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A New Horizon: Changing Our Approach to Parental Substance Abuse

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Key Points

- No one size fits all substance use disorder treatments. Parents should have the choice of their treatment plan.
- There are systemic barriers to seeking treatment, such as criminal punishment, custody loss, stigma, and child care. Seeking treatment is difficult.
- Untreated substance use disorders have a high price tag for taxpayers and the state.
- Expanding community-based care would allow communities to tackle geographic substance use disorder problems and to increase treatment capacity.
- Texas Family Code should include safe harbor provisions in statute for pregnant women seeking treatment, requiring CPS to prove additional grounds for removal beyond substance abuse during pregnancy.

Executive Summary

Substance use among parents has been increasing across the nation for the last decade. In Texas specifically, Child Protective Services (CPS) cases involving substance abuse rose by more than 50 percent during that time. In 2018, 67 percent of cases that resulted in removal cited substance abuse as a contributing factor.

Mothers and pregnant women, in particular, face significant barriers to substance abuse treatment, not the least of which is the very real possibility of losing custody of their children while seeking sobriety. Despite substantial evidence that people who are actively involved in choosing their preferred program increase their chances to successfully achieve sobriety, mothers involved with CPS often have little influence on what treatment plan they receive. Instead, many mothers are instructed to complete treatment unilaterally ordered by the agency.

The current child welfare system is unfavorable for drug-using parents and requires policy solutions to ameliorate the punitive approach to addressing substance abuse. Texas has already started to respond to underlying factors aggravating legal and illicit drug dependency in our communities. By implementing a community-based foster care model, the state is allowing communities to develop tailored responses to localized substance abuse-related issues and build regional treatment capacity. As a highly diverse state, both geographically and demographically, there is no single, statewide solution to parental substance abuse. Thus, community-based care allows a flexible approach to addressing root causes and effective solutions to local level substance abuse and must continue to be implemented throughout the entire state.

Looking ahead to future policy solutions, the state must prioritize parental choice in treatment planning through representation of parental interest in CPS planning meetings. We must also work to incentivize treatment, not punish those who proactively seek help. Creating safe harbor provisions for pregnant mothers with substance use disorders to get treatment for the sake of their child without fear of CPS intervention is critical.

The status quo of the child welfare system's response to substance use is outdated and ineffective. As the focus of the response to child maltreatment shifts to prevention, Texas is primed to take important steps forward in the fight against parental substance use and the critically important work of strengthening—rather than separating—families.

Introduction

The Rise in Substance Abuse Cases

For more than a decade after the turn of the century, America saw a period of steady decline in the number of kids entering foster care, but this trend is now

continued

reversing. The rate of entry began increasing in 2012 and rose by 10 percent in just four years (Radel et al., 1).

Many researchers and child welfare practitioners have attributed the increase of children entering care, in part, to persistent and rising parental drug abuse—the link between drug abuse and foster care is observable. One study found that at the county level, higher rates of overdose deaths and drug hospitalization were strongly correlated with increased rates of foster care placements (Radel et al., 2).

Between 2007 and 2017, the rate of child protective removals due to parental substance abuse skyrocketed by 53 percent, meaning 131 out of every 100,000 children in 2017 entered foster care because of parental substance abuse (Sepulveda and Williams).

These national statistics hit closer to home for Texans where Child Protective Services (CPS) cited substance abuse in 67 percent of cases that resulted in removal in 2018, making Texas one of the highest substance abuse removal states in the country (DFPS 2019b). Women are among the hardest hit by this trend.

In the cases where a child is removed for parental substance use, it is most often the mother who is the substance-abusing parent. Of women in substance abuse treatment nationally, 70 percent have children, and the rate of substance abuse among women is only increasing (Niccols et al., 2).

Substance use among mothers presents unique challenges for the child welfare system. It is not difficult to understand that children of mothers who abuse substances are at increased risk of harm, including a higher risk of impaired development, health, and cognitive functioning, among other things (Niccols et al., 2). Too often, however, the child welfare system's response fails to differentiate between the varying manifestations of substance use, treating all users as addicts, and ignores the underlying factors that lead a person to use. For example, a mother's use of substances may be tied to life stressors and socioeconomic challenges, such as unemployment or unstable housing, or comorbid mental health issues.

It is an oversimplification to assume that parents with substance use disorders (SUDs) do not love their children enough to stop using substances. The Department of Family and Protective Services' (DFPS) *Substance Use Resource Guide* teaches caseworkers to assume that "parents who use drugs love their children just as much as any other parent" (DFPS 2018, 3).

This guidance, while helpful for changing the way caseworkers think about parents, is not enough. The child welfare system status quo inadequately addresses parental substance use and is failing both mothers and their children. With the rising numbers of children entering foster care due to parental substance abuse, increases in substance use among women of reproductive age, and a lack of available rehabilitative program slots for parents, it is beyond time for states to make fundamental changes to their response to this growing problem. This shift in the focus of child welfare practice to prevention and the upcoming implementation of the federal Family First Prevention Services Act present an unprecedented opportunity to make these changes. By approaching parental substance use as a vehicle to strengthen substance involved families and prioritizing treatment over removal, the child welfare system can help reduce the number of children entering foster care.

The outsized representation of infants in the child welfare system due to parental substance abuse demonstrates the need for innovative responses to this emerging crisis.

Prenatal Exposure

Mirroring statistics of overall growth in caseloads related to SUDs, one study suggests that 10 states* have seen massive growth in neonatal abstinence syndrome (NAS), the term for opioid withdrawal in newborns (Radel et al.). It is estimated that 15 percent of births each year are affected by prenatal alcohol or illicit drug exposure (NCSACW 2020).

There are myriad reasons for increased cases, but one important explanation points to the opioid epidemic reaching demographics that historically have not had large roles in other illicit drug crises. According to Jones et al., "the greatest increases in heroin use [between 2002 and 2013] occurred in demographic groups that historically have had lower rates of heroin use: doubling among women and more than doubling among non-Hispanic whites" (Jones et al., 722).

Opioid overdose deaths among women increased 96 percent, from 7,770 women in 2010 to 15,263 in 2017. Within that same time period in Texas, opioid overdose death among women increased 26 percent (KFF).

As the rate of opioid use among women has increased in the state, so have the effects on infants: 9.4 of every 1,000 births were affected by drugs in utero in 2016 with 35 percent of

* CA, CO, HI, ME, MO, NE, NH, SC, WV, WY.

these diagnosed with NAS, an opioid specific designation (Van Horne et al., 7). While the exact number of child welfare cases involving infants with prenatal substance exposure is unknown due to differences in state identification and reporting procedures, available data indicates that increased prenatal substance exposure is one factor driving the rise in removals into foster care. One report published by the National Center on Substance Abuse and Child Welfare found that the number of child welfare cases in which parental alcohol or drug use was a contributing factor to the removal increased by nearly 17 percent between 2000 and 2016 (NCSACW 2019).

Today, children under one year of age enter foster care at a higher rate than any other age group and are considerably more likely to have substantiated findings related to substance use than older children (NCSACW 2019; CSCWD). As of September 2019, children under 2 years of age made up more than one-quarter of the total Texas foster care population (DFPS 2019a). The outsized representation of infants in the child welfare system due to parental substance abuse demonstrates the need for innovative responses to this emerging crisis.

Due to the disproportionate number of infants removed into foster care related to substance use, it is critical these responses include changes to how the system engages with pregnant women and new mothers. Between 1999 and 2010, reproductive-aged women had a 400 percent increase in prescription opioid pain relievers overdoses and a study of reproductive-aged women with nonmedical opioid use indicated that polysubstance use is the norm (Jarlenski et al.). Women are more likely to develop SUDs during their reproductive years (Forray, 3). The number of women with opioid use disorder at labor was four times greater in 2014 than in 1999 (Haight et al.).

Substance use does not equal child abuse.

Policies that treat all substance use cases with the same punitive prescriptions ignore that adversarial legal measures against prenatal substance usage can lead to worse outcomes for child and parent (Bishop et al., 5). Harsh criminal and civil penalties, for example, can discourage women from seeking treatment and other prenatal healthcare services necessary to protect their health and the health of their baby. The current one-size-fits-all approach to substance use by the child welfare system ignores the unique and varied needs of families who struggle with these challenges.

A Basis for Change

One-Size-Fits-All Fits No One

In discussing substance use, there is an important distinction between drug use, addiction, and dependency. Substance use exists on a spectrum and can range from occasional use to substance use disorders with physiological dependence, meaning not all substance use or substance use disorders manifest the same way. Child welfare concerns begin not at usage, but when parental substance abuse places the child at imminent risk of harm.

Among parents who use substances, negative outcomes for children are highly variable and depend on co-occurring risk factors such as mental health disorders, stressful family environments, marital discord, residential and caretaker instability, and overall life stressors. The severity level of substance use disorders is also a predictor of child impairment (Solis et al.).

The negative outcomes for kids may include poor academic functioning, anxiety, depression, aggression, or adolescent drug use (Lander et al.). Children living in a home with substance abuse have a higher risk of child maltreatment, but not all children whose parents abuse substances will suffer maltreatment or other negative outcomes (Child Welfare Information Gateway 2014). Substance use does not equal abuse, and child welfare systems must be cautious not to conflate the two while dealing with mothers.

Nevertheless, some child advocates argue that quick removals, faster court proceedings to terminate parental rights, and quick out-of-home placement permanence in substance abuse cases benefit children. In 2018, Kentucky and Arizona moved to pass laws allowing child welfare workers to immediately begin moving newborns toward adoption if born exposed to opioids (Kelly). Similar practices have recently come under scrutiny in Texas. Taylor County, for example, has one of the highest removal rates in the state. The chief of CPS prosecution with the Taylor County Criminal District Attorney's Office attributes these numbers to the local CPS policy of drug testing most kids whose guardians are suspected of substance abuse. When the local agency adopted this policy in 2013, the county's removal numbers skyrocketed from fairly comparable to statewide numbers to significantly higher than other counties (Texas House of Representatives).

Children who are removed quickly because of parental substance use are more likely to stay in foster care longer than their foster peers (Child Welfare Information Gateway

2014). While removal may ultimately be necessary in some cases, foster care placement is traumatic itself and compounds the experience of alleged maltreatment. The longer a child remains in care, the more trauma the child experiences due to the increasing likelihood that the child will experience situations that disrupt the stability of life, like changes in foster placements, schools, caseworkers, and service providers (Herrick and Piccus).

This trauma can ultimately lead to an increased risk for a number of long-term negative outcomes including disproportionate rates of homelessness, drug abuse, mental and physical health challenges, poor educational performance, and incarceration (Baker et al.; Conn et al.; Courtney et al.; Riebschleger et al.; Vaughn et al.). Studies further indicate that any kind of contact with the foster care system, regardless of the length of time spent in care, can have long-term negative effects on the child (Lawrence et al., 71-72). Thus, removals must be carefully weighed with safe options that keep families together.

If keeping families together is the system's priority, and the case plan goal for many families is reunification, treatment participation on the trajectory and outcome of a CPS case is crucial. One quantitative study found that individual background and demographic characteristics of mother and child have less impact on the likelihood of reunification than the type and intensity of services provided (Grella et al.). Another study of 159 families indicated that treatment completion increased the likelihood that a judge order reunification (Smith).

The longer a child remains in care, the more trauma the child experiences

While access to treatment is vital, it is equally important to match the treatment type with an individual's unique circumstances and needs. In observing that "no single treatment is appropriate for everyone," the National Institute on Drug Abuse stresses that "matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success" (NIDA 2018). Yet, options available to parents are limited as many rehabilitation services offered by the state utilize the same, one-size-fits-all approach to treatment. Thomas McLellan, CEO of the Treatment Research Institute, indicated that offering varying treatment options would "get more people into treatment and keep them longer," as opposed to dropping out before treatment completion (Fletcher). Indeed, a meta-analysis of publications in the *Journal of Clinical Psychology* found individuals were less likely to drop out of treatment and 60 percent more likely to show improvement when admitted to their preferred treatment program (Swift and Callahan).

In Texas, however, treatment choice for mothers involved with CPS is more figurative than practiced. Following the removal of a child into foster care, Texas law requires the Department of Family and Protective Services to work collaboratively with the family to develop the service plan that sets out the steps necessary to either return the child home or allow the child to remain in the home under supervision (Texas Family Code Chapter 263). It is during this service planning stage that parents may, in theory, voice treatment preferences before a treatment program is ordered by a judge. In practice, however, parents are limited by a prescriptive system in which the state controls both the assessment and treatment recommendations.

Prior to submitting a service plan to the court for approval, the department requires parents with substance use issues to receive an assessment and recommended treatment plan from a licensed chemical dependency counselor employed by an Outreach, Screening, Assessment, and Referral (OSAR) center contracted with the department. There are currently only 14 OSARs under contract with the department, and in most parts of the state, there is only one approved OSAR serving entire regions that can be as large as 30 counties (Texas Health and Human Services). Based on the OSAR's assessment, CPS will request a judge order the recommended treatment program as part of the family's service plan (DFPS 2019c).

Current department practice in this area not only denies parents a meaningful opportunity to participate in developing their service plan, but it is also contrary to best practices for promoting successful recovery. For the process to provide the greatest accountability, as well as the greatest choice to parents receiving services, parents must be able to request outside evaluation and treatment options in their service plans for court consideration. Effective representation of parents by legal counsel is an important part of helping parents effectively advocate for their preferences and needs. Appointing counsel for parents prior to the first CPS court hearing is one way that states can better set families up for success in addressing substance abuse issues and prevent unnecessary separations (Hardin and Koenig, 101).

Expanding parental choice is not a novel idea. The U.S. Department of Health and Human Services implemented a grant program between 2004 and 2014 known as Access to Recovery III (ATR III), which offered grants to individuals to purchase substance abuse treatment of their choice.

The grant program stated that one of its primary goals was to expand consumer choice resulting in "an unparalleled opportunity to create profound change in substance use disorders treatment and recovery financing and service delivery" (Office of the Assistant Secretary for Planning and Evaluation).

While parents, specifically mothers, need increased access to individually appropriate treatment, many promising evidence-based models are producing positive results for parents and families.

Family-focused interventions have shown great results toward parent recovery and family preservation. Home-based substance abuse interventions like Building Stronger Families (BSF), for example, found that 93 percent who enrolled in the program completed treatment, and 75 percent of parents successfully held custody of their children during treatment (Oliveros and Kaufman; Swenson and Schaeffer, 113). Parents of the program saw sustained sobriety, stable mental health, and secure housing after program completion.

Other programs such as Family Based Recovery (FBR) engages parents with substance abuse and co-occurring issues like psychiatric diagnoses and domestic violence. In this program, 64 percent of infants and young children were able to remain at home throughout the treatment (Oliveros and Kaufman).

The Gateway Community Services outpatient and residential treatment program found that one year after treatment discharge, out of a random sample of 60 women, 72 percent reported being clean, and 92 percent reported no further involvement with police, court, or probation (Young et al., 93).

These programs all have varying treatment times, program expectations, and intensities. Ensuring treatment plans address the specific needs of the parent and child while tailoring treatment to the needs of the family is critical. CPS must promote harm reduction strategies by considering the behavior of parents in treatment and recovery in addition to child safety (Young et al., 87). Thus, moving away from a one-shot treatment to a disease management approach is paramount in substance abuse cases.

Community-Based Care

Encouraging diversity in treatment offering, as well as customizing plans for parental needs are strengths of Texas' newly implemented community-based foster care model, which allows communities to solve problems at their local level. The 85th Texas Legislature redesigned Texas' foster care system by localizing the administration of child placement services and the continuum of child care services. Independent nonprofit agencies or local governments can apply to contract with the Department of Family and Protective Services to run a region's or regions' foster care system. These subcontractors are known as Single Source Continuum Contactors (SSCCs).

The advantages of moving to a community-based model include the opportunity for innovation in services provided, greater service capacity tailored to the unique needs of the community, ability to address specific local needs, and increased accountability for the performance of child welfare services. In addition, under Stage II of implementation, full case management responsibilities are transferred to the local SSCCs, allowing them to work with parents to develop customized service and treatment plans.

These advantages boil down to flexibility in providing services, which is sorely needed in the child welfare response to parental substance abuse. Allowing the regions to have the autonomy to increase treatment availability and type will provide a more diverse treatment portfolio that can directly respond to the needs of local parents and serve more families.

Current department practice is contrary to best practices for promoting successful recovery.

The need for provider flexibility is demonstrated by the considerable difference in substance usage between the different regions. In 2018, 77 percent of child welfare cases in Region 2 included parental substance abuse as reason for removal. On the other end of the spectrum, parental substance abuse only represented 59 percent of removals in Region 3. From this 18 percent difference between regions, it can be inferred that substance usage varies by community and resource division, and, therefore, must be led by the community.

The regions under community-based care have already proven their desire to improve the child welfare system in their areas for their families. Prior to CBC, Region 3b had no residential treatment center for teens. Under the regional contractor, Our Community Our Kids (OCOK), three facilities are coming online as well as the launch of Professional Home-Based Care, a therapeutic foster home placement program for the highest-need kids, the first of its kind in Texas (OCOK).

This type of engagement with local gaps in services will particularly benefit parents struggling with substance use disorders as publicly funded treatment services in Texas are waitlisted and are few and far between.

In advocating for more parental choice regarding treatment programs, increasing availability and capacity of programs is imperative. With Texas having more individuals in need of treatment than there are available slots throughout the state, community-based care contractors have a unique opportunity to make sure the parents in their regions have access to quality services that fit their needs and preferences.

As community-based care continues to roll out across the state of Texas, the restructuring of how the state can use federal foster care funds under the new Family First Prevention Services Act provides an additional opportunity to change the way CPS responds to parental substance use.

Family First, passed in 2018 and scheduled to be implemented in Texas by October 2021, is intended to redirect the primary focus of the state toward preventing removals of children into foster care. Under this legislation, federal Title IV-E funds, which previously were restricted solely to providing services to children already in foster care, may now be used to provide services to children at risk of entering foster care that will allow them to remain with their families. It also contains provisions that will help improve the state response to child welfare involvement or potential involvement due to substance abuse.

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One such provision allows states to use foster care payments for up to 12 months toward licensed residential family-based substance abuse treatment facilities where parent and child can live together. Optional funding is also available to at-risk families for prevention services for substance abuse and in-home parent skill-based programs.

By demonstrating greater interest in prevention and early intervention strategies, the legislation follows a public health approach to child welfare services. The public health approach to substance use promotes harm reduction and focuses resources on prevention, early intervention, and treatment (Bishop et al., 8). This translates into addressing the root causes of usage, such as mental illness, trauma, abuse, and poverty.

Punitive Measures as a Barrier to Treatment

As discussed earlier, mothers struggling with substance use issues face various barriers to accessing treatment. Seeking help for substance abuse is critical for the health of the entire family and should be encouraged. Unfortunately, many parents, and mothers specifically, endure structural, and sometimes criminal, deterrents to seeking help.

Addressing custodial concerns is paramount in discussing treatment barriers, but it is still important to note two other obstacles: stigma and child care. Mothers seeking treatment often face the stigma of being labeled neglectful, the shame of which serves as a powerful deterrent to getting help. Additionally, most programs do not offer child care and do not allow children to reside with their mothers during treatment, which forces a catch-22: whether to enter treatment or care for their child. Programs that offer child care and treatment are scarce, with only eight centers in Texas that offer substance treatment alongside daycare or child residential and education services (Center for Substance Abuse Treatment; Drug Rehab Centers).

While acknowledging various barriers exist and require solutions, the potential involvement with child protective services can be particularly deterrent for women who may face loss of custody, prosecution, and incarceration for seeking treatment during pregnancy (Center for Substance Abuse Treatment). Many mothers, or soon to be mothers, seek treatment to stabilize and strengthen their families, not be separated from them. Again, the current system forces a losing choice between seeking treatment and caring for one's child. The punitive measures women face can impede the diagnosis of substance use disorders, availability of services, and access to care (Chavkin and Breitbart).

Women have described efforts to minimize the risk of arrest or punishment through social isolation, withholding relevant medical information, avoiding prenatal care, skipping treatment appointments, or avoiding treatment altogether (Stone).

With the concerning rate of infants entering foster care due to parental substance abuse, special policy consideration must be given to pregnant women abusing substances. Policies regarding how newborns with substance exposure

are identified to CPS and whether the notice constitutes a report of maltreatment vary by state and sometimes community.

Texas employs a universal mandatory reporting standard, meaning all citizens who suspect the presence of abuse or neglect are legally required to report the allegations to child protective services. Professional reporters, such as medical professionals, have a stronger obligation to report suspected maltreatment due to the nature of their interaction with the child. As the Texas Family Code defines physical abuse of a child to include use of a controlled substance that results in physical injury to a child, medical professionals treating pregnant women using alcohol or drugs would be legally compelled to report to CPS (Texas Family Code Chapter 261).

While treatment options exist for pregnant women, including medically assisted treatment (MAT), the threat of CPS investigation and potential removal of a child can serve as a deterrent.

The perverse incentives that hinder women from seeking health care and treatment can in turn harm the children and babies the system is working to protect. Pregnant mothers attempting to abstain from opioids without medical care may risk miscarriage, preterm labor, or fetal distress (CDC). Additionally, pregnant substance use without medically assisted treatment can cause a child to be born with more severe withdrawal symptoms and birth defects than if the mother stepped down dependency through controlled substances from a medical professional. For non-pregnant mothers, untreated substance abuse has the potential to lead to impairment of parenting skills and negative outcomes for the children.

In the event a child is born to a substance-using mother, federal law requires states to develop a plan of safe care. While not mandated before birth, plans of safe care can also be developed during pregnancy. These plans direct services for the safety and needs of the infant and the health and substance use disorder treatment of the caregiver (Lopez, 2). These plans can address primary, obstetric, and gynecological care, along with substance use and mental health treatment for the mother alongside family support, infant safety, and infant development.

Plans of safe care are different from CPS safety plans, which focus on the immediate safety of a child. Plans of safe care do, however, still trigger a notification to the CPS agency when an infant is deemed prenatally exposed to alcohol or drugs. The agency then follows a typical investigation where cases are either screened in or out (NCSACW 2018, 15-16).

Plans of safe care, at their best, have the ability to guide mothers through pregnancy, early motherhood, and substance abuse treatment without the looming threat of CPS involvement and custody loss. In fact, a strong plan of safe care may "prevent the removal of an infant from his/her family" (NCSAWC 2018, 15).

However, these plans can also be used against women seeking treatment for substance use disorders. One study found that almost 30 percent of parents in treatment had at least one child removed. Of those parents, more than 35 percent had parental rights terminated. Pamela Petersen-Baston argues that many treatment providers understand that "not enough is done to stabilize and heal these families and to prevent the need for CPS involvement" (Marlowe et al., 31-32). Serving this population of substance-abusing mothers requires compassionate care, wider availability of treatment programs, and innovative protections from criminal and civil punishments.

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The Economic Cost of Substance Abuse

Substance abuse is not only costly in social capital for affected families but also has an impact on communities, states, and the country. A report in 2000 revealed that of estimated costs for 33 different diseases, alcohol ranked second, and drug disorders ranked seventh (Miller and Hendrie, 1). Drug use in the United States has only increased since.

The costs to the United States include increased medical services, crime, and lost productivity, totaling $740 billion in some estimates (NIDA 2020).

At a local level, Central Texas substance use rates are higher than in other regions throughout the state. A Travis County-specific study estimated booking and jail bed-day costs associated with substance abuse were $463,866 and $304,181, respectively. Emergency Medical Services transport and direct care costs resulted in over $4 million billed to patients (Austin Travis County Integral Care, 6).

While some expenses seem obvious, such as treatment and prevention services, others include substance-use related medical condition management, lost earnings attributable to premature death, substance-use related illness, loss of

employment, reduced workdays, lost goods associated with substance-use related crime, adjudication and sanctioning expenses, and motor vehicle crashes, to name a few (Miller and Hendrie, 6-7).

In comparison to the massive sunk costs associated with substance abuse, research aimed at the return on investment of effective substance abuse treatment provides reason for optimism. Cost-benefit studies that examined various states' public treatment systems found that every dollar spent offered a return between four to seven dollars. Additionally, investing in substance abuse treatment, which on average costs $1,500 per individual, can see returns close to $11,500 of monetary benefit to society (Miller, 6).

Policy Recommendations

Effective policy should set the table to allow communities to address the needs of their people, provide oversight for the responsible division of resources, and protect those seeking help for their conditions.

Community-Based Care

Despite the positive steps toward loosening federal funds for substance abuse treatment programs and moving toward a rehabilitative mentality, more must be done. Regional contractors must have fair access to the prevention funds centralized in the department. Contractors must have complete discretion in which treatment services and programs with which they want to contract.

The Legislature must continue to protect and support the timely rollout of community-based care to every region and fight for flexibility in the pull down of federal foster care funds so that Texas regions may access it.

Safe Harbor Provision

Adding a safe harbor provision to plans of safe care could ameliorate potential CPS overreach and unnecessary dissolution of families for women seeking treatment for SUD. The provision would protect women actively engaging with the treatment program in the plan from CPS investigation specifically for grounds of prenatal substance usage.

As long as the mother remains compliant with treatment standards, and barring any significant risk of harm unrelated to the SUD being treated, the woman should not risk the loss of custody of her child. Seeking help for the benefit of oneself and one's child ought to qualify for protection from familial separation under the law.

Requiring active medical care and treatment of substance use disorders does not tie the hands of child protective services for action but rather requires a finding that the maltreatment is beyond a mother seeking to stop the harmful behavior.

With current research showing that stopping drug use outside of medically supervised withdrawals can lead to fetal distress, including miscarriage, and the alternative being continued substance use, encouraging women to seek treatment through codified protections is the safest option for mother and child.

Providing safe harbor protections is not a far cry from other protections we already offer women. For women who feel unable to care for their newborns, Baby Moses laws exist that allow parents to leave their infant at a designated safe place without prosecution for neglect.

If we can protect women who cannot or do not want to care for their child, we should provide even greater protections for women who are actively choosing treatment for the sake of healthy parenting.

Conclusion

Drug use disorders in America are only increasing, affecting every part of society, most importantly, vulnerable children. As scientific research on child development and best treatment practices show, substance abuse is a family disease and must be addressed as such.

Keeping children in their families despite the presence of substance use is possible in many cases. Effective treatment and resources targeted at co-occurring issues can build strong, healthy families.

With the shift in Texas' foster care system, the change in federal child welfare funding, and pressure to find solutions to the increasing number of kids in care for parental substance abuse, this is the time to impact widespread change.

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