Federal and Pennsylvania Laws on Reporting and Designing Plans of Safe Care for Substance-Exposed Infants

When must a Pennsylvania health care provider make a report about an infant "affected by" prenatal substance exposure?

Pennsylvania's Child Protective Services Law (CPSL) requires that certain substance-exposed infants (up to age one) be referred to a county children and youth agency when the health care provider has been involved in the delivery or care of the infant "born and affected by" any of the following:

1. "Illegal substance abuse by the child's mother.
2. Withdrawal symptoms resulting from prenatal drug exposure unless the child's mother, during the pregnancy, was:
   A. under the care of a prescribing medical professional; and
   B. in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional.
3. A Fetal Alcohol Spectrum Disorder."

Pennsylvania's law, first enacted in 2006, was responsive to a provision in the federal Child Abuse Prevention and Treatment Act (CAPTA).

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In July 2015, Pennsylvania law was amended (affecting #2 in the chart below)[1] by House Bill 1276 to waive the reporting provision when the infant's prenatal drug exposure results from the mother taking a legally prescribed drug as directed by a medical professional.

House Bill 1276 (now Act 15 of 2015), placed into statute, existing guidance from the Office of Children, Youth and Families within the Pennsylvania Department of Human Services (DHS). This 2007 Bulletin (3490-08-04) stated, in part, "Health care professionals are not required to report a mother who is in a methadone maintenance program for heroin use and delivers a child affected by methadone or another medication provided within these programs as this is an appropriate form of substance abuse treatment."[2]

Federal Law[3] *Child Abuse Prevention and Treatment Act (CAPTA)*	**Pennsylvania Law**[4] *(Enacted in 2006 updated by Acts 4 of 2014 and 15 of 2015)*
The Governor must certify 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 (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by: • illegal 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, except that such notification shall not be construed to— • establish a definition under Federal law of what constitutes child abuse or neglect; or • require prosecution for any illegal action; (iii) the development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.	§ 6386. Mandatory reporting of children under one year of age. (a) When report to be made.--A health care provider shall immediately make a report or cause a report to be made to the appropriate county agency if the provider is involved in the delivery or care of a child under one year of age who is born and identified as being affected by any of the following: (1) Illegal substance abuse by the child's mother. (2) Withdrawal symptoms resulting from prenatal drug exposure unless the child's mother, during the pregnancy, was: C. under the care of a prescribing medical professional; and D. in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional. (3) A Fetal Alcohol Spectrum Disorder.

What federal law provides the framework for the reporting of and response to substance exposed infants?

Pennsylvania's 2006 law[5] was responsive to provisions in the federal Child Abuse Prevention and Treatment Act (CAPTA).

In 2003, Congress amended CAPTA to include language spearheaded by former Pennsylvania Congressman James Greenwood.

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[1] House Bill 1276 was signed by Governor Tom Wolf on July 1, 2015 becoming Act 15 of 2015 retrieved at http://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2015&sInd=0&body=H&type=B&bn=1276

[2] http://www.pccyfs.org/dpw_ocyfs/OCYF_Bulletin_3490-08-04_NewReportingRequirements-CPSL.pdf

[3] 42 U.S. Code § 5106(b)(2)(B)(ii) and (iIi) - Grants to States for child abuse or neglect prevention and treatment programs

[4] http://www.legis.state.pa.us/WU01/LI/LI/CT/PDF/23/23.PDF

[5] Act 146 of 2006 was signed by Governor Edward Rendell in November 2006. Act 146 can be retrieved at http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2006&sessInd=0&smthLwInd=0&act=146

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Greenwood, himself a former children and youth caseworker and state lawmaker, fought for the CAPTA provision reinforcing he was intent on ensuring that substance-exposed infants receive "interventions," including that "social workers can come in and meet with the mother and establish a safe plan of care."[6]

While CAPTA requires health care providers to notify children and youth, the federal law also stipulates that such notification "shall not be construed to establish a definition under Federal law of what constitutes child abuse; or require prosecution for any illegal action."

Initially Greenwood's push to include Fetal Alcohol Sprectrum Disorder (FASD) was not accepted. A United States Senate Committee indicated that it "felt constrained" in how best to address "prenatal exposure to alcohol" in CAPTA because "of limited ability to detect and diagnose it at birth."[7] It concluded, however, "The committee remains concerned about the effects of alcohol on infants and possible later diagnosis of fetal alcohol syndrome."[8] It would take until 2010 for CAPTA to include FASD within the CAPTA reporting and Plan of Safe Care provisions. [9]

As Congress was debating the initial effort to amend CAPTA, the Washington Post wrote a series (*'Protected' Children Died as Government Did Little*).[10] The Post series noted[11], "The babies got lost in a system where no one assumes direct responsibility for them. Vague legal definitions and poor communication among caregivers hamstring those who would like to help. "The newspaper also reported on the "frustration" of hospital employees who have routinely notified child protective services about these infants only to be told that child welfare "cannot act on simply drug-exposed babies without any other concerns." Journalists underscored the challenge – then and now - "Social workers, doctors and city lawyers disagree about how deeply the government should intervene in these cases. The debate pits those who believe that mothers and children should be separated only as a last resort against others who argue that the government needs to do more to protect children from unsafe homes."

Even as CAPTA requires states to certify that health care providers are required to notify the child welfare agency and that the state has a law or some statewide program to develop a "Plan of Safe Care," federal law does not then set forth specific expectations about screening for and measuring the scope of substance-exposed infants. Consider that the federal Department of Health and Human Services (HHS), through its Health Resources and Services Administration (HRSA), outlines recommended screenings that should occur during pregnancy and upon an infant's birth. Absent from the list is any related to prenatal substance exposure.[12] There is also no established data requirements about substance-exposed infants (e.g., overall numbers, services rendered, or children placed outside the home) within The National Child Abuse and Neglect Data System. Also unaddressed is the identification of best practices in how inter-disciplinary teams should work to develop and be accountable for dual-generation Plans of Safe Care.

In other words, the CAPTA provision exists in virtual isolation unconnected to other key federal laws or funding streams, including those authorizing funding for child welfare (Social Security Act, Title IV), maternal and child health (Social Security Act, Title V), or Medicaid. Additionally, there is little, if any, guidance about how required Plans of Safe Care should build upon (and prioritize) other key services and supports for infants and families (e.g., clinically appropriate drug treatment, evidence-based home visiting, early intervention, subsidized child care).

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[6] http://www.gpo.gov/fdsys/pkg/CREC-2002-04-23/pdf/CREC-2002-04-23-pt1-PgH1502-5.pdf#page=1
[7] http://www.gpo.gov/fdsys/pkg/CRPT-108srpt12/pdf/CRPT-108srpt12.pdf
[8] Ibid.
[9] Public Law 111-320 retrieved at http://thomas.loc.gov/cgi-bin/bdquery/z?d111:S.3817
[10] http://www.washingtonpost.com/wp-dyn/content/article/2007/06/29/AR2007062901407.html
[11] Ibid.
[12] http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/index.html

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Does the federal reporting requirement or development of a Plan of Safe Care provision apply only when the infant has been born "affected" by an illegal drug?

Federal law requires reporting if the infant is "affected by" illegal substance abuse; **or** withdrawal symptoms resulting from prenatal drug exposure, **or** a Fetal Alcohol Spectrum Disorder (FASD). Federal law does not specifically negate the reporting requirement and development of a Plan of Safe Care if the "withdrawal symptoms" result from prenatal drug exposure linked to legal versus illegal substances.

Meanwhile, Pennsylvania policymakers acted in 2015 to remove the reporting requirement if the "affected" infant had been exposed to a legally prescribed drug the infant's mother took, as prescribed.

As noted earlier, this 2015 change was driven by a push to put the provisions of a 2007 Bulletin (3490-08-04)[13] issued by the Pennsylvania Department of Human Services (DHS) into statute. That 2007 guidance from PA DHS was that reporting of "affected" infants was "not required" if the mother was "in a methadone maintenance program for heroin use and delivers a child affected by methadone or another medication provided within these programs as this is an appropriate form of substance abuse treatment."

Pennsylvania policy makers acted to change the law in 2015 in the shadow of local and state fatality reviews convened in response to the death of 6-week-old Brayden Cummings in Carbon County. These reviews are required by Act 33 of 2008.[14]

In October 2014, Brayden died while sleeping in bed with his mother and father. The coroner ruled the cause of death as asphyxia and the "manner of death was ruled a homicide." The infant, who like his mother was prescribed and receiving methadone, died after spending multiple weeks in a neonatal intensive care unit (NICU). On the night of the infant's death the mother "had numerous drugs in her system including amphetamine, methamphetamine, Xanax." Children and youth officials "determined that the mother caused the victim child's death by co-sleeping while under the influence of controlled substances." Earlier this year, the mother, who was twenty years old at the time of the infant's death, pleaded guilty to involuntary manslaughter and endangering the welfare of children and was sentenced to prison.

As a youth, the victim child's mother was involved with the children and youth agency in 2009 and 2010. This involvement was linked to her "drug use and defiant behavior."

The Carbon County local fatality review report put forth by the children and youth agency focused on how the infant "could have been seen by so many different professionals before and after the baby's birth and yet no one considered calling Children and Youth to file a report." The Act 33 local report continues that the mother "was involved with the Adult Probation office and was known to have substance abuse issues and had failed to comply with all urine screen requests, but yet no one called Children and Youth. The baby was seen by his pediatrician who was also aware of the baby being on methadone but yet no one called Children and Youth." The report concludes, "It took only two weeks for (redacted) to become so overwhelmed with the daily care of a baby that (redacted) resorted to using substances. Although on the surface it did not appear that there was any obvious signs of concern for the child, there were enough risk indicators evident that any one of these professionals, these mandated reporters, should have called Children and Youth even if it was just to give a heads up."

As required by state law, the local review team outlined recommendations toward preventing future child abuse and neglect fatalities including:

[13] http://www.pccyfs.org/dpw_ocyfs/OCYF_Bulletin_3490-08-04_NewReportingRequirements-CPSL.pdf

[14] Senate Bill 1147 was signed by Governor Edward Rendell in July 2008 becoming Act 33 of 2008 retrieved at http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2008&sessInd=0&smthLwInd=0&act=33.

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"The first recommendation involved continuing and ongoing training of mandated reporters in their responsibility of reporting their concerns regarding possible child abuse and neglect." The report cites the many "red flags obvious to many different agencies involved with this family" that should have necessitated a call to the children and youth agency. The local review team concluded, "Mandated reporters need to continuously be educated on the signs and risk factors of possible abuse and neglect and know why they are obligated to call Children and Youth."

PA DHS's own Act 33 fatality report[15] cites as a "county weakness" that upon the birth of Brayden "no referrals had been made to Children and Youth regarding mother's drug use and the baby needing (redacted) despite that the mother's adult probation officer was familiar with the mother as she was the closing caseworker for the mother as a juvenile in 2010."

The local team and PA DHS did not address how Brayden's life and subsequent death were impacted by DHS' long-standing guidance (now PA law) relieving health care providers of the responsibility to make a report to the children and youth agency when the infant's withdraw is linked to the mother taking methadone, as prescribed. PA DHS also made no recommendations about how, in the absence of a report to the children and youth agency, effective Plans of Safe Care for infants could still be implemented.

Is a PA county children and youth agency required to take specific steps in response to a report involving an infant "affected" by prenatal substance exposure?

Yes, beginning in 2014 Pennsylvania amended the CPSL to provide clarity and set forth an expectation that a county children and youth agency must take specific actions in response to a report from a health care provider as required by § 6386 (Mandatory reporting of children under one year of age).

Prior to April 2014, Pennsylvania law permitted a county children and youth agency to screen out a report related to an affected substance exposed infant without ever seeing the infant, talking with the parents or undertaking a risk or safety assessment. Today, Pennsylvania law outlines specific timelines and steps to be taken by the county children and youth agency, including that the parents must be contacted within 24 hours of the report being received and the infant seen within 48 hours. The chart below provides fuller detail about the required response outlined in state law.

Pennsylvania Law *(Enacted in 2006 updated by Acts 4 of 2014 and 15 of 2015)*
Upon receiving a report from a health care provider the county agency "shall perform a safety assessment or risk assessment, or both, for the child and determine whether child protective services or general protective services are warranted." The county agency (where the child is to reside) "shall" 1. **Immediately** "ensure the safety of the child and see the child immediately if emergency protective custody is required or has been or shall be taken or if it cannot be determined from the report whether emergency protective custody is needed." 2. **Within 24 hours** of receiving the report – "contact the parents of the child" 3. **Within 48 hours** of receiving the report "physically see the child" The agency shall also then "provide or arrange reasonable services to ensure the child is provided with proper parental care, control and supervision."

Can an entity other than the county children and youth agency be responsible for the development of a Plan of Safe Care?

Federal law is sufficiently unclear about which entity is expected to develop the Plan of Safe Care.

[15] http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_199444.pdf

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In 2011, the federal Administration for Children and Families (ACF) within the federal Department of Health and Human Services (HHS) addressed a specific question about what entity is responsible for the Plan of Safe Care.[16]

ACF noted that the federal statute (Child Abuse Prevention and Treatment Act) did not specify whether it is the formal child welfare agency or another entity (e.g., hospital, community-based providers) expected to develop and implement this plan. ACF underscored more on the intent of the plan writing "it should address the needs of the child as well as those of the parent(s), as appropriate, and assure that appropriate services are provided to ensure the infant's safety." [17]

The ambiguity in this response demonstrates a challenge. It could, however, also be seen as an opportunity for states, since it appears HHS' may support flexibility in designing and implementing Plans of Safe Care, beyond the formal child welfare system.

In the meantime, existing Pennsylvania law is clear that the children and youth agency "shall" not only respond to the report and see the child and parents, but also then "provide or arrange reasonable services to ensure the child is provided with proper parental care, control and supervision."

Are reports about substance exposed infants made to ChildLine?

No. Pennsylvania law specifically § 6313 of the Child Protective Services Law requires that a mandated reporter "shall immediately make an oral report of suspected child abuse to the department via the Statewide toll-free telephone number under section 6332 (relating to establishment of Statewide toll-free telephone number) or a written report using electronic technologies under section 6305 (relating to electronic reporting)." Policymakers, informed by the Task Force on Child Protection, sought to have all reports – child protective and general protective services – directed to ChildLine, the state's centralized suspected child abuse reporting system.

It was intentional that all types of reports, including GPS reports, were to be received at ChildLine and included, with some restrictions, in the statewide database toward informing any future investigations undertaken by the children and youth agency or law enforcement. A centralized reporting and data collection system would also better inform policy makers about the scope and type of child maltreatment or risk experienced by Pennsylvania children.

Despite the intention to streamline reports, state policymakers took a different approach with the reports related to substance-exposed infants. Instead of calling ChildLine, the health care provider "shall immediately make a report or cause a report to be made to the appropriate county agency."

Can a health care provider face criminal penalties for failing to report an infant "affected by" prenatal substance exposure?

A report about a substance-exposed infant required under § 6386 is not a report of suspected child abuse or neglect.

The mandatory reporting of infants "affected by" prenatal substance exposure is contained outside the Child Protective Services Law's Subchapter B. Provisions and Responsibilities for Reporting Suspected Child Abuse. Instead § 6386 (Mandatory reporting of children under one year of age) is included in Subchapter E. Miscellaneous Provisions.

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[16] https://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=351

[17] Child Welfare Policy Manual produced by the Children's Bureau, an Office of the Administration for Children and Families. Question 2.1F.1 CAPTA, Assurances and Requirements, Infants Affected by Illegal Substance Abuse, Plan of Safe Care. Retrieved at http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=351

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Pennsylvania law does not specifically stipulate that a report made under § 6386 is not suspected child abuse or neglect. It is, however, understood in part, as a result of CAPTA, that a report related to an infant "affected" by prenatal substance exposure is not, in and of itself, equivalent to a report of suspected child abuse or neglect.

The 2007 bulletin issued by the Pennsylvania Department of Human Services advised county agencies, social service agencies and other stakeholders that reports required by § 6386 related to "affected" substance exposed infants "are to be considered general protective services reports, not child abuse reports."

Within the CPSL, general protective services (GPS) are defined as "Those services and activities provided by each county agency for cases requiring protective services, as defined by the department in regulations." Regulations promulgated by the PA DHS[18] then define GPS as "Services to prevent the potential for harm to a child" who meets one of a number of conditions, including but not limited to:

i. Is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, or morals.
ii. Has been placed for care or adoption in violation of law.
iii. Has been abandoned by his parents, guardian or other custodian.
iv. Is without a parent, guardian or legal custodian."

These same regulations then offer this definition of "Potential for harm: likely, if permitted to continue, to have a detrimental effect on the child's health, development or functioning."

The CPSL's immunity from civil and criminal liability provisions outlined in §6318 do extend to a person, hospital school or other agency when the person or institution has, "acting in good faith," made either "a report of suspected child abuse" or made "a referral for general protective services, regardless of whether the report is required to be made under this chapter."

Still, the penalties for failure to report outlined in § 6319 are applicable to when "A person or official required by this chapter to report a case of suspected child abuse……willfully fails to do so." These penalties are not then understood as applicable to § 6386 related to substance exposed infants, since they are not reports of suspected child abuse or neglect.

How many Pennsylvania infants are born "affected" by prenatal substance exposure?

It is hard to know with any certainty.

Even where data does exist it is may be housed by different cabinet level departments (e.g., Drug and Alcohol Programs, Health, Human Services). Gaining access to richer data is also complicated, in part, because the reports from health care providers are filed directly with the children and youth agency versus ChildLine.

Another complication is that Neonatal Abstinence Syndrome (NAS) is not a reportable health condition in Pennsylvania. NAS refers to "a constellation of typical signs and symptoms of withdrawal that occurs in infants that have been exposed to and have developed dependence to certain illicit drugs or prescription medications during fetal life."[19] The constellation of signs and symptoms can be "behavioral and physiological." An infant with "clinical features of NAS" can experience "neurological excitability" (e.g.

[18] 55 Pa. Code § 3490.201 *et. seq*. retrieved at ttp://www.pacode.com/secure/data/055/chapter3490/s3490.223.html
[19] Neonatal Abstinence Syndrome Clinical Management Document, Gateway Health Plan, August 2010. Retrieved at https://www.gatewayhealthplan.com/sites/default/files/documents/PAMA_neonatal.pdf

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tremors, seizures, high-pitched crying, irritability) and/or gastrointestinal dysfunction (e.g., poor weight gain, nasal stuffiness, diarrhea, poor feeding).

Data retrieved, through a Right to Know Request (RTK), from the Office of Clinical Quality Improvement within PA DHS' Office of Medical Assistance Programs (OMAP) reveals that in 2012, Medicaid covered the birth and hospitalization costs for 1,122 infants diagnosed with NAS at a total cost of approximately $17.3 million. A 2015 RTF request filed by the Center for Children's Justice (C4CJ) to obtain 2013 and 2014 data was denied by the Pennsylvania Department of Human Services (DHS). Below is the data from the earlier answered RTK request.

Diagnosed with Neonatal Abstinence Syndrome (NAS) During Inpatient Birth Stay[20]

CY	Gender	Birth Count	Gender %	Average LOS (Days)[21]	Total Paid	Average Cost
2010	F	403	45.6%	21.5	$6,817,622	$ 16,917.18
	M	480	54.4%	21.1	$8,272,032	$ 17,233.40
	Totals	883		21.3	$15,089,654	$ 17,089.08
2011	F	489	45.5%	20.4	$8,081,397	$ 16,526.38
	M	586	54.5%	19.2	$9,831,202	$ 16,776.80
	Totals	1,075		19.8	$17,912,600	$ 16,662.88
2012	F	544	48.5%	19.1	$8,568,966	$ 15,751.77
	M	578	51.5%	18.8	$8,765,493	$ 15,165.21
	Totals	1,122		19.0	$17,334,459	$ 15,449.61

Another data point worth review is the number of live births in PA where the infant was exposed to illegal drugs prenatally or FASD.

Pennsylvania live births exposed to illegal drugs or with FASD (2002-2014)[22]Year (July 1st – June 30th)[1]	Live births exposed to illegal drugs before birth	Live births with Fetal Alcohol Spectrum Disorder
2013-2014[2]	3,119	37
2012-2013	2,706	33

[20] Data provided by the Office of Clinical Quality Improvement, Office of Medical Assistance Programs, Department of Human Services, March 23, 2015 in response to a request from C4CJ about data that would reveal the costs and numbers of Pennsylvania infants born onto Medical Assistance that were diagnosed with NAS. The data shared with C4CJ was from an earlier response prepared by PA DHS in response to a Right to Know request from the media.

[21] The numbers provided include very low birth weight (<1500 grams). The JAMA study excludes those counts from their overall figure. Citation included in the

[22] Prepared from data submitted by Pennsylvania hospitals to the Department of Health. Retrieved at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=596752&mode=2

[1]Chart compiled from annual hospital data specific to Infant/neonatal services and utilization. Information can be retrieved at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=596752&mode=2

[2] Act 4 of 2014 was signed into law on January 22, 2014 with an effective date of 90 days. Act 4 required reporting of any child, up to age one, affected by "(1) Illegal substance abuse by the child's mother, (2) Withdrawal symptoms resulting from prenatal drug exposure, (3) A Fetal Alcohol Spectrum Disorder."

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Pennsylvania live births exposed to illegal drugs or with FASD (2002-2014)[22]Year (July 1st – June 30th)[1]	Live births exposed to illegal drugs before birth	Live births with Fetal Alcohol Spectrum Disorder
2011-2012	2,686	20
2010-2011	2,586	16
2009–2010	2,588	---
2008–2009	2,356	19
2007–2008	2,728	42
2006–2007	3,288	29
2005-2006	3,092	32
2004–2005	2,389	50
2003-2004	2,325	32
2002–2003	2,533	24

It is instructive to look at NAS data from Tennessee, which has implemented a mandatory public health surveillance reporting system related to infants born with a diagnosis of NAS. By making NAS a reportable disease, TN is gaining (close to real-time) data [23]about the incidence of NAS. The NAS data is tracked by communities permitting more targeted prevention and intervention strategies.

The TN data indicates that approximately 1,000 infants were born with NAS in both 2013 and 2014 and the about 60 to 70 percent of these NAS infants were born to mothers who are using "at least one substance prescribed by a health care provider (e.g., opioid pain relievers or maintenance medications for opioid dependency)."[24]

Also of interest is that in 2011, Tennessee's Medicaid program (TennCare) covered the birth and hospitalization costs of 528 infants born with NAS. Twenty-two percent (n=120) of the infants were in the "custody" of the TN Department of Children Services within a year of the infant's birth.[25]

Are infants "affected" by prenatal substance exposure required to be referred for early intervention services?

The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states have provisions and procedures in place "for referral of a child under age 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Improvement (IDEA) Act."

Many see this as a high threshold given that many children that come into contact with the children and youth agency will never become victims of a substantiated report of abuse or neglect. Also, at issue, is the

[23] http://health.tn.gov/mch/nas/nas_summary_archive.shtml
[24] Mortality and Morbidity Weekly Report, 2015 Feb 13; 64(5):125-8.
[25] Ibid.

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varied expectations and approaches to screening for early intervention (EI) services versus an actual referral for EI services.

In 2011, the federal Child Welfare Policy Manual was updated responding to a question about the CAPTA EI requirements. The federal Administration for Children and Families (ACF) within HHS wrote, "CAPTA does not specifically require that every child under the age of three who is involved in a substantiated case of child abuse or neglect must be referred to Part C services. Therefore, States have the discretion as to whether to refer every such child under the age of three for early intervention services, or to first employ a screening process to determine whether a referral is needed. We believe that this is consistent with the purpose of the provision, which is to assure that all children who have a substantiated case of child abuse or neglect will be given special attention to determine whether they need early intervention services and to assure referral when such services are warranted."[26]

Beyond CAPTA, when IDEA was reauthorized in 2004, it built upon the CAPTA requirements. This federal law requires that for states to be eligible for funding they must submit an application to the Secretary of Education that includes: "a description of the State policies and procedures that require the referral for early intervention services under this part of a child under the age of 3 who:

- is involved in a substantiated case of child abuse or neglect; or
- is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure"

In 2011, the federal Department of Education issued final regulations for the Early Intervention Program for Infants and Toddlers with Disabilities[27] in response to the 2004 statutory changes.

In releasing the regulations, it was noted that there was a request for "clarification of the scope" of "affected by illegal substance abuse." Federal officials underscored the importance of young children, affected by prenatal substance exposure, being connected to EI services because "there is a likelihood that these children may experience developmental delays and thus be eligible for early intervention services under Part C of the Act." Still, the regulations were clarified to add "directly" before "affected by illegal substance abuse." Education officials indicated they did so because the statutory "language is vague."

The federal Department of Education also received comments addressing that CAPTA does not require "referral to Part C services of children under the age of three who are affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure." It was requested then that the Department clarify this point in the regulations. Education officials responded that CAPTA "requires that each State that receives CAPTA funds assure that it has policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure."

What is the Protecting Our Infants Act?

On November 25th, President Obama signed 799 – the Protecting Our Infants Act.[28]

Pennsylvania U.S. Senator Bob Casey joined with Republican (and Senate Majority Leader) Mitch McConnell (R-KY) earlier this year in introducing the legislation.

The legislation directs the federal Department of Health and Human Services (HHS) to study "gaps in research and any duplication, overlap or gaps in prevention and treatment programs related to prenatal

[26] https://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=354
[27] http://idea.ed.gov/part-c/downloads/IDEA-Regulations.pdf
[28] https://www.govtrack.us/congress/bills/114/s799

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opioid abuse and infants born with opioid withdrawal." HHS has to issue a report to Congress within eighteen months after meeting with diverse stakeholders to develop recommendations toward preventing and treating "prenatal opioid abuse and infants born dependent on opioids."

HHS and the Centers for Disease Control and Prevention (CDC) is expected "to work with states and help improve their public health response to this epidemic."

Majority Leader McConnell encouraged unanimous support for S. 799 stating, "As the father of three daughters, particularly concerning to me is the increase in prenatal opiate abuse, which has resulted in a staggering 300-percent increase in the number of infants born suffering from withdrawal symptoms since 2000."[i]

Upon Senate passage, Senator Casey said, "I am pleased that the Senate passed this bill without opposition. Over the past thirty years, there has been a substantial increase in heroin and prescription drug abuse, with tragic consequences for infants and newborns." He continued, "These children and their families go through an unimaginable struggle, but there's far too little known about how to treat newborn withdrawal. The Protecting Our Infants Act will help hospitals and medical professionals better understand how to address the rising tide of infants with this condition."[ii]

Senator Kelly Ayotte (R- NH) underscored, "One of the tragic results of this growing opioid abuse epidemic--it has often been overlooked--is the increasing number of infants who are born dependent on opioids and suffering from withdrawal."

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[i] http://thomas.loc.gov/cgi-bin/query/D?r114:1:./temp/~r114uuRbsv::

[ii] http://www.casey.senate.gov/newsroom/releases/casey-mcconnell-bill-addressing-prenatal-addiction-and-infant-opioid-withdrawal-one-step-closer-to-becoming-law

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