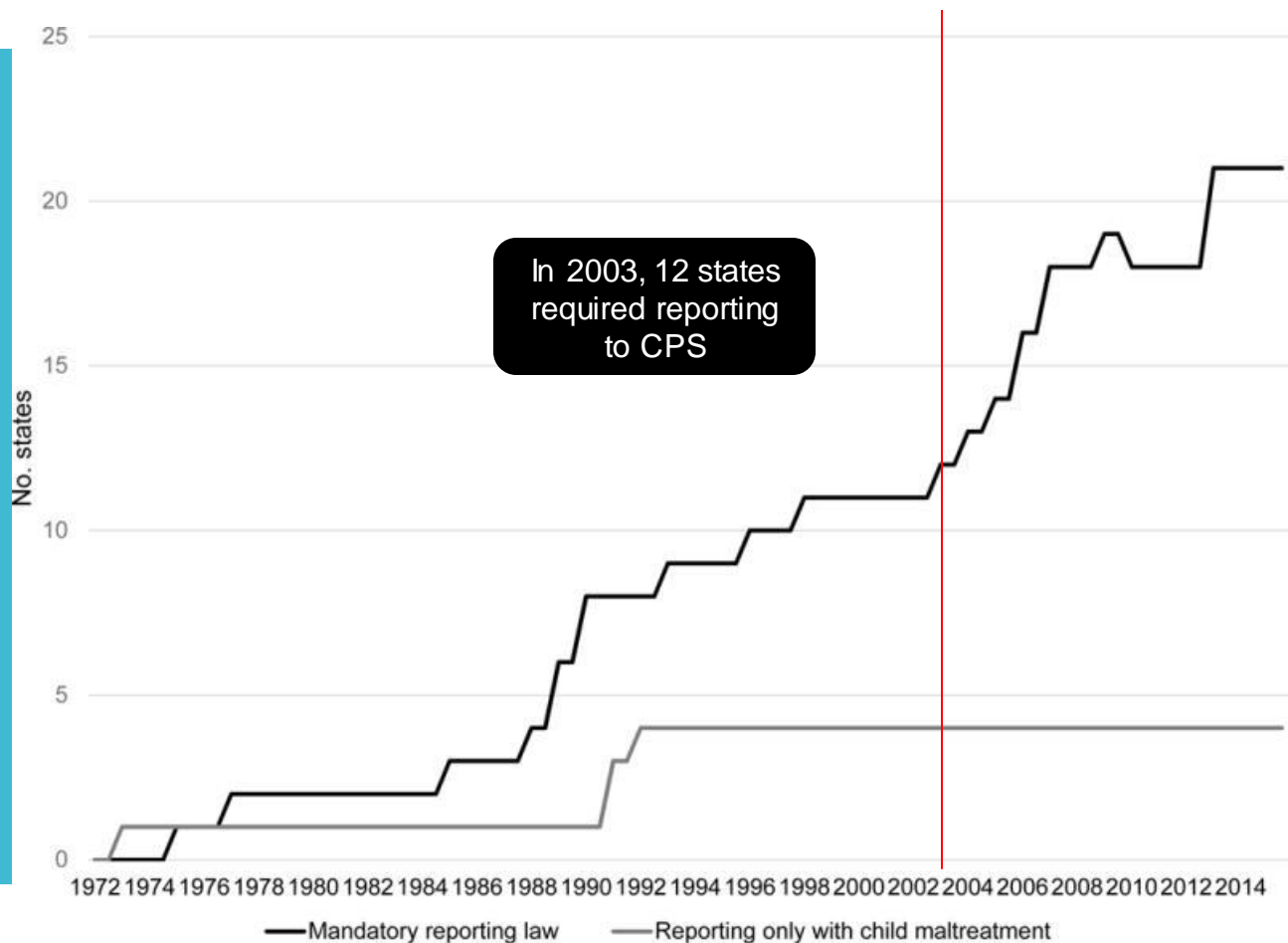
CAPTA 2010: Revised to include FASD

2016

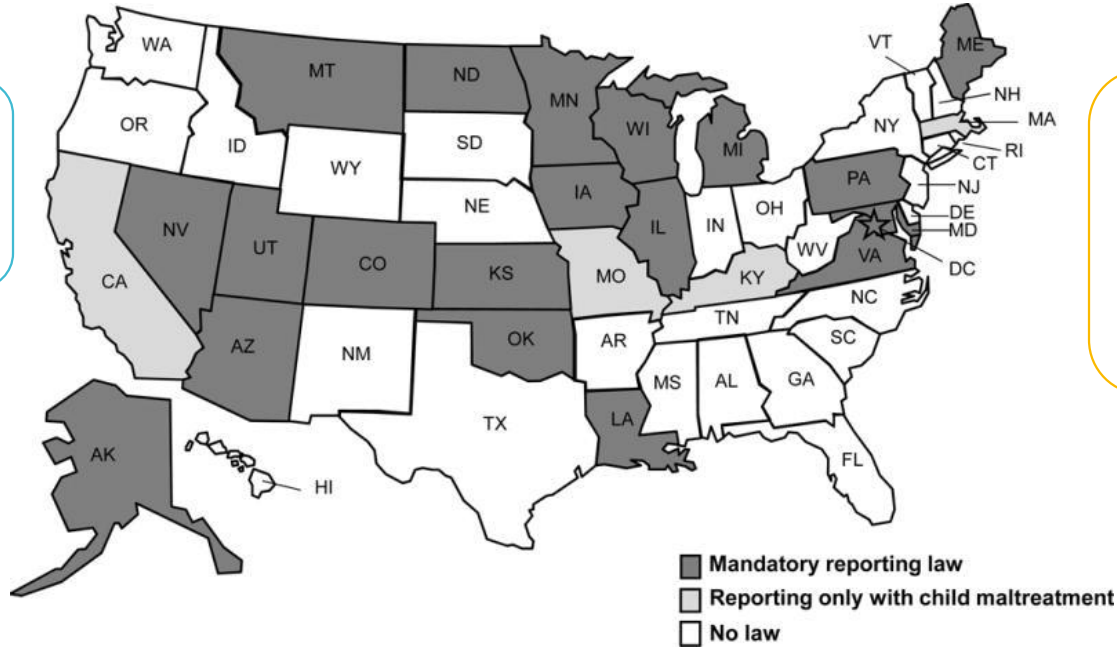
CARA 2016: Revised CAPTA to include legal drugs (e.g. Rx); PoSC to address health & SUD needs of mom & baby

What Happened in 2003?

What Was the Effect of Change to Federal Law?



18% of births occurred in states that mandate reporting for IPSE only with child maltreatment



31% of births occurred in states with mandated reporting laws for IPSE

Jarlenski et al, 2018

In 2017, 20 states Required Reporting IPSE

EFFECTS OF PUNITIVE POLICIES

Decrease in methadone and psychotherapy

Higher rates of NOWS

Increased infant maltreatment reports

Reduced prenatal care and substance use treatment

Higher foster care admissions rates

Delayed reunification, particularly among Black infants

45% increase in opioid overdoses



Effects of Maternal-Infant Separation

Prolongs withdrawal symptoms in newborns

- Infants with opioid withdrawal who remain with their mother vs. recovering in NICU spend less time in the hospital, require less medication
- Breastfeeding reduces duration and severity of withdrawals

Negatively impacts child development

- Higher levels of aggressive behaviors at ages 3 and 5
- Delays in socioemotional and fine motor development
- Animal studies show increased anxiety, impaired social flexibility, and increased reward-seeking behavior, and adverse effects to immune functioning in adulthood

Effects of Maternal- Infant Separation

Exacerbates maternal mental health issues

- Heightens depression, anxiety, and stress
- Hinders substance use recovery
- Animal studies indicate memory impairment in mothers separated from offspring during postpartum period

Increase risk of subsequent substance- exposed birth

- Mothers with SUD who lose parental rights are three times more likely to give birth to a subsequent infante with prenatal exposure vs. mothers who maintain custody



WHAT TO DO IF PUNITIVE APPROACHES DO NOT ACHIEVE INTENDED OUTCOMES AND YET FAMILIES REMAIN AT-RISK FOR UNTREATED SUBSTANCE USE DISORDER, CHILD MALTREATMENT, AND SOCIOECONOMIC BURDEN?

A Public Health Approach

Population-level surveillance to target resources

Emphasis on universal prevention

Non-punitive secondary or tertiary intervention to address high-risk groups

Healthier Births

Accessing integrated substance use treatment while pregnant vs. after deliver is associated with higher birth weights, larger head circumferences, fewer birth complications, and fewer positive toxicology screens

Healthier Development

Infants who receive early intervention services after delivery and throughout early childhood have improved cognition, language, and gross motor development

EARLY
IDENTIFICATION
& DYADIC
INTERVENTION

Requires that hospital providers “notify” CPS of IPSE birth

Specifies that federal law does not define PSE as child abuse or neglect

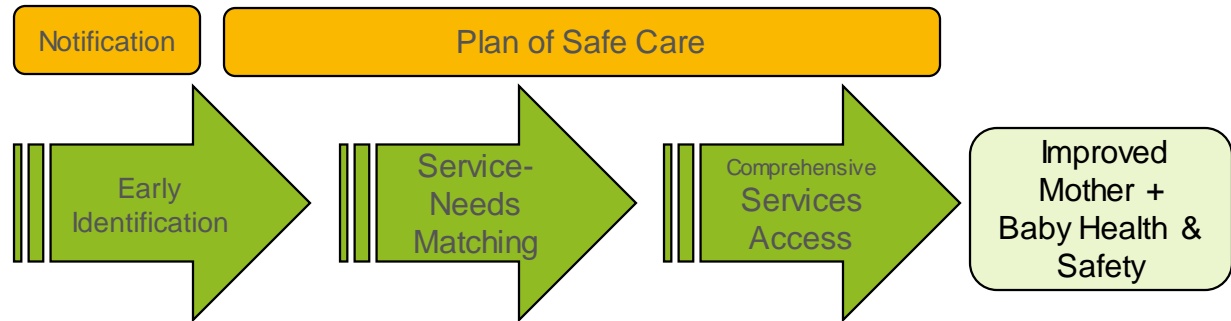
Requires a plan of safe care/family care plan for all identified caregiver-infant dyads addressing the health and substance use treatment needs of the family

Requires states to develop/implement monitoring systems to determine whether/how local entities are providing referrals to, and delivery of, POSC services.

Directs states to report to HHS the number of IPSE, number of infants with POSC, and number of infants with referrals.

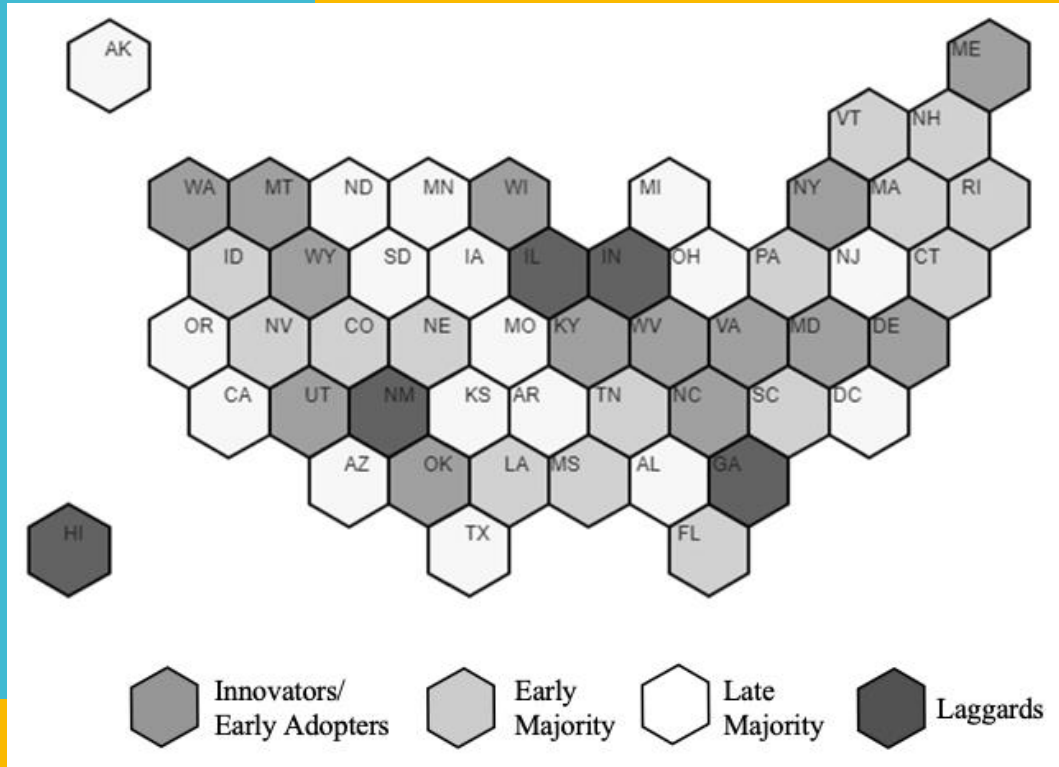
What Does CAPTA Require?

FCP Target Key Mechanisms of Service Utilization



(Lloyd, Nichols, & Chasnoff, 2022)

GREAT GOALS, CHALLENGING IMPLEMENTATION



Why?

- Complex
- Un/under-funded
- Ill-defined
- Affects multiple populations
- Incompatible with existing systems
- Limited research proving effectiveness

CT's Family Care Plan Policy

Substance use in pregnancy identified in pregnancy or at delivery

Family Care Plan (FCP) developed for all infants identified

Healthcare provider *notifies* DCF of the birth

Notification excludes any identifying information

Policy has created new, non-punitive pathway via the blinded notification & FCP

Possible Outcomes

Blinded Notification

- FCP in place
- No suspicions of abuse/neglect
- No concern that substance use will affect maternal functioning
- No indication that exposure due to maternal substance misuse

Report + FCP

- FCP in place, but
- Suspicions of abuse/neglect, and/or
- Concern that substance use will affect maternal functioning, and/or
- Indication that exposure due to maternal substance misuse

Report + No FCP

- No FCP in place, and/or
- Suspicions of abuse/neglect, and/or
- Concern that substance use will affect maternal functioning, and/or
- Indication that exposure due to maternal substance misuse

Best Case Scenarios

Mother/birthing person using MOUD prior to pregnancy; maintains MOUD adherence; POSC developed in pregnancy; dyad diverted at birth to receive supportive services in the community

Mother/BP using cannabis prior to pregnancy; screens/tests positive at first prenatal visit; counseled on potential harms to fetus; abstains/decreases use during pregnancy; POSC developed in pregnancy with referral to SUD assessment if needed; dyad diverted at birth



Mother/BP arrives at hospital to deliver with no PNC and altered mental state, screens/tests positive for illegal substances, POSC developed at hospital *and* report to CPS. Mom & baby move into residential Tx with POSC to guide post-delivery supportive services.

Best Case Scenarios

Low risk mother-IPSE dyads are identified in pregnancy, provided POSC, and diverted, resulting in statewide reduction in rate of reports

Moderate risk mother-IPSE dyads are identified in pregnancy or at delivery, provided POSC, and diverted or reported as appropriate, resulting in statewide reduction in % of low-risk cases in CPS

High risk mother-IPSE dyads are identified and appropriately reported to CPS with a POSC; dyads receive two-generation supportive services without separation whenever possible



DOES
CONNECTICUT'S
APPROACH RESULT
IN THESE BEST-
CASE SCENARIOS?

Connecticut CAPTA Findings: March 2019 – July 2021



Acknowledgments

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- **Ethical Approval:** This article contains research using administrative data. All research activities were approved by the University of Connecticut Institutional Review Board. All study procedures in this study were in accordance with the ethical standards of the respective IRB.
- **Acknowledgements:** These data were provided by the Connecticut Department of Children & Families (DCF) Information Systems from the DCF's data system(s). DCF specifically disclaims responsibility for any analyses, interpretations or conclusions.

CAPTA DATASET

- CAPTA notifications are entered online in a data collection web system engineered specifically for collecting data on substance exposed infants (“the CAPTA portal”)
- Notifications capture 29 data elements including the date and location of notification, type of substance exposure from a list of 11 substance types, toxicology test (if used) and finding, and race/ethnicity data on mother and infant
- No personally identifying information is collected

Analytic Sample

Analysis limited to notifications from March 15, 2019 (launch of CAPTA portal) to July 21, 2021 (date of data extract)

After excluding cases with missing data, the remaining CAPTA sample size was $n=4,763$

Analytic Approach

Univariate & Bivariate Descriptives

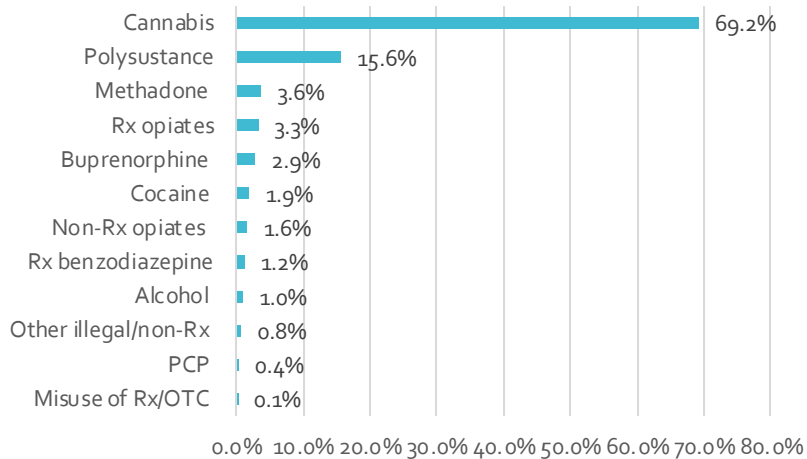
Multinomial Logistic Regression Examining Likelihood of:

- POSC with Notification
- POSC with Report
- POSC without Report

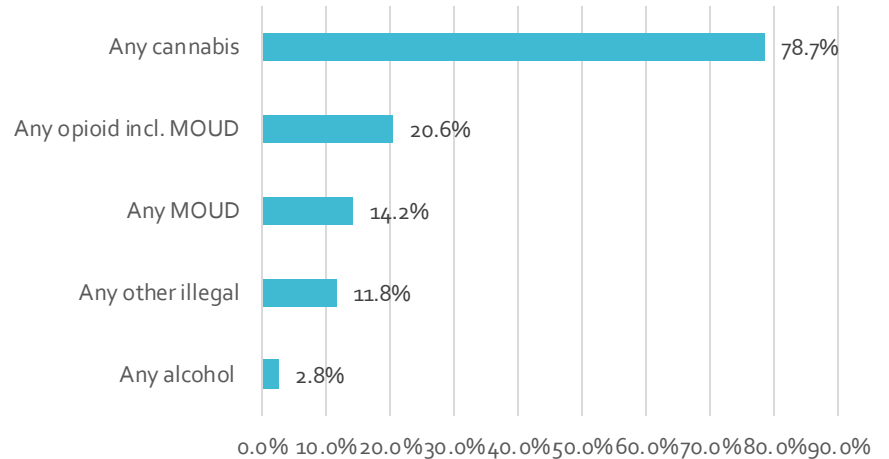
Sample Characteristics vs. State Population of Births

	State		Notifications	
	N or Mean	% or SD	N or Mean	% or SD
Maternal Age	30.62	5.57	27.91	5.78
Maternal Race/Ethnicity				
White	31858	53.70%	2118	44.50%
Black	7764	13.10%	1050	22.00%
Hispanic	15673	26.40%	959	20.10%
Other/ Multi-race	3920	6.60%	56	1.20%
Declined/Not disclosed	58	0.00%	580	12.20%

% of Exposure Types (Single & Polysubstance Separate)

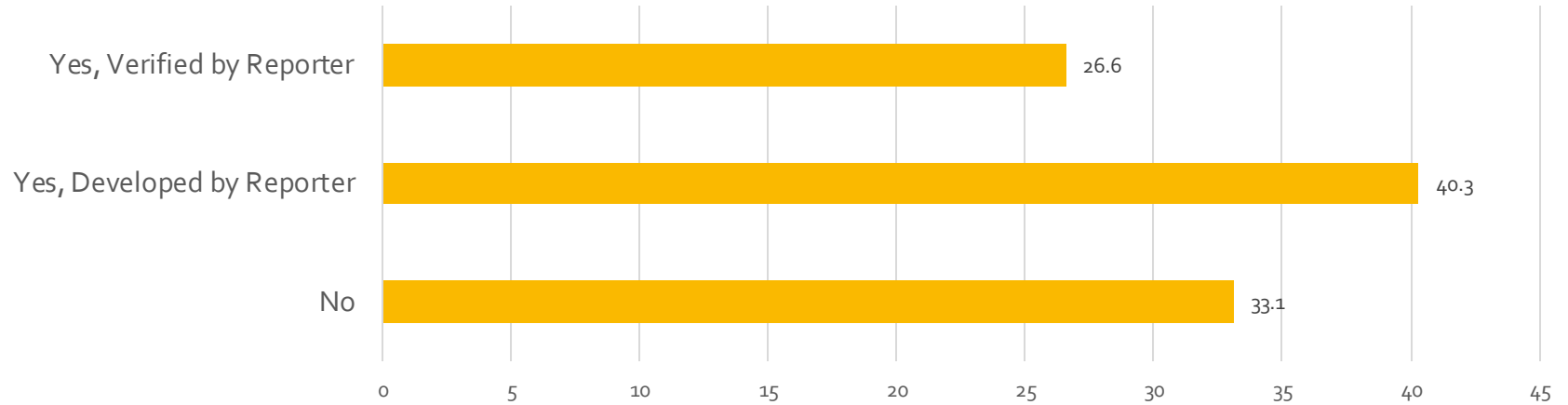


% of Exposure Types (Single & Polysubstance Combined)



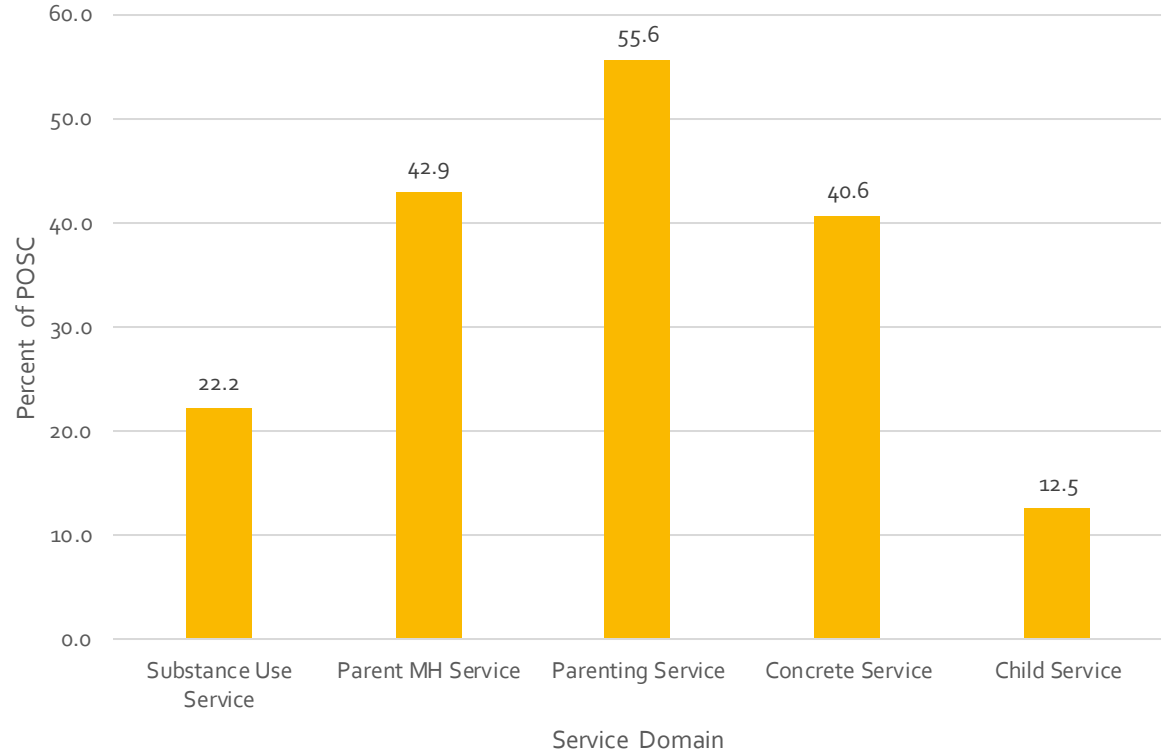
78.7% of Notifications Included Cannabis

Percent of Notifications with POSC

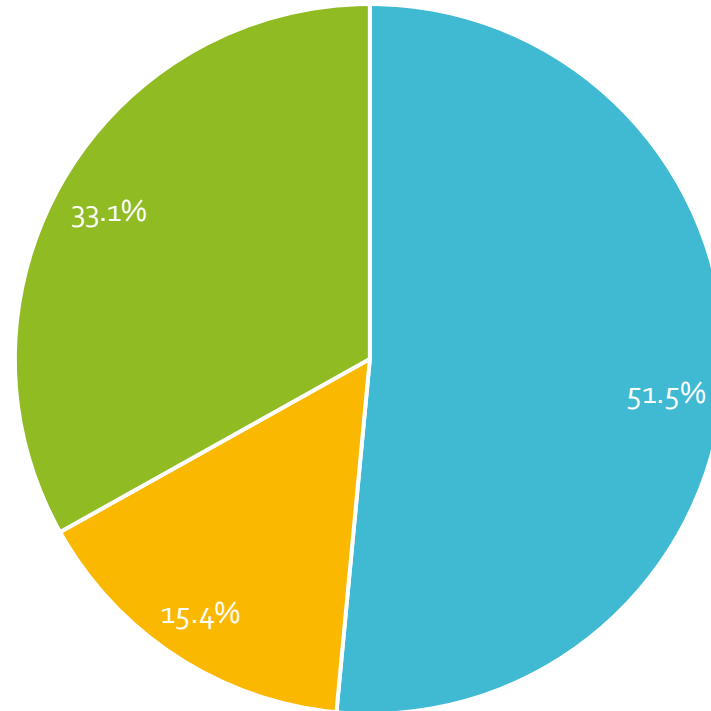


65.9% with Plan of Safe Care

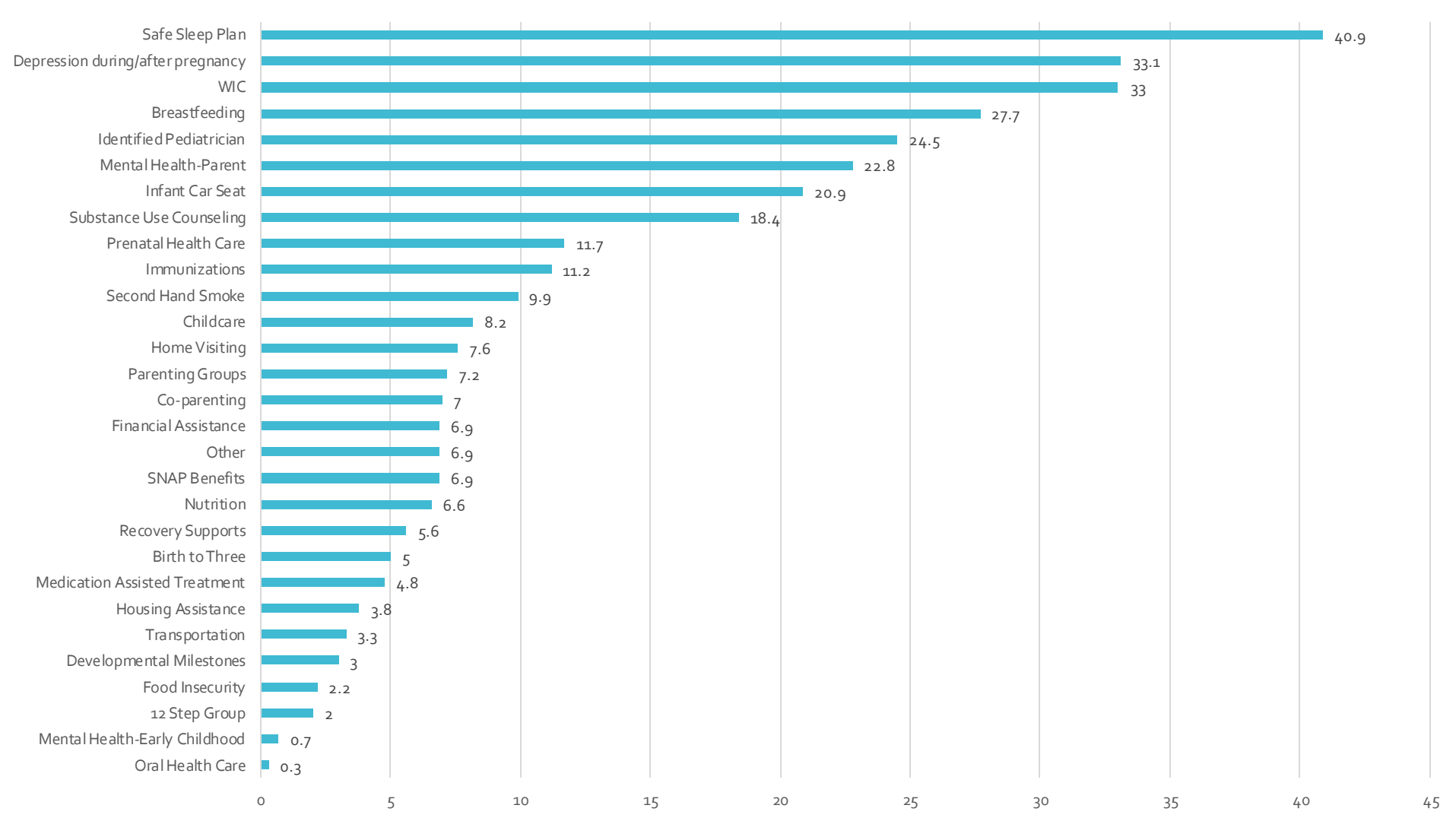
Plan of Safe Care Contents



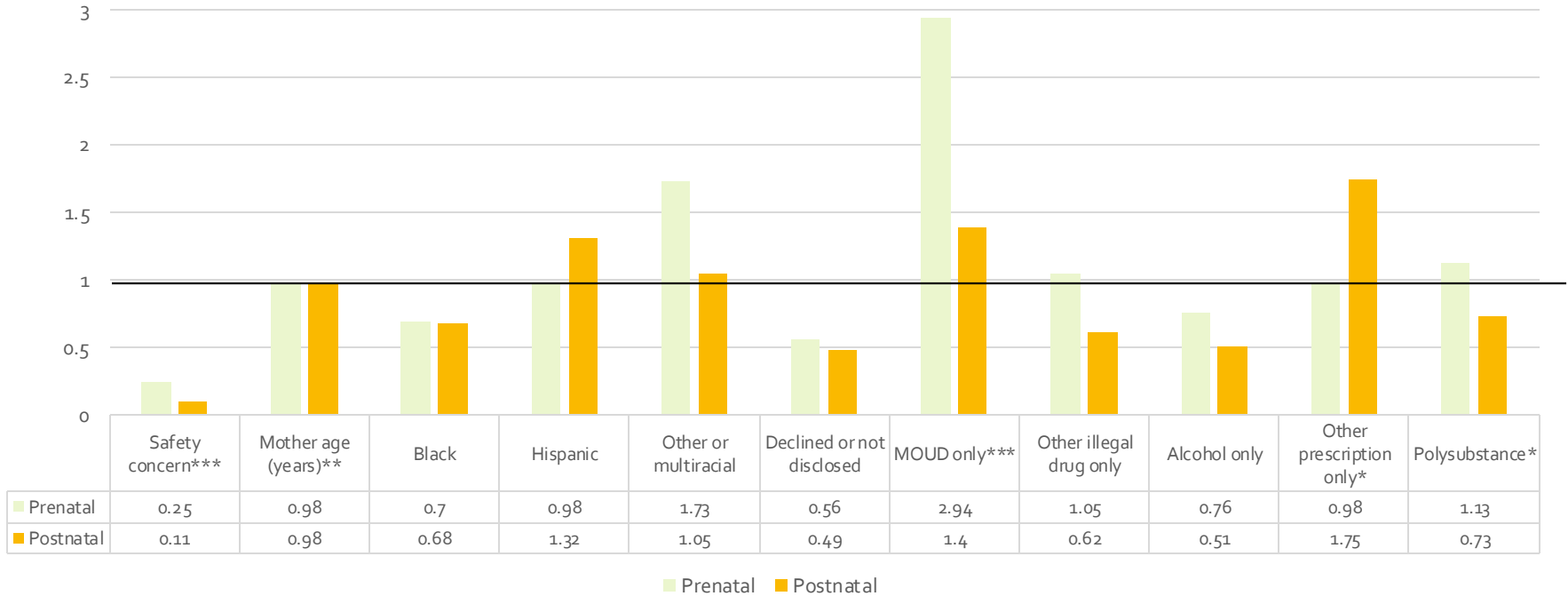
Over 50%
Diverted with
POSC



■ Diverted with POSC ■ Reported with POSC ■ Reported without POSC

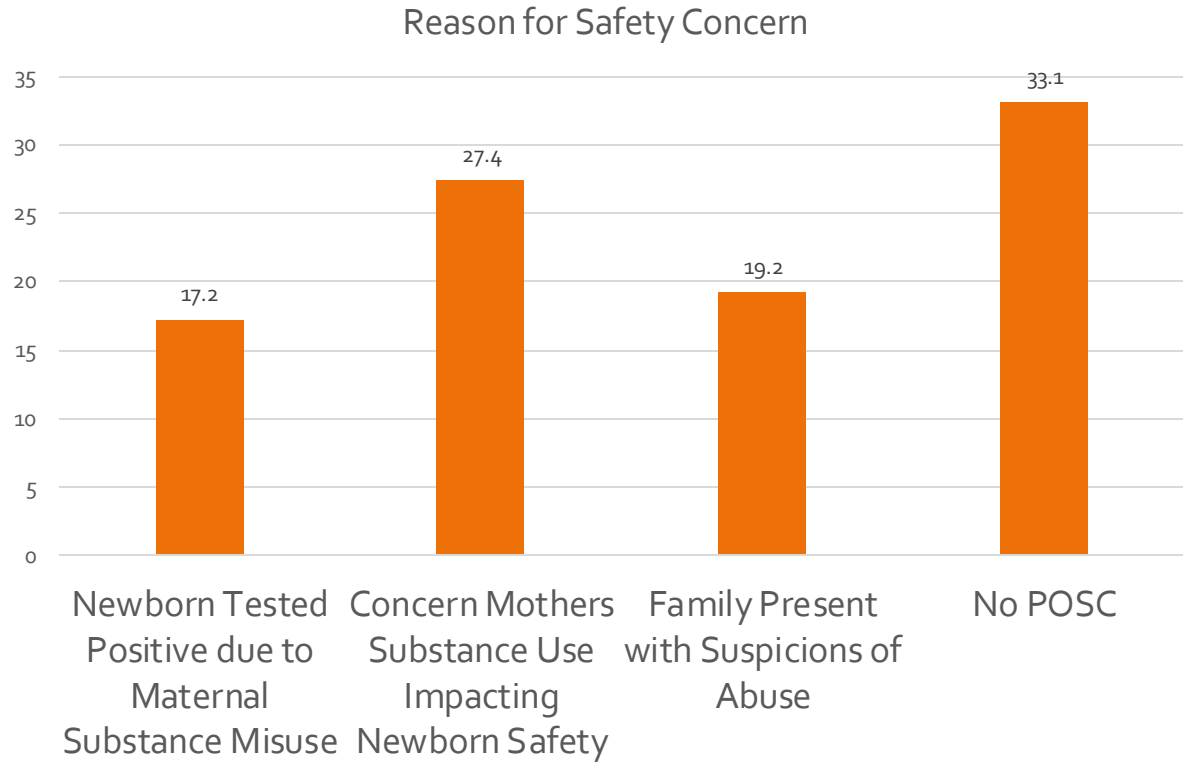


Odds Ratios for Pre- or Postnatal POSC vs. No POSC

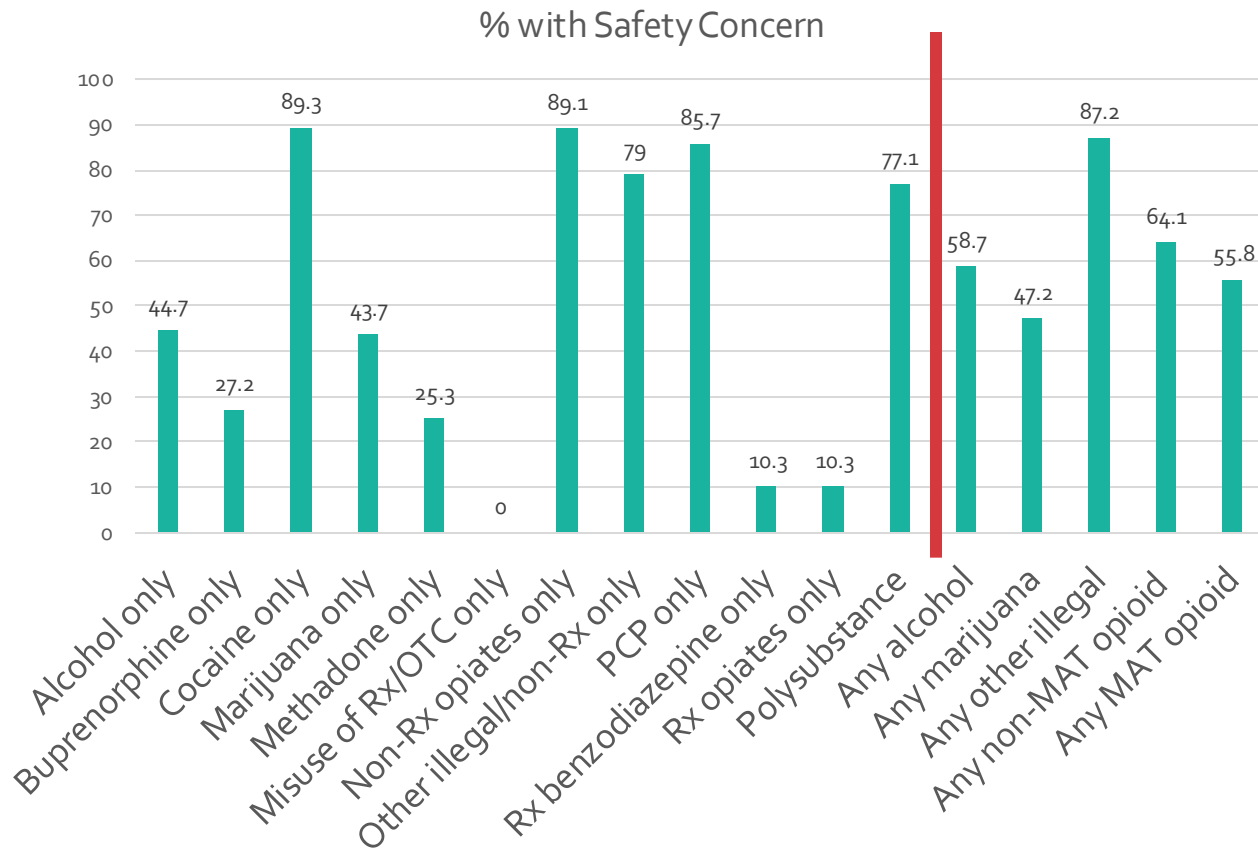


Mothers Using MOUD Getting Prenatal POSC

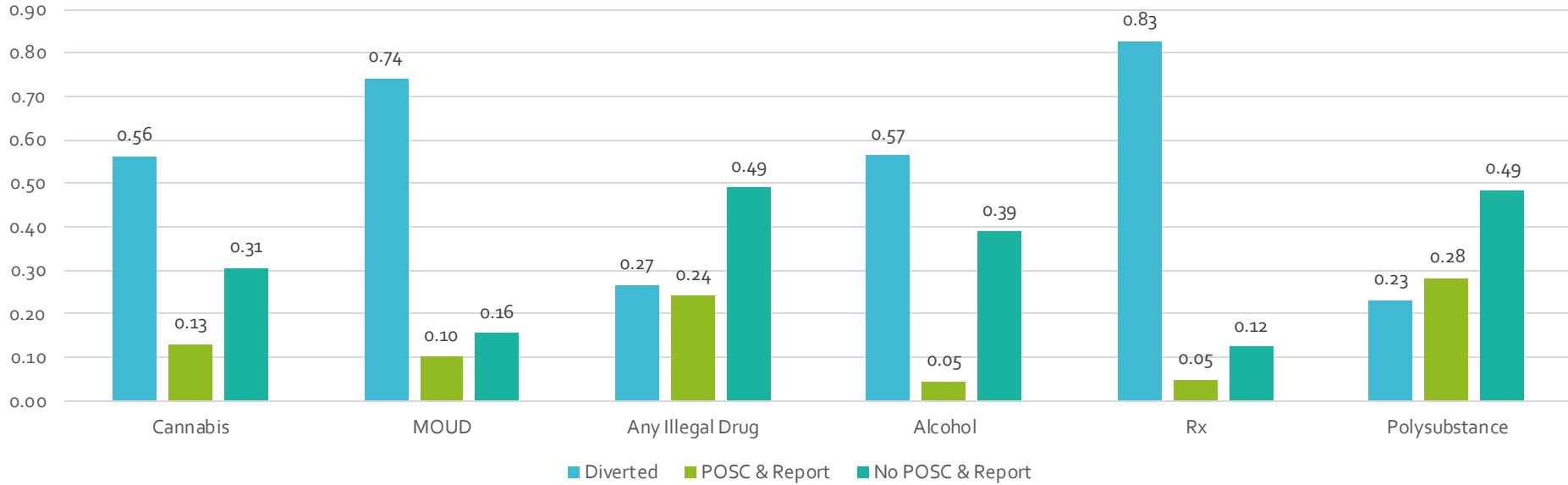
48.5% with
Safety
Concern



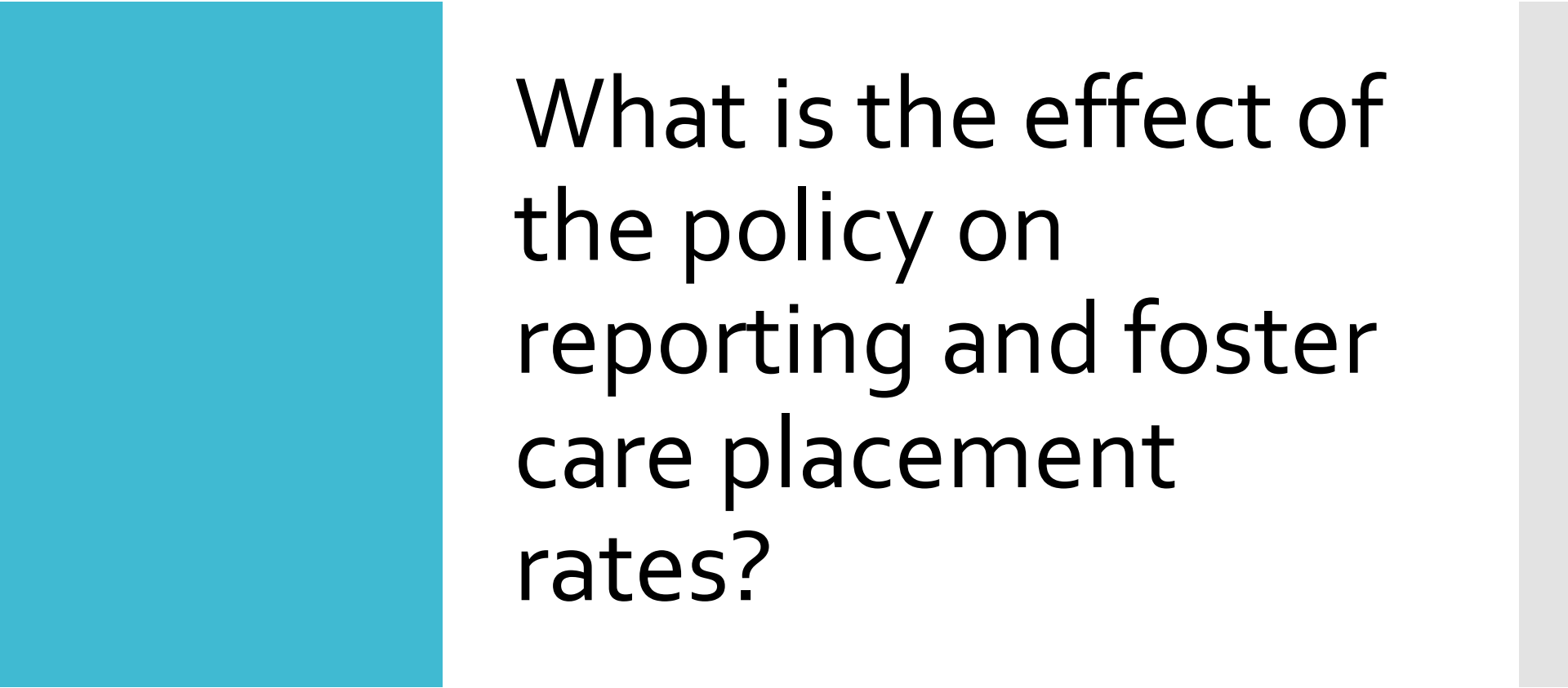
Safety Concern Varies Across Substance Type



Predicted Probabilities

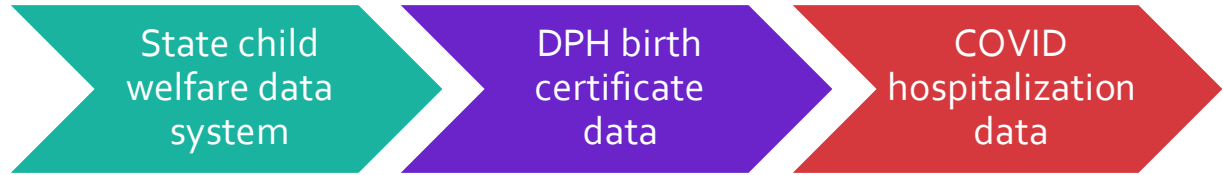


Legal Substances More Likely Diverted vs. Illegal Substances



What is the effect of the policy on reporting and foster care placement rates?

Datasets



- Identifiable
- Record at the level of allegation
- Includes victim demographic information
- Data transformed into aggregate monthly total

- Identifiable
- Records date of birth
- Includes infant demographic information
- Includes some birth history information
- Data transformed into aggregate monthly total

- Monthly hospitalizations & deaths

Analytic Sample

Analysis limited to births from March, 2017 (2 years prior to policy) to August, 2022 (date of data extract)

Unit of analysis is month of year (n = 66)

Analytic Approach

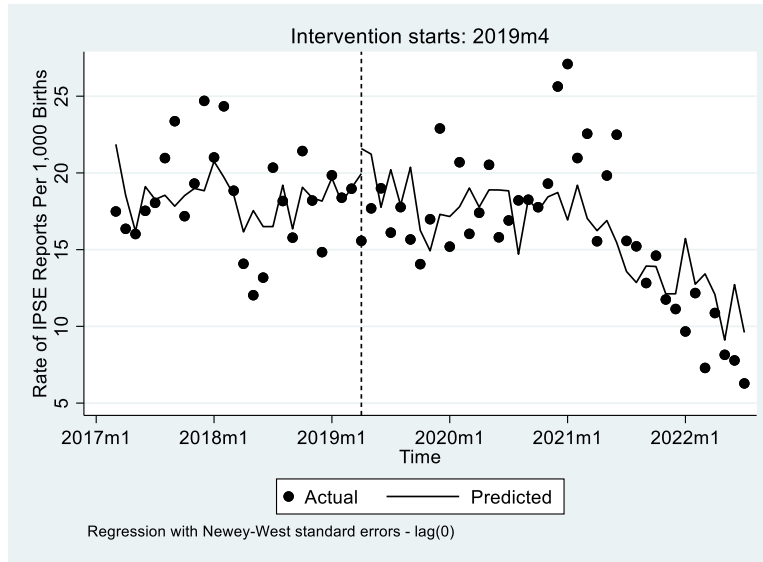
Bivariate Descriptives

Interrupted Time Series with Segmented Linear Regression

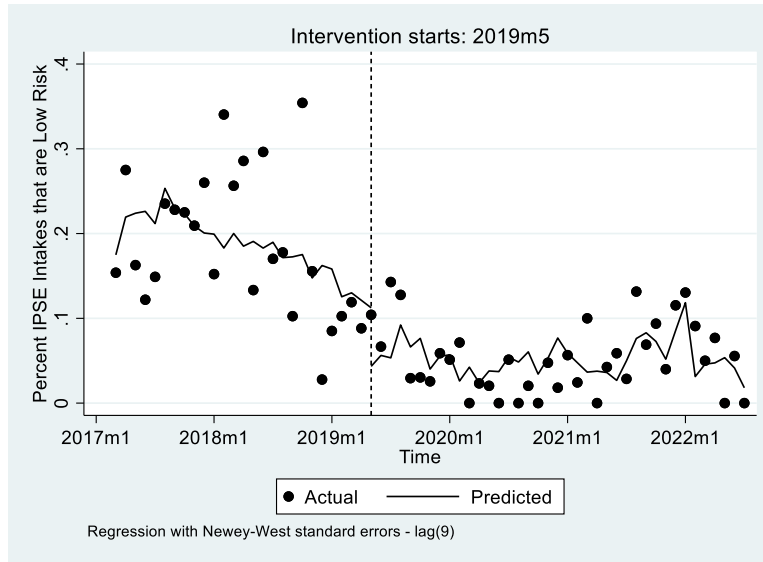
- Rate of Reports per 1,000 Births
- Percent of Intakes Assessed as “Low Risk”
- Percent of IPSE Reports that Result in Foster Care Placement

	Before the Policy	After the Policy	Sig.
% of All Newborns Reported	2.7%	2.4%	
% of Newborn Reports due to Substance Exposure	68.4%	66.1%	
% of Newborn Reports that Lead to Intake	82.4%	84.2%	
% of Newborn Intakes that are Low Risk	19.1%	5.4%	***
% of Newborn Reports that Result in Foster Placement	34.1%	28.9%	*

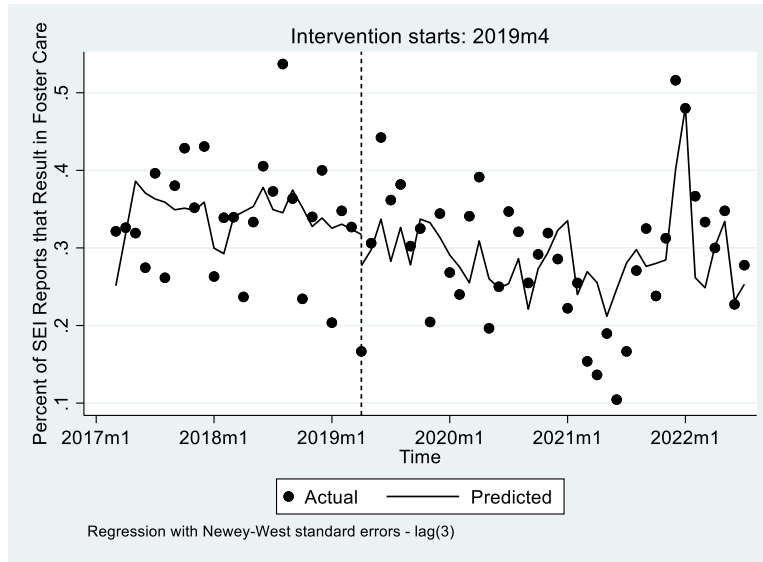
Lower Risk Newborns Are Being Diverted



DECREASED REPORTS TO CPS



REDUCTION DUE TO DIVERSION OF LOWER-RISK INFANTS



HIGH-RISK DYADS STILL RECEIVING DCF INTERVENTION

Conclusions

Exposure type predicts maltreatment report

MOUD-exposures most likely to be diverted

Illegal drug & polysubstance exposures most likely to be reported (with & without POSC)



CONCLUSIONS

Rate of reports decreasing along with percent of intakes that are assessed as low-risk

No change in foster care rates suggests that high risk cases are being identified, referred, and handled in a manner consistent with the pre-policy time period

LIMITATIONS

- It is unknown whether all IPSE received a notification
 - Hospitals use varied methods at identification
- It is unknown how long the substance exposure occurred
 - Duration and severity are most predictive of effects
- We could not account for salient protective factors such as substance use treatment utilization in pregnancy
- Results may not be generalizable to other settings

The background is a light teal color with a pattern of abstract, overlapping geometric shapes in various shades of teal and light blue. These shapes include circles, ovals, and elongated rectangles, some of which are slightly blurred or faded, creating a sense of depth and movement. On the left side, there is a solid dark teal rectangular box containing the text.

Implications for Providers

Support Prenatal Providers in POSC Development

- POSC offered to all women with substance use in pregnancy
- For women using medication according to doctor's orders, POSC can emphasize safe storage after delivery, postpartum mental health supports, and potential need for early intervention services to support healthy development in infant (NCSACW, 2023)
- For women with substance use disorder, POSC should aim to connect woman to treatment, as well as leverage harm reduction principles and early intervention services to support healthy development infant (NCSACW, 2023)


Support Pediatricians in POSC Implementation

Ideally, POSC shared with pediatrician in infant's discharge records

Pediatrician postpartum screening may include brief substance use screener with referral and warm handoff to substance use treatment provider or peer support specialist

Focus on supporting breastfeeding, *Eat Sleep Console* and skin-to-skin for lingering withdrawal symptoms, safe sleep, developmental milestones, and connection to non-punitive evidence-based supports (e.g., home visiting, early intervention, etc.)





Implications for State & County Systems

Support Systems in Public Health Surveillance & Intervention

CPS reporting is not set up as public health surveillance system
Providers do not report all infants for range of reasons including fear of consequences (Roberts et al., 2022)

Alternative, non-report mechanism for documenting IPSE incidence including:

- Type & timing of exposure
- Rx, Illicit, Illegal status
- Treatment access in pregnancy
- Unmet needs & referrals made

Two-generation family-centered service needs matching

Ensure Trained CPS Workforce

If reported, imperative that CPS workers understand effects of PSE

- IPSE and birthing people with SUD have unique and time-sensitive healthcare needs (Forray, 2016)
- Traumatic interaction with CPS could derail recovery efforts and undermine parent-child attachment
- Without accurate identification, IPSE health needs could go unidentified and unmet

Additional Resources



Model Substance Use During Pregnancy and Family Care Plans Act from Legislative Analysis and Public Policy Association



CT Dept. of Children & Families CAPTA information including FAQ



Children & Family Futures resources on infants with prenatal substance exposure

Questions?

- Atkins, D. N., & Durrance, C. P. (2021). The impact of state-level prenatal substance use policies on infant foster care entry in the United States. *Children and Youth Services Review*, 130, 106194. <https://doi.org/10.1016/j.childyouth.2021.106194>
- Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child Abuse & Neglect*, 70, 11-27. <https://doi.org/10.1016/j.chiabu.2017.05.005>
- Cataldo, I., Azhari, A., Coppola, A., Bornstein, M. H., & Esposito, G. (2019). The Influences of Drug Abuse on Mother-Infant Interaction Through the Lens of the Biopsychosocial Model of Health and Illness: A Review. *Frontiers in public health*, 7, 45. <https://doi.org/10.3389/fpubh.2019.00045>
- Chasnoff, I. J., Landress, H. J., & Barrett, M. E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *The New England journal of medicine*, 322(17), 1202–1206. <https://doi.org/10.1056/NEJM199004263221706>
- Faherty, L. J., Kranz, A. M., Russell-Fritch, J., Patrick, S. W., Cantor, J., & Stein, B. D. (2019). Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy With Rates of Neonatal Abstinence Syndrome. *JAMA network open*, 2(11), e1914078. <https://doi.org/10.1001/jamanetworkopen.2019.14078>
- Forray, A. (2016). Substance use during pregnancy. *F1000Research*, 5, F1000 Faculty Rev-887. <https://doi.org/10.12688/f1000research.7645.1>
- Håkansson, U., Söderström, K., Watten, R., Skårderud, F., & Øie, M. G. (2018). Parental reflective functioning and executive functioning in mothers with substance use disorder. *Attachment & human development*, 20(2), 181–207. <https://doi.org/10.1080/14616734.2017.1398764>
- Hubberstey, C., Rutman, D., Schmidt, R. A., Van Bibber, M., & Poole, N. (2019). Multi-Service Programs for Pregnant and Parenting Women with Substance Use Concerns: Women’s Perspectives on Why They Seek Help and Their Significant Changes. *International Journal of Environmental Research and Public Health*, 16(18). <https://doi.org/10.3390/ijerph16183299>
- Jarlenski, M., Koma, J. W., Zank, J., Bodnar, L. M., Tarr, J. A., & Chang, J. C. (2018). Media portrayal of prenatal and postpartum marijuana use in an era of scientific uncertainty. *Drug and alcohol dependence*, 187, 116–122. <https://doi.org/10.1016/j.drugalcdep.2018.02.021>
- Kozhimannil, K. B., Interrante, J. D., Henning-Smith, C., & Admon, L. K. (2019). Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007-15. *Health affairs (Project Hope)*, 38(12), 2077–2085. <https://doi.org/10.1377/hlthaff.2019.00805>
- Lester, B.M., Andreozzi, L. & Appiah, L. (2004). Substance use during pregnancy: time for policy to catch up with research. *Harm Reduction Journal*, 1(5) <https://doi.org/10.1186/1477-7517-1-5>

Lloyd, M. H., Nichols, C. D., & Chasnoff, I. J. (2022). Child Abuse Prevention and Treatment Act, family care plans and infants with prenatal substance exposure: Theoretical framework and directions for future research. *Infant and Child Development*, 31(3).
<https://doi.org/10.1002/icd.2309>

Lloyd Sieger, M. H., Rebbe, R., & Patrick, S. W. (2021). The 2021 Reauthorization of CAPTA - Letting Public Health Lead. *The New England journal of medicine*, 385(18), 1636–1639.
<https://doi.org/10.1056/NEJMp2111378>

Maclean, J. C., Witman, A., Durrance, C. P., Atkins, D. N., & Meinhofer, A. (2022). Prenatal Substance Use Policies And Infant Maltreatment Reports. *Health affairs (Project Hope)*, 41(5), 703–712.
<https://doi.org/10.1377/hlthaff.2021.01755>

McLafferty, L. P., Becker, M. A., Dresner, N., Meltzer-Brody, S., Gopalan, P., Glance, J., St Victor, G., Mittal, L., Marshalek, P., Lander, L., & Worley, L. L. (2016). Guidelines for the Management of Pregnant Women With Substance Use Disorders. *Psychosomatics*, 57(2), 115–130.
<https://doi.org/10.1016/j.psych.2015.12.001>

NCSACW. (2023). Infants and Families Affected by Prenatal Substance Exposure: Five Points of Family Intervention.
<https://ncsacw.acf.hhs.gov/files/five-points-family-intervention-infants-with-prenatal-substance-exposure-and-their-families.pdf>

Ostfeld-Johns, S., & Schiff, D. (2022). Increasing Awareness Is Needed Among Pediatric Hospitalists About Prenatal Substance Exposure: Policy, Advocacy, and Clinical Care. *Hospital pediatrics*, 12(10), e374–e376.
<https://doi.org/10.1542/hpeds.2022-006837>

Patrick, S. W., Dudley, J., Martin, P. R., Harrell, F. E., Warren, M. D., Hartmann, K. E., Ely, E. W., Grijalva, C. G., & Cooper, W. O. (2015). Prescription opioid epidemic and infant outcomes. *Pediatrics*, 135(5), 842–850.
<https://doi.org/10.1542/peds.2014-3299>

Prindle, J. J., Hammond, I., & Putnam-Hornstein, E. (2018). Prenatal substance exposure diagnosed at birth and infant involvement with child protective services. *Child Abuse & Neglect*, 76, 75–83.
<https://doi.org/10.1016/j.chiabu.2017.10.002>

Ralph, W., Cobrinik, R., Hood, T., Chusid, E. (1959). The effect of maternal narcotic addiction on the newborn infant. Review of Literature and Report of 22 Cases. *American Academy of Pediatrics*, 24(2), 288–304.
<https://doi.org/10.1542/peds.24.2.288>

Rebbe, R., Mienko, J. A., Brown, E., & Rowhani-Rahbar, A. (2019). Child protection reports and removals of infants diagnosed with prenatal substance exposure. *Child abuse & neglect*, 88, 28–36.
<https://doi.org/10.1016/j.chiabu.2018.11.001>

Rebbe, R., Lloyd Sieger, M., Reddy, J. & Prindle, J. (January 15, 2023). Rates of infants reported to CPS at birth for prenatal substance exposure: a panel data analysis. Paper at the 27th meeting of the Society for Social Work & Research. Phoenix, Arizona.

Roberts, S. C., & Nuru-Jeter, A. (2012). Universal screening for alcohol and drug use and racial disparities in child protective services reporting. *The journal of behavioral health services & research*, 39(1), 3–16. <https://doi.org/10.1007/s11414-011-9247-x25711>.

Roberts, S.C., Zaugg, C. & Martinez, N. (2022). Health care provider decision-making around prenatal substance use reporting. *Drug and Alcohol Dependence*, 237(2022), 109514. <https://doi.org/10.1016/j.drugalcdep.2022.109514>

Rutman, D., Hubberstey, C., Poole, N., Schmidt, R. A., & Van Bibber, M. (2020). Multi-service prevention programs for pregnant and parenting women with substance use and multiple vulnerabilities: Program structure and clients' perspectives on wraparound programming. *BMC Pregnancy and Childbirth*, 20(1), 441. <https://doi.org/10.1186/s12884-020-03109-1>

SAMHSA, Center for Behavioral Health Statistics and Quality. (2020). Table of Contents – Results from the 2020 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ. <https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/NSDUHDetailedTabsTOC2020.htm>

SAMHSA, Center for Behavioral Health Statistics and Quality. (2018). Cover – Results from the 2018 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetailedTabsTOC2018.htm>

SAMHSA, Center for Behavioral Health Statistics and Quality. (2021). 2021 NSDUH Detailed Tables. CBHSQ Data. <https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables>

Sanmartin, M. X., Ali, M. M., & Lynch, S. (2019). Foster care admissions and state-level criminal justice-focused prenatal substance use policies. *Children and Youth Services Review*, 102, 102–107. <https://doi.org/10.1016/j.childyouth.2019.03.050>

Sanmartin, M. X., Ali, M. M., Lynch, S., & Aktas, A. (2020). Association Between State-Level Criminal Justice–Focused Prenatal Substance Use Policies in the US and Substance Use–Related Foster Care Admissions and Family Reunification. *JAMA Pediatrics*, 174(8), 782. <https://doi.org/10.1001/jamapediatrics.2020.1027>

Sieger, M. L., Nichols, C., Chen, S., Sienna, M., & Sanders, M. (2022). Novel Implementation of State Reporting Policy for Substance-Exposed Infants. *Hospital pediatrics*, 12(10), 841–848. <https://doi.org/10.1542/hpeds.2022-006562>

Wallin, C. M., Bowen, S. E., & Brummelte, S. (2021). Opioid use during pregnancy can impair maternal behavior and the Maternal Brain Network: A literature review. *Neurotoxicology and Teratology*, 86, 106976. <https://doi.org/10.1016/j.ntt.2021.106976>