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Research article

Prenatal substance exposure diagnosed at birth and infant involvement with child protective services



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ABSTRACT

Infants have the highest rates of maltreatment reporting and entries to foster care. Prenatal substance exposure is thought to contribute to early involvement with child protective services (CPS), yet there have been limited data with which to examine this relationship or variations by substance type. Using linked birth, hospital discharge, and CPS records from California, we estimated the population prevalence of medically diagnosed substance exposure and neonatal withdrawal disorders at birth. We then explored the corresponding rates of CPS involvement during the first year of life by substance type after adjusting for sociodemographic and health factors. Among 551,232 infants born alive in 2006, 1.45% ($n = 7994$) were diagnosed with prenatal substance exposure at birth; 61.2% of those diagnosed were reported to CPS before age 1 and nearly one third (29.9%) were placed in foster care. Medically diagnosed prenatal substance exposure was strongly associated with an infant's likelihood of being reported to CPS, yet significant variation in the likelihood and level of CPS involvement was observed by substance type. Although these data undoubtedly understate the prevalence of prenatal illicit drug and alcohol use, this study provides a population-based characterization of a common pathway to CPS involvement during infancy. Future research is needed to explicate the longer-term trajectories of infants diagnosed with prenatal substance exposure, including the role of CPS.

1. Introduction

In 2014, more than 3.6 million referrals for child abuse or neglect were made in the United States (U.S. Department of Health and Human Services, 2016). Infants had the highest rate of maltreatment referrals and substantiated victimization (24.4 per 1000; U.S. Department of Health and Human Services, 2016). Parental substance abuse is believed to be an important contributor to the risk of maltreatment and involvement of child protective services (CPS) (Barth, 2001; O'Donnell et al., 2009; Olsen, 2015; Walsh, MacMillan, & Jamieson, 2003; Smith & Testa, 2002). Worldwide, studies have suggested that parental substance abuse is a concern in approximately 11% to 40% of investigated reports of child maltreatment (Dolan, Casanueva, Smith, Lloyd, & Ringeisen 2012; Sun, Shillington, Hohman, & Jones, 2001; Testa & Smith, 2009). Among children placed in the US foster care system, estimates range from 16 to 79% (Anthony, Austin, & Cormier, 2010; Taplin & Mattick, 2015; Murphy et al., 1991; U.S. General Accounting Office, 1994), although many of these findings are decades old and relied on inconsistent measurements of parental substance abuse.

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1.1. Consequences of prenatal substance exposure

Research on the effects of prenatal exposure to illicit drugs and alcohol has produced mixed results, yet has suggested that maternal substance use during pregnancy can cause direct health concerns, such as low birth weight (Anthony et al., 2010; Kelly et al., 2002; Pan & Yi, 2013; Patrick et al., 2012), preterm birth (Barth, 2001; Kelly et al., 2002; O'Donnell et al., 2009), hypoxia due to maternal malnutrition or drug-affected placental functioning (Behnke & Smith, 2013), congenital and neurological abnormalities (Behnke & Smith, 2013; Burns, Mattick, & Cooke, 2006; Pan & Yi, 2013), heart problems, and seizures resulting from neonatal abstinence or withdrawal (Burns et al., 2006; Pan & Yi, 2013). Maternal substance abuse has also been shown to pose indirect threats to a child's well-being in utero and throughout infancy through exposure to domestic violence (Choenni, Hammink & Van de Mheen, 2017; O'Shea, Collins, Allis, & Daly, 2016), tobacco and other toxic drug exposure through the air or skin-to-skin contact (Olsen, 2015; Boomgaarden-Brandes et al., 2011), unsafe postnatal home environment (Burke, 2007), and co-occurring maternal mental illness (Canfield, Radcliffe, & Marlow, 2017; O'Donnell et al., 2009).

1.2. Reporting of prenatal substance exposure

Prenatal substance exposure can be detected through toxicology screening during pregnancy or at birth (Gray & Huestis, 2007; Wexelblatt et al., 2015). In a majority of US states, positive toxicology results lead to a child maltreatment report (Drescher-Burke & Price, 2005), and in some, such as Tennessee, laws allow for criminal charges to be brought against substance abusing pregnant women (Olsen, 2015). Yet in other states, including California, there is no legal mandate to make a report to CPS based on evidence of maternal prenatal alcohol or substance use absent other safety concerns (Child Abuse, 2000). Variability in CPS reporting following positive toxicology results has been attributed to the stigma associated with illicit, so-called 'hard' drugs, and cultural assumptions about more mainstream substances, including alcohol and marijuana (Chasnoff, 2017; Choenni et al., 2017; Olsen, 2015). Indeed, alcohol and other illicit substances are known to have differential physiological and behavioral consequences for children, yet to date, few studies have assessed differences in child outcomes by substance type (Chasnoff, 2017; Choenni et al., 2017).

1.3. Impact of prenatal substance exposure on CPS involvement

Prenatal use of illicit drugs and alcohol during pregnancy may be noted in CPS case records, and many states have standard fields for recording this information (Barth, 2001). Local data-entry practices and policies, however, vary greatly (Testa & Smith, 2009; U.S. Department of Health and Human Services, 2013). Retrospective evaluations using CPS records alone provide a crude measure of population-level incidence rates of prenatal substance exposure. Research on prenatal substance use based on self-reports (Ebrahim & Gfroerer 2003; O'Donnell et al., 2009; Substance Abuse and Mental Health Administration, 2012), toxicology screens (Azadi and Diggy, 2008), and medical billing records (Kelly et al., 2002; O'Donnell et al., 2009) have produced widely varying prevalence rates. Very few studies have examined the rate of prenatal substance exposure among infants reported to CPS (Burns et al., 2006; O'Donnell et al., 2009; Smith & Testa, 2002). Only a small number of U.S. studies have examined CPS involvement following medically diagnosed prenatal substance exposure and have tended to be based on small samples from which it is challenging to make broader generalizations (Chasnoff, Landress, & Barrett, 1990; Leventhal et al., 1997; Qi et al., 1997; Smith & Testa, 2002). Internationally, several recent studies have documented the association between parental maternal substance abuse and poor child welfare outcomes, though most are restricted to populations already known to CPS (Forrester & Harwin, 2008; Laslett, Dietze, & Room, 2013). A 2017 study from Finland used substance abuse ICD-10 codes and other administrative data to prospectively follow full birth cohorts and evaluate the effects of maternal substance abuse on child health outcomes (Raitasalo & Holmila, 2017). CPS involvement, however, was not included as a measure of child health or wellbeing. It is currently unknown how many infants diagnosed with prenatal substance exposure become involved with CPS, or how involvement may vary by substance type.

1.4. Goals of current study

In the present analysis, we examined prenatal substance exposure and CPS involvement in California by linking maternal and infant hospital discharge records to infant CPS records. The objectives of this population-based California birth cohort study were to: (a) generate information concerning the prevalence of medically diagnosed prenatal substance exposure at birth; (b) characterize the population distribution of substance-related diagnoses across sociodemographic and pregnancy-related attributes; and (c) examine the relationship between substance type and an infant's likelihood of varying degrees of CPS involvement during the first 12 months of life, after adjusting for other factors.

2. Methods

2.1. Data

This analysis is based on a linked file of three administrative sources of data: (a) vital birth records from the California Department of Public Health; (b) maternal and infant hospital discharge records from California's Office of Statewide Health Planning and Development; and (c) CPS records from the California Department of Social Services. Birth and hospital discharge records are

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