Session 3 – Justice & Advocacy: Protecting Families in Crisis

Examining how law, policy, and system responses can either help or harm families impacted by opioid use disorder (OUD).

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Understanding the Context

OUD occurs in the context of systems

Opioid Use Disorder (OUD) occurs in the context of: Family stress, Neighborhood instability, Trauma and historical inequality, Policing practices, Child-welfare policies, Clinical documentation and hospital protocols

How Systems Respond Determines Outcomes

Punitive Systems Lead To:

- Surveillance
- Criminalization
- Removal
- Destabilization

Supportive Systems Lead To:

- Treatment
- Stabilization
- Reunification
- Recovery

OUD is a brain disease, not a behavioral failure. However, the U.S. has historically treated OUD — especially in pregnancy — as a criminal problem rather than a medical one. This session focuses on healing justice: aligning law, healthcare, and advocacy to protect mothers and families.

Why This Session Matters

Hospital policies, CPS actions, family-court decisions, and police interactions shape whether families: Enter treatment, Remain together, Avoid incarceration, Prevent recurrence of ACEs, Reduce risk of postpartum overdose, Access recovery supports

Punitive Models Worsen Outcomes

- ↓ Prenatal care
- ↓ Disclosure of substance use
- ↑ Preterm births
- ↑ NAS rates
- ↑ Maternal mortality
- ↑ Racial disparities

Nevada

Clark County high-instability ZIP codes 89101, 89104, 89106 show overlap between: OUD, Eviction, Probation & parole, CPS involvement, Poverty, Limited MOUD access

These ZIP codes experience structural instability, NOT higher biological risk.

Session Objectives

Participants will learn to:

01

Interpret Nevada's prenatal substance exposure reporting laws

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Distinguish between punitive vs non-punitive state policies

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Identify gaps and barriers in re-entry systems for parents

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Understand how family treatment courts divert families away from trauma

05

Use optimized clinical documentation that protects families

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Advocate effectively to CPS, courts, and policymakers using medical framing

> "This session gives you the tools to protect mothers and children using evidence, clear documentation, and trauma-informed advocacy."

Pre-Test: Knowledge Check

Before we begin, please answer these three questions:

1. Nevada law requires mandatory reporting to CPS whenever:

a) A pregnant person tests positive for any substance

b) A mother is enrolled in medication-assisted treatment (MAT)

c) An infant is determined to be at risk of harm due to substance exposure

d) Any prenatal substance use is detected

2. Research shows that states with punitive prenatal substance use laws experience:

a) Increased prenatal care attendance

b) Decreased prenatal care attendance

c) No change in prenatal care patterns

d) Improved maternal outcomes

3. A Plan of Safe Care (POSC) is designed to:

a) Automatically remove infants from mothers with substance use disorders

b) Provide supportive services to keep families together safely

c) Criminally prosecute mothers for prenatal substance exposure

d) Replace medication-assisted treatment with abstinence-only programs

Core Themes

Four pillars of justice-informed care

1. Law & Ethics

Who MUST report?

Understanding mandatory reporting requirements

What triggers a CPS report?

Distinguishing between risk and automatic triggers

What counts as "neglect" under Nevada law?

Legal definitions and thresholds

When is POSC required?

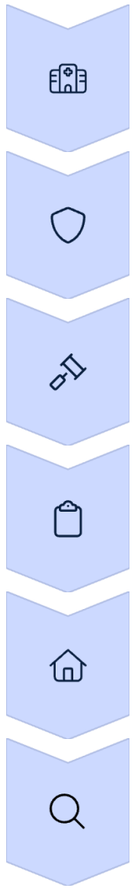
Federal and state requirements

What legal protections exist for pregnant people with OUD?

Rights and safeguards

2. Systems Navigation

Families move through a maze:



Hospital

CPS

Court

Probation

Housing

Treatment

One negative note or misunderstanding can shape an entire case.

3. Equity & Access

Disparities Exist In:

- Racial surveillance differences
- Insurance disparities
- ZIP code–driven care
- AI/AN communities navigating dual jurisdictions

4. Advocacy in Action

EMR documentation that reduces harm

Using language that protects families

Letters to courts

Medical framing that influences decisions

Data-driven advocacy

Using evidence to change policy

Partnering with legal and child-welfare systems

Building collaborative relationships

Nevada Law

Reporting & Prenatal Substance Exposure

Nevada Revised Statutes (NRS) 432B — Child Abuse & Neglect

This is the law governing CPS reporting.

Important Clarifications

Nevada does NOT automatically classify prenatal substance exposure as child abuse. Unlike some states (Alabama, South Carolina), Nevada's law is non-punitive in pregnancy.

What NRS 432B *Does* — Key Features & Definitions

Definition of "Abuse or Neglect"

According to NRS 432B.020:

- "Abuse or neglect of a child" means (unless excepted) one or more of the following:
  1. **Physical or mental injury of a non-accidental nature.** Justia Law+1
  2. **Sexual abuse or sexual exploitation.** Justia Law+1
  3. **Negligent treatment or maltreatment** as defined in NRS 432B.140. Justia Law+1
- "Negligent treatment or maltreatment" (NRS 432B.140) includes situations where a child is: abandoned; left without proper care, supervision; lacks necessary basic needs (food, shelter, medical care, education, etc.); or otherwise deprived of care because the responsible person fails or refuses to provide such care when able. Justia Law
- Physical abuse can include a broad range of injuries: sprains, dislocations, broken bones, internal injuries, burns, cuts, lacerations, permanent or temporary disfigurement, or impairment of a bodily function. Excessive corporal punishment may be considered abuse. Child Welfare Website+1
- Emotional or mental injury ("mental injury") is also covered: if a child's intellectual, psychological, or emotional condition is impaired (observable and substantial) such that their ability to function is disrupted. Child Welfare Website+1

Thus, NRS 432B defines a wide scope of what counts as "abuse or neglect," including physical, sexual, emotional harm, and deprivation of basic needs or care.

Reporting Requirements

- Under NRS 432B.220 (and related sections), certain **mandated reporters** — including medical professionals, hospital staff, therapists, counselors, childcare providers, teachers, law enforcement, and others — must report any reasonable cause to believe a child is abused or neglected. Justia Law+2Justia Law+2
- Reports must be made “as soon as reasonably practicable.” In cases of newborns affected by **prenatal substance exposure or withdrawal symptoms**, medical providers are explicitly required to notify the child-welfare agency within a specified timeframe and refer caregivers to services. Extension | University of Nevada, Reno+2Justia Law+2
- Failure to report by mandated reporters is a misdemeanor (or a gross misdemeanor on repeated violation). Washoe County+1

Thus, NRS 432B establishes a clear **mandatory reporting system** for alleged child abuse or neglect.

Child Welfare Process — Investigation, Custody, and Services

If a report is made, the agency (often Nevada Division of Child and Family Services, DCFS) may investigate. Depending on findings, they may decide:

- to provide services to the family,
- to place the child in protective custody (foster care),
- or to refer for criminal prosecution if abuse/neglect rises to a criminal offense. Justia Law+2Nevada Bar+2

The law includes provisions for administrative appeals, confidentiality, requirements for foster/residential placements, protections for children's rights in custody, and oversight (e.g., review committees for child deaths, data reporting). Justia Law+2FindLaw Codes+2

The statute also requires that agencies make "reasonable efforts" to preserve or reunify families before permanent removal — unless certain disqualifying conditions (e.g., serious abuse) exist. Nevada Legislature+1

What NRS 432B *Does Not Automatically Do / What Is Not Explicit*

While NRS 432B provides a broad framework for child protection, there are **important limitations or ambiguities** when applying it to cases involving prenatal substance exposure or parental substance use disorder (SUD):

- **Substance use alone** (e.g., a positive toxicology or a mother having OUD) is **not automatically defined** as "abuse or neglect." The statute requires *harm or threatened harm to the child's health or welfare*. Justia Law+1
- The statute does **not mandate automatic removal of newborns** solely based on prenatal substance exposure. Rather, any removal must be based on findings of actual—or threatened—harm or neglect.
- There is **no explicit requirement** that SUD treatment, MOUD, or "Plan of Safe Care" be offered under 432B; the statute does not frame SUD as a medical condition warranting health-based intervention rather than punitive response.
- Reporting requirements are broad, but the statute does **not guarantee** uniformity of hospital policies across the state (i.e., how providers interpret "reasonable cause," or how strictly they report prenatal substance exposure, can vary widely).
- Confidentiality and due process protections exist for investigated caregivers, but outcomes depend on investigation, judicial discretion, and local agency practice — leading to **large variability** in how 432B is applied.

Therefore, while 432B gives statutory authority to protect children from real abuse or neglect, it does **not inherently require punitive action** simply for maternal substance use or SUD — though in practice many hospitals or CPS offices treat it as cause for investigation or removal.

Implications for Advocacy & Policy Work

If you're working in maternal health / substance use reform in Nevada:

- You can argue that **prenatal substance exposure alone should not trigger removal under 432B**, because the law requires actual or threatened harm, not mere exposure or SUD.
- You can push for **standardized, non-punitive implementation across hospitals** so that 432B is applied fairly — with access to treatment, supportive services, and family preservation rather than automatic removal.
- You can highlight that **MOUD, peer support, harm reduction, and "Plan of Safe Care"** align with the statute's goal: protecting children's welfare — by stabilizing parents, preventing neglect, and reducing harm.
- You can use 432B's requirement for "reasonable efforts to preserve families" to advocate for **treatment-first, family-centered court and CPS practices** rather than punitive ones.

Reporting Requirements

Providers must report when:

1 **The infant is at risk of harm**

NOT simply if a substance is detected.

2 **There is evidence of neglect**

Neglect = failure to provide care, supervision, or safe environment.

What Does NOT Trigger Automatic Reporting?

- Maternal OUD
- Positive drug test alone
- Prenatal buprenorphine or methadone use
- Medically supervised MOUD

Federal Requirement: CAPTA

CAPTA (Child Abuse Prevention and Treatment Act) requires Plans of Safe Care (POSC) for substance-affected infants — NOT punishment. Nevada follows CAPTA's supportive model.

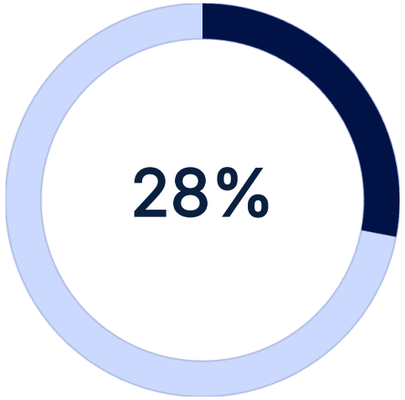
Hospitals MUST:

- Develop a Plan of Safe Care
- Coordinate follow-up
- Connect mothers to treatment and wraparound supports
- Avoid automatic removals unless safety concerns exist

The Evidence

Punitive Policy Consequences

Research Findings: States with Punitive Laws Show



Decrease in prenatal care

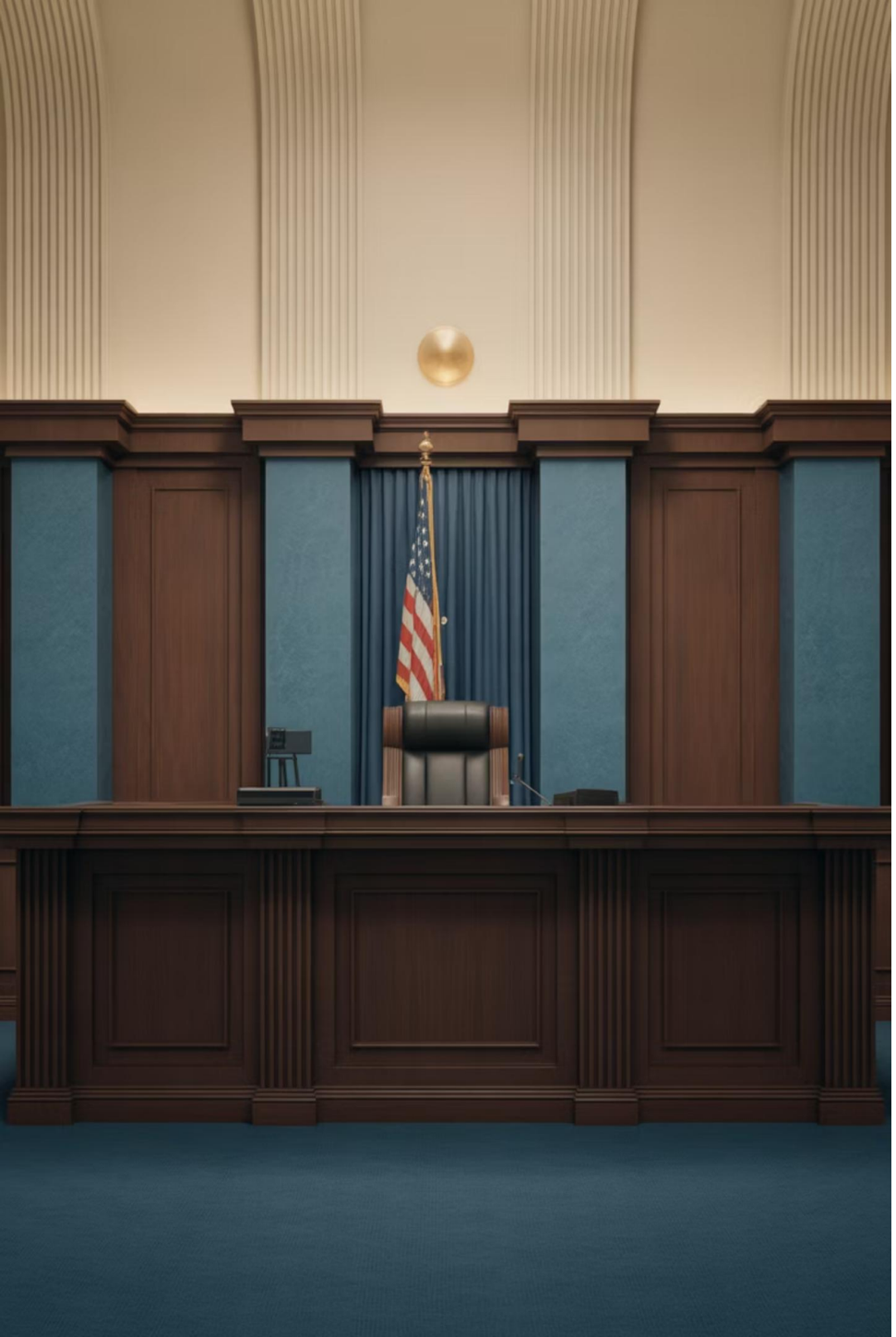
Increase in neonatal complications

Increase in emergency, unassisted home births

Increase in hospital avoidance

Increase in maternal mortality

Racial disparities widen dramatically



Case Study: Tennessee "Fetal Assault Law"

Law (2014–2016) allowed arrest for drug use during pregnancy.

Outcomes:

- No improvement in infant outcomes
- More babies born without prior prenatal care
- Increased fear of hospitals
- Higher maternal arrests
- Disproportionate impact on rural, low-income White and Black mothers

Law allowed to sunset due to harm.

National Model

New Mexico's CARA POSC Approach

New Mexico: A National Leader

New Mexico is widely viewed as a national leader in how it addresses substance use during pregnancy — not with punishment, but with public health, care coordination, and family preservation at the center. Their model combines CARA requirements (from the federal Comprehensive Addiction and Recovery Act) with a non-punitive Plan of Safe Care (POSC) strategy.

Care Navigators

New Mexico uses trained CARA Care Coordinators who follow families from pregnancy through early childhood. They help mothers:

- Access prenatal care
- Enroll in Medicaid or insurance
- Get connected to SUD/OUD treatment
- Arrange transportation and childcare
- Navigate the hospital and CPS systems
- Follow through on their Plan of Safe Care

Why it works: Families don't get lost in the system. Pregnant/postpartum people have ONE person responsible for bridging medical, behavioral, and social services.

Care Navigators

New Mexico braids funding from multiple Medicaid pathways to pay for services, including:

- Case management
- Peer support
- SUD treatment
- Home visiting
- Behavioral health
- Extended postpartum Medicaid coverage

Why it works: It allows the state to sustain care coordination, rather than rely solely on grants. Hospitals and community programs actually get PAID for supporting vulnerable families.

Non-Punitive POSC — What Does POSC Mean?

POSC = Plan of Safe Care

A federal requirement under the CARA legislation. It applies to infants affected by substance exposure (prescription medications, MAT like methadone/suboxone, cannabis, alcohol, illicit drugs).

A POSC outlines:

- What supports the infant needs
- What supports the mother needs
- Safety planning that avoids unnecessary child removal
- Treatment, mental health, housing, and follow-up services

"Non-Punitive" POSC Means:

NO automatic child removal

Just because a mother is receiving treatment or has a positive drug test.

NO criminalization of maternal substance use

NO automatic referral to law enforcement

POSCs focus on support, not surveillance.

Instead, the emphasis is on:

- Treatment over punishment
- Keeping families together
- Reducing fear of seeking prenatal care
- Building trust between mothers and the medical system

This is the major differentiator between New Mexico and many other states.

Family-Centered Support

New Mexico recognizes that substance use doesn't occur in isolation. Their model provides services to: Mothers, Fathers/partners, Caregivers, Older children in the home

Supports include:

- Home visiting
- Early intervention services
- Parenting support
- Social services (housing, transportation, food access)
- Trauma-informed counseling

Why it works: Family engagement decreases relapse rates, improves infant outcomes, and reduces the likelihood of CPS involvement.

Harm Reduction

New Mexico integrates harm-reduction into maternal care — a major reason their outcomes surpass punitive states. This includes:

- **Naloxone distribution**
- **Safe prescribing practices**
- **Access to MAT (methadone/suboxone) without penalty**
- **Syringe services**
- **Education on safer use**
- **Non-judgmental care**

Why it works: Evidence shows that harm reduction dramatically decreases overdose risk during pregnancy and postpartum — the period with the highest mortality risk.

Why New Mexico's CARA POSC Model Is Considered a National Best Practice

It keeps mothers engaged in care instead of driving them away through fear.

It reduces foster care entry by focusing on supports rather than punishment.

It addresses root causes: housing, trauma, addiction treatment, mental health.

It improves maternal and infant health outcomes.

It is aligned with federal CARA expectations but implemented in a way that protects families from unnecessary criminalization.

Result:

✓ More prenatal care
✓ More treatment engagement
✓ Fewer removals

Critical Issue

Racial & Geographic Inequities

Black mothers are 2–3× more likely to be reported

Sources: This statistic comes from multiple national studies showing racial disparities in *hospital reporting* and *CPS involvement*related to substance use in pregnancy.

Key sources include:

✔ National Institutes of Health (NIH) / Pediatrics Journal

- Studies in *Pediatrics* (e.g., Chasnoff et al.) found that Black women were **10× more likely** to be reported for prenatal drug exposure despite **similar or lower actual substance use rates** compared to White women.

✔ Department of Health & Human Services (HHS) / SAMHSA

- HHS analyses show Black birthing people experience **2–3× higher reporting rates** to CPS for drug exposure.

✔ Child Welfare Information Gateway

- National child welfare reporting shows disproportionate referrals and investigations for Black families.

In summary: Black women are not using substances at higher rates — they are simply *reported* more.

AI/AN mothers face the highest rates of newborn removal

Sources: This has been consistently documented in:

✔ National Child Abuse and Neglect Data System (NCANDS)

- AI/AN infants have the **highest rate of foster care entry**, including for reasons tied to substance exposure.

✔ NICWA (National Indian Child Welfare Association)

- AI/AN newborns experience removal at **2–4× the rate** of White newborns.

✔ The Indian Child Welfare Act (ICWA) literature

- Much of the need for ICWA reform arose from extreme over-removal of AI/AN children, including infants affected by prenatal exposure.

Why this happens: Colonial trauma, jurisdictional conflicts, underfunded tribal systems, hospital bias, and mandatory reporting policies all drive disproportionate removals.

Privately insured White mothers receive treatment; Medicaid-insured mothers receive surveillance

Sources: This pattern is widely documented in studies examining **treatment access** versus **criminal/legal responses** to substance use during pregnancy.

Major sources include:

✔ New England Journal of Medicine (NEJM) & Health Affairs

- Research shows that providers are significantly more likely to:
  - Offer **treatment, counseling, or MAT** to *privately insured* White women
  - Order **drug screens, documentation, and CPS reports** for Medicaid-insured or uninsured women

✔ Studies on hospital drug testing policies

- Hospitals serving low-income populations perform more **non-consented drug tests**, triggering surveillance rather than treatment.

✔ National Perinatal Quality Collaborative Data

- White, privately insured mothers receive referrals to behavioral health; low-income mothers receive punitive pathways.

✔ Work by Dr. Roberts, Dr. Faherty, and Dr. Patrick (Vanderbilt OUD research)

- Shows Medicaid patients are much more likely to encounter CPS referrals and barriers, even when the severity of use is identical.

In summary: Insurance status = differential treatment.
Race = differential reporting.
Both together = deep systemic inequity.

Insurance-Based Disparities

Privately Insured White Mothers

Receive:

- Treatment referrals
- Counseling
- MAT access
- Behavioral health support

Medicaid-Insured Mothers

Receive:

- Drug screens
- Documentation
- CPS reports
- Surveillance

Insurance status = differential treatment. Race = differential reporting. Both together = deep systemic inequity.

Nevada: Geographic Patterns

Clark County:

Reports and removals cluster in 89101, 89104, 89106. High overlap with homelessness, incarceration, domestic violence. Predictable intersection of: poverty + policing + lack of care

Washoe County:

AI/AN families disproportionately investigated. Lower access to treatment unless tribal partnerships are strong

Why this matters: Geography predicts justice involvement more than biology or behavior.

Comparing State Approaches

Model Approach	Key Features	Impact on Families	Example
Supportive / Public Health	Care navigators, Medicaid-funded treatment, non-punitive POSC, harm reduction, family-centered services	Higher engagement in prenatal care, fewer CPS removals, safer outcomes for mom & baby	New Mexico (CARA POSC Model)
Mixed / Evolving	Required POSC but inconsistent implementation, limited care navigation, patchy harm reduction access, hospital-driven policies	Mothers unclear about rights; inconsistent reporting; fear of CPS involvement reduces care engagement	Nevada (Current Landscape)
Punitive / Criminalization	Mandatory reporting, arrest laws, automatic CPS involvement, drug screens without consent, severe penalties	High rates of late/no prenatal care, increased maternal mortality, infant separation, trauma, overdose risk	Punitive States (e.g., TN, AL, SC)

Federal Requirement

Plan of Safe Care (POSC)

POSC Must Address:

- Infant safety
- MOUD treatment continuation
- Mental-health screening & therapy
- Housing supports
- Food security
- Transportation
- Domestic violence risk
- Care coordination
- Infant developmental follow-up

Why POSC Works

- Keeps infants safely with caregivers
- Reduces CPS removals
- Increases maternal OUD treatment engagement
- Reduces maternal overdose risk postpartum

Model State: New Mexico

Justice Innovation

Family Treatment Courts

What Family Treatment Courts Do Well

Family Treatment Courts (also called Family Drug Courts or Dependency Courts) are specialized court programs designed for parents with substance use disorders who are involved with child welfare. Instead of punishment, they use a therapeutic, accountability-based model that keeps families together when possible.

Treat OUD/SUD as a Medical Condition — Not a Crime

FTCs operate from a public health approach. Judges, caseworkers, and clinicians collaborate to support treatment, not incarceration.

Why this matters: Parents are more likely to enter care, stay in care, and recover when they are not threatened with jail or automatic termination of parental rights.

Offer Structured, Supervised Recovery

Courts provide:

- Frequent check-ins with a judge
- Random drug testing
- Case management
- Treatment progress monitoring

This creates accountability without punishment, giving families a realistic path to recovery.

Keep Infants with Mothers When Safe

One of the most important features: FTCs aim to avoid unnecessary removal and allow babies to remain with mothers when safety can be assured.

Why this matters:

- Supports bonding
- Improves breastfeeding and attachment outcomes
- Reduces foster care trauma
- Reduces relapse risk

Support Reunification Instead of Permanent Removal

For cases where children are temporarily removed, FTCs actively work to accelerate safe reunification through treatment and resource support.

Outcome: Parents in FTCs reunify with their children at much higher rates compared to traditional dependency courts.

Provide Full Wraparound Services

Family Treatment Courts coordinate the services needed for a parent's recovery and the child's well-being:

MOUD (Medication for Opioid Use Disorder)

Methadone, buprenorphine, naltrexone — not punished, but supported.

Parenting Classes

Evidence-based programs that repair the parent-child relationship.

Mental Health Therapy

Including trauma therapy, postpartum mental health care, grief counseling.

Domestic Violence Support

Safety planning, shelter resources, partner violence treatment.

Housing Assistance

Short-term and long-term housing support — a major predictor of successful reunification.

Why wraparound works: it addresses the actual causes that lead to CPS involvement, not just the symptom of substance use.

Where Family Treatment Courts Exist in the United States

Family Treatment Courts operate in nearly every region of the U.S., although access varies by state. As of 2024:

- There are over 350 FTCs nationwide.
- They operate in at least 43 states, plus Washington D.C.
- Supported by the Office for Juvenile Justice and Delinquency Prevention (OJJDP) and the National Association of Drug Court Professionals (NADCP).

States with Strong FTC Systems

- California
- New York
- New Mexico
- Colorado
- Nevada (exists but varies by county)
- Arizona
- Florida
- Georgia
- Minnesota
- North Carolina
- Washington State
- Oregon
- Kentucky
- Tennessee

States with limited or pilot FTCs include:

Alabama, Mississippi, South Dakota, WyomingStates with no formally operating FTCs typically rely on:

- Traditional dependency court
- Punitive models
- Hospital-only reporting workflows

(This is usually associated with higher rates of TPR – termination of parental rights and lower reunification rates.)

Evidence: National Reviews

Evidence (national reviews):

↑ Reunification rates

↓ Foster care length

↓ Recidivism

↑ Long-term stability

State Example: Vermont

The opioid epidemic led to innovative treatment dockets:

- High-touch case management
- Trauma-informed judges
- Reduced adversarial hearings
- Priority access to treatment

Key Takeaway

> Family Treatment Courts are one of the most effective justice-health partnership models in the U.S. They treat OUD as a chronic illness, not a crime, and are associated with: Higher treatment retention, Lower relapse rates, Faster reunification, Less foster care entry, Better maternal mental health outcomes

They represent a middle ground between punitive systems and fully supportive models like New Mexico's CARA POSC program.

Best Practice Model

West Virginia – Drug Free Moms and Babies (DFMB)

A Statewide, Coordinated Model for Treating Substance Use in Pregnancy

West Virginia has one of the highest rates of substance use in the nation — and because of that, they created one of the most structured, evidence-based perinatal treatment systems in the U.S. The DFMB initiative (launched in 2011–2012) builds a continuum of care that follows pregnant and postpartum people before, during, and long after delivery.

DFMB Program Components

01

Universal Screening Using SBIRT

SBIRT = Screening, Brief Intervention, and Referral to Treatment. DFMB requires or encourages universal screening of all pregnant patients, not just those suspected of substance use.

02

Immediate Access to MOUD

DFMB ensures that pregnant patients can quickly access: Methadone, Buprenorphine (Suboxone/Subutex), Naltrexone (in select cases postpartum)

03

Integrated OB + Addiction Medicine

Instead of making women go to separate clinics, DFMB combines: Prenatal care, Addiction medicine, Mental health treatment, Social services. All in one location.

04

Peer Support Specialists

DFMB includes moms with lived experience in recovery who walk alongside pregnant patients.

05

Postpartum Follow-Up for at Least 1 Year

West Virginia recognizes that the highest overdose risk occurs postpartum (especially 6–12 months after birth).

06

Recovery Coaches

These are trained professionals (not peers) who offer: Case management, Care navigation, Crisis response, Skill-building, Relapse prevention tools

07

Relapse-Prevention Plans

Each patient develops a personalized plan addressing: Triggers, Stressors, Mental health needs, Safety planning, Overdose prevention

Why DFMB Is Considered a "Best Practice" Model

It reduces NAS severity (neonatal withdrawal).	It increases treatment retention.	It decreases postpartum overdose.
It increases reunification and decreases CPS removals.	It builds trust between families and the medical system.	

DFMB is often compared with New Mexico's CARA POSC program as a national gold standard for states struggling with high opioid burdens.

Results:

↑ Prenatal care
↓ NAS severity
↑ MOUD uptake
↓ CPS removals

Nevada Application: How This Model Could Be Rapidly Deployed

Nevada is uniquely positioned to adopt a rapid implementation of a family-centered, non-punitive maternal substance use model — because its largest hospitals and tribal health systems already have the foundations needed.

UMC – University Medical Center (Las Vegas)

Why UMC is ideal:

It is a safety-net hospital, meaning it sees a high proportion of Medicaid patients and high-acuity pregnancies. UMC already has case management, social work teams, and maternal mental health support in place. It handles many Neonatal Opioid Withdrawal Syndrome (NOWS) cases.

Rapid deployment could include:

- Integrating SBIRT universal screening into OB intake and L&D triage.
- Embedding MOUD access through existing hospital addiction services or partnering with local OTPs.
- Training staff on non-punitive POSC workflows (reducing unnecessary CPS reporting).
- Developing care navigator roles or reallocating existing social workers to focus on POSC.
- Partnering with Clark County agencies for postpartum follow-up up to one year.

UMC could realistically become Nevada's first full CARA POSC demonstration site.

Renown Health (Reno)

Why Renown is ideal:

Renown is a regional referral center for northern Nevada. It has a strong perinatal program and an established behavioral health division. They already participate in state quality collaboratives.

Rapid deployment could include:

- Creating an integrated OB + Addiction Medicine clinic (similar to West Virginia DFMB).
- Leveraging their robust EMR system to automate POSC creation and tracking.
- Embedding peer support specialists and recovery coaches directly into prenatal care.
- Offering a postpartum follow-up program for up to one year via telehealth, which Renown already excels in.
- Coordinating with Washoe County child welfare to reduce punitive responses.

Renown is well-positioned to become Nevada's northern hub for family-centered SUD treatment in pregnancy.

Sunrise Hospital (Las Vegas)

Why Sunrise is ideal:

Sunrise delivers more babies than any other hospital in Nevada. As a high-volume hospital, it sees a high number of substance-exposed newborns. They have Neonatal Abstinence Syndrome protocols and a large NICU.

Rapid deployment could include:

- Standardizing universal SBIRT screening across all OB providers.
- Implementing non-punitive POSC policies that prioritize treatment and avoid automatic removal.
- Integrating peer mentors and recovery coaches into postpartum rounding.
- Training all NICU and L&D staff in trauma-informed care and harm reduction.
- Creating fast-track referral partnerships with community MOUD providers.

Because of its size, Sunrise could drive statewide normalization of a supportive POSC model.

Post-Test: Knowledge Check

Now that we've completed this session, please answer these three questions:

1. Nevada law requires mandatory reporting to CPS whenever:

a) A pregnant person tests positive for any substance

b) A mother is enrolled in medication-assisted treatment (MAT)

c) An infant is determined to be at risk of harm due to substance exposure

d) Any prenatal substance use is detected

2. Research shows that states with punitive prenatal substance use laws experience:

a) Increased prenatal care attendance

b) Decreased prenatal care attendance

c) No change in prenatal care patterns

d) Improved maternal outcomes

3. A Plan of Safe Care (POSC) is designed to:

a) Automatically remove infants from mothers with substance use disorders

b) Provide supportive services to keep families together safely

c) Criminally prosecute mothers for prenatal substance exposure

d) Replace medication-assisted treatment with abstinence-only programs

Post-Test Answer Key

Correct Answers:

Question 1: c) An infant is determined to be at risk of harm due to substance exposure

Explanation: Nevada does NOT automatically classify prenatal substance exposure as child abuse. Reporting is required only when there is evidence the infant is at risk of harm—not simply because a substance was detected or a mother is in treatment.

Question 2: b) Decreased prenatal care attendance

Explanation: Research consistently shows that punitive laws lead to a 28% decrease in prenatal care, increased maternal mortality, and worse outcomes. Fear of prosecution drives pregnant people away from the care they need.

Question 3: b) Provide supportive services to keep families together safely

Explanation: Plans of Safe Care (POSC) are a federal requirement under CAPTA designed to support families—not punish them. POSC connects families to treatment, housing, mental health services, and other resources to ensure infant safety while keeping families together whenever possible.

References

Key Sources:

1. Nevada Revised Statutes (NRS) 432B – Child Abuse and Neglect Reporting Requirements
2. Child Abuse Prevention and Treatment Act (CAPTA) – Federal Requirements for Plans of Safe Care
3. Stone, R. (2015). "Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care." Health & Justice, 3(2).
4. Angelotta, C., et al. (2016). "A Clinical Pathway for Treating Newborns with Neonatal Abstinence Syndrome." Hospital Pediatrics, 6(8), 494-502.

5. New Mexico Department of Health – CARA POSC Implementation Guidelines
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