

LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

MODEL SUBSTANCE USE DURING PREGNANCY AND FAMILY CARE PLANS ACT

MARCH 2023



LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

This project was supported by Grant No. G21990NDCP03A awarded by the Office of National Drug Control Policy. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the Office of National Drug Control Policy or the United States Government. Research current as of October 2022.

© 2023 Legislative Analysis and
Public Policy Association.

This document is intended for informational purposes only and does not constitute legal advice or opinion. For questions about this document or the information contained herein, please contact LAPPA via email at info@thelappa.org.

MODEL SUBSTANCE USE DURING PREGNANCY AND FAMILY CARE PLANS ACT

ACKNOWLEDGMENTS

The Legislative Analysis and Public Policy Association (LAPPA) is grateful to the Office of National Drug Control Policy for its support in funding, enabling, and contributing to this Model Act.

This Model Act could not have been developed without the valuable input of the Model Substance Use During Pregnancy and Family Care Plans Act working group. LAPPA wishes to thank its distinguished members, many of whom are listed below, for providing their expertise, guidance, and suggestions that contributed to the model's development.

Daniel Blaney-Koen, JD
American Medical Association

David LaBahn, Esq.
Association of Prosecuting Attorneys

Nelson Bunn
National District Attorneys Association

Margaret Lloyd Sieger, PhD
University of Connecticut, School of Social Work

Katherine Cooney, Esq.
Office of National Drug Control Policy

Stephen Patrick, MD
Office of National Drug Control Policy
Vanderbilt Center for Child Health Policy

Kelly M. Corredor, JD
American Society of Addiction Medicine

Frank Russo, Esq.
National District Attorneys Association

Lauren Jansson, MD
Johns Hopkins University, School of Medicine

Mishka Terplan, MD
Friends Research Institute

Hendrée Jones, PhD
The University of North Carolina at Chapel Hill,
Department of Obstetrics and Gynecology

Nancy K. Young, PhD
Children and Family Futures

MODEL SUBSTANCE USE DURING PREGNANCY AND FAMILY CARE PLANS ACT

TABLE OF CONTENTS

SECTION I. SHORT TITLE.....	3
SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.....	3
SECTION III. DEFINITIONS.	9
SECTION IV. SCREENING FOR SUBSTANCE USE DISORDERS.....	19
SECTION V. TREATMENT OF PREGNANT AND POSTPARTUM INDIVIDUALS FOR SUBSTANCE USE DISORDER.	21
SECTION VI. NOTIFICATION TO [DEPARTMENT].....	23
SECTION VII. FAMILY CARE PLANS.....	27
SECTION VIII. EDUCATION AND TRAINING.....	30
SECTION IX. MEDICAID AND OTHER INSURANCE COVERAGE.....	34
SECTION X. STATE PERINATAL COORDINATING COUNCIL.	35
SECTION XI. LOCAL COORDINATING COUNCILS.....	38
SECTION XII. DATA COLLECTION AND SHARING.....	41
SECTION XIII. FUNDING.	44
SECTION XIV. RULES AND REGULATIONS.....	46
SECTION XV. SEVERABILITY.....	46
SECTION XVI. EFFECTIVE DATE.	46

SECTION I. SHORT TITLE.

This Act may be referred to as the “Model Substance Use during Pregnancy and Family Care Plans Act,” “the Act,” or “Model Act.”

SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) Legislative findings.—The [legislature]¹ finds that:

- (1) “Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences.”² Individuals “with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences”;³
- (2) In 2020, an estimated 169,000 pregnant women in the United States aged 15 to 44 reported illicit drug use, with the vast majority (164,000) reporting cannabis use.⁴ An additional 8,000 reported use of opioids, while 215,000 reported any alcohol use. Finally, 171,000 reported using tobacco while pregnant;⁵
- (3) Medications are currently available to treat opioid use disorder, alcohol use disorder, and nicotine use disorder and are effective in treating those substance use disorders by reducing or eliminating withdrawal symptoms or by blocking the brain’s receptors helping to reduce the incidence of a return to use, and medications for

¹ This Act contains certain bracketed words and phrases (e.g., “[legislature]”). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

² *Definition of Addiction*, AM. SOC’Y OF ADDICTION MED. (Sept. 15, 2019), [asam's-2019-definition-of-addiction-\(1\).pdf](#).

³ *Id.*

⁴ *2019-2020 National Survey on Drug Use and Health, Table 6.20A*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), U.S. DEP’T OF HEALTH & HUM. SERVS. (Jan. 2022), [2020 NSDUH Detailed Tables | CBHSQ Data \(samhsa.gov\)](#). “Illicit drug use” is the term used by the National Survey on Drug Use and Health (NSDUH) in the report and, as mentioned in paragraph (2), includes cannabis, which has been legalized for medical use in 37 states, three territories, and D.C., and legalized for recreational use in 19 states, two territories, and D.C. (See, *State Medical Cannabis Laws*, NAT’L CONF. OF STATE LEGISLATURES (Sept. 12, 2022), [State Medical Cannabis Laws \(ncsl.org\)](#).)

⁵ *Id.* Note that information regarding methamphetamine use during pregnancy is unavailable for 2020 due to low precision but more than 460,000 non-pregnant women reported methamphetamine use for that year. “Low precision” is defined by SAMHSA to mean “estimates based on a relatively small number of respondents or with relatively large standard errors.” See, Appendix A, Glossary. States may wish to replace this paragraph with state-specific information.

addiction treatment are the standard of care for pregnant individuals with opioid use disorder;⁶

- (4) People of color are less likely to receive medications for addiction treatment for alcohol or opioids than their white counterparts (for example, in 2020, 936,000 white individuals received medications for addiction treatment while only 104,000 people of color, including Black, Hispanic or Latino, and Asian people, received medications for addiction treatment);⁷
- (5) Further, Black women⁸ are more likely than individuals of other races to be tested for drug use during pregnancy and are more likely to be incarcerated or lose custody of their child immediately after birth for prenatal drug use;⁹
- (6) Untreated substance use disorder in pregnant individuals can result in fatal overdose or premature birth, as well as health and developmental problems for infants.¹⁰ Further, untreated substance use disorder is also linked to a risk of pregnancy-associated suicide;¹¹
- (7) In 2016, pregnancy-associated deaths involving opioids accounted for ten (10) percent of all pregnancy-associated deaths in twenty-two (22) states and the District

⁶ See, *Principles of Drug Addiction Treatment: A Research-based Guide (Third Edition) Evidence-based Approaches to Drug Addiction Treatment*, NAT'L INST. ON DRUG ADDICTION (Jan. 2018), [Evidence-Based Approaches to Drug Addiction Treatment | National Institute on Drug Abuse \(NIDA\) \(nih.gov\)](#) and *Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy*, 130(2) OBSTETRICS & GYNECOLOGY e81, e84-e85 (Aug. 2017), [Committee Opinion No. 711: Opioid Use and Opioid Use Disorder... : Obstetrics & Gynecology \(lww.com\)](#).

⁷ 2019-2020 National Survey on Drug Use and Health, Table 5.41A, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), U.S. DEP'T OF HEALTH & HUM. SERVS. (Jan. 2022), [2020 NSDUH Detailed Tables | CBHSQ Data \(samhsa.gov\)](#). There was low precision of information for the American Indian/Alaska Native population for the year 2020, so that population of individuals is not included in the statistics for this subsection. See Note 5 for more information on “low precision.”

⁸ This paragraph refers to “Black women” rather than using the gender neutral phrase “Black pregnant individuals” as the study involved people who all identified as women. LAPPa recognizes that trans men and non-binary individuals can also become pregnant.

⁹ Kathi L. Harp & Amanda M. Bunting, *The Racialized Nature of Child Welfare Policies and the Social Control of Black Bodies*, 27(2) SOC. POL. 258-281 (Oct. 23, 2019), [The Racialized Nature of Child Welfare Policies and the Social Control of Black Bodies - PMC \(nih.gov\)](#).

¹⁰ Stephen W. Patrick et al., *Neonatal Opioid Withdrawal Syndrome*, 146(5) PEDIATRICS, Nov. 2020, [Neonatal Opioid Withdrawal Syndrome | Pediatrics | American Academy of Pediatrics \(aap.org\)](#).

¹¹ Jacquelyn Campbell et al., *Pregnancy-associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence*, 30(2) J. OF WOMEN'S HEALTH 236-244, Feb. 2021, [Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence - PMC \(nih.gov\)](#). “Pregnancy-associated death” is defined as a death occurring while pregnant or within one year of being pregnant.

- of Columbia, with seventy (70) percent of those deaths occurring during pregnancy or within forty-two (42) days following the end of the pregnancy;¹²
- (8) The use of prescription drugs, including medications for addiction treatment, non-prescription drugs, controlled substances, or alcohol during pregnancy can result in a newborn infant showing signs of withdrawal;¹³
- (9) An analysis of the incidence of neonatal abstinence syndrome (NAS) in the United States from 2010 to 2017 showed a relative increase in the incidence of NAS of eighty-two (82) percent;¹⁴
- (10) In [most recent year for which data is available], there were [number of infants] born affected by parental substance use disorder or who were identified as being in withdrawal from drugs or alcohol in [state];¹⁵
- (11) In [most recent year for which data is available], there were [number of infants] placed in out-of-home care in [state], and the percentage of infants being placed in care has increased; further, [percentage] of infants placed in care have parental substance use as a factor associated with their need for placement;¹⁶
- (12) Family care plans, also known as plans of safe care,¹⁷ can be helpful in preventing child removals, keeping families together, and ensuring the health and well-being of parents with substance use disorder and infants born affected by parental substance use disorder when the plans focus on identifying the needs of the family unit and working to meet those needs;

¹² Alison Gemmill, Mathew V. Kiang, & Monica J. Alexander, *Trends in Pregnancy-associated Mortality Involving Opioids in the United States, 2007-2016*, 220(1) AM. J. OF OBSTETRICS & GYNECOLOGY 115-116, Sept. 28, 2018, [Trends in pregnancy-associated mortality involving opioids in the United States, 2007–2016 - American Journal of Obstetrics & Gynecology \(ajog.org\)](https://doi.org/10.1016/j.ajog.2018.08.031). The study involved the 22 states that, as of the start date of the study in 2007, indicated pregnancy status – currently pregnant or gave birth within one year prior to death – on the death certificate.

¹³ See *Neonatal Abstinence Syndrome*, MARCH OF DIMES (last reviewed June 2019), [Neonatal abstinence syndrome \(NAS\) \(marchofdimes.org\)](https://www.marchofdimes.org/neonatal-abstinence-syndrome) and Saminathan Anbalagan & Magda D. Mendez, *Neonatal Abstinence Syndrome*, STATPEARLS [INTERNET] (last updated May 1, 2022), [Neonatal Abstinence Syndrome - StatPearls - NCBI Bookshelf \(nih.gov\)](https://www.ncbi.nlm.nih.gov/books/NBK537038/).

¹⁴ Ashley H. Hirai et al., *Neonatal Abstinence Syndrome and Maternal Opioid-related Diagnoses in the US, 2010-2017*, 325(2) JAMA NETWORK 146-155 (Jan. 12, 2021), [Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the US, 2010-2017 | Neonatology | JAMA | JAMA Network](https://doi.org/10.1001/jama.2020.20171).

¹⁵ The statistics referenced in this subsection should be supplied by the state.

¹⁶ The statistics referenced in this paragraph should be supplied by the state and can be located here:

<https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/afcars>.

¹⁷ This Act uses “family care plan” and “plan of safe care” interchangeably.

(13) Family care plans should serve multiple purposes including, but not limited to, connecting pregnant and postpartum individuals to appropriate services such as substance use disorder treatment, mental health and other medical treatment, peer support services, and housing, employment, and educational assistance, and ensuring the safety and well-being of the newborn infant; and

(14) Notwithstanding any other law to the contrary, using substances during pregnancy or giving birth to an infant affected by parental substance use disorder or experiencing withdrawal is not, in and of itself, child abuse or neglect.

(b) Purpose.—The purpose of this Act is to:

(1) Provide certain protections to pregnant or postpartum individuals with a substance use disorder so that such individuals are not penalized for receiving medical treatment, including medication(s) to treat the substance use disorder;

(2) Establish that an infant born affected by parental substance use disorder or showing signs of withdrawal is not, by itself, grounds for submitting a report of child abuse or neglect;

(3) Recommend that healthcare professionals conduct a screening for substance use disorders during the first visit with a pregnant individual;

(4) Establish priority of care requirements for treating pregnant individuals who are diagnosed as having, or identified as at risk of having, substance use disorders;

(5) Establish recommendations for the implementation of prenatal family care plans for all pregnant individuals diagnosed as having, or identified as at risk of having, substance use disorder that focuses on connection to treatment and providing wraparound services to support the individual;

(6) Establish requirements for the implementation and support of postnatal family care plans for all infants born affected by parental substance use disorder and infants experiencing withdrawal;

(7) Establish a confidential notification system that is separate and distinct from the child abuse and neglect reporting system for the purpose of compliance with the Child Abuse Prevention and Treatment Act (CAPTA), which would allow healthcare professionals to notify the [department] of the occurrence of a child born affected by parental substance use disorder or showing signs of withdrawal, but

which shall not interfere with existing mandatory reporting requirements for cases of alleged child abuse and neglect;

- (8) Require the [department] to develop education and training materials related to infants born affected by parental substance use disorder, infants experiencing withdrawal, fetal alcohol spectrum disorders, and family care plans and provide funding for such education and training materials;
- (9) Provide funding for the creation and implementation of family care plans for healthcare professionals, hospitals, birthing centers, and other appropriate facilities in the state; and
- (10) Establish confidential data collection and evaluation policies and procedures.

Commentary

“Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences.”¹⁸ Substance use disorders, including alcohol use disorder, opioid use disorder, and stimulant use disorder, affect millions of people in the United States each year, and use of illicit drugs overall increased among pregnant individuals from 2019 to 2020.¹⁹

This Act emphasizes a family focused, preventive, public health approach to treating pregnant individuals with substance use disorders rather than a punitive approach, while also setting out provisions for complying with federal Child Abuse Prevention and Treatment Act (CAPTA) requirements. CAPTA provides grants to states for the purpose of improving the child protective services systems in the various states.²⁰ In order to receive a grant under CAPTA, states must submit a plan to the U.S. Secretary of Health and Human Services that includes information on how the grant funds will be used and which must include an assurance from the state governor that the state has in effect a state law or program that includes policies and procedures related to addressing,

...the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants...²¹

¹⁸ AM. SOC’Y OF ADDICTION MED., *supra*, note 2.

¹⁹ See, e.g., *2019-2020 National Survey on Drug Use and Health, Tables 5.1A and 6.20A*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), U.S. DEP’T OF HEALTH & HUM. SERVS. (Jan. 2022), [2020 NSDUH Detailed Tables | CBHSQ Data \(samhsa.gov\)](#).

²⁰ 42 U.S.C.A. § 5106a.

²¹ *Id.*

It is important to note that CAPTA, and this Act, distinguish between a *notification* to the state child welfare agency and a *report* of alleged child abuse or neglect. Notifications do not include any identifying information, do not result in child welfare investigations, and are made for the purposes of public health surveillance and allocation of resources to areas where they are most needed. By contrast, reports of alleged child abuse or neglect do result in an investigation and potentially removal of the child or criminal action against the birthing individual or parent. As mentioned several times in this Act, both in the statutory language and in commentary, using substances during pregnancy or giving birth to an infant born affected by parental substance use disorder or experiencing withdrawal is not, without more, grounds for the submission of a *report*; however, the birth of such infant does require the submission of a *notification*.

In line with the White House's plan for improving outcomes for pregnant individuals with substance use disorder, subsection (a)(14) specifies that, notwithstanding any other law to the contrary, using substances during pregnancy or giving birth to an infant born affected by parental substance use disorder or experiencing withdrawal is not, by itself, child abuse or neglect.²² This provision is specifically intended to supersede any other law a state may have to the contrary; however, working group members (as listed in the Acknowledgments to this Act) strongly recommend that states repeal any such laws.

CAPTA also requires that states have a law or program that includes the development of family care plans for infants

...born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder, to ensure the safety and well-being of such infant following release from the care of health care providers, including through (I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver, and (II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver...²³

This Act goes one step further than CAPTA to include a recommendation that healthcare professionals create a prenatal family care plan for pregnant individuals with a substance use disorder so that substance use disorder treatment and other services, such as housing, employment, or education assistance, or parenting supports, can begin prior to the birth of the child. (See the commentary following Sections IV and VII for a more in-depth discussion of prenatal and postnatal family care plans.)

²² *Substance Use Disorder in Pregnancy: Improving Outcomes for Families*, OFF. OF NAT'L DRUG CONTROL POL'Y, THE WHITE HOUSE, EXEC. OFF. OF THE PRESIDENT 3 (Oct. 21, 2022), [ONDCP_Report-Substance-Use-Disorder-and-Pregnancy.pdf \(whitehouse.gov\)](https://www.whitehouse.gov/wp-content/uploads/2022/10/ONDCP-Report-Substance-Use-Disorder-and-Pregnancy.pdf).

²³ *Id.* It is important to note that fetal alcohol spectrum disorder is not diagnosed at birth and may take years for children to show the signs of being affected by a fetal alcohol spectrum disorder.

Early treatment and intervention services for pregnant and postpartum individuals and infants born affected by parental substance use disorder is imperative in order to improve health outcomes for both the infant and parent.²⁴ It is, therefore, crucial that pregnant individuals be able to confide in their healthcare professionals without fear of state action, particularly for racialized people of color who are reported for child abuse or neglect by healthcare professionals for substance use during pregnancy at a much higher rate than white individuals. Additionally, American Indian/Alaska Native “children are overrepresented in foster care at a rate 2.7 times greater than their proportion in the general population.”²⁵

Accordingly, the purpose of this Act is to: (1) provide certain legal protections to pregnant individuals with substance use disorder and individuals who have given birth to infants affected by substance use disorder or experiencing withdrawal; (2) improve care for such newborns; (3) provide support for parenting individuals and family members engaged in supportive care; and (4) provide an avenue through the creation of family care plans for both parent and child to receive the services and assistance they need in order to maintain the family unit, where possible and in the best interests of the child, and assure the best outcomes for parent and child.²⁶

SECTION III. DEFINITIONS.

[States may already have definitions in place for some or all of the following terms. In such case, states may use the existing definitions in place of those listed below.]

For purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given to them in this section:

- (a) Alcohol use disorder.—“Alcohol use disorder” or “AUD” means a problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two diagnostic criteria, as set out in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions, occurring within a 12-month period;²⁷
- (b) Assessment.—“Assessment” means a biopsychosocial assessment, including a process for defining the nature of a substance use disorder, diagnostic formulations, and developing specific treatment recommendations, including identification of the

²⁴ *Basics about FASDs*, CENTERS FOR DISEASE CONTROL & PREVENTION (last reviewed Jan. 11, 2022), [Basics about FASDs | CDC](#).

²⁵ *Disproportionality Table*, NAT’L INDIAN CHILD WELFARE ASS’N (2017), [Disproportionality-Table.pdf \(nicwa.org\)](#).

²⁶ For information regarding civil rights protections for individuals with substance use disorder, please see: [Medication-Assisted Treatment | National Center on Substance Abuse and Child Welfare \(NCSACW\) \(hhs.gov\)](#).

²⁷ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, 490-491, 2013.

immediate, short- and long-term physical, social, emotional, mental health, and other needs of the individual;²⁸

- (c) Birthing individual.—“Birthing individual” means the individual that physically gave birth to a newborn infant;
- (d) Cannabis.—“Cannabis” means all parts of the plant *Cannabis sativa* L., whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin;²⁹
- (e) Cannabis use disorder.—“Cannabis use disorder” means a problematic pattern of cannabis use leading to clinically significant impairment or distress, as manifested by at least two diagnostic criteria, as set out in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions, occurring within a 12-month period;³⁰
- (f) Case management.—“Case management” means a set of social service functions, including screening, assessment, planning, linkage, monitoring, and advocacy, that help individuals access the resources needed to help treat substance use disorder, mental health disorder, or co-occurring disorders. These resources may be external to the individual, such as medication for addiction treatment, housing, and education, or internal to the individual, such as identifying and developing skills;³¹
- (g) Community-based organization.—“Community-based organization” means a public or private organization, formal or informal, that is representative of a community, or significant segments of a community, and which is engaged in meeting human, health, educational, environmental, or public safety community needs;³²

²⁸ The American Society of Addiction Medicine provides a free Criteria Assessment Interview Guide for clinicians to help with conducting an assessment. The Guide can be found here: <https://www.asam.org/asam-criteria/criteria-intake-assessment-form>.

²⁹ 21 U.S.C.A. § 802 (West 2022).

³⁰ AM. PSYCHIATRIC ASS’N, *supra* note 27, at 509.

³¹ See *Comprehensive Case Management for Substance Abuse Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 3 (2000), <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4215.pdf> (describing the types of services case management entails).

³² *Model Syringe Services Program Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Dec. 2021), [Model Syringe Services Program Act • LAPP \(legislativeanalysis.org\)](https://legislativeanalysis.org/).

- (h) Controlled substance.—“Controlled substance” means a drug, substance, or immediate precursor included in Schedules I, II, III, IV, or V of the federal Controlled Substances Act, 21 U.S.C. § 812 or 21 C.F.R. § 1308, or the [state] Controlled Substances Act [statutory reference];³³
- (i) Co-occurring disorder.—“Co-occurring disorder” means the coexistence of both a mental health and a substance use disorder;³⁴
- (j) Delegate.—“Delegate” means an individual designated by a healthcare professional, substance use disorder treatment provider, mental health treatment professional, or hospital to act as the agent of that healthcare professional, substance use disorder treatment provider, mental health treatment professional, or hospital;
- (k) [Department].—“[Department]” means the [State] Department of [Children and Family Services];
- (l) Drug.—“Drug” means any of the following:
- (1) Any substance recognized as a drug, medicine, or medicinal chemical in the official United States Pharmacopoeia, official National Formulary, official Homeopathic Pharmacopoeia, or official Veterinary Medicine Compendium, or other official drug compendium or supplements thereto;
 - (2) Any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animal;
 - (3) Any chemical substance, other than food, intended to affect the structure or any function of the body of man or other animal; or
 - (4) Any substance intended for use as a component of any items specified in paragraphs (1), (2), or (3) of this subsection, but does not include medical devices or their components, parts, or accessories;³⁵
- (m) Drug testing, toxicology testing, or testing.—“Drug testing,” “toxicology testing,” or “testing” means the collection and analysis of urine, blood, saliva, hair, meconium, or

³³ Taken from WASH. REV. CODE ANN. § 69.50.101 (West 2022).

³⁴ *Mental Health and Substance Use Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (last updated Apr. 27, 2022), <https://www.samhsa.gov/find-help/disorders>.

³⁵ Taken from WASH. REV. CODE ANN. § 69.04.009 (West 2022).

umbilical cord blood or tissue samples to determine the presence of controlled substances or other drugs;

- (n) Family care plan or plan of safe care.—“Family care plan,” “plan of safe care,” or “POSC” means a written or electronic plan created to address the health and substance use treatment needs of a pregnant or postpartum individual, infant born affected by parental substance use or experiencing withdrawal, and the affected family or caregiver, which may include mental health or other medical treatment, emotional, developmental, housing, educational, or other services;³⁶
- (o) Harm reduction.—“Harm reduction” means a program, service, support, or resource that attempts to reduce the adverse consequences of substance use among people who continue to use substances. Harm reduction addresses conditions that give rise to substance use, as well as the substance use itself, and may include, but is not limited to, syringe service programs, naloxone distribution, and education about Good Samaritan fatal overdose prevention laws;³⁷
- (p) Harm reduction organization.—“Harm reduction organization” means an organization that provides a range of harm reduction services designed to lessen the negative social, psychological, and/or physical consequences associated with drug use without an expectation that an individual cease using drugs;³⁸
- (q) Health insurance entity.—“Health insurance entity” means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the state insurance commissioner, that contracts or offers to contract to provide health insurance coverage in this state including, but not limited to, an insurance company, a health maintenance organization, a nonprofit hospital and medical service corporation, an employer sponsored plan, a governmental plan, and the state medical assistance plan;³⁹
- (r) Healthcare professional.—“Healthcare professional” means a physician, nurse, physician assistant, midwife, and any other individual licensed, registered, or certified in this state

³⁶ Taken from DEL. CODE ANN. tit. 16, § 902B (West 2022).

³⁷ *Model Opioid Litigation Proceeds Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Sept. 2021), [Model Opioid Litigation Proceeds Act • LAPP \(legislativeanalysis.org\)](#).

³⁸ LEGIS. ANALYSIS & PUB. POL’Y ASS’N, *Model Syringe Services Program Act*, *supra* note 32.

³⁹ Taken from ALASKA STAT. ANN. § 21.42.422 (West 2022) and TENN. CODE ANN. § 56-7-109 (West 2022).

and who is authorized pursuant to such license, registration, or certification to provide medical services to pregnant individuals and infants;

(s) Infant.—“Infant” means a child under the age of one year;

(t) [Option 1] Infant born affected by parental substance use disorder.—“Infant born affected by parental substance use disorder,” “substance use disorder affected infant,” and “infant born affected by substance use disorder,” mean a newborn infant for whom prenatal substance exposure is indicated and subsequent examination by the infant’s treating healthcare professional identifies any detectable physical or behavioral signs associated with prenatal exposure to drugs or alcohol, except for those drugs taken by the birthing individual as prescribed or recommended by a healthcare professional;⁴⁰

[Option 2] Infant born affected by parental substance use disorder.—“Infant born affected by parental substance use disorder,” “substance use disorder affected infant,” and “infant born affected by substance use disorder,” mean a newborn infant for whom prenatal substance exposure is indicated and subsequent examination by the infant’s treating healthcare professional identifies any detectable physical or behavioral signs associated with prenatal exposure to drugs or alcohol, including any drugs taken by the birthing individual as prescribed or recommended by a healthcare professional;

(u) Medications for addiction treatment.—“Medications for addiction treatment” or “MAT” means drugs approved by the U.S. Food and Drug Administration for the treatment of substance use disorders;⁴¹

(v) Mental health disorder.—“Mental health disorder” means a syndrome characterized by a clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning;⁴²

(w) Mental health treatment professional.—“Mental health treatment professional” means a psychiatrist, psychologist, advanced practice nurse practitioner with a specialty in mental health, clinical social worker, professional clinical counselor, marriage and family

⁴⁰ Taken from OHIO ADMIN. CODE 5101:2-1-01 (2022) and OR. ADMIN. R. 413-080-0050 (2022).

⁴¹ This definition is taken from the definition of “medication assisted treatment” found at www.samhsa.gov/medication-assisted-treatment.

⁴² AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION (DSM-5) 20 (2013).

therapist, or any other individual or entity licensed, registered, certified, or otherwise authorized to provide mental health services in [state];⁴³

(x) Newborn or newborn child.—“Newborn” or “newborn child” means a child who is born and who is under twenty-eight (28) days of age;⁴⁴

(y) Non-prescription drug.—“Non-prescription drug” means any drug which may be sold without a prescription, and which is prepackaged for use by consumers and labeled in accordance with the requirements of state and federal law;⁴⁵

(z) Notification.—“Notification” means the submission of non-identifying, confidential information, by a healthcare professional, or an appointed delegate, involved in the delivery or care of an infant born affected by parental substance use disorder or experiencing withdrawal, to the [department] for purposes of compliance with the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. Sec. 5101, *et seq.*, and the Comprehensive Addiction and Recovery Act (CARA) of 2016, P.L. 114-198 and any amendments thereto. A notification does not constitute a report of alleged child abuse or neglect;

(aa) Opioid.—“Opioid” means natural, synthetic, or semi-synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain. This class of drugs includes FDA-approved opioid analgesics, such as oxycodone, hydrocodone, codeine, and morphine, as well as heroin and synthetic opioids such as fentanyl;⁴⁶

(bb) Opioid use disorder.—“Opioid use disorder” means a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two diagnostic criteria, as set out in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions, occurring within a 12-month period;⁴⁷

(cc) Peer support specialist.—“Peer support specialist” means someone with the lived experience of recovery from a substance use disorder, mental health disorder, or co-

⁴³ Taken from the *Model Overdose Fatality Review Teams Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Feb. 2021), [Model Overdose Fatality Review Teams Act • LAPP \(legislativeanalysis.org\)](https://legislativeanalysis.org/).

⁴⁴ The age of the child in this definition was recommended by the working group member subject matter experts.

⁴⁵ WISC. STAT. ANN. § 118.29 (West 2021).

⁴⁶ *Model Expanded Access to Emergency Opioid Antagonists Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Sept. 2021), [Model Expanded Access to Emergency Opioid Antagonists Act • LAPP \(legislativeanalysis.org\)](https://legislativeanalysis.org/).

⁴⁷ AM. PSYCHIATRIC ASS’N, *supra* note 27, at 541.

occurring disorder, or who has experience navigating the child welfare system, who provides non-clinical, strengths-based support to others experiencing similar challenges;⁴⁸

(dd) Postpartum.—“Postpartum” means the twelve (12) month period after a person has delivered an infant;⁴⁹

(ee) Prescription drug.—“Prescription drug” means any drug required by federal or state law or regulation to be administered, distributed, furnished, or dispensed only on the written, oral, or electronic prescription of an authorized healthcare professional;⁵⁰

(ff) Recovery support services.—“Recovery support services” means non-clinical supports, including peer support, often provided by individuals who are in recovery themselves that assist individuals in initiating and sustaining recovery from substance use disorder, mental health disorder, or co-occurring disorders;⁵¹

(gg) Report.—“Report” means a report of alleged child abuse or neglect to the [department] as required by [insert reference to state law(s) related to mandatory reporting by healthcare professionals];

(hh) Screening.—“Screening” means an evidence-based strategy, typically a standardized oral or written instrument, used to: (1) identify conditions or risk markers for substance use disorder; and (2) determine whether an individual needs further assessment for substance use disorder;⁵²

(ii) Stimulant.—“Stimulant” means a class of drugs that produce a temporary increase in the functional activity or efficiency of an organism or any of its parts and include substances such as caffeine, amphetamines, methamphetamine, cocaine, and diet aids;⁵³

⁴⁸ *Value of Peers*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (2017), [Value of Peers, 2017 \(samhsa.gov\)](https://www.samhsa.gov).

⁴⁹ 20 ILL. COMP. STAT. ANN. 2310/2310-222 (West 2022).

⁵⁰ Taken from MD. CODE ANN. HEALTH-GEN. § 21-201 (West 2022) and DEL. CODE ANN. tit. 16, § 4701 (West 2022).

⁵¹ *What are Recovery Support Services?*, NEW JERSEY COAL. FOR ADDICTION RECOVERY SUPPORT, [What Are Recovery Support Services? - New Jersey Coalition for Addiction Recovery Support \(nj-cars.org\)](https://www.nj-cars.org).

⁵² *Model Withdrawal Management Protocol in Correctional Settings Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (June 2021), [Model Withdrawal Management Protocol in Correctional Settings Act • LAPP \(legislativeanalysis.org\)](https://www.legislativeanalysis.org).

⁵³ See, *Stimulant*, MERRIAM-WEBSTER (accessed Sept. 1, 2022) and *Drug Fact Sheet: Stimulants*, DRUG ENF’T ADMIN. (April 2020), [Drug Fact Sheet: Stimulants \(dea.gov\)](https://www.dea.gov).

- (jj) Stimulant use disorder.—“Stimulant use disorder” means a pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two diagnostic criteria, as set out in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions, occurring within a 12-month period;⁵⁴
- (kk) Substance use disorder.—“Substance use disorder” or “SUD” means a pattern of use of alcohol, cannabis, hallucinogens, opioids, sedatives, or other drugs leading to clinical or functional impairment, in accordance with the definition in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or in any subsequent editions, and includes, but is not limited to, alcohol use disorder, opioid use disorder, and stimulant use disorder;⁵⁵
- (ll) Substance use disorder treatment provider.—“Substance use disorder treatment provider” or “treatment provider” means any individual or entity who provides treatment for substance use disorder, including medications for addiction treatment, and is licensed, registered, certified, or otherwise authorized to practice or provide substance use disorder treatment services within [state];⁵⁶
- (mm) Telehealth.—“Telehealth” means the delivery of healthcare services, including tech-assisted peer support services, through interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, treatment, or the provision of recovery support services;⁵⁷
- (nn) Trauma-informed care.—“Trauma-informed care” means the services to be provided to, or on behalf of, an individual under an organizational structure and treatment framework that involves: (1) understanding, recognizing, and responding to the effects of all types of

⁵⁴ AM. PSYCHIATRIC ASS’N, *supra* note 27, at 561.

⁵⁵ Taken in part from LEGIS. ANALYSIS & PUB. POL’Y ASS’N, *Model Withdrawal Management Protocol in Correctional Settings Act*, *supra* note 52.

⁵⁶ *Model Overdose Fatality Review Teams Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Feb. 2021), [LAPPA Model Overdose Fatality Review Teams Act \(legislativeanalysis.org\)](https://legislativeanalysis.org/LAPPA-Model-Overdose-Fatality-Review-Teams-Act).

⁵⁷ Taken from *Model Access to Medication for Addiction Treatment in Correctional Settings Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Oct. 2020), [Model Access to Medication for Addiction Treatment in Correctional Settings Act • LAPPA \(legislativeanalysis.org\)](https://legislativeanalysis.org/Model-Access-to-Medication-for-Addiction-Treatment-in-Correctional-Settings-Act) and *Model Expanding Access to Peer Recovery Support Services Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Oct. 2020), [Model Expanding Access to Peer Recovery Support Services Act • LAPPA \(legislativeanalysis.org\)](https://legislativeanalysis.org/Model-Expanding-Access-to-Peer-Recovery-Support-Services-Act).

- trauma in accordance with recognized principles of a trauma-informed approach; and (2) trauma-specific interventions to address trauma’s consequences and facilitate healing;⁵⁸
- (oo) Treatment.—“Treatment” means the medical and/or behavioral management of, and care for, individuals with substance use disorder, mental health disorder, or co-occurring disorders and the individual’s family, in accordance with an individualized assessment and clinical placement criteria, with care that may include assessment, diagnosis, case management, medical, psychiatric, psychological and social services, medication for addiction treatment, counseling, and recovery support services;⁵⁹
- (pp) [Option 1] Withdrawal.—“Withdrawal” means a group of physiological features that follow the abrupt discontinuation of a drug that has the capability of producing physical dependence, but which does not include withdrawal due to exposure to drugs taken by a pregnant individual as prescribed or recommended by a healthcare professional, including medications for addiction treatment;⁶⁰
- [Option 2] Withdrawal.—“Withdrawal” means a group of physiological features that follow the abrupt discontinuation of a drug that has the capability of producing physical dependence.

Commentary

Many of the terms defined in this section may already be defined under state law. However, some of the definitions included in this section have been revised so that they better fit the needs and circumstances of this Act. In particular, working group members highly recommend that states refrain from including any reference to toxicology or drug testing, alone or in isolation, in the definition of “infant born affected by parental substance use disorder” as a single toxicology test showing the presence of drugs for the pregnant individual, birthing individual, or child is not indicative of substance use disorder in a pregnant individual or birthing individual. It is, therefore, recommended that states carefully consider the nuances of the terms included in this section before eschewing one definition in favor of another.

This Act primarily uses the term “family care plan,” although the term is at times used interchangeably with “plan of safe care.” “Family care plan” is the preferred term among subject matter experts as it is less stigmatizing to pregnant individuals and birthing individuals, hopefully making those individuals more likely to engage in the process and accept services.

⁵⁸ COL. REV. STAT. ANN. § 19-1-103 (West 2022).

⁵⁹ See 5 ILL. COMP. STAT. ANN. 810/10 (West 2022) and *Model Law Enforcement and Other First Responder Deflection Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Sept. 2021), [Model Law Enforcement and Other First Responder Deflection Act • LAPP \(legislativeanalysis.org\)](https://legislativeanalysis.org/).

⁶⁰ DEL. CODE ANN. tit. 16, § 902B (West 2022).

Further, as of the drafting of this Act, “family care plan” is the term used in pending U.S. Senate Bill 1927, the CAPTA Reauthorization Act of 2021, to replace “plan of safe care” in the Child Abuse Prevention and Treatment Act and the Comprehensive Addiction and Recovery Act of 2016.⁶¹

This Act also uses the term “medications for addiction treatment (MAT)” rather than “medications for opioid use disorder (MOUD)” as MAT encompasses medications used to treat all types of substance use disorders, including alcohol use disorder, while MOUD is limited to medications used only to treat opioid use disorder. Further, research shows progress towards finding medications for use in treating stimulant use disorder, as well.⁶² The drafters and working group members emphasize that the Act uses the term “MAT” due to its familiarity to legislators and members of the public but acknowledge that using “MAT” in lieu of simply using the term “medication” may perpetuate the stigma surrounding the use of medications to treat substance use disorders.⁶³

The working group members were divided regarding whether there should be an exception for prescription drugs taken as prescribed in the definitions for “infant born affected by parental substance use disorder” and “withdrawal.” Therefore, the drafters included two options for those terms. Option 1 for both terms contains exceptions for prescription drugs taken as prescribed, while option 2 does not. Numerous prescription drugs, including medications for addiction treatment and medications used for the treatment of mental health disorders, can result in an infant being born affected by parental substance use disorder or experiencing withdrawal. Congress modified CAPTA in 2016 to remove references to “*illegal* substance abuse,” so as to include prescription drugs, but it does not currently distinguish between withdrawal experienced by an infant due to substances taken by the birthing individual during pregnancy as prescribed and withdrawal due to the use of any other substances by the birthing individual during pregnancy. In 2017, the Department of Health and Human Services (HHS) issued guidance in this area, noting that “[s]tates have flexibility to define the phrase ‘infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure,’ so long as the state’s policies and procedures address the needs of infants born affected by both legal (e.g., prescribed drugs) and illegal substance abuse.”⁶⁴ Therefore, states should choose the definition that best fits their needs, bearing in mind that not including an exception for prescription drugs taken by the birthing individual as prescribed will result in those individuals being subject to the notification and family care plan requirements of this Act.

⁶¹ See CAPTA Reauthorization Act of 2021, S. 1927, 117th Cong. (2022), [S.1927 - 117th Congress \(2021-2022\): CAPTA Reauthorization Act of 2021 | Congress.gov | Library of Congress](#) and Comprehensive Addiction and Recovery Act of 2016, P.L. 114-198, §§ 501 – 504 (2016).

⁶² See, e.g., *Combination Treatment for Methamphetamine Use Disorder Shows Promise in NIH Study*, NAT’L INST. OF HEALTH (Jan. 13, 2021), [Combination treatment for methamphetamine use disorder shows promise in NIH study | National Institutes of Health \(NIH\)](#).

⁶³ In its September 15, 2019 definition of “addiction,” the American Society of Addiction Medicine recommended using the term “medication” to refer to any FDA-approved medication used to treat addiction, but recognized “the continued widespread use of the acronym ‘MAT’ in laws, regulations, academic literature, the media, and the vernacular.” See, *supra*, note 2.

⁶⁴ *Guidance on Amendments Made to the Child Abuse Prevention and Treatment Act (CAPTA) by Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016*, ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP’T OF HEALTH & HUM. SERVS. 3 (Jan. 17, 2017), [ACYF-CB-PI-17-02 \(hhs.gov\)](#).

However, as expressed by working group members, the purpose of a family care plan is to both ensure the safety and well-being of the infant, and also to provide services, including treatment and wrap-around services, to pregnant and postpartum individuals.

Certain definitions, or alterations to standard definitions, included in this section are based on language suggested or provided by working group members, including the emphasis on making clear that a notification required pursuant to CAPTA shall not be construed to mean a report of alleged child abuse or neglect. This Model Act intends to increase access to evidence-based care for pregnant and postpartum individuals and infants born affected by parental substance use disorder or experiencing withdrawal, or who may live in a family setting where substance use disorder is present. The working group strongly encourages states to review the definitions to help promote stigma-free treating environments that address the wide range of medical, physical, mental, social, and other needs of pregnant and postpartum individuals, their infants, families, and other children.

SECTION IV. SCREENING FOR SUBSTANCE USE DISORDERS.

- (a) Initial screening.—As part of a comprehensive initial examination, during the first visit with a pregnant individual, a healthcare professional, or an appointed delegate, should, with consent of the patient, conduct a written or verbal screening for substance use disorder to determine whether the individual requires an assessment.
- (b) Follow-up screenings.—Healthcare professionals, or an appointed delegate, may conduct follow-up screenings for substance use disorder at any point during treatment of the patient.
- (c) Assessment.—If a healthcare professional, or an appointed delegate, determines through the screening process that a pregnant individual may have a substance use disorder, the healthcare professional should either conduct an assessment of the individual to determine whether and what type of treatment and/or other services the individual may need, or refer the individual to another practitioner or entity better able through training and experience to conduct such assessment.
- (d) Prenatal family care plan.—If, based on the outcome of the completed assessment or other information provided by the patient, the healthcare professional or other individual or entity that conducted the assessment diagnoses the pregnant individual with an untreated substance use disorder, the healthcare professional, an appointed delegate, or other appropriate individual or entity should, with consent of the patient, complete a

prenatal family care plan on behalf of the individual in accordance with Section VII of this Act.

Commentary

Working group members disagreed as to whether screenings conducted pursuant to this section should be required or recommended. The argument in favor of making substance use disorder screening mandatory for healthcare professionals to perform at every pregnant individual's first visit is that screenings would thereby be conducted uniformly for every patient regardless of race or socioeconomic status. The American College of Obstetricians and Gynecologists (ACOG) recommends early universal screening of all pregnant individuals during the first visit because:

[s]ubstance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Screening based only on factors such as poor adherence to prenatal care or prior adverse pregnancy outcome can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.⁶⁵

A July 2020 study found that pregnant individuals surveyed indicated that they approved of screening for alcohol, tobacco, and other drug use during pregnancy and, further, that they would honestly disclose any alcohol, tobacco, or other drug use to their healthcare professional.⁶⁶ However, some working group members expressed concern that mandatory screening might lead to discrimination in other areas, such as by increased drug testing of individuals that would unfairly target people of color. A November 2021 review of information regarding stigma and substance use in pregnancy stated,

The rationale for screening pregnant people for substance use is that it may reduce the potential harms associated with substance use and improve parental and neonatal outcomes. Furthermore, pregnancy is a time when many are highly motivated for treatment. The potential benefits of screening must be weighed against the potential risks, including stigmatization, discrimination, legal charges, and the possibility of losing custody or parental rights.⁶⁷

⁶⁵ *Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy*, 130(2) OBSTETRICS & GYNECOLOGY e81, e84-e85 (Aug. 2017), [Committee Opinion No. 711: Opioid Use and Opioid Use Disorder... : Obstetrics & Gynecology \(lww.com\)](#).

⁶⁶ Signy M. Toquinto et al., *Pregnant Women's Acceptability of Alcohol, Tobacco, and Drug Use Screening and Willingness to Disclose Use in Prenatal Care*, 30(5) WOMEN'S HEALTH ISSUES 345-352 (Sept. 2020), [Pregnant Women's Acceptability of Alcohol, Tobacco, and Drug Use Screening and Willingness to Disclose Use in Prenatal Care - Women's Health Issues \(whijournal.com\)](#).

⁶⁷ Andrea Weber et al., *Substance Use in Pregnancy: Identifying Stigma and Improving Care*, 12 SUBSTANCE ABUSE & REHAB. 105, 109 (Nov. 2021), [Substance Use in Pregnancy: Identifying Stigma and Improving Care - PMC \(nih.gov\)](#).

For example, a California case study of two hospitals, one with a substance use disorder screening protocol in place and one without, conducted over a period of three and a half years found that the hospital with a “high risk” screening protocol in place referred five times more Black families to child protective services than white families and “did not reduce disparities in [child welfare services] referrals.”⁶⁸ In addition, “[f]ear of screening for substance use in pregnancy, or fear of consequences due to a positive screen, have been reported anecdotally as reasons pregnant people may delay seeking prenatal care or avoid prenatal care altogether.”⁶⁹ This fear seems to be founded as twenty-five (25) states and the District of Columbia consider prenatal exposure to substances, including alcohol in some states, to be child abuse or neglect, and in at least one state, prenatal substance use by the birthing individual may be grounds for termination of parental rights.⁷⁰ Therefore, this section *recommends* screening for all pregnant individuals but does not require it.

Following a screening, if the patient presents as likely having a substance use disorder, subsection (c) recommends that practitioners either conduct an assessment to determine whether the patient has a substance use disorder and what treatment or services the patient may need or refer the patient to another practitioner or entity who is better able through training and experience to conduct the assessment. Likewise, if the pregnant individual consents and the practitioner or other individual or entity that performs an assessment determines that the individual would benefit from one, a prenatal family care plan should be created and implemented to address the treatment and other needs of the pregnant individual before the birth of the child. (Family care plans are set forth in detail in the commentary for Section VII.)

SECTION V. TREATMENT OF PREGNANT AND POSTPARTUM INDIVIDUALS FOR SUBSTANCE USE DISORDER.

- (a) Priority of treatment.—A pregnant or postpartum individual referred for substance use disorder treatment shall be given priority for available treatment from a substance use disorder treatment provider.⁷¹ Treatment may be provided via telehealth.
- (b) Refusal to treat.—Mental health and substance use disorder treatment providers that receive state or federal funds may not refuse to treat a patient solely because the individual is pregnant or postpartum, as long as appropriate services are offered by the provider. A pregnant or postpartum individual shall also not be denied treatment because the individual is receiving medications for addiction treatment.⁷²

⁶⁸ *Id.*, at 110, citing Sarah C. M. Roberts et al., *Does Adopting a Prenatal Substance Use Protocol Reduce Racial Disparities in CPS Reporting Related to Maternal Drug Use? A California Case Study*, 35 J. OF PERINATOLOGY 146-150 (2015).

⁶⁹ Weber et al., *supra* note 67, at 111.

⁷⁰ See LAPP 50-state survey on prenatal exposure as child abuse or neglect (pending) and TENN. CODE ANN. § 33-10-104 (West 2022).

⁷¹ See MO. ANN. STAT. § 191.731 (West 2022).

⁷² See MO. ANN. STAT. § 191.731 (West 2022) and TENN. CODE ANN. § 33-10-104 (West 2022).

- (c) Justice involved individuals.—Pregnant or postpartum individuals who are incarcerated in a state or local correctional facility or jail, who are in a court-supervised program, or who are on parole or probation shall receive or continue to receive substance use disorder treatment, including medications for addiction treatment, as recommended by the individual’s treating physician and with the consent of the individual, for the duration of their incarceration, parole, probation, or participation in a court-supervised program.⁷³ Funding through Medicaid and other federal, state, and local medical support services should remain available for the individual.
- (d) Acceptance of insurance.—If a provider otherwise accepts insurance payments, prior to directly billing a patient for substance use disorder treatment, a substance use disorder treatment provider must receive: (1) a rejection of prior authorization from the patient’s insurer or Medicaid; (2) a rejection of a submitted claim from the patient’s insurer or Medicaid; or (3) a written denial from the patient’s insurer or Medicaid denying coverage for such treatment.⁷⁴ This provision shall not prevent a patient, at the patient’s discretion, from paying cash for services rendered even if the patient has health insurance or Medicaid.

Commentary

One of the key components of the White House’s plan to improve outcomes for families is to improve access to effective treatment for pregnant and postpartum individuals.⁷⁵ As mentioned in the plan, “pregnant and postpartum [individuals] with SUD face substantial systemic and cultural barriers in accessing [SUD treatment].”⁷⁶ A study conducted over a period of six months in 2019 asked whether “pregnancy and insurance status” are “associated with a [person’s] ability to obtain an appointment with an opioid use disorder treatment clinician.”⁷⁷ In the study, simulated-patient callers (“callers”) made 28,651 calls to 6,324 randomly selected clinicians (opioid treatment providers (OTPs) and buprenorphine-waivered clinicians) in 10 states seeking an initial appointment for opioid use disorder treatment.⁷⁸ Callers contacted each of the clinicians posing as either a pregnant or nonpregnant woman to determine whether any

⁷³ See *Model Access to Medication for Addiction Treatment in Correctional Settings Act*, LEGIS. ANALYSIS & PUB. POL’Y ASS’N (Oct. 2020), [Model Access to Medication for Addiction Treatment in Correctional Settings Act • LAPPA \(legislativeanalysis.org\)](https://legislativeanalysis.org/LAPPA).

⁷⁴ W. VA. CODE ANN. § 16-5Y-5 (West 2022).

⁷⁵ See OFF. OF NAT’L DRUG CONTROL POL’Y, *supra* note 22.

⁷⁶ *Id.* at 2.

⁷⁷ Stephen W. Patrick et al., *Association of Pregnancy and Insurance Status with Treatment Access for Opioid Use Disorder*, JAMA NETWORK OPEN (Aug. 14, 2020), [Association of Pregnancy and Insurance Status With Treatment Access for Opioid Use Disorder - PMC \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/34684441/).

⁷⁸ *Id.*

barriers to receiving treatment with the clinician existed and, if so, what type (*e.g.*, unwilling to schedule an appointment, cash-only, unwilling to prescribe buprenorphine or other MAT).⁷⁹ Overall, those callers posing as nonpregnant were more likely than those posing as pregnant (73.9 percent vs. 61.4 percent) to obtain an initial appointment with a buprenorphine-waivered clinician, but no significant difference existed in those attempting to obtain an initial appointment with an OTP (88.6 percent for pregnant callers vs. 89.4 percent for nonpregnant).⁸⁰

With regard to insurance coverage, nonpregnant callers with Medicaid were less likely than those with private insurance to obtain an initial appointment with buprenorphine-waivered providers (40.3 percent vs. 49.2 percent).⁸¹ Among pregnant callers, there was no significant difference.⁸² Of note, 26.1 percent of buprenorphine-waivered providers and 32.5 percent of OTPs refused to schedule an initial appointment unless the caller agreed to pay cash for the treatment.⁸³ As stated in the study, “for both pregnant and nonpregnant women in any treatment setting, challenges with acceptance of insurance and common expectations for cash payment present substantial barriers to care.”⁸⁴

The drafters of this model act included most of the provisions in this section as a result of the aforementioned study to ensure that pregnant individuals face as few barriers as possible and are able to readily access treatment.

The purpose of subsection (c) is to ensure the initiation or continuation of substance use disorder treatment for pregnant individuals who are incarcerated, who are in a court-supervised program, or who are on probation or parole.

SECTION VI. NOTIFICATION TO [DEPARTMENT].

- (a) Notification by healthcare professionals.—A healthcare professional, or an appointed delegate, involved in the delivery or care of an infant born affected by parental substance use disorder or experiencing withdrawal, shall, within [n] [hours/days] of the birth of such infant, submit a confidential notification to the [department] via an online portal or in writing in a form and in a manner as prescribed by the [department] by rule, pursuant to the requirements of the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. Sec. 5101, *et seq.*, and the Comprehensive Addiction and Recovery Act (CARA) of 2016, P.L. 114-198, and any subsequent amendments thereto. A notification shall not be construed to be a report of alleged child abuse or neglect.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

(b) Duties of [department].—The [department] shall:

- (1) Create a system to allow healthcare professionals, or their appointed delegate, to submit the notification required by subsection (a) via an online portal through the [department]'s website or in writing, so long as no identifying information is transmitted;
- (2) Ensure that no identifying information, including the identity of the individual submitting the notification, is submitted through the online portal;
- (3) Establish the information required to be submitted with the notification which shall include, at a minimum, the following:
 - (A) The zip code where the birthing individual resides or, if unhoused, of the facility where the birth occurred;
 - (B) The race/ethnicity of the birthing individual and the race/ethnicity of the infant;
 - (C) Whether the infant was born preterm, as defined in [insert reference to state law or other reference material];
 - (D) The name of the substance or substances the birthing individual used during the pregnancy, if known;
 - (E) Whether an authorized healthcare professional prescribed, dispensed, administered, or furnished such substance or substances to the birthing individual;
 - (F) The name of the substance or substances by which the infant was affected;
 - (G) Whether the birthing individual had a prenatal family care plan;
 - (H) Whether the birthing individual was offered, or referred to, services including, but not limited to, substance use disorder treatment, mental health disorder treatment, housing support, employment services, legal services, and education services, and, if so, the types of services offered or to which referral was made;
 - (I) Whether the healthcare professional making the notification required by subsection (a) made a concurrent report to the [department] alleging child abuse or neglect by the birthing individual; and
 - (J) Any other information required to be submitted by rule; and
- (4) Promulgate such rules and regulations as are necessary to effectuate the provisions of this section.

- (c) Toxicology tests.—Notwithstanding any other law to the contrary, a toxicology test of the birthing individual during the prenatal or postpartum period, or of the newborn infant at the time of birth, showing the presence of drugs is not a sufficient basis by itself for making a report to the [department] of child abuse or neglect.⁸⁵
- (d) Notification is not a report of child abuse or neglect.—Notwithstanding any other law to the contrary, neither:
- (1) Use of a controlled substance, prescription drug, non-prescription drug, alcohol, cannabis, or other substance while pregnant; nor
 - (2) Giving birth to an infant born affected by parental substance use disorder or an infant experiencing withdrawal,
- is, in and of itself, a report, finding, or presumption of alleged child abuse or neglect, and a notification made pursuant to this section shall not result in an investigation by the [department], removal of the child, criminal sanctions, or other punitive measures against the birthing individual.
- (e) Report of alleged child abuse or neglect.—Nothing in this section shall prevent a healthcare professional or other person from making a report of alleged child abuse or neglect to the [department] if factors other than substance use by the birthing individual are present that impact the health or safety of the newborn infant.
- (f) Confidentiality.—Except as otherwise provided for in this Act, the information submitted to the notification portal pursuant to subsection (a) is confidential and not subject to subpoena, discovery, or open records laws pursuant to [insert reference to state open records law]. Nothing in this subsection shall prevent child welfare caseworkers or other individuals with a state or local child welfare services agency from obtaining identifying information on a pregnant or postpartum individual or infant born affected by parental substance use or withdrawal symptoms for the purpose of participating in a multi-disciplinary collaboration with other agencies, entities, and individuals in order to provide services to the pregnant or postpartum individual, infant, and other family members pursuant to a prenatal or postnatal family care plan.

⁸⁵ Taken from CAL. PENAL CODE § 11165.13 (West 2022).

Commentary

The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states receiving grants have policies and procedures in place that require healthcare professionals involved in the delivery or care of a substance use disorder affected infant notify the state department of children’s services (or similar agency) of the occurrence of a child born substance use disorder affected in their facility.⁸⁶ Pursuant to 42 U.S.C. § 5106a, states receiving a federal CAPTA grant must submit a state plan which includes an assurance that the state has in effect and is enforcing a state law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes policies and procedures: “to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or [fetal alcohol spectrum disorders].”⁸⁷ Such policies and procedures must include a requirement that healthcare professionals “involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants.”⁸⁸ The purpose of subsection (a) is to meet that requirement. It should be noted that this requirement is for notification only and does not – and should not – result in a law enforcement or child protective services investigation, removal of the child from the parent, criminal investigation, or any other punitive action against the birthing individual or family in the absence of other immediate safety factors that place the infant at risk of abuse or neglect.

The purpose of subsection (b) is to require the state department(s) charged with investigating reports of child abuse or neglect to create a notification system that is separate and distinct from the system currently in place for reporting alleged abuse or neglect. Notifications made pursuant to subsection (a) are for the purpose of monitoring and public health surveillance. As can be seen from the data elements required to be reported pursuant to the notification (Section XII, *infra*), no identifying information is included; thus, the identity of the birthing individual is kept confidential, ensuring that a notification cannot be used as the basis for a child protective services or law enforcement investigation. The reason for this is simple – “drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.”⁸⁹

Subsection (e) provides that, where cause exists, practitioners and other individuals can make a separate report of abuse or neglect. However, as set out in Section VIII below,

⁸⁶ 42 U.S.C. Sec. 5101, *et seq.*

⁸⁷ 42 U.S.C. Sec. 5106a.

⁸⁸ *Id.*

⁸⁹ *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (reaffirmed 2022), [Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist | ACOG](#). See also NAT’L CTR. ON SUBSTANCE ABUSE & CHILD WELFARE, HOW STATES SERVE INFANTS AND THEIR FAMILIES AFFECTED BY PRENATAL SUBSTANCE EXPOSURE – IDENTIFICATION AND NOTIFICATION: BRIEF 1, [How States Serve Infants and Their Families Affected by Prenatal Substance Exposure: Identification and Notification, Brief 1 \(hhs.gov\)](#) (“From NCSACW’s work providing technical assistance, stakeholders have reported that child maltreatment statutes can deter pregnant women from seeking health care, including early prenatal care and substance use disorder treatment, to avoid a maltreatment report to CPS at the time of delivery.”)

practitioners and other healthcare professionals should receive education and training regarding what constitutes cause for reporting alleged abuse or neglect.

SECTION VII. FAMILY CARE PLANS.

- (a) Voluntary.—Participation by a pregnant individual or birthing individual, caretaker, or custodian of an infant born affected by parental substance use disorder in the creation and implementation of a family care plan is voluntary and no complaint of child abuse or neglect shall be predicated solely upon an individual's refusal to engage in a family care plan.
- (b) Prenatal family care plan.—Pursuant to subsection (d) of Section IV, if a pregnant individual is diagnosed with a substance use disorder that may cause or lead to an infant being born affected by parental substance use or to experience withdrawal, the healthcare professional, an appointed delegate, the individual or entity that performed the assessment, or the individual's substance use disorder treatment provider, as appropriate, should, with the consent of the pregnant individual, create a family care plan for the pregnant individual that addresses the substance use disorder treatment, medical treatment, mental health treatment, housing, education, employment, transportation, and other needs of that individual.
- (c) Oversight of prenatal family care plan.—A prenatal family care plan should be overseen by a healthcare professional, the pregnant individual's substance use disorder treatment provider, mental health treatment professional, case management provider, peer support specialist, or any other professional agreed upon by the pregnant individual who is the subject of such plan. Oversight of a prenatal family care plan shall be transferred to another professional upon request of the individual who is the subject of such plan.
- (d) Postnatal family care plan.—Every time a notification is submitted to the [department], the healthcare professional, or an appointed delegate, or an individual designated by the hospital, birthing center, or other facility where the pregnant individual gave birth, shall create a family care plan for the newborn infant born affected by parental substance use disorder or experiencing withdrawal from drugs or alcohol which shall address the substance use disorder treatment, mental health or other medical treatment, housing,

education, employment, transportation, legal, and other needs of the infant, the birthing individual, and the infant's caregivers and family members.

- (e) Oversight of postnatal family care plan.—A postnatal family care plan shall be overseen by a case worker for the [department]; the healthcare professional or an appointed delegate; an individual designated by the hospital, birthing center, or other facility where the pregnant individual gave birth; the individual's substance use disorder treatment provider, mental health treatment professional, case management provider, peer support worker, or any other professional agreed upon by the birthing individual or the infant's caretaker or custodian if not the birthing individual. Oversight of a postnatal family care plan shall be transferred to another professional upon request of the birthing individual or the infant's caretaker or custodian.
- (f) Multi-disciplinary collaboration.—Implementation of prenatal and postnatal family care plans should involve collaboration between multiple state and private agencies and entities, which should include, as appropriate, the following:
- (1) Public health agencies;
 - (2) Maternal and child health agencies;
 - (3) Child welfare agencies;
 - (4) Tribal agencies;
 - (5) Home visitation programs;
 - (6) Substance use disorder treatment providers;
 - (7) Mental health treatment professionals;
 - (8) Harm reduction organizations;
 - (9) Public and private children and youth agencies;
 - (10) Early intervention and development services;
 - (11) Family courts, juvenile courts, and drug courts;
 - (12) State and local law enforcement and prosecutorial agencies;
 - (13) Housing agencies;
 - (14) Local education agencies;
 - (15) Managed care organizations;
 - (16) Hospitals and medical providers;
 - (17) Faith based organizations or entities; and

- (18) Any other individual, agency, or entity that might be relevant or necessary to ensuring the success of a prenatal or postnatal family care plan based on an assessment of an individual's or child's needs.⁹⁰
- (g) Duration of family care plan.—A prenatal or postnatal family care plan shall remain in effect for as long as the individual or entity overseeing the family care plan and the individual who is the subject of such plan, or the caretaker or custodian of an infant born affected by parental substance use disorder, agree that services, including mental health or other medical treatment, emotional, developmental, housing, educational, or other services, including educational services for the affected child, are still needed. A pregnant individual, birthing individual, caretaker, or custodian may opt out of participation in the family care plan at any time.
- (h) Provision of family care plans.—The individual or entity that created a prenatal or postnatal family care plan shall provide a copy of such prenatal or postnatal family care plan to:
- (1) The infant's healthcare professional(s);
 - (2) The individual or entity responsible for overseeing the implementation of the family care plan;
 - (3) The infant's birthing individual, caretaker, or custodial family member who is present at discharge; and
 - (4) A de-identified copy to the [department]. If a report of child abuse or neglect is made, an identified copy shall be sent to the [department].⁹¹

Commentary

According to the Children's Bureau in the Office of the Administration for Children & Families at the U.S. Department of Health and Human Services (Children's Bureau), a family care plan "is a plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following his or her release from the care of a healthcare provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver."⁹² While addressing the needs of an infant after birth is certainly important, the sooner a pregnant individual engages in treatment and supportive services as facilitated by a family care

⁹⁰ Taken from N.M. STAT. ANN. § 32A-3A-13 (West 2022).

⁹¹ Taken from N.M. STAT. ANN. § 32A-3A-13 (West 2022).

⁹² *Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families: State Statutes*, CHILDREN'S BUREAU, ADMIN. FOR CHILD. & FAM., U.S. DEP'T OF HEALTH & HUM. SERVS. 2 (Aug. 2019), [Plans of Safe Care for Infants With Prenatal Substance Exposure and Their Families \(childwelfare.gov\)](#).

plan, the better the outcomes for both parent and child. Therefore, this Act includes provisions for both prenatal and postnatal family care plans. It should be noted that only the creation of postnatal family care plans is required pursuant to CAPTA, though birthing individuals are not obligated to accept services pursuant to such plans.

Child welfare agencies should not be the sole entities charged with initiating and monitoring family care plans; however, they are integral to the process. Any number of entities and individuals involved with a pregnant or postpartum individual can initiate and monitor a family care plan including, but not limited to, healthcare providers, substance use disorder treatment providers, and case management providers, as well as child welfare agencies.⁹³ Plans should be tailored to meet the specific needs and circumstances of the individual and child (in the case of postnatal family care plans) for whom the plan is created. The individual or agency in the best position to assist the family, help to reduce barriers to engaging in services, and adapt plans as needed should monitor the plans, though monitors should remember that engagement in family care plans is voluntary on the part of pregnant individuals. Per the Children’s Bureau, “it is best practice that the [family care plan] be developed with input from the parents or caregivers and in collaboration with the health-care provider and other professionals and agencies involved in serving the affected infant and family.”⁹⁴ States may also wish to contract with a public or private agency, such as a treatment agency or public health agency, to oversee the creation and implementation of pre- and postnatal family care plans.

Subsection (d) provides that the postnatal family care plan shall be created for every infant born affected by parental substance use disorder or experiencing withdrawal and for whom a notification has been submitted to the department. These plans are intended to address the needs of the infant, the birthing parent, and any other caretakers or family members in need of services within the family unit.

Subsection (f) sets out the individuals and entities that should, at a minimum, be considered for involvement as part of the multi-disciplinary collaboration. Individuals may not need every service listed in the statutory language; however, it is important that these agencies participate in the process to provide as comprehensive an array of services as possible.

SECTION VIII. EDUCATION AND TRAINING.

- (a) Education and training.—The [department], in collaboration with [list of potential state agency partners, including the board of medicine, board of nursing, board of pharmacy, child welfare agency, department of insurance, state Medicaid agency, etc.], shall create and distribute educational and training materials to support and educate healthcare professionals, representatives from health care systems, discharge planners, social workers, child welfare case workers, and others involved in the care and treatment of a

⁹³ *Id.*

⁹⁴ *Id.*

pregnant individual, birthing individual, or infant born affected by parental substance use disorder regarding the following:

- (1) Reducing stigma and discrimination associated with substance use disorders, including using non-stigmatizing language;
 - (2) Reducing healthcare inequity and racial disparities in the treatment of people of color with substance use disorder and addressing implicit bias;
 - (3) Making the notification required pursuant to Section VI;
 - (4) Recognizing the circumstances when a report of alleged child abuse or neglect may be required and how to make the report to child welfare services;
 - (5) Creating and implementing a prenatal or postnatal family care plan;
 - (6) Implementing trauma-informed care when treating individuals with substance use disorders and integrating substance use disorder treatment into health care; and
 - (7) Promoting early intervention services.⁹⁵
- (b) Availability of materials.—The educational and training materials created pursuant to subsection (a) shall be:
- (1) Made available in English, Spanish, and [any other language(s) that is prevalent in the state or local area];
 - (2) Posted to the [department]’s website; and
 - (3) Made available in print upon request.
- (c) Education for pregnant and postpartum individuals.—The [department], in collaboration with [list of potential state partners, including the state authority on substance use disorders], shall create and distribute educational materials to support and educate pregnant individuals and individuals who may become pregnant who have a substance use disorder or are using prescription or non-prescription drugs that may lead to a child being born substance use disorder affected, regarding the following:
- (1) The availability of birth control and condoms, including information on where to obtain such contraceptives, to help prevent pregnancy and reduce the spread of sexually transmitted diseases and HIV;

⁹⁵ Taken in part from N.M. STAT. ANN. § 32A-3A-13 (West 2022).

- (2) The purpose, creation, implementation, and oversight of prenatal and postnatal family care plans;
 - (3) Rights of the pregnant individual or birthing individual;
 - (4) Harm reduction services available in the community;
 - (5) The notification requirements of this Act;
 - (6) The distinction between a notification to the [department] and a report of alleged child abuse or neglect; and
 - (7) The fact that being diagnosed with, or having clinical signs of, a substance use disorder is not, in and of itself, grounds for a report of alleged child abuse or neglect or removal of a newborn infant from the custody of the birthing individual.
- (d) Availability of materials.—The educational materials created pursuant to subsection (c) shall be:
- (1) Posted on the [department]’s website;
 - (2) Provided by the [department] and [list of state partners] at no cost to entities that engage with pregnant, postpartum, and parenting individuals and individuals who may become pregnant who have a substance use disorder or are receiving substance use disorder treatment, or who are using prescription or non-prescription drugs which may lead to a child being born substance use disorder affected. These entities include, but are not limited to: educational institutions, syringe services programs, substance use disorder treatment providers, local health departments, faith-based organizations, organizations that work with the unhoused, local health clinics, women’s clinics, domestic violence shelters, law enforcement, and emergency medical services personnel;
 - (3) Posted in a conspicuous place in all healthcare professionals’ offices or provided in writing by such practitioners to pregnant and postpartum individuals;
 - (4) Made available in English, Spanish, and [any other language(s) that is determined to be prevalent in the state or local area]; and
 - (5) Made available at a sixth (6th) grade reading level.
- (e) General education and training.—The [department], in collaboration with [list of potential state agency partners, including the state department of safety or other organization with oversight of law enforcement, the state board of professional

responsibility, the child welfare agency, the state agency on mental health and substance abuse services, etc.], shall create and distribute educational and training materials to support and educate law enforcement; judges; prosecutors; public defenders; employees, volunteers, and contractors working for state and local child welfare agencies; and others involved in the investigation and prosecution of complaints of child abuse and neglect regarding the following:

- (1) Reducing the stigma and implicit bias associated with substance use disorders;
- (2) The circumstances requiring a notification pursuant to Section VI;
- (3) The circumstances requiring a report of alleged child abuse or neglect;
- (4) The use of medications for addiction treatment during pregnancy, including the civil rights protections afforded to this population; and
- (5) Family care plans.

Commentary

A study of health professionals conducted between 2019 and 2020 in Utah evaluated the stigma held by those health professionals toward harm reduction and pharmacotherapy for substance use disorders.⁹⁶ The study did not examine the usual course of investigation for these evaluations (stigma toward the people who use drugs) but rather the stigma toward the treatments and harm reduction services for people who use drugs.⁹⁷ The authors created a training curriculum that focused on “drivers of intervention stigma,” including: (1) false ideas regarding how medications for addiction treatment and harm reduction services impact people who use drugs and their communities; (2) lack of knowledge regarding the evidence base for particular substance use disorder interventions; and (3) lack of knowledge regarding how pharmacotherapy and harm reduction services can improve outcomes for people who use drugs.⁹⁸ The authors first conducted a survey of the individuals to whom the training curriculum was to be provided to gauge their attitudes toward harm reduction and pharmacotherapy.⁹⁹ The survey “graded” the participants’ stigma in the range of 0 to 1.1 (low to high), and most of the scores decreased after the training, reflecting the importance of education and training in overcoming stigma and providing patients with the best possible care.¹⁰⁰

In addition to education and training related to stigma for healthcare professionals and others involved in the care of pregnant individuals with substance use disorders or problem substance use, subsection (a) includes requirements for education and training related to: (1)

⁹⁶ Sandra H. Sulzer et al., *Professional Education to Reduce Provider Stigma toward Harm Reduction and Pharmacotherapy*, DRUGS: EDUC., PREVENTION & POL’Y (July 8, 2021), [Full article: Professional education to reduce provider stigma toward harm reduction and pharmacotherapy \(tandfonline.com\)](https://doi.org/10.1177/1043986221101111).

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

making the required notifications; (2) when it is required to make a referral for child abuse and neglect; (3) trauma-informed care; and (4) early intervention services. Each of these education and training requirements is designed to ensure that healthcare professionals and others have the requisite knowledge to best assist the parent and child, including the creation of prenatal and postnatal family care plans. State healthcare professional licensing boards should consider making the education and training set out in this subdivision part of the required continuing education curriculum.

Subsection (c) provides education to pregnant individuals and individuals who may become pregnant who have a substance use disorder so that they are aware of their rights under the law, including their civil rights protections. Providing these individuals with this information may increase the likelihood that they will engage in regular prenatal care with improved outcomes for both the individual and the child.

The drafters included subsection (e) at the request of working group members from the National District Attorneys Association, who expressed an interest in being included in the education and training opportunities provided by this section.

SECTION IX. MEDICAID AND OTHER INSURANCE COVERAGE.

- (a) In general.—The [state Medicaid agency] and every health insurance entity that provides an insurance contract, plan, or policy that includes medical cost coverage that is delivered, issued for delivery, amended, or renewed in this state on or after [effective date of this Act], shall create ongoing billing and other permanent support mechanisms to reimburse healthcare practitioners, substance use disorder treatment providers, harm reduction organizations, case management workers, hospitals, birthing centers, mental health treatment professionals, behavioral health practitioners or entities, and any other entity that provides the services required by this Act, including, but not limited to:
- (1) Conducting an initial or follow-up screening of a pregnant individual for substance use disorder;
 - (2) Conducting an assessment of a pregnant individual;
 - (3) Creating and/or implementing a prenatal or postnatal family care plan; and
 - (4) Overseeing a prenatal or postnatal family care plan.
- (b) Prohibitions.—A health insurance entity is prohibited from requiring prior authorization, step therapy, retrospective denials of care, or other administrative requirements as a condition of reimbursement or payment for mental health or substance use disorder

treatment services received by a pregnant or birthing individual as recommended by the individual's treatment provider.

- (c) Reimbursement.—The [state Medicaid agency] shall develop and implement a methodology and reimbursement rate to support and incentivize provision of the services required and/or recommended by this Act by establishing a reasonable and fair reimbursement rate, approved by the single state authority on drugs and alcohol, for such services including, but not limited to, conducting an initial or follow-up screening for substance use disorders, conducting an assessment, creating or implementing a prenatal or postnatal family care plan, and overseeing a prenatal or postnatal family care plan.

Commentary

The purpose of this section is to leverage Medicaid and other insurance dollars to support the provisions of this Act and provide incentives to healthcare professionals and other individuals and entities for performing the services set out in this Act.¹⁰¹ Ideally, reimbursement should be at a rate or rates designed to incentivize and reward healthcare professionals and others for providing the voluntary and mandatory services (e.g., screening, assessment, creation of prenatal family care plans, etc.) required by this Act.

SECTION X. STATE PERINATAL COORDINATING COUNCIL.

- (a) Establishment of council.—If there is not a council currently in existence in the state, the [department] shall establish a state perinatal coordinating council for the purpose of coordinating activities related to substance use in pregnancy, infants born affected by parental substance use disorder, supporting families, and preventing unnecessary family separations at the state level.
- (b) Council membership.—The state council shall consist of the following members who, as a whole and to the extent possible, reflect the racial and ethnic composition of the state's population of individuals who can become pregnant:
- (1) The commissioner of the state department of health, or an appointed delegate, who shall serve as the chair of the council;
 - (2) At least one representative from the [department], appointed by the [department];

¹⁰¹ See [Value-Based Payment | Medicaid](#) for more information.

- (3) At least one representative with knowledge of the Social Security Administration, Title V Maternal and Child Health block grant, appointed by the [state department that administers grant funds];
- (4) At least one representative from [state child welfare services agency], appointed by the [state child welfare services agency];
- (5) At least one representative from the single state authority on substance abuse;
- (6) An individual with knowledge of pregnant individual and child health services, appointed by the [appropriate state agency];
- (7) A representative from an organization that focuses on diversity and access to equitable healthcare;
- (8) An individual with knowledge of outreach and intervention services, appointed by the [appropriate state agency];
- (9) An individual with knowledge of early intervention, Early Head Start, and Head Start programs and services, appointed by the state department of education, or other appropriate agency;
- (10) At least one individual who is a substance use disorder treatment provider, appointed by the state board of medicine;
- (11) At least one individual with lived experience of substance use while pregnant or child welfare system involvement due to substance use, appointed by the [appropriate state department];
- (12) At least one representative from a law enforcement or prosecuting agency, who may be a victim coordinator or representative, appointed by the [appropriate state department]; and
- (13) One or more representatives from any other agency or entity or group that the [department] may include by rule.

(c) Terms of membership.—

- (1) Upon creation of the council, the members appointed under subsection (b)(1) through (6) shall serve an initial two (2) -year term, and the members appointed under subsection (b)(7) through (12) shall serve an initial one (1)-year term to enable the staggering of terms.

- (2) Except for the initial terms established in subsection (c)(1), each council member shall serve a three (3)-year term, with each term ending on [date].
- (d) Vacancy.—In the event of a vacancy in council membership, the vacancy shall be filled in the same manner as the original appointment, and the newly appointed individual shall serve out the remainder of the term.
- (e) Term limits.—No council member shall serve more than two (2) consecutive terms.
- (f) Duties of council.—The council shall have the following duties:
 - (1) Identify the extent of the perinatal substance use disorder problem in the state based on data provided to the council by the [department] pursuant to Section XII;
 - (2) Develop coordinated responses by state health and social services agencies and departments, including the development of the workforce in areas where services may not be available or in which there is a shortage, which responses shall address the perinatal substance use disorder problem in the state;
 - (3) Conduct an evaluation of data received pursuant to Section XII;
 - (4) Coordinate with the local councils established pursuant to Section XI to address the perinatal substance use disorder problem in each county;
 - (5) Monitor policy implementation for racial/ethnic disparities and unintended consequences;
 - (6) Promote the educational and training materials developed pursuant to Section VIII throughout the state;
 - (7) Communicate with policymakers at the state and federal level regarding prevention and treatment needs for pregnant individuals and birthing individuals with substance use disorder and their children;
 - (8) Allocate resources where needed;
 - (9) Identify services that emphasize coordination of treatment services with other health, child welfare, child development, criminal justice, legal, and education services; and
 - (10) Any other duties determined by the [department] by rule.¹⁰²

¹⁰² The provisions of this section are taken from CAL. HEALTH & SAFETY CODE § 11757.61 (West 2022).

- (g) Meetings.—The council shall meet at least once every [month/quarter]. A meeting may be called by a majority of the council members. Members may attend meetings in person, remotely by audiovisual means, or by audio-only means. Meetings of the perinatal coordinating council shall be confidential and shall not be subject to [reference to state open meetings and open records law(s)].
- (h) Compensation.—Each council member who is not an officer or employee of this state is entitled to receive a stipend of not more than [\$] for each day or portion of a day spent on council meetings. Members may also be reimbursed for their actual and necessary expenses incurred in carrying out their duties pursuant to [reference to state law].

Commentary

This section establishes a state perinatal coordinating council for the purpose of overseeing activities related to infants born affected by parental substance use disorder within the state. Council membership in the state council, and in the local councils established in Section XI below, includes representatives from a variety of agencies across state government, as well as individuals directly involved in treating pregnant individuals and birthing individuals with substance use disorder, in order to ensure that there is representation among all agencies and entities with which a pregnant individual or birthing individual might have contact during the perinatal period. The state and local councils should be made up of individuals of all races and economic backgrounds in order to best represent the racial, gender, and economic makeup of the state's population of individuals who can become pregnant. For example, in areas with a significant indigenous (American Indian or Alaska Native) population, councils should include tribal representatives.

As set out in this section, the state council should direct state and federal resources, including federal grant funds, to where they are most needed and develop coordinated responses between state agencies to address the perinatal substance use disorder problem within the state.

SECTION XI. LOCAL COORDINATING COUNCILS.

- (a) Establishment of local councils.—If such councils are not already in existence, the [department] shall establish perinatal coordinating councils for each county, or group of counties where resources are limited, for the purpose of coordinating activities related to substance use in pregnancy, infants born affected by parental substance use disorder, supporting families, and preventing unnecessary family separations at the local level.
- (b) Council membership.—The council shall consist of the following members who, as a whole and to the extent possible, reflect the racial and ethnic composition of the local population of individuals who can become pregnant:

- (1) At least one representative from the local department of health, appointed by the director of the local department of health;
 - (2) At least one representative from the local child welfare services agency, appointed by the director of the local agency;
 - (3) At least one individual with local knowledge of pregnant individual and child health services, appointed by the local department of family health services;
 - (4) At least one individual with local knowledge of outreach and intervention services, appointed by the director of the local department of health;
 - (5) At least one individual with local knowledge of early intervention, Early Head Start, and Head Start programs and services, appointed by the [appropriate agency];
 - (6) At least one individual with local knowledge of developmental services, appointed by the director of the local department of health;
 - (7) At least one substance use disorder treatment provider with experience treating pregnant individuals with substance use disorder, appointed by the state board of medicine;
 - (8) A representative from an organization that focuses on diversity and access to equitable healthcare;
 - (9) At least one individual with lived experience of substance use disorder while pregnant, appointed by the director of the local department of health;
 - (10) At least one representative from a local law enforcement or prosecuting agency, who may be a victim coordinator or representative, appointed by the local law enforcement or prosecuting agency;
 - (11) One or more representatives from local community-based organizations, at least one of which is focused on diversity and access to equitable health care, appointed by the director of the local department of health; and
 - (12) Representatives from any other agency or entity or group that the [department] may include by rule.
- (c) Terms of membership.—
- (1) Upon creation of the council, the members appointed under subsection (b)(1) through (5) shall serve an initial two (2)-year term, and the members appointed

under subsection (b)(6) through (11) shall serve an initial one (1)-year term to enable the staggering of terms.

(2) With the exception of the initial terms established in subsection (c)(1), each council member shall serve a three (3)-year term, with each term ending on [date].

(d) Vacancy.—In the event of a vacancy in council membership, the vacancy shall be filled in the same manner as the original appointment, and the newly appointed individual shall serve out the remainder of the term.

(e) Term limits.—No council member shall serve more than two (2) consecutive terms.

(f) Duties.—The council shall have the following duties:

(1) Identify the extent of the perinatal substance use disorder problem in the county or counties served by the council based on data provided by the [department] pursuant to Section XII;

(2) Develop coordinated responses by county health and social services agencies and departments, which shall address the perinatal substance use disorder problem in each county;

(3) Develop coordinated responses by local agencies and disseminating resources, including education and training materials, based on data received from the [department] pursuant to Section XII;

(4) Identify elements that should be included in a prenatal or postnatal family care plan, taking into consideration the resources available in the county or counties served by the council;

(5) Monitor policy implementation for racial/ethnic disparities and unintended consequences;

(6) Promote the educational and training materials developed pursuant to Section VIII;

(7) Communicate with policymakers at the state and federal level regarding prevention and treatment needs for pregnant individuals, birthing individuals, and their families that need to be addressed in the county or counties served by the council;

(8) Submit reports to the state perinatal coordinating council as required by Section X;

(9) Coordinate treatment services with health, child welfare, child development, criminal justice, legal, education, employment, and other services as needed in the county or counties served by the council; and

(10) Any other duties determined by the [department] by rule.

(g) Meetings.—The council shall meet at least once every [month/quarter]. A meeting may be called by a majority of the council members. Members may attend meetings in person, remotely by audiovisual means, or by audio-only means. Meetings of local perinatal coordinating councils shall be confidential and shall not be subject to [reference to state open meetings and open records law(s)].

(h) Compensation.—Each council member who is not an officer or employee of this state is entitled to receive a stipend of not more than [\$] for each day or portion of a day spent on local council meetings. Members may also be reimbursed for their actual and necessary expenses incurred in carrying out their duties pursuant to [reference to state law].

Commentary

Like the state perinatal coordinating council in Section X, the primary purposes of the local councils are to direct resources and coordinate responses between various local agencies and entities to address the issue of substance use among pregnant individuals and birthing individuals, but on a smaller, more focused, scale. Local councils should have a much better idea of the resources and services available in their communities. Additionally, some members will have working relationships with individuals at other local agencies, and the council can, ideally, use those already established relationships to more readily address issues within the county, disseminate educational and training materials, coordinate services, and better assist the individuals in their community.

SECTION XII. DATA COLLECTION AND SHARING.

(a) Aggregation of data.—Within one (1) year of the date this Act is enacted, and annually by that date thereafter, the [department] shall aggregate data received through the notification process described in Section VI.

(b) County reports.—The [department] shall use the aggregate data referenced in subsection (a) to compile county reports, based on zip code, which shall include, at a minimum, the following information:

- (1) The number of notifications received for that county;
- (2) The number of notifications received by zip code;
- (3) The number of notifications received by race;

- (4) The substances used by pregnant individuals in that county by type (*e.g.*, opioids, benzodiazepines, stimulants, cannabis, tobacco, alcohol) and whether such substances were taken pursuant to a prescription, if known;
 - (5) The substances identified as affecting infants in that county by type (*e.g.*, opioids, benzodiazepines, stimulants, cannabis, tobacco, alcohol);
 - (6) The number of prenatal and postnatal family care plans entered into by pregnant individuals and birthing individuals, caretakers, or custodians of infants born affected by parental substance use disorder in the county;
 - (7) The number of pregnant individuals in the county who accepted services and the type(s) of service(s) accepted (*e.g.*, substance use disorder treatment, home visitation services, employment assistance);
 - (8) The number of concurrent reports of child abuse or neglect made in the county and the race(s) of the individuals so reported; and
 - (9) Any other information required by rule.
- (c) Report to state perinatal coordinating council.—The [department] shall provide copies of each county report to the state perinatal coordinating council for the purpose of coordinating with the local councils as required by Section X.
- (d) Report to legislature.—Within one (1) year of the date that this Act is enacted, and annually by that date thereafter, the [department] shall use the data aggregated pursuant to subsection (a) to compile a report that includes, at a minimum, the following information:
- (1) The number of notifications received;
 - (2) The number of notifications received by zip code;
 - (3) The number of notifications received by race;
 - (4) The substances used by pregnant individuals by type (*e.g.*, opioids, benzodiazepines, stimulants, cannabis, tobacco, alcohol) and whether such substances were taken pursuant to a prescription, if known;
 - (5) The substances identified as affecting infants born in the state by type (*e.g.*, opioids, benzodiazepines, cannabis, tobacco, alcohol);

- (6) The number of prenatal and postnatal family care plans entered into by pregnant and postpartum individuals, caretakers, or custodians of infants born affected by parental substance use disorder in the state;
 - (7) The number of pregnant individuals who accepted services and the type(s) of service(s) accepted (*e.g.*, substance use disorder treatment, home visitation services, employment assistance), if available;
 - (8) The number of concurrent reports of child abuse or neglect made and the race(s) of the individuals so reported; and
 - (9) Any other information required by rule.
- (e) Submission of report.—The [department] shall provide the annual report required by subsection (d) to the [appropriate legislative committees] by [date] each year and shall make the report available to the public via the [department]’s website.
- (f) Federal reporting requirements.—The [department] shall comply with all federal reporting requirements under the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. Sec. 5101, *et seq.*, and the Comprehensive Addiction and Recovery Act (CARA) of 2016, P.L. 114-198 and any amendments thereto.

Commentary

This section requires the department to aggregate data received as a result of the notification process set out in Section VI in order to provide that data in the form of reports to the state perinatal coordinating council established in Section X and the local councils established in Section XI. The primary purpose of this requirement is to provide the state and local councils with information necessary to inform their decisions as to where to allocate resources within the state and, on a more granular level, within each county. Having this information will allow local councils to determine where, in their county, they might need to expend more resources on education and training or early intervention programs. Additionally, including data regarding the race of individuals reported to the department for allegations of child abuse or neglect can alert the local council to any potential bias that might be present and the need for additional training for healthcare professionals related to when it is appropriate to refer individuals for allegations of child abuse or neglect. As mentioned in the commentary following Section IV, people of color are more likely to face punitive action as a result of substance use during pregnancy; therefore, it is important to address any racial disparities in reporting as quickly as possible.¹⁰³

This section also requires that the department provide a separate report to the state legislature, which report will also be posted to the department’s website. The purpose of this is to

¹⁰³ Harp & Bunting, *supra* note 9.

give the legislature an overall picture of the incidence of substance use disorder affected infants or infants experiencing withdrawal within the state.

Federal CAPTA requirements provide that states must submit an annual data report that includes the number of infants identified as being substance use disorder affected, for whom a family care plan was developed, and for whom a referral was made to needed services, including services for the birthing individual or caregiver.¹⁰⁴ Section (f) is included to ensure that states comply with the CAPTA reporting requirements; however, this section also includes additional data elements beyond those required by CAPTA in order to assist states with allocating resources.

SECTION XIII. FUNDING.

- (a) Fund established.—There is established within the [state] treasury a local perinatal coordinating council program grant fund.
- (b) Local perinatal coordinating council program grant fund.—
 - (1) In general.—The local perinatal coordinating council program grant fund is established and shall be administered by the [department]. Grants provided under the program shall be used to fund the local perinatal coordinating councils established under this Act.
 - (2) Guidelines and requirements.—The [department] may adopt guidelines and requirements to direct the distribution of funds for expenses related to local councils.
 - (3) Eligible activities.—Activities eligible for funding under this Act may include, but are not limited to:
 - (A) Administrative costs;
 - (B) Local council member compensation for travel and expenses associated with participation; and
 - (C) Other costs associated with the activities of the councils.
 - (4) Budget allocation.—The legislature shall appropriate [dollar amount] for fiscal years [20XX- 20XX] to the local perinatal coordinating council program grant fund for the purpose of funding, in whole or in part, the grant program.

¹⁰⁴ CAPTA, *supra* note 20.

- (c) Funding of state perinatal coordinating council.—Unless otherwise fully funded through the U.S. Department of Substance Abuse and Mental Health Services Administration’s Substance Abuse Prevention and Treatment Block Grant, the legislature shall appropriate [dollar amount] for fiscal years [20XX-20XX] for the purpose of funding the state perinatal coordinating council and the activities required by the state perinatal coordinating council by this Act.
- (d) Additional appropriations.—In addition to any other funds received by the [department], the legislature shall appropriate [dollar amount] for fiscal years [years] to the [department] for the purpose of the data collection requirements and for creating, disseminating, and periodically updating the education and training provisions of this Act.
- (e) Pursuit of funding.—The [department], the state perinatal coordinating council, and local perinatal coordinating councils shall pursue all federal funding, matching funds, and foundation or other charitable funding for the initial start-up and ongoing activities required under this Act.
- (f) Acceptance of gifts.—The [department] may accept such gifts, grants, and endowments, from public or private sources, as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of this Act and expend the same or any income derived from it according to the terms of the gift, grant, or endowment.

Commentary

Funding sections in model laws can be complicated, as states fund projects through legislation in a variety of ways, and there is no “one size fits all.” However, if the Model Act omits the funding discussion altogether, the legislation gives the appearance of an unfunded mandate.

Since it is impractical to have funding language that appropriates funding to each individual local perinatal coordinating council, the drafters determined that the best solution is the inclusion of a state grant program using language modeled after Illinois and Pennsylvania legislation.¹⁰⁵

¹⁰⁵ See 5 ILL. COMP. STAT. ANN. 820/35 (West 2019) and H.B. 424, Leg. Sess. (Pa. 2019).

SECTION XIV. RULES AND REGULATIONS.

The Department shall promulgate such rules and regulations as are necessary to effectuate this Act.

SECTION XV. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provisions or applications, and to this end, the provisions of this Act are severable.

SECTION XVI. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effective date].

ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

Based in Washington D.C., and led by and comprised of experienced attorneys, the Legislative Analysis and Public Policy Association is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces timely model laws and policies that can be used by national, state, and local public health, public safety, and substance use disorder practitioners who want the latest comprehensive information on law and policy as well as up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to fact sheets. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorders, medication-assisted treatment in correctional settings, and the involuntary commitment and guardianship of individuals with alcohol or substance use disorders.

