



Babies born withdrawing from opioids trigger concern and confusion

Federal and state statutes contain reporting and plan of safe care provisions, but PA created 2015 "loophole"

August 15th – This week the Washington Post reported on the multidimensional complications and magnified stigma associated with a woman being pregnant and also being a person who has an addiction to opioids (best framed as a person with an opioid use disorder).

The Post's [Pregnant women addicted to opioids face tough choices, fear treatment can lead to separation and harm](#) informed readers that health care professionals "are legally required to report cases involving newborn withdrawal symptoms directly to child-welfare agencies."¹

The Post's explored the added hurdles for women with an OUD accessing evidence-based treatment also how often these women – many prescribed opioid medications, including as part of medication assisted treatment for an OUD - worry about being reported to child welfare officials when they give birth to a baby born dependent on opioids.

It was also the Washington Post 16 years ago that provided powerful reporting in their series - [Without Help, Frail Infants Died](#).² At that time, Post reporters wrote:

"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."

Since that 2001 Post series was published, a federal law has been enacted (and amended twice – once in 2010 and then July 2016) and states have enacted statutes to identify the practice by which health care workers and child welfare agencies, along with other partners, are to work together to identify and intervene with substance exposed infants and their families.

Among the most significant sticking points is if, when and how these professionals and systems should respond to the infant born dependent to a drug the infant's mother took as prescribed to her for pain (e.g., codeine or oxycodone) or as part of OUD treatment (e.g., methadone or buprenorphine).

Become a CJAR Subscriber <http://www.c4cj.org/files/CJARsubscription122014.pdf>

¹ https://www.washingtonpost.com/national/pregnant-women-addicted-to-opioids-face-tough-choices-fear-treatment-can-lead-to-separation-and-harm/2017/08/13/8844e51a-6d78-11e7-b9e2-2056e768a7e5_story.html?hpid=hp_hp-more-top-stories_opioidmoms627pm%3Ahomepage%2Fstory&utm_term=.46d32d565062

² <http://www.washingtonpost.com/wp-dyn/content/article/2007/07/02/AR2007070200951.html>

By 2015, it was two investigative reporters for Reuters revisiting the complex reality of infants born in withdrawal and how federal and state laws and practices were insufficiently leading to improved outcomes for infants and their families ([Helpless and Hooked: the most vulnerable victims of America's opioid epidemic](#)).³

Reuters spotlighted the death of a 6-week-old infant in Carbon County, Pennsylvania, including an interview with the infant's 20-year-old mother.

During her pregnancy, the mother had been paroled from prison in order to participate in medication assisted treatment (MAT).

After her baby was born, he spent weeks in the Neonatal Intensive Care Unit (NICU) before his death in October 2014.

Shortly after discharge from the hospital, the baby 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."

At the time of Brayden's death, his mother tested positive for Methadone, Amphetamine, Methamphetamine and Alprazolam. Some, but not all, of these drugs were prescribed to the mother.

Brayden's dependence on opioids and his time in the NICU were known to hospital professionals, his pediatrician, and the mother's probation officer. Still no one ever called the children and youth agency and no plan of safe care was created.

The reason can be found in that 16 year old reporting from the Washington Post:

*"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."*⁴

And recently the complex web of competing (and conflicting) viewpoints about pregnant women and addiction as well as the required reporting (to child welfare) were highlighted as part of The Bucks County Courier Times' [Born into Addiction series](#).⁵

In its July 26th story ([Pennsylvania law keeps some drug-exposed infants off child welfare radar, advocates say](#)), the author underscores that "Federal law requires that babies exposed to drug use in the womb or with withdrawal symptoms at birth be reported to child welfare agencies, though state law requires the reporting only of illegal drug."⁶

Now, the chairwoman of the Pennsylvania House of Representatives' Children and Youth Committee Chairwoman Kathy Watson (R-Bucks) is seeking to close a "loophole" in Pennsylvania's statute created by Pennsylvania lawmakers and Governor Tom Wolf in July 2015.

³ <http://www.reuters.com/investigates/special-report/baby-opioids/>

⁴ <http://www.washingtonpost.com/wp-dyn/content/article/2007/07/02/AR2007070200951.html?sid=ST2008092602295>

⁵ <http://www.buckscountycouriertimes.com/news/born-into-addiction/>

⁶ http://www.buckscountycouriertimes.com/news/born-into-addiction/pennsylvania-law-keeps-some-drug-exposed-infants-off-child-welfare/article_8b4d99d0-397c-11e7-a45b-e33871830470.html

Earlier this month, Watson invited her fellow state representatives to co-sponsor legislation to “require all cases of diagnosed substance-exposed newborns to be reported by health care providers to county child protective services.”⁷

Watson stipulated that the legislation, now introduced as [House Bill 1707](#), will put the “safety of infants first.”

In a later press release, Watson stipulated, “As the opioid crisis continues, hundreds of newborns are born dependent on opioids, and yet young children are sent home with parents who are incapable of caring for them due to their addiction.”⁸ She continued, “As a result, we must revisit this law and take appropriate action to ensure that the proper authorities are notified and supply whatever services may be needed to ensure the health and welfare of these infants and any other children living in the home.”

Watson has also shepherded bipartisan legislation ([House Bill 235](#)) through the Pennsylvania House of Representatives seeking to create a “special task force to improve the safety, well-being and permanence of substance exposed infants and other young children affected by parents’ substance abuse disorders.”⁹

The Center for Children’s Justice (C4CJ) mobilized diverse stakeholders in March 2016 to request such a state-level task force.¹⁰

Calls to children and youth agencies regarding substance exposed infants are not reports of “suspected child abuse”

Federal law (the Child Abuse Prevention and Treatment Act) and state statute (the Child Protective Services Law) set forth requirements under which certain infants – affected by prenatal drug exposure – are to trigger a referral from a health care provider to a child welfare agency.

The federal and state statutes also set forth an understanding that when a health care provider calls child welfare about an infant affected by prenatal drug exposure this call is not to be automatically equated with that professional having filed a report of suspected child abuse.

Instead these referrals were envisioned, by Congress, as establishing a mechanism by which assessment of the infant and his/her family could occur and a multidisciplinary plan of safe care could be developed for the infant and his/her family.

In fact, Pennsylvania’s CPSL does not cite these required referrals within the CPSL’s Subchapter B, § 6311 (*Persons required to report suspected child abuse*).

Rather, state lawmakers created a Subchapter E for “miscellaneous provisions” and it here that “§ 6386 Mandatory reporting of children under one year of age” is found within the CPSL.¹¹ In addition to § 6386 being distinct from the “persons required to report suspected child abuse” element of the CPSL, it also establishes a different reporting procedure.

In the case of an infant affected by prenatal drug exposure, the CPSL directs the health care provider to contact the “appropriate county agency.” This procedure differs from the CPSL’s § 6313 (Reporting procedure) where mandated reporters are legally required to “immediately make an oral report of

⁷ <http://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2017&slnd=0&body=H&type=B&bn=1707>

⁸ <http://www.pahousegop.com/NewsItem.aspx?NewsID=267881>

⁹ *Ibid.*

¹⁰ <http://www.c4cj.org/files/SEItaskforce.pdf>

¹¹ <http://www.legis.state.pa.us/WU01/LI/LI/CT/PDF/23/23.PDF>

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.”

Also, the penalties for failure to report are set forth in Subchapter B, § 6319 and apply to “A person or official required by this chapter to report a case of suspected child abuse or to make a referral to the appropriate authorities commits an offense if the person or official willfully fails to do so.”

Without debate, PA law changes in 2015 setting up conflict with federal law

In July 2015, the Pennsylvania General Assembly was debating a bill that would amend the CPSL related to which individuals would be required to obtain comprehensive criminal and child abuse background checks to work or volunteer with children.

Slipped into that legislation (House Bill 1276), without any debate of fanfare, was language to statutorily recognize the provisions of a 2007 Bulletin issued by the Office of Children, Youth and Families within the Pennsylvania Department of Human Services (DHS).

The 2015 amendment (*see Table 1*), which was included in the legislation that became Act 15 of 2015, waived the requirement that health care providers notify a county children and youth agency about certain infants exposed to drugs prenatally. That 2007 Bulletin stated: “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.”

That bulletin and later Act 15 of 2015 affected not just the number of infants reported to a children and youth agency, but also led to the unintended consequence of limiting the number of infants for whom a plan of safe care was created.

Table 1: Comparison of Mandatory reporting of children under one year of age requirements

Before July 2015	After July 2015
<p>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:</p> <ol style="list-style-type: none"> 1. Illegal substance abuse by the child's mother. 2. Withdrawal symptoms resulting from prenatal drug exposure. 3. A Fetal Alcohol Spectrum Disorder. 	<p>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:</p> <ol style="list-style-type: none"> 1. Illegal substance abuse by the child's mother. 2. Withdrawal symptoms resulting from prenatal drug exposure <u>unless the child's mother, during the pregnancy, was:</u> <ol style="list-style-type: none"> i. <u>under the care of a prescribing medical professional; and</u> ii. <u>in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional.</u> 3. A Fetal Alcohol Spectrum Disorder.

Act 33 review process and recommendations overlook impact of 2007 bulletin

The 2015 statutory change in Pennsylvania occurred absent any legislative hearings or debate and also in the shadow of local and state fatality reviews convened in response to the death of 6-week-old Brayden Cummings in Carbon County on October 17, 2014. These reviews are required by Act 33 of 2008.¹²

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 died just a few short weeks after spending multiple weeks in a neonatal intensive care unit (NICU) required after he was born dependent on an opioid.

His mother had been incarcerated, but was paroled in July 2014 during her pregnancy in order to participate in medication assisted treatment (MAT). At the time of Brayden’s death, his mother tested positive for Methadone, Amphetamine, Methamphetamine and Alprazolam.¹³ Some, but not all, of these drugs were prescribed to the mother.

According to the Act 33 reports, children and youth officials “determined that the mother caused the victim child’s death by co-sleeping while under the influence of controlled substances.”

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.¹⁴

The victim child’s mother was known to the child welfare system, as a youth in 2009 and 2010, in part, related to her “drug use and defiant behavior.”

The Carbon County fatality review report issued by the county Act 33 team questioned 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 local Act 33 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 concluded, “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. Included in the recommendations:

- “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

¹² 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>.

¹³ <https://ujportal.pacourts.us/DocketSheets/CPReport.ashx?docketNumber=CP-13-CR-0000287-2013>

¹⁴ Ibid.

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 report¹⁵ cites as a “county weakness” that upon the birth of Brayden in October “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 any implications from the 2007 bulletin issued by the state in 2007 that relieved health care providers of the responsibility to make a report to the children and youth agency when the infant’s withdraw was linked to a legally prescribed drug like Methadone. PA DHS also made no recommendations about how, in the absence of a report to the children and youth agency, an effective plan of safe care for infants, affected by prenatal drug exposure, might still be implemented if the family had no child welfare involvement.

The 2015 change happened just a year after state lawmakers had taken a promising step in setting up statutory requirements for a children and youth agency in response to reports about substance exposed infants.¹⁶

Act 4 of 2014 (effective in late April 2014) narrowed the opportunity for a county agency to screen out reports about substance exposed infants.

This legal change outlines specific timelines and steps to be taken by the county children and youth agency.

For instance, 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.”

Promoting guidance and best practices related to treating a pregnant woman with opioids

The Department of Health, in partnership with the Pennsylvania Medical Society, have crafted a number of prescribing guideline documents.¹⁷

Specific guidelines have been issued related to the Use of Addiction Treatment Medications in the Treatment of Pregnant Patients with Opioid Use Disorder.¹⁸

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

¹⁶ <http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=4>

¹⁷ <https://www.pamedsoc.org/tools-you-can-use/topics/opioids/guidelines/DownloadPAOpioidGuidelines>

¹⁸ <http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/Prescribing%20Guidelines%20Pregnant%20Patients.pdf>

The guidelines specific to pregnant women “address stabilization, treatment and recovery management for opioid use disorder (OUD) during pregnancy. The document provides a primer on Medication assisted treatment (MAT) noting it the “the use of FDA-approved medications in combination with evidence-based behavioral health therapies to treat substance use disorders.” The DOH guidance reminds that there are currently “only two FDA-approved medications indicated for the treatment of SUD during pregnancy are methadone and buprenorphine.”

DOH’s document also stipulates, “It is not recommended to conduct medically supervised withdrawal from opioids for pregnant patients with opioid use disorders because it is associated with high relapse rates.”

The guidance reinforces that the “recommended standard of care” for pregnant women with an OUD is MAT. DOH acknowledges that “any opioid use during pregnancy, including MAT medications, can increase the risk of neonatal abstinence syndrome.” Still they offer that MAT can “improve maternal and infant outcomes” by preventing “erratic maternal opioid levels” and protecting the “fetus from repeated episodes of withdrawal.” Finally MAT for this population of women “can also reduce the risk of other self-injurious drug and alcohol use.”

Become a CJAR Subscriber <http://www.c4cj.org/files/CJARsubscription122014.pdf>