Research on child welfare reporting requirements

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Key points

- Health care providers overreport birthing people who use drugs to child welfare. This overreporting disproportionately affects Black and Indigenous birthing people, babies, and families.
- Reporting requirements do not keep babies safe. Reporting requirements expose babies to the harms of family separation.
- Health professionals should focus on reducing overreporting by limiting the use of urine drug tests to the very few clinical indications.

Background

Health care providers are a significant source of child welfare reports related to pregnant and birthing people's substance use. A key policy relevant to this reporting is the Child Abuse Prevention and Treatment Act (CAPTA), a federal law first enacted in 1974. CAPTA provides funding and guidance regarding prevention, investigation, and intervention of child abuse and neglect. Although CAPTA did not originally include reporting requirements related to pregnant and birthing people's substance use, subsequent CAPTA reauthorizations introduced reporting requirements related to pregnant and birthing people's substance use.[1] In the past two decades, state governments have adopted a range of reporting requirements, many of which go above and beyond federal requirements. The number of states that have one or more child welfare reporting requirements related to pregnant or birthing people's substance use increasing from 11 in 2000 to 26 in 2021.[2]

Health care providers overreport birthing people who use drugs to child welfare. This overreporting disproportionately affects Black and Indigenous birthing people, babies, and families.

While some reports to child welfare related to birthing people's substance use by medical professionals are legally required, many are not and consist of "overreports" to child welfare agencies. "Overreports" are reports that go beyond what is legally mandated, for example reporting a birthing person based solely on them having a history of a substance use disorder or receiving treatment for a substance use disorder.[3,4]

Between 2000 and 2021, the rates of infants investigated by child welfare have doubled, with investigations following reports by medical professionals increasing more rapidly than investigations following reports by other mandatory reporters.[5] More than one-third of

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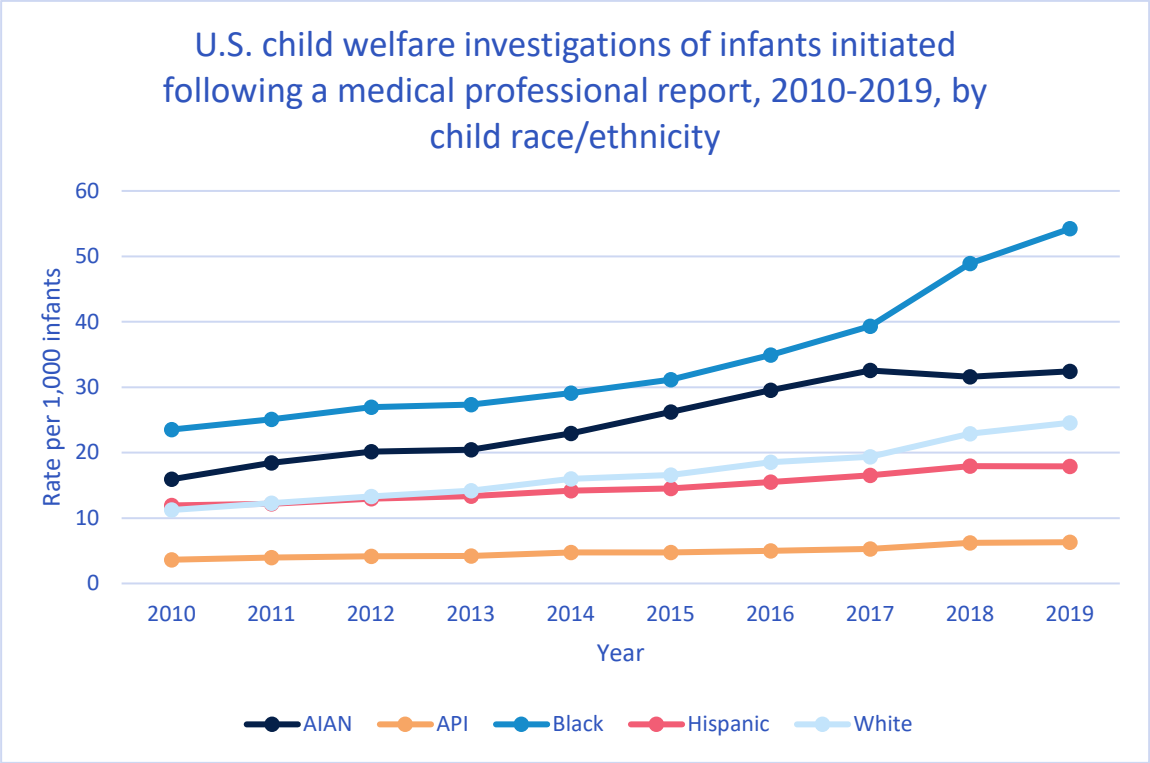
these investigations of infants relate to birthing people's substance use.[5] The racial inequities in these investigations are stark, with 5.4% of Black, 3.2% of Indigenous, and 2.5% of White infants investigated.[5] Healthcare provider reports are a big source of these racial inequities in investigations. Research has found that health care providers report Black newborns to child welfare or health authorities up to four to 10 times more often than they report White newborns.[6-8] There are racial inequities at each step along the child welfare pathway (i.e. from report, to investigation, to temporary family separation, to permanent severance of legal ties).[9]



Source: Edwards et al. 2023

Reporting requirements do not keep babies safe. Reporting requirements expose babies to the harms of family separation.

One reason health care providers overreport to child welfare is that they believe that, if they do not report, the baby might be harmed.[10] Unfortunately, evidence does not support that reporting requirements actually keep babies safe or improve their health. Statutes that mandate child welfare reporting related to pregnant people's substance use are not associated with reduced infant maltreatment or improved infant health.[11-14] Instead, a long body of research indicates that these reports lead pregnant and parenting people who use drugs to mistrust healthcare providers and thus avoid and disengage from health care and treatment,[15-18] and increase risk for adverse maternal and infant health outcomes, including maternal morbidity and mortality.

Health professionals should focus on reducing overreporting by limiting the use of urine drug tests to the very few clinical indications.

Making urine drug testing universal or standardizing urine drug testing and reporting protocols does not reduce racial inequities in reporting.

Urine drug testing is often the first step in starting a process that leads providers to report a pregnant or birthing person to child welfare.[10] Healthcare providers disproportionately test Black birthing people and newborns for drugs.[19,20] For decades, people have suggested that making drug testing universal eliminates bias related to urine drug testing. Unfortunately, making drug testing universal does not actually eliminate bias, as there are racial inequities in responses to positive drug tests, with providers reporting more Black than White newborns after positive tests.[7,21] For decades, people have suggested that standardizing hospital protocols regarding urine drug testing and child welfare reporting related to birthing people's drug use will reduce racial inequities in reporting. Unfortunately, standardizing these protocols has not helped and instead institutionalizes the racism that already existed.[6]

Routine drug testing of birthing people and newborns conflicts with professional society recommendations.[22,23] Research indicates that routine urine drug testing of birthing people and newborns does not affect clinical care,[24] which means that standardized testing policies and universal testing policies that increase testing just expose more people to the adverse consequences of a positive test, including a report to child welfare. Instead, health professionals should address overreporting by restricting urine drug testing to only the very few clinically indicated reasons.[25]

References

1. Child Welfare Information Gateway. About CAPTA: A legislative history. https://www.childwelfare.gov/pubs/factsheets/about/ Accessed 12/6/2023. Department of Health and Human Services; Children's Bureau, ed. Washington, DC: U.S. 2019.
2. NIAAA. Alcohol Policy Information System. http://www.alcoholpolicy.niaaa.nih.gov/. Accessed January 31, 2023.
3. Zaugg C, Terplan M, Roberts SCM. Clinician views on reporting pregnant and birthing patients who use alcohol and/or drugs to child welfare. *Am J Obstet Gynecol MFM.* 2023;5(10):101109.
4. Work EC, Muftu S, MacMillan KDL, et al. Prescribed and penalized: the detrimental impact of mandated reporting for prenatal utilization of medication for opioid use disorder. *Matern Child Health J.* 2023:1-9.
5. Edwards F, Roberts SCM, Kenny KS, Raz M, Lichtenstein M, Terplan M. Medical Professional Reports and Child Welfare System Infant Investigations: An Analysis of National Child Abuse and Neglect Data System Data. *Health Equity.* 2023;7(1):653-662.
6. Roberts SCM, Zahnd E, Sufrin C, Armstrong MA. Does adopting a prenatal substance use protocol reduce racial disparities in CPS reporting related to maternal drug use? A California case study. *J Perinatol.* 2015;35(2):146-150.
7. Roberts SCM, Nuru-Jeter A. Universal screening for alcohol and drug use and racial disparities in child protective services reporting. *J Behav Health Serv Res.* 2012;39(1):3-16.
8. Chasnoff IJ, Landress HJ, Barrett ME. The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *N Engl J Med.* 1990;322(17):1202-1206.
9. Child Welfare Information Gateway. Child welfare practice to address racial disproportionality and disparity. 2021. Accessed 8/31/2021. https://www.childwelfare.gov/resources/child-welfare-practice-address-racial-disproportionality-and-disparity/
10. Roberts SC, Zaugg C, Martinez N. Health care provider decision-making around prenatal substance use reporting. *Drug Alcohol Depend.* 2022;237:109514.
11. Faherty LJ, Heins S, Kranz AM, Patrick SW, Stein BD. Association between punitive policies and neonatal abstinence syndrome among Medicaid-insured infants in complex policy environments. *Addiction.* 2022;117(1):162-171.
12. Kozhimannil KB, Dowd WN, Ali MM, Novak P, Chen J. Substance use disorder treatment admissions and state-level prenatal substance use policies: Evidence from a national treatment database. *Addict Behav.* 2019;90:272-277.
13. Subbaraman MS, Thomas S, Treffers R, et al. Associations between state-level policies regarding alcohol use among pregnant women, adverse birth outcomes, and prenatal care utilization: results from 1972 to 2013 Vital Statistics. *Alcohol Clin Exp Res.* 2018;42(8):1511-1517.
14. Roberts SCM, Schulte A, Zaugg C, Leslie D, Corr TE, Liu G. Association of pregnancy-specific alcohol policies with infant morbidities and maltreatment. *JAMA Netw Open.* 2023; 6(8):e2327138

15. Stone R. Pregnant women and substance use: fear, stigma, and barriers to care. *Health & Justice.* 2015;3:2.
16. Roberts SCM, Pies C. Complex calculations: how drug use during pregnancy becomes a barrier to prenatal care. *Matern Child Health J.* 2011;15(3):333-341.
17. Wolfson L, Schmidt RA, Stinson J, Poole N. Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework. *Health Soc Care Community.* 2021;29(3):589-601.
18. Proulx D, Fantasia HC. The Lived Experience of Postpartum Women Attending Outpatient Substance Treatment for Opioid or Heroin Use. *J Midwifery Womens Health.* 2021;66(2):211-217.
19. Jarlenski M, Shroff J, Terplan M, Roberts SCM, Brown-Podgorski B, Krans EE. Association of Race With Urine Toxicology Testing Among Pregnant Patients During Labor and Delivery. *JAMA Health Forum.* 2023;4(4):e230441.
20. Perlman NC, Cantonwine DE, Smith NA. Racial differences in indications for obstetrical toxicology testing and relationship of indications to test results. *Am J Obstet Gynecol MFM.* 2022;4(1):100453.
21. Roberts SC, Nuru-Jeter A. Universal alcohol/drug screening in prenatal care: a strategy for reducing racial disparities? Questioning the assumptions. *Matern Child Health J.* 2011;15(8):1127-1134.
22. ASAM. Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People. 2022. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/2022-sud-pregnant-postpartum.pdf?sfvrsn=61e2c93a_7/%202022-SUD-Pregnant-Postpartum%20.pdf Accessed February 5, 2024.
23. Committee on Obstetric Practice. Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. *Obstet Gynecol.* 2017;130(2):e81-e94.
24. Siegel MR, Cohen SJ, Koenigs K, et al. Assessing the clinical utility of toxicology testing in the peripartum period. *Am J Obstet Gynecol MFM.* 2023;5(7):100963.
25. Martinez NG, Roberts SCM, Achu-Lopes RA, Samura TL, Seidman DL, Woodhams EJ. Reconsidering the use of urine drug testing in reproductive settings. *Am J Obstet Gynecol MFM.* 2023;5(12):101206.