Summer 7-29-2020

A Mother's Touch: The Comprehensive Addiction and Recovery Act and its Impact on Prenatally Substance-Exposed Newborns and their Families as Observed by Family Service Workers

Raissa Ames
rames@harding.edu

A Mother's Touch: The Comprehensive Addiction and Recovery Act and its Impact on Prenatally Substance-Exposed Newborns and their Families, as Observed by Family Service Workers

Raissa Ames

Harding University

Comprehensive Addiction Recovery Act and Its Impact on Caseworkers

Henry Kempe's paper "The Battered Child" awakened the medical community and, subsequently, the community at large to the problem of physical abuse. Erikson (2000) notes that the term "battered child syndrome" was first coined by K. H. Kempe and his colleagues in 1962, drawing attention to the large number of infant deaths resulting from physical abuse inflicted on them by a parent or guardian. Prompted by media attention and a call for action from professionals, Congress passed the Child Abuse Prevention and Treatment Act (CAPTA) in 1974 as the first piece of federal legislation that provided minimum standards when defining physical abuse, neglect, and sexual abuse, mandating that states create systems of reporting and investigating cases of child abuse and neglect. Since that time, the Act has been reauthorized; and revisions and amendments have occurred to account for new understandings of what constitutes child maltreatment. CAPTA required that states include these definitions within their individual legislations in order to receive funding (Lloyd, Luczak, & Lew, 2019). This act was passed as a response to the findings by Congress that close to one million children were victims of maltreatment and that many of these children did not receive adequate protection or treatment (Erikson, 2000). Through the money that this policy provides, states are able to create prevention and treatment activities, assessment tools, investigation, and prosecution strategies that aid in protecting children.

Comprehensive Addiction Recovery Act

As a result of reauthorization every four to eight years, the 1974 policy has been amended several times, including the most recent change in 2016 as a response to the opioid crisis and its expected danger to children in the uterus (Rebbe, Mienko, Brown, Rowhani-Rahbar, 2019). The

Comprehensive Addiction Recovery Act (CARA) in 2016 expanded CAPTA in a number of ways, the most pertinent being the inclusion of a child's exposure to, not only illegal, but legal substances as grounds for Child Protective Services (CPS) involvement (Chasnoff, Barber, Brook, & Akin, 2018; Lloyd, Luzak & Lew, 2019). This addition not only serves as protection for all newborn children impacted by substance, but the amendment also provides treatment for mothers suffering from addiction. Within the past few decades, the number of CPS cases that involved prenatal substance exposure (PSE) has increased exponentially, making these cases among the top concerns for maltreatment present-day (Berger & Font, 2015; Lloyd, et al. 2019; Prindle, Hammond & Putnam-Hornstein, 2018; Putman-Hornstein, Prindle & Leventhal, 2016). The mass increase in these types of cases became alarming, persuading the federal government to mandate states to address the crisis on a more local level. Cases involving the substance exposure of children are considered a form of maltreatment because of the implications that they have on the later development and health of the child postnatally as these children are "disproportionally at risk for both poor developmental outcomes and for being abused or neglected" (Berger, Slack Waldfogel & Bruch, 2010, p. 199). How to address the needs of not only the children but also the mothers suffering from addiction became pertinent.

Type of Child Protective Service Involvement

In addition to addressing the treatment needs for PSE infants and their mothers, CARA also mandates that states develop some form of data collection and monitoring of referrals for services needed (Lloyd, et al. 2019). In order to receive that type of data, however, there must be a clear mechanism amongst service providers to dictate whether cases require notification or report to CPS. To notify CPS of prenatal exposure differs from a report in the sense that it does

not substantiate the claim that abuse or neglect has occurred. For this reason, a notification is seen as nonpunitive to the mother but serves as an opportunity to see if there are any additional factors within the parent's life that could point to possible maltreatment in the future, so that she may receive appropriate services. Some sources deem a positive toxicology test alone as grounds for reporting (Prindle et al, 2018; Rebbe, Mienko, Brown & Rowhani-Rahbar, 2019) while Barth (2001) and Korn(2016) indicate that, by itself, a positive test is not indicative of the necessity of a report to child services but rather a notification, because there is no intrinsic proof that the mother cannot provide adequate parenting. The presence of substance, in some states, does not warrant a report to CPS unless it is in the presence of other safety risks to the child. Additional factors in conjunction with a positive toxicology test that would lead to reporting rather than notification may include, past CPS involvement (Berger et al, 2010; Hoerr et al, 2018; Kerker, Horwitz & Leventhal, 2004), insufficient maternal care, poor nutrition (Tuhkanena, Jussilac, & Ekholm, 2019), criminal activity, and or little social support (Hoerr et al, 2018). Notification rather than report may serve these children better by not unnecessarily separating PSE infants from their mothers when there are no additional indications of risk.

Implications for PSE Infants

Prior to the distinction between the needs of notification and reporting, understanding the implications that substances have overall on the newborn is important. Exposure to narcotics, illegal or legal, and alcohol are believed to have consequences not only to the health of the child once it is born but also in utero, whether that be structural and functional changes to the fetal brain (Chasnoff et al., 2018) or the increased likelihood of lower birth rate, behavioral problems, and or poor motor skills (Hoerr et al., 2018; Price et al. 2012). Due to the types of CPS

involvement, through notifying or reporting, created by the language in CARA, the extent to which children are "affected by" (Lloyd et al, 2019, p. 344) substance abuse created disparities in service providers' urgency to alert CPS. Because of the differing opinions, the initial involvement of CPS by service providers is dependent on the beliefs that they hold regarding "certain types of substances" (Lloyd et al, 2019, p. 351) and the threat they pose for newborns. Thus, creating disparities in cases that are brought to the attention of protective services due to variation in perceptions such as, substance type and the severity of the harm they bring, as well as possible racial and ethnic biases of the mothers (Rebbe et al, 2019). Prior to CARA in 2016, which included more substances as a cause for alarm, many service providers may have excluded the possibility of the impact that alcohol, tobacco, and even prescription drugs have on the health of a newborn. Chasnoff et al (2014) and Prindle et al (2018), however, point out that prenatal alcohol and tobacco exposure have just as many short-term and long-term implications to child health illegal drugs.

Regarding possible racial disparity, despite prenatal substance exposure impacting expectant mothers of all races, it has been reported that when it comes to CPS involvement in these cases, service providers may disproportionately report women of color. Inaccurate assumptions that substance abuse, particularly during pregnancy, is an issue that predominantly impacts black women (Chasnoff et al, 1990; Kerker et al, 2004) may lend some explanation as to why these women are more likely to not only be screened for PSE but also then reported to child services. For example, Hoerr et al (2018, p. 207) discovered, "a ten-fold higher rate of reporting blacks, as compared to whites" despite universal screening and similar rates of substance use among the various racial groups. Ultimately, the racial/ethnic biases that service providers may

have can unnecessarily increase this population's interaction with CPS, causing a negative impact on the children involved.

Early Prevention

Embedded in the intention of CARA is the promotion of access and distribution of services that not only protect children but also mothers from the ramifications that substance abuse can have on their lives. CPS involvement does not always serve as the best course of intervention when dealing with PSE cases, nor does it always have to be an option as long as substance-dependent mothers are properly identified ahead of time and provided supportive services (Chasnoff et al, 2014; Barth 2001). Health care providers have a special opportunity in educating expecting persons about the risks of using substances while with child; and if the mother happens to disclose present or past addiction, these service providers may also refer her to adequate resources for help (Korn, 2016, Lloyd et al, 2018; Price et al, 2012; Prindle et al, 2018; Rebbe et al, 2019), which could decrease her chances of becoming involved with CPS once her baby arrives. Early prevention to avoid the long-term consequences of PSE may include not removing the child from its mother upon birth as it may decrease the child's chances of creating a bond with her. Allowing the baby to be in the presence of its mother post-birth, allowing her to "console, feed, and cuddle" (Lloyd et al, 2019, p. 352), can have a positive effect on the health implications that the child may experience as a result of substance exposure. Removing the child during the neonatal period can become counterproductive to child welfare policy's goal of best practices for treatment (Hoerr et al, 2018; Korn, 2016; Rebbe et al, 2019). However, perceptions of how well the 2016 amendment to CARA is doing to adequately protect children who are victims of PSE from caseworkers who have to implement its practices are

unclear. Considering this may give additional insight to the weaknesses of the policy and what could be done to more appropriately service and protect these children.

The amendment to CARA served as a way to federally address the identification, treatment and prevention options for children that have been prenatally exposed to illegal and legal substances. In addition to the protection of children, the act also set in place legislation that mandated states to put action plans in place to adequately service mothers suffering from addiction. Considering the types of CPS involvement pertaining to these cases, PSE infants' experiences, and early prevention options provided by this act ultimately leave an opportunity to discover the extent to which this legislation has served its purpose in protecting children.

The task of implementing CARA falls on medical professionals and designated family service workers. However, little research has been completed and studied regarding the opinions of these professionals as to the effectiveness of the policy. Exploring these may give child welfare policy makers insight as to how to improve legislation surrounding this issue.

Purpose of Study

The purpose of this study is to investigate the opinions that family service providers within the state of Arkansas have regarding the effectiveness of the CARA amendment to the Child Abuse Prevention and Treatment Act and its effectiveness in servicing children and their families experiencing prenatal substance-exposure.

Research Questions

1. Is the 2016 CARA amendment serving its purpose of identifying and serving children who have been prenatally exposed to substances?

2. How has the policy served family service providers and their interactions with these families?

Methods

Participants

The eight participants in this study were collected through purposive and snowball sampling from among family service providers within the state of Arkansas. Through one initial interview, the researcher was able to collect the information of the seven other participants. Each respondent fell between the ages of 23 and 55. With 62.5% of the respondents having less than ten years of experience within their field and 37.5% having more than a decade under their belts, these participants reflected varied knowledge and experience concerning CARA. Fifty percent of the participants had an educational background in psychology while the other half had earned degrees in social work.

Table of Participants

Participant Pseudonym	Age Range	Educational Background	Years of Service
Carrie	34-44	Masters in Social Work	7
Monica	34-44	Bachelors in Psychology	10
Leigh	34-44	Currently seeking Masters in Social Work	3
Kate	45-55	Bachelors in Social Work	27

Ned	23-33	Bachelors in Psychology	7
Wilmington	23-33	Masters in Social Work	2
Wanda	45-55	Bachelors in Psychology	19
Joe	45-55	Bachelors in Psychology	6

Instruments

The interviews were conducted via Zoom (video call) and email response. Each participant was sent a copy of the interview protocol prior to the meeting, which included consent to record the interviews, a brief summary of the policy, an explanation as to why they were chosen to participate, and the questions that were to be asked.

Interview Questions:

1. Briefly describe your experience with prenatal substance-exposed children.
    a. Have you seen any discrepancies in how you handle these cases dependent on the type of substance?
2. What are the things that you like best about this policy? What are its benefits?
3. What are the things that you like the least about this policy? What are its shortcomings?
    a. Are there improvements that you feel can be made?
4. Are there sufficient resources available to address the issue of prenatal substance-exposed children? If so, what do they include?

Procedure

During the Zoom interviews, the participants were asked to verbally consent to the recording of the interview. Each was made aware of when the researcher began and ended the

recording . Later, the recordings were transcribed verbatim, with little editing except for the deletion of repeated phrases and filler words such as, “um” and “uh.” The recordings were destroyed at the conclusion of the research. Due to schedule conflicts, two of the interviewees sent in their responses via email. After all interviews were conducted and transcribed, they were analyzed through structured coding to identify commonalities in the responses to the themes created from the interview questions. The themes were as follows:

1. Approaches to families with substance-exposed newborns dependant on substance,
2. Perceived benefits of the policy,
3. Shortcomings of the policy,
4. Resources and services.

Results

Analysis of the interview transcripts in consideration of the four themes presented, allowed for a more holistic understanding of how family service providers within the state of Arkansas feel about the effectiveness of the 2016 CARA amendment and its service to families with prenatally substance-exposed children. Understanding the differences in approaches to these families, the perceived benefits of the policy, shortcomings of the policy, and sufficiency of resources/services all aid in promoting improvement of the amendment when it undergoes reauthorization. In this way the population for whom the legislation was created will be better served.

Differences in Approaches

The involvement that the Department of Human Services (DHS) has in a PSE child’s life varies according to the type of substance for which the child or mother tests positive. This

determination influences how family service providers proceed. "...[E]xposure to cannabis has a low probability of eliciting either a report or removal; while infants exposed to cocaine and amphetamines have higher probabilities to be reported and removed from their parents' care" (Rebbe et al, 2019, p. 33). When discussing their experiences with prenatally substance-exposed children and any discrepancies that they noticed when working with these families, three (37.5%) of the participants responded that in the cases of newborns or mothers that tested positive for marijuana there was hardly any push for the removal of that child. However, when it came to positive toxicology tests of "harder drugs" such as methamphetamine, DHS was more than likely to perform a removal. A study published in 2007 (Smith, 2007) showed about 40,000 births within the state of Arkansas with about 11% of every thousand births being cases dealing with substance-exposed newborns. Although marijuana was the most common drug that showed up on toxicology tests, the substance also presented "no health problems" in infants meaning they were least likely to be associated with removals. In contrast to that, despite stimulants like cocaine and amphetamines presenting themselves in 25% of the cases, they were associated with higher rates of child removal due to their greater health implications in infants. Monica stated that her agency's involvement in these cases was also dependent on the judge that presides over a district by saying:

> "Generally, if the mother tests positive for THC, we just work with the family. We don't generally remove for THC. And a lot of it has to do with the judge in your district...If that child is born with meth or multiple drugs, he's wanting them taken."

As a way to further explain why there may be differences in DHS involvement in these cases, two participants discussed that the substance for which a mother tests positive for has some influence on her cooperation with the department as well as other safety factors in her life.

It was noted that mothers who only test positive for marijuana are more willing to receive help and presented no other external dangers that could jeopardize the safety of the child when released into the mother's care. Kate, 27 years seasoned professional, responded:

> "Some parents who just test positive for marijuana and they are more willing to work on the issue, we can safely have those children remain in the home."

As for additional safety concerns, mothers testing positive for THC were noted to have a positive toxicology test as the only substantial threat to the newborn. It was clarified that a positive test for illicit substances is grounds for an intervention of some type; however, it is the extent of that involvement that is dependent on a more holistic observation of the family's life. Joe stated:

> "If a newborn tests positive for THC, if there are no other safety or risk factors, we likely as an agency are going to allow that child to go home with the mother. However, if it is methamphetamine, it is likely that the child is coming into foster care."

In contrast to this, however, there were two respondents that reported that the type of substance was not influential in how they were involved in these cases. Rather, from the start, whether it was a positive test for THC or opiates, their approach to these families rested on the totality of the case. Determining the best course of action for these participants was more of a case by case decision. Wanda reported:

> "We actually take into consideration the totality of that family. So is there a history with the family and substance abuse? Is there a history of previous children being exposed? And if so, what were the parents' responses to earlier interventions? What do the protecting factors look like? Who lives in the home, what the parents' response to the situation is, what does the home environment look like?"

In addition to this, one participant speaks to the health implications that marijuana, despite common belief, can have on the future development of a child. "Infants exposed to

alcohol and marijuana were reported at comparatively lower rates, despite a plethora of empirical evidence documenting the harmful impact of both substances on a child's outcomes" (Prindle et al, 2018, p. 81). As a result of this, it leads her to assess all aspects of the child's life regardless of the substance. Leigh states:

> "Personally, I handle the cases the same. I would assess for the health and safety of that child and the functioning of their parents. I think that historically people tend to think if it's marijuana, it's not a big deal; but if it's meth, it's a really huge deal. I always treat them the same as marijuana because the research shows that it can cause some significant health problems for newborns. And then also the parents' functioning is altered in both."

The idea that prenatal exposure to marijuana does not create the same level of alarm as "harder" substances leads some family service providers to knowingly or unknowingly present biases when serving in these cases.

Perceived Benefits

When discussing what these participants thought the policy did best in serving PSE children and their families, all eight spoke to CARA's inclusion of preventative measures. These precautionary acts, however, are unable to be performed by any of the respondents in this research because of their roles within the Department of Human Services and work in crisis intervention (Carrie), requiring the child to be born before services can be rendered. Despite this though, all were able to recognize the importance of the interactions that a mother and her unborn child have with medical professionals, as they are often the first ones to notice when an expecting mother may be battling substance abuse. The policy seems to understand the unique opportunity that these professionals have when educating women on how to ensure the safety of their child while also referring them to treatment services as needed (Prindle et al, 2017). One participant reported:

> "The earlier you can intervene with children exposed to substances, the better,so that we can start to provide services to help these families affected."

Not only does early intervention benefit this population by promoting the health and safety of the mother and child, but it also could decrease the family's chances of coming into contact with child protective services. Nathan, a supervisor at the Department of Human Services, said this:

> "The best part about it is going to be the preventative portion. I think it also assists us, keeping reports from coming in. It addresses the issue before the child is born so the mother can get on her feet."

Although the department's ultimate goal is to strengthen families, some believe that lack of interaction when it may result in the removal of a child may, in the long run, benefit the family. The safety of children is always of highest priority and, while that may include alternative care for the child, "separation runs against the social services approach of supporting the child-parent relationship" (Hoerr et al, 2018, p. 207). Department of Children and Family Services worker, Joe, had this to contribute to the idea:

> "When we take a newborn into care, we are likely creating significant long term trauma in both the child and the parent's lives."

Preventive measures that are the least restrictive can aid in long term strength of child-parent relationships, but the removal of a child experiencing maltreatment, specifically the prenatal exposure to illicit substances, is a measure that is exercised when needed. Title 1 sections 102 and 103 of the 2016 CARA amendment specifically mention "awareness campaigns" and "community-based coalition enhancement grants to address local drug crises" as means of prevention and education. Medical professionals such as the nurses and OB GYNs that come into contact with the expecting mother are placed in an important role when it comes to

potentially stopping or intervening in the maltreatment of an unborn child. This mother-practitioner relationship can ensure that needs are being addressed early and services are being provided in hopes of stopping harmful behaviors. Leigh, a pediatric worker at a Children's hospital stated:

> "The parents are more prone to take their substance abuse issues more seriously ensuring that a lot of children are kept safe. And that's the most important thing that their needs are being addressed immediately. Overall it just really benefits the child."

What the Policy Lacks

According to the participants in this research, CARA does a decent job in its inclusion of preventative measures through education and campaigns that raise awareness for expecting mothers. However, what the amendment fails to address are sufficient resources that service the families that education alone are unable to influence. These resources include the accessibility of existing outpatient treatment facilities, especially in rural areas, as well as the creation of additional centers. Ned, a family service provider, had this to say:

> "I think the shortcomings [of CARA] are definitely going to be the amount of programs we have due to such a major issue".

In relation to the lack of services available for mothers living in rural areas, two participants, both working in rural Arkansas counties, spoke about the difficulty their clients have in receiving the services outside as well as within their areas. One participants said this:

> "We're a very rural part of the state and we don't have a lot. For our babies, infants, toddlers, or mothers to get any type of extra help they're going to have to go to Jonesboro or Little Rock".

Another respondent spoke about the absence of a program within her county that larger districts have access to:

> "In a lot of counties across the state, they have an intervention called TDM. But our area, which is ____ County, we don't actually have that service. I think all children that have been born with substances in their system in counties that have TDM get that service. So that would be beneficial for us to have as well."

In an article from AdvoKids ("Team Decision Making", n.d.), TDM focuses on "placement issues for children involved or potentially involved in foster care". These meetings occur prior to the family's court hearing and involve the caseworkers, their supervisors, as well as all other service providers involved in the placement of foster children. These teams help to ensure that the family is made aware of all placement options for their child if necessary. Not having a service such as this leaves mothers unaware of the support she could utilize within her own community when it comes to providing alternative care for her child.

In addition to this, the research seemed to also point out the lengthy waitlists as well as the lack of treatment facilities that allow mothers to bring with them their newborn baby and or pre existing children. These obstacles promote higher chances of relapse amongst those mothers waiting for an opening as well as disruptions within families that are already fragile. Kate, a seasoned family service provider, had this to say:

> "Some of the things that I see right now are the waiting lists for inpatient treatment. If a parent says, *I need inpatient, I need it*, there is usually a waiting list to get those parents in and that is what is most frustrating. Because sometimes that [having to wait] changes their minds completely and they go out and they repeat drugs."

Three participants spoke to the lack of inpatient treatment facilities that allow mothers to bring their children if they are over a certain age and how it deters them from receiving services at all. One participant stated:

> "In the rehab centers in this part of Arkansas, a mom can go if she's pregnant or postpartum. But if she's got a nine year old kid, they won't take in that child. Children five and under can go into treatment with their mom and they give them parenting classes. But any child over that age, that's a barrier in services for that mom. They have

> the option of putting their kids in DHS custody while they go into treatment but a lot of them say, *no way, I'm not doing that*."

Another respondent added:

> "It's not necessarily prenatal. I mean we have it all the way up to a 17 year old with a parent that is using drugs. So I think that it [treatment services] needs to be expanded and that funding can be used for more programs to address the different age groups who have parents suffering with substance abuse"

Lastly, one respondent, Monica, had differing views when discussing what she believed the policy lacked, commenting:

> "I do wish something more would be done criminally with them. I think if you are going to have a child maltreatment of finding where a child is exposed to a substance that they unknowingly ingested, it's a criminal act and something should be done about it"

Pointing out that she believes that Title II, the law enforcement and treatment section, of CARA could stand to promote stricter consequences for mothers who prenatally expose their children to substances was a clear contrast to the other respondents and their advocacy for an increase in inclusive treatment facilities.

Resources and Services

In light of observations made by those who have to implement the policy, it seems that although there are services available for prenatally substance-exposed children and their mothers, they are not sufficient in meeting all of the needs of this population. One participant had this to say:

> "We need more available opportunities for substance abuse treatment that a parent can go to and feel like they won't necessarily lose or disrupt their entire family".

Some respondents spoke about the loss in resources that the substance abuse community often experiences and how it negatively impacts the available treatment options for their clients. Making services harder to obtain and fewer to come by. Ned stated:

> "I can tell you that here in ____ County, we actually had a drug rehab center, but from my understanding it shut down. So we lost that. I definitely think there needs to be more resources".

Another then said:

> "The policy sounds good but does not have concrete findings to make it effective in communities. Every year either the substance abuse community loses resources or the resources are more difficult to obtain. The grants are not rewarded to the clients. Many individuals who are wanting to recover from substance use disorder cannot afford proper treatment."

The resources and services available for this population are either overcrowded, causing waiting lists that keep those who need it from treatment, inaccessible due to location, or unrealistic for mothers who would be unable to bring their children. From the responses of these participants, it is evident that CARA created gaps that leave many of these children and their mother's at risk.

Discussion

Findings

This study was conducted in order to determine how family service providers feel about the effectiveness of the 2016 CARA amendment when addressing the issue of prenatally substance-exposed newborns and their mothers. Common themes of differences in approaches, perceived benefits, noticed shortcomings, and services/resources helped to conclude that, although these family service providers experienced general satisfaction when implementing this policy, there is a need for an expansion in funding for the creation of more treatment facilities.

Making rehabilitation services available for families and children suffering from substance abuse that works best with their current circumstances is a way in which the child welfare system can provide individualistic care to families.

Limitations

Limitations that presented themselves during the completion of this research included the small sample size. Due to the COVID-19 pandemic, meeting with participants face to face was banned in order to receive IBS approval, meaning that alternative ways of conducting interviews had to be utilized. In addition to Zoom meetings, due to difficulty of scheduling, email responses were collected from two of the eight participants. Another limitation was only interviewing family service providers who can render services only when a child is physically present. Medical professionals who first detect toxic children were not included in the study. Because of this, many of them were unable to provide a clear description of what preventative resources were available for these children and their families.

Recommendations

When building from this research in the future, it would be beneficial to explore the opinions of the medical professionals such as nurses, OB/GYNs, and even hospital social workers that have more contact with mothers and their unborn children. Understanding how these providers feel about the preventative services that they are mandated by CARA to implement will help to further improve legislations regarding prenatally substance exposed children.

References

Barth RP. (2001). Research outcomes of prenatal substance exposure and the need to review policies and procedures regarding child abuse reporting. *Child Welfare*, *80*(2), 275–296

Berger, L. M., & Font, S. A. (2015). The Role of the Family and Family-Centered Programs and Policies. *Future of Children*, *25*(1), 155–176. https://doi-org.libraryproxy.harding.edu/10.1353/foc.2015.0007

Chasnoff, I. J., Barber, G., Brook, J., & Akin, B. A. (2018). The Child Abuse Prevention and Treatment Act: Knowledge of Health Care and Legal Professionals. *Child Welfare*, *96*(3), 41–58.

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.

Erickson, P. E. (2000). Federal Child Abuse and Child Neglect Policy in the United States since 1974: A Review and Critique. *Criminal Justice Review (Georgia State University)*, *25*(1), 77–92. https://doi-org.libraryproxy.harding.edu/10.1177/073401680002500105

Feature: Arkansas Law Punishing Mothers Whose Newborns Test Positive for Drugs Accomplishes Little, Study Finds. (2007, February 8). Retrieved July 23, 2020, from https://stopthedrugwar.org/chronicle/2007/feb/08/feature_arkansas_law_punishing_m

Hoerr, J. J., Heard, A. M., Baker, M. M., Fogel, J., Glassgow, A. E., Kling, W. C., Clark, M. D., & Ronayne, J. P. (2018). Substance-exposed newborn infants and public health law:

Differences in addressing the legal mandate to report. *Child Abuse & Neglect*, *81*, 206–213. https://doi-org.libraryproxy.harding.edu/10.1016/j.chiabu.2018.04.021

Kerker, B. D., Horwitz, S. M., & Leventhal, J. M. (2004). Patients' Characteristics and Providers' Attitudes: Predictors of Screening Pregnant Women for Illicit Substance Use. *Child Abuse & Neglect: The International Journal*, *28*(2), 209–223.

Korn, A. E. (2016). Detoxing the Child Welfare System. *Virginia Journal of Social Policy & the Law*, *23*(3), 293–349.

Lloyd, M. H., Luczak, S., & Lew, S. (2019). Planning for safe care or widening the net?: A review and analysis of 51 states' CAPTA policies addressing substance-exposed infants. *Children and Youth Services Review*, *99*, 343–354. https://doi-org.libraryproxy.harding.edu/10.1016/j.childyouth.2019.01.042

Price, A., Bergin, C., Luby, C., Watson, E., Squires, J., Funk, K., Wells, K., Betts, W., & Little, C. (2012). Implementing Child Abuse Prevention and Treatment Act (CAPTA) Requirements to Serve Substance-Exposed Newborns: Lessons From a Collective Case Study of Four Program Models. *Journal of Public Child Welfare*, *6*(2), 149–171. https://doi-org.libraryproxy.harding.edu/10.1080/15548732.2012.667730

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.libraryproxy.harding.edu/10.1016/j.chiabu.2017.10.002

Putnam-Hornstein, E., Prindle, J. J., & Leventhal, J. M. (2016). Prenatal Substance Exposure and Reporting of Child Maltreatment by Race and Ethnicity. *Pediatrics*, *138*(3). https://doi-org.libraryproxy.harding.edu/10.1542/peds.2016-1273

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.libraryproxy.harding.edu/10.1016/j.chiabu.2018.11.001

Tuhkanen, H., Pajulo, M., Jussila, H., & Ekholm, E. (2019). Infants born to women with substance use: Exploring early neurobehavior with the Dubowitz neurological examination. *Early Human Development*, *130*, 51–56. https://doi-org.libraryproxy.harding.edu/10.1016/j.earlhumdev.2018.12.019