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Children's Justice & Advocacy Report

To promote community responsibility so every Pennsylvania child is protected from child abuse, including sexual abuse.

In the April 25th edition:

Opioid Crisis Response Act unanimously clears U.S. Senate HELP Committee

Tuesday, the United States Senate Committee on Health, Education, Labor and Pensions (HELP) unanimously approved S.2680 - Opioid Crisis Response Act of 2018.[1]

United States Senator Bob Casey, Jr. is a member of the HELP Committee.

The legislation weaves together 40 stand-alone pieces of opioid-related legislation crafted by 38 senators (from both sides of the political aisle), including provisions related to pregnant women with substance use disorders (SUDs) and infants born affected by withdrawal symptoms.

HELP Committee Chairman Lamar Alexander (R-TN) vowed he would next notify Senate Majority Leader Mitch McConnell (R-KY) and Minority Leader Senator Chuck Schumer (D-NY) that the HELP committee "acted in an urgent, bipartisan and effective way to try and make a contribution to dealing with the opioid epidemic."

Alexander underscored that the bill moved through the committee with an "unusual unanimous vote" and that should motivate Senate leaders to quickly work in the Senate and then with the U.S. House of Representatives to get a final bill to President Donald Trump's desk this summer. The HELP Committee

[1] https://www.help.senate.gov/hearings/s-2680-s-2315-s-2597-s-382-and-nominations

Chairman concluded, "It is what the country expects us to do and we have a work product that is worth doing that."

United States Senator Bob Casey, Jr. (D-PA) spoke of the "horror" of the opioid crisis and how the unfolding bipartisan work is more than a signal of "good intentions", it also reflects "the gravity of the problem."

Highlights of The Opioid Crisis Response Act approved by the HELP Committee Tuesday include:

- Reauthorization of the 21st Century CURES State response to the opioid abuse crisis grants. The original CURES Act, enacted in December 2016, authorized up to $1 billion – over two years – to address the opioid crisis. Pennsylvania was eligible for approximately $26 million in FFY 2017 and FFY 2018.[2] The Senate HELP approved opioid bill would authorize $500 million annually for federal fiscal years 2019, 2020 and 2021. It also recognizes that some states are confronting substance use disorder (SUD) challenges that are not related to opioids so the funding would come with some flexibility for states to identify the challenges they face and then target resources to address them.
- Additional funding would be authorized for residential treatment programs for pregnant and postpartum women to allow for $29.9 million to be available (as compared to $16.9 million) annually in federal fiscal years 2019 through 2023.
- Creates a $10 million (annually) competitive grant program for the establishment of "comprehensive opioid recovery centers."
- The federal government, in consultation with patients with a history of OUDs and other stakeholders, "shall identify or facilitate the development of best practices, which may include model laws for implementing suggested minimum standards, for operating recovery housing."
- Permits (with a "may" provision) the Director of the Centers for Disease Control and Prevention (CDC), "in cooperation with the states" to "collect and report data on adverse childhood experiences through the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, and other relevant public health surveys or questionnaires."
- Establishes an Interagency Task Force on Trauma-Informed Care expected to "identify, evaluate, and make recommendations regarding best practices with respect to children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma."

Supporting Infant Plans of Safe Care Implementation legislation woven into HELP approved opioid legislation

United States Senator Bob Casey, Jr. continues to put a spotlight on how the opioid crisis is impacting pregnant women and very young children, including those infants born in withdrawal after having been exposed prenatally to opioids.

"Whether it is from the youngest among us, the babies born with Neonatal Abstinence Syndrome, or what happens when grandparents have to raise grandchildren we have all been horrified but what we have seen in our communities."

[2] http://www.post-gazette.com/news/health/2016/12/14/Money-from-Cures-Act-will-fight-opioid-abuse/stories/201612140136

The Pennsylvania Democrat, who joined with Republican Majority Leader Mitch McConnell in 2015 to get the Protecting Our Infants Act enacted, is once again partnering with the leader to secure "an update on the implementation of the recommendations" in the Final Strategy unveiled last summer (***Protecting Our Infants Act: Final Strategy***).[3] Casey and McConnell also want to know if additional funding is needed "to implement the strategy" that tackles prevention, treatment and services. The bipartisan senators included this discussion, as well as additional funding for residential treatment programs for pregnant and parenting women with children, in a stand-alone bill - Protecting Moms and Infants Act (S. 2710).[4] S. 2710 is now captured in the broader opioid bill passed by the HELP Committee Tuesday.

Casey also secured provisions in the comprehensive opioid bill intended to "support states in implementing plans of safe care for vulnerable infants whose mothers used or abused opioids during pregnancy."

The senator just recently introduced the Supporting Infant Plans of Safe Care Implementation Act (S.2696) with the hope of creating a $60 million (annually) competitive grant program to assist states in implementing the infant plan of safe care requirements within the federal Child Abuse Prevention and Treatment Act (CAPTA).

It is this CAPTA provision (originally enacted in 2003, updated in 2010 and further updated in 2016) that has linked states' eligibility for a (very modest) share of federal CAPTA funding to the state having a requirement (in statute or administrative policy) that directs health care providers, who identify an infant born affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, to then notify child welfare.

CAPTA does not establish this notification requirement as setting forth a federal definition of child abuse or to encourage criminal proceedings against a woman who uses drugs during pregnancy. Instead it was expected that the notification would lead to the child welfare agency, health care providers and other partners collaborating and engaging the family in the development of a plan of safe care that ideally is in place when the infant is discharged from the hospital.

States, including Pennsylvania, have long struggled with how to comply with this federal CAPTA provision. The struggle has been linked to an absence of fuller context and definitions (e.g., what is affected by, what is a plan of safe care), direction about what entity (other than child welfare) might well develop and monitor the plan of safe care as well as the absence of any federal resources to fulfill the expectations set forth within CAPTA.

As states struggled, critical incidents – even lethal events – happened for infants born affected by prenatal drug exposure upon their discharge to home and early in the infant's life. Pennsylvania infants were among those that died. The critical incidents and deaths were not directly caused by the infant having been prenatally exposed to drugs. Instead it was that early life reality for the infant and his/her family served as a cautionary reminder that there could be added risk and vulnerability particularly if the infant and family were without supports and services after they left the hospital.

[3] https://www.samhsa.gov/sites/default/files/topics/specific_populations/final-strategy-protect-our-infants.pdf
[4] https://www.congress.gov/bill/115th-congress/senate-bill/2710?q=%7B%22search%22%3A%5B%22s+2710%22%5D%7D&r=1

Reuters unveiled an investigative series – Helpless and Hooked: The most vulnerable victims of America's opioid epidemic in December 2015.[5]

It was this investigative series, which highlighted the 2014 death of Brayden Cummings in Carbon County that captured Congress' attention.

By July 2016, Congress had included the Infant Plan of Safe Care Improvement Act into the 2016 Comprehensive Addiction and Recovery Act (CARA).

The CAPTA provisions in CARA provided some clarity to states, but per usual there remained insufficient direction and no funding for states to work with key partners to effectively establish the notification process as well as the development and monitoring of plans of safe care.

Last month, Congress – influenced by Senator Casey – included a $60 million increase for CAPTA within the 2018 Consolidated Appropriations (H.R. 1625) bill. This funding increase was directed to the CAPTA Child Abuse State Grant line item and was described in this way:

"The agreement provides an increase of $60,000,000 for CAPTA State Grants. Within the increase, the agreement directs States to prioritize infant plans of safe care, including compliance with the requirements in section 106(b)(2)(B)(iii) of CAPTA. The incidence of neonatal abstinence syndrome has increased as the opioid crisis has worsened, and this funding is intended to help States improve their response to infants affected by substance use disorder and their families. The agreement also directs HHS to provide the necessary technical assistance, monitoring, and oversight to assist and evaluate State's activities on plans of safe care. The agreement requests an update on those activities in the fiscal year 2020 Congressional Justification."[6]

Recognizing the $60 million is an important first step, Senator Casey then introduced his stand-alone plan of safe care legislation. The senator had suggested a competitive grant program as a means of allocating the $60 million. Ultimately, the decision (at least as outlined in the Opioid Response Act approved by the HELP Committee) affirms the $60 million investment (each year between federal fiscal year 2019 and 2023), but requires that such funding flow to states via a formula grant process.

The chart included below outlines the key provisions of Section 410 (Plans of Safe Care) approved by the HELP Committee.

Provision	**PROPOSED** **Opioid Crisis Response Act of 2018, Section 410 (Plans of Safe Care)** *(As set forth in the Manager's Amendment adopted on April 24, 2018 by the U.S. Senate HELP Committee)*[7]
Federal Funding for "Grants to States to improve and coordinate their responses to ensure the safety, permanency, and well-	**FFY 2019 through 2023:** $60 million authorized for formula grants* *note that the proposed legislation stipulates certain funding reservations:

[5] https://www.reuters.com/investigates/special-report/baby-opioids/

[6] Division H – Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act, 2018 retrieved at http://docs.house.gov/billsthisweek/20180319/DIV%20H%20LABORHHS%20SOM%20FY18%20OMNI.OCR.pdf

[7] https://www.help.senate.gov/download/amendments-offered

Provision	PROPOSED **Opioid Crisis Response Act of 2018, Section 410 (Plans of Safe Care)** *(As set forth in the Manager's Amendment adopted on April 24, 2018 by the U.S. Senate HELP Committee)*[7]
being of infants affected by substance use	• "no more than 3 percent" related to "providing technical assistance, including programs of in-depth technical assistance to States, territories, and Indian Tribes and tribal organizations in accordance with the substance-exposed infant initiative developed by the National Center on Substance Abuse and Child Welfare" **and** related to "issuing guidance on the requirements of this Act with respect to infants born with and identified as being affected by substance use or withdrawal symptoms or fetal alcohol spectrum disorder"; and • "up to 3 percent for "grants to Indian Tribes and tribal organizations"
Plan of Safe Care Grant Program	Adds a (7) related to: ''Grants to states to improve and coordinate their response to ensure the safety, permanency, and well-being of infants affected by substance use. (A) PROGRAM AUTHORIZED.—The Secretary shall make grants to States for the purpose of assisting child welfare agencies, social services agencies, substance use disorder treatment agencies, hospitals with labor and delivery units, medical staff, public health and mental health agencies, and maternal and child health agencies to facilitate collaboration in developing, updating, implementing, and monitoring plans of safe care described in section 106(b)(2)(B)(iii)."
Application for Plan of Safe Care Grant Funding	The application would include the following elements: • Specific data elements • Identification of "the challenges the State faces in developing, implementing , and monitoring plans of safe care" • Identification of the "lead agency for the grant program" and how that agency "will coordinate with relevant State entities and programs, including the child welfare agency, the substance use disorder treatment agency, hospitals with labor and delivery units, health care providers, the public health and mental health agencies, programs funded by the Substance Abuse and Mental Health Services Administration that provide substance use disorder treatment for women, the State Medicaid program, the State agency administering the block grant program under title V of the Social Security Act (42 U.S.C. 701 et seq.), the State agency administering the programs funded under Part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.), the maternal, infant, and early childhood home visiting program under section 511 of the Social Security Act (42 U.S.C. 711), the State judicial system, and other agencies, as determined by the Secretary." • Description of how the state "will monitor local development and implementation of plans of safe care." This should include how plans of safe care "address differences between substance use disorder and medically supervised substance use, including for the treatment of a substance use disorder." • Demonstration of how the state meets the federal requirements within the Public Health Services Act (42 U.S.C. 300x-27) related to Treatment services for pregnant women.

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	• Discussion of how the State "plans to utilize funding authorized under Part E of title IV of the Social Security Act (42 U.S.C. 670 et seq) to assist in carrying out any plan of safe care, including such funding authorized under section 471 (e) of such Act (as in effect on October 1, 2018) for mental health and substance abuse prevention and treatment services and in-home parent skill-based programs and funding authorized under such section 472(j) (as in effect on October 1, 2018) for children with a parent in a licensed residential family-based treatment facility for substance abuse." • Assessment of the "treatment and other services and programs available in the State, to effectively carry out any plan of safe care developed, including identification of needed treatment, and other services and programs to ensure the wellbeing of young children and their families affected by substance use disorder, such as programs carried out under part C of the Individuals with Disabilities Education Act and comprehensive early childhood development services and programs such as Head Start programs." • Description of how the state will use the grant funding and assure compliance with parts B and E of title IV of the Social Security Act. Also how the state complies with "requirements to refer a child identified as substance-exposed to early intervention services."
Data to Accompany an Application for Plan of Safe Care Grant Funding	Application would require that states describe: "The impact of substance use disorder in such State, including with respect to the substance or class of substances with the highest incidence of abuse in the previous year." The state would further have to provide data demonstrating: • "The aggregate rate of births in the State of infants affected by substance abuse or withdrawal symptoms or a fetal alcohol spectrum disorder (as determined by hospitals, insurance claims, claims submitted to the State Medicaid program, or other records), if available and to the extent practicable; and • The number of infants identified, for whom a plan of safe care was developed, and for whom a referral was made for appropriate services, as reported under section 106(d)(18)."
Uses of Plan of Safe Care Grant Funding	Funding awarded to states "may be used for the following activities": • "Improving State and local systems with respect to the development and implementation of plans of safe care" which must then include ("shall include") parent and caregiver engagement and "may include activities such as" those related to: • "Developing policies, procedures, or protocols for the administration or development of evidence-based and validated screening tools for infants who may be affected by substance use withdrawal symptoms or a fetal alcohol spectrum disorder" and for "pregnant, perinatal, and

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	postnatal women whose infants may be affected by substance use withdrawal symptoms or a fetal alcohol spectrum disorder." • "Improving assessments used to determine the needs of the infant and family." • Improvement of "ongoing case management services." • Improved "access to treatment services, which may be prior to the pregnant woman's delivery date." • Developing "policies, procedures, or protocols in consultation and coordination with health professionals, public and private health facilities, and substance use disorder treatment agencies to ensure that appropriate notification to child protective services is made in a timely manner" also then that a "plan of safe care is in place" before the infant is discharged from the birth or health care facility." • Training for health professionals and health system leaders, child welfare workers, substance use disorder treatment agencies and other related professionals "such as home visiting agency staff and law enforcement" on "relevant topics" that include: o State mandatory reporting laws "and the referral and process and requirements for notification to child protective services when child abuse or neglect reporting is not mandated." o The co-occurrence of pregnancy and substance use disorder and implications of prenatal exposure. o Clinical guidance about treating substance use disorder in pregnant and postpartum women. o Appropriate "screening and interventions for infants affected by substance use disorder, withdrawal symptoms, or a fetal alcohol spectrum disorder" o Appropriate "multigenerational strategies to address the mental health needs of the parent and child together." • "Establishing partnerships, agreements, or memoranda of understanding between the lead agency and health professionals, health facilities, child welfare professionals, juvenile and family court judges, substance use and mental disorder treatment programs, early childhood education programs and maternal and child health and early intervention professional including home visiting providers, peer-to-peer recovery programs such as parent mentoring programs and housing agencies to facilitate the implementation" of plans of safe care. Such partnerships and/or agreements "may" address: o "Developing a comprehensive, multidisciplinary assessment and intervention process for infants, pregnant women, and their families who are affected by substance use disorders, withdrawal symptoms, or a fetal alcohol spectrum disorder, that includes meaningful engagement with and takes into account the unique needs of each family and addresses differences between medically supervised substance use, including for the treatment of substance use disorder, and substance use disorder." o Working to ensure that "treatment approaches for serving infants, pregnant women, and perinatal and postnatal women whose

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	infants may be affected by substance use, withdrawal symptoms or a fetal alcohol spectrum disorder, are designed to, where appropriate, keep infants with their mothers during both inpatient and outpatient treatment." o "Increasing access to all evidence-based medication-assisted treatment approved by the Food and Drug Administration, behavioral therapy, and counseling services for the treatment of substance use disorders, as appropriate." • Developing and updating systems of technology "for improved data collection and monitoring" included related to "existing electronic medical records, to measure the outcomes achieved through the plans of safe care, including monitoring systems to meet the requirements of this Act and submission of performance measures."
Reporting Requirements	States receiving funding would have to identify (in an aggregate way): 1. The number of infants who experienced removal associated with parental substance use; 2. The number who experienced "removal and are subsequently reunified with parents, and the length of time between such removal and reunification;" 3. The number "referred to community providers without a child protection case;" 4. The number receiving "post reunification services within 1 year after a reunification occurred;" and 5. The number who experienced a return to out-of-home placement within 1 year "after reunification."

In 2017, Pennsylvania counties received 1,548 General Protective Service reports involving infants affected by prenatal drug exposure

If Congress still needed any evidence that it was the right move to direct $60 million in federal funding to assist states in implementing plans of safe care for infants affected by prenatal drug exposure, lawmakers need only dig deeper on Pennsylvania data.

Data from Pennsylvania's Child Welfare Information Solution (CWIS) Data Warehouse or hospital reports about the number of live births exposed to illegal drugs before birth or infants eligible for Medicaid and diagnosed with Neonatal Abstinence Syndrome (NAS) all prove revealing.

Data from the CWIS Data Warehouse (so child welfare administrative data) reveals that in calendar year 2017, Pennsylvania county children and youth agencies received 1,548 General Protective Service (GPS) reports involving an infant born and identified as being affected by drug withdrawal symptoms resulting from prenatal drug exposure or illegal substance abuse by the child's mother.

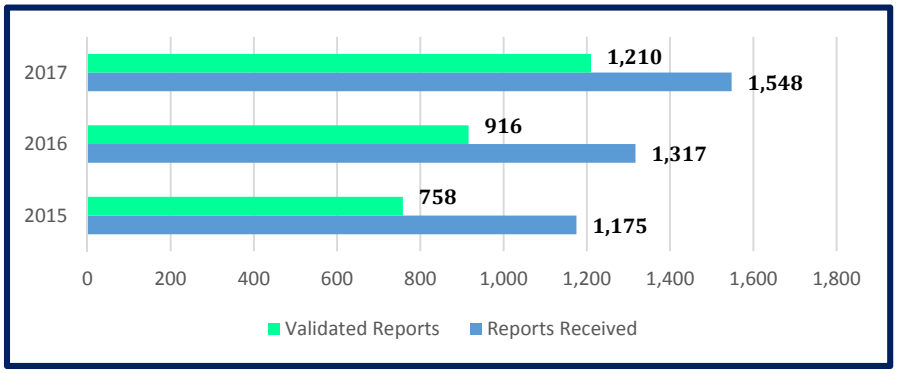
Over a three year period (2015 through 2017), more than 4,000 Pennsylvania infants were identified as affected by prenatal drug exposure triggering a health care provider to file a GPS report with a local child welfare agency (*Tables 1 and 3*).

An infant can be born affected after having been prenatally exposed to an illegal substance (e.g., heroin) or a legal substance that is prescribed and taken as directed (e.g., prescribed pain medicine) by the infant's mother.

Less understood is that an infant can develop withdrawal symptoms even when the infant's only prenatal drug exposure was to a medication prescribed (e.g., Methadone and Buprenorphine) as treatment for a pregnant woman with an opioid use or substance use disorder (OUD/SUD).

Infants can also be exposed to other legal substances like alcohol or tobacco products that can impact the infant's health and development, but not necessarily rise to the level of the infant being determined to be "affected" particularly prior to discharge from a birthing center or hospital.

Table 1: Pennsylvania counties recording, at least 11, Section 6386 GPS referrals in 2017



According to the Pennsylvania Department of Human Services (PA DHS), a GPS report "does not suggest suspected child abuse, but does suggest a need for social services or other services or assessment" and it is "not classified as child abuse in Pennsylvania."[8]

GPS reports "that are assessed by the county agency and are determined to be valid" will be retained in the statewide database for a period of five years. This information is retained solely for the purpose of informing any future child abuse investigations or GPS reports involving the child and family. GPS reports do not lead to the infant's parent(s) being included in Pennsylvania's statewide registry of persons named as perpetrators of child abuse, since GPS reports are not child abuse reports.

The Center for Children's Justice (C4CJ) requested data from the Pennsylvania Department of Human Services (PA DHS) to better understand the numbers of GPS reports counties have been receiving and the responses then being provided to infants affected by prenatal drug exposure.

PA DHS supplied aggregate, non-identifying statewide and county-level data. In order to guard against identifying any infant or his/her family, PA DHS did not supply a specific number when the county children and youth agency had received fewer than 11 infant referrals.

In 2017, more than 90 percent (n= 62) of Pennsylvania's 67 counties received, at least one, referral for and responded to an infant affected by prenatal drug exposure.

[8] Child Maltreatment 2016 published February 1, 2018, Appendix D: State Commentary, page 214 retrieved at https://www.acf.hhs.gov/cb/resource/child-maltreatment-2016.

Approximately half (n=34) of Pennsylvania counties received, at least 11, General Protective Services (GPS) referrals related to infants born affected by drug withdrawal symptoms resulting from prenatal drug or illegal substance abuse by the child's mother (*Table 2*). There remain significant limitations in accessing data that would also then aid in identifying the type of drug(s) involved in the infant's prenatal exposure.

As illustrated on Table 2, thirty-four counties accounted for 91 percent (n=1,414) of the total (n=1,548) of the GPS referrals received in 2017 related to these infants. At least 75 percent (n=1,062) of these GPS referrals were validated by a county children and youth agency. Determining the exact number and percentage of referrals that were validated is limited by the fact that some of the counties validated fewer than 11 reports.

34 counties received 11 or more of these GPS reports and 4 counties each received over 100 in 2017.

Allegheny County requested approximately $246,000 to provide care coordination for these infants and their families. Washington County requested $86,240.

28 Pennsylvania counties received at least one, but fewer than 11, such infant referrals. Five counties (Forest, Juniata, Montour, Snyder and Sullivan) were identified, by PA DHS, has having received no referrals for such infants in 2017.

Beyond review of the numbers of affected infants, also instructive is examination of counties' needs based plan and budget requests. Some Counties have begun requesting specific funding from the Commonwealth to provide care coordination for these infants and their families. For example, Allegheny County requested $246,000 for both 2017-2018 and also 2018-2019, while Washington County requested $86,240.

Table 2: Thirty-four Pennsylvania counties, recording at least 11 GPS reports, as required by Title 23, Section 6386 in 2017

County	Region	County Type	Section 6386 GPS Reports Received	Validated Section 6386 GPS Reports	Percent of Section 6386 GPS Reports Validated
Adams	Central	Rural-Mix	16	11	68.7%
Allegheny	Western	Urban	144	113	78.4%
Armstrong	Western	Rural-Mix	18	17	94.4%
Beaver	Western	Urban-Mix	24	13	54.1%
Berks	Southeast	Urban-Mix	35	24	68.5%
Blair	Central	Urban-Mix	32	31	96.8%
Bucks	Southeast	Urban	108	99	91.6%
Butler	Western	Rural-Mix	17	14	82.3%
Cambria	Central	Rural-Mix	27	26	96.2%
Carbon	Northeast	Rural-Mix	12	<11	---
Chester	Southeast	Urban	51	23	45.0%
Crawford	Western	Rural	16	14	87.5%
Cumberland	Central	Urban-Mix	22	19	86.3%
Dauphin	Central	Urban	51	44	86.2%
Delaware	Southeast	Urban	107	82	76.6%
Elk	Western	Rural	13	<11	---
Erie	Western	Urban-Mix	49	41	83.6%
Fayette	Western	Rural-Mix	50	41	82.0%
Greene	Western	Rural	20	<11	---
Lancaster	Central	Urban	28	20	71.4%
Lawrence	Western	Rural-Mix	18	<11	---
Lehigh	Northeast	Urban	44	27	61.3%

County	Region	County Type	Section 6386 GPS Reports Received	Validated Section 6386 GPS Reports	Percent of Section 6386 GPS Reports Validated
Luzerne	Northeast	Urban	18	11	61.1%
Mercer	Western	Rural-Mix	35	31	88.5%
Monroe	Northeast	Rural-Mix	13	<11	---
Montgomery	Southeast	Urban	54	47	87.0%
Northampton	Northeast	Urban	23	18	78.2%
Philadelphia	Southeast	Urban	196	165	84.1%
Schuylkill	Northeast	Rural-Mix	13	<11	---
Somerset	Central	Rural-Mix	23	13	56.5%
Venango	Western	Rural	21	19	90.4%
Washington	Western	Urban-Mix	33	25	75.7%
Westmoreland	Western	Urban-Mix	51	49	96.0%
York	Central	Urban-Mix	32	25	78.1%

Table 3: Pennsylvania counties receiving GPS reports, as required by Title 23, Section 6386 (2015-2017)

County	Region	County Type	2015 Section 6386 GPS Reports	2015 Section 6386 Validated GPS Reports	2016 Section 6386 GPS Reports	2016 Section 6386 Validated GPS Reports	2017 Section 6386 GPS Reports	2017 Section 6386 Validated Reports
Statewide			**1,175**	**64.5% (n=758)**	**1,317**	**69.5% (n=916)**	**1,548**	**78.1% (n=1210)**
Adams	Central	Rural-Mix	11	11	13	<11	16	11
Allegheny	Western	Urban	149	94	168	107	144	113
Armstrong	Western	Rural-Mix	15	<11	18	16	18	17
Beaver	Western	Urban-Mix	13	<11	15	<11	24	13
Bedford	Central	Rural-Mix	12	11	13	<11	<11	<11
Berks	Southeast	Urban-Mix	16	<11	14	<11	35	24
Blair	Central	Urban-Mix	<11	<11	17	17	32	31
Bradford	Northeast	Rural	<11	<11	0	0	<11	<11
Bucks	Southeast	Urban	44	29	72	54	108	99
Butler	Western	Rural-Mix	18	<11	22	21	17	14
Cambria	Central	Rural-Mix	16	16	27	27	27	26
Cameron	Western	Rural	0	<11	<11	<11	<11	<11
Carbon	Northeast	Rural-Mix	<11	<11	<11	<11	12	<11
Centre	Central	Urban-Mix	<11	<11	<11	<11	<11	<11
Chester	Southeast	Urban	28	12	30	8	51	23
Clarion	Western	Rural	<11	<11	<11	<11	<11	<11
Clearfield	Western	Rural	<11	<11	12	<11	<11	<11
Clinton	Central	Rural	0	0	<11	<11	<11	<11
Columbia	Central	Urban-Mix	<11	0	<11	<11	<11	<11

County	Region	County Type	2015 Section 6386 GPS Reports	2015 Section 6386 Validated GPS Reports	2016 Section 6386 GPS Reports	2016 Section 6386 Validated GPS Reports	2017 Section 6386 GPS Reports	2017 Section 6386 Validated Reports
Crawford	Western	Rural	15	<11	19	<11	16	14
Cumberland	Central	Urban-Mix	<11	<11	<11	<11	22	19
Dauphin	Central	Urban	21	11	39	29	51	44
Delaware	Southeast	Urban	49	45	92	63	107	82
Elk	Western	Rural	<11	<11	<11	<11	13	<11
Erie	Western	Urban-Mix	33	18	37	30	49	41
Fayette	Western	Rural-Mix	42	29	34	24	50	41
Forest	Western	Rural	----	---	---	---	---	---
Franklin	Central	Rural-Mix	<11	0	<11	<11	<11	<11
Fulton	Central	Rural	<11	<11	<11	<11	<11	<11
Greene	Western	Rural	15	<11	25	12	20	<11
Huntingdon	Central	Rural	<11	<11	0	0	<11	<11
Indiana	Western	Rural	<11	<11	<11	<11	<11	<11
Jefferson	Western	Rural	<11	<11	<11	<11	<11	<11
Juniata	Central	Rural	0	0	<11	<11	0	0
Lackawanna	Northeast	Urban	<11	<11	<11	<11	<11	<11
Lancaster	Central	Urban	23	<11	14	<11	28	20
Lawrence	Western	Rural-Mix	20	<11	14	<11	18	<11
Lebanon	Central	Urban-Mix	<11	0	<11	<11	<11	<11
Lehigh	Northeast	Urban	22	<11	30	12	44	27
Luzerne	Northeast	Urban	<11	<11	<11	<11	18	11
Lycoming	Central	Rural-Mix	<11	<11	<11	<11	<11	<11
McKean	Western	Rural	<11	<11	<11	<11	<11	<11
Mercer	Western	Rural-Mix	26	23	27	23	35	31
Mifflin	Central	Rural	<11	0	<11	<11	<11	<11
Monroe	Northeast	Rural-Mix	<11	<11	15	<11	13	<11
Montgomery	Southeast	Urban	44	35	48	42	54	47
Montour	Central	Rural-Mix	<11	---	0	---	0	---
Northampton	Northeast	Urban	11	<11	22	16	23	18
Northumberland	Central	Rural-Mix	<11	0	<11	<11	<11	<11
Perry	Central	Rural-Mix	<11	<11	<11	<11	<11	<11
Philadelphia	Southeast	Urban	272	203	191	146	196	165
Pike	Northeast	Rural	<11	<11	<11	<11	<11	<11
Potter	Western	Rural	0	0	<11	<11	<11	<11
Schuylkill	Northeast	Rural-Mix	<11	<11	<11	<11	13	<11
Snyder	Central	Rural	0	0	<11	<11	0	0

County	Region	County Type	2015 Section 6386 GPS Reports	2015 Section 6386 Validated GPS Reports	2016 Section 6386 GPS Reports	2016 Section 6386 Validated GPS Reports	2017 Section 6386 GPS Reports	2017 Section 6386 Validated Reports
Somerset	Central	Rural-Mix	<11	<11	<11	<11	23	13
Sullivan	Northeast	Rural	0	0	0	0	0	0
Susquehanna	Northeast	Rural-Mix	<11	<11	<11	<11	<11	<11
Tioga	Northeast	Rural	<11	<11	<11	<11	<11	<11
Union	Central	Rural	0	0	<11	<11	<11	<11
Venango	Western	Rural	<11	<11	18	15	21	19
Warren	Western	Rural	<11	0	<11	<11	<11	<11
Washington	Western	Urban-Mix	38	28	34	26	33	25
Wayne	Northeast	Rural-Mix	<11	<11	<11	<11	<11	<11
Westmoreland	Western	Urban-Mix	52	21	54	35	51	49
Wyoming	Northeast	Rural-Mix	<11	<11	<11	0	<11	<11
York	Central	Urban-Mix	20	<11	23	17	32	25

Pennsylvania county children and youth agencies also utilize their need based plan and budget document (child welfare funding request), which is submitted to PA DHS, to request funding for evidence-based or promising practices to address the needs of families with young children.

Known as the Special Grants Initiative (SGI) a county can request funding in order to advance evidence or research-informed practices. SGI funding means that the county has to put forth fewer match dollars. Approved evidence-based practices are eligible for 95 percent state reimbursement, with a 5 percent match from the county. Meanwhile, promising practices require a 10 percent county match.

A number of Pennsylvania's counties request SGI funding to underwrite the costs of evidence-based home visiting services for families with young children. Such services can serve as one (underscore one) element of a comprehensive plan of safe care created for the infant born affected by prenatal drug exposure.

The Center for Children's Justice (C4CJ) requested fiscal data from the Pennsylvania Department of Human Services (PA DHS) to understand, to what degree, county child welfare agencies sought and secured funding for evidence-based home visiting programs. C4CJ's request for financial information was limited to the following evidence-based home visiting models: Healthy Families, Nurse-Family Partnership, Nurturing Parenting Program, Parents as Teachers, SafeCare and Triple P.

Review of the PA DHS supplied data revealed that, in state fiscal year 2017-2018, twenty-four counties received approximately $5 million in SGI funding to connect families with services through these evidence-based home visiting models. (*Table 4*). PA DHS has tentatively approved SGI funding of $7.2 million for 28 counties that requested funding to support these evidence-based home visiting models in 2018-2019 (*Table 4*).

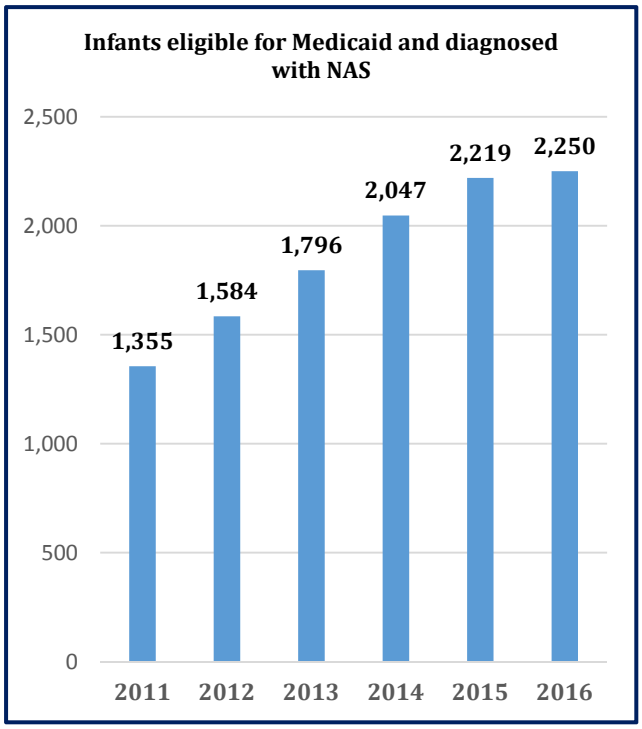
Table 4: Special Grant Funding for Evidence-Based Home Visiting Services Requested in NBB

	Healthy Families[9]	Nurse Family Partnership[10]	Nurturing Parenting Program[11]	Parents as Teachers[12]	SafeCare[13]	Triple P[14]	Total
2017-2018 - Final	$85,000	$537,182	$1,432,813	$1,801,748	$223,513	$765,244	**$5,040,500**
2018-2019 - Tentative	$85,000	$703,380	$2,723,664	$2,211,154	$194,954	$1,313,586	**$7,231,738**

There are databases, beyond the CWIS Data Warehouse, that offer additional insight into how many Pennsylvania infants are prenatally exposed to drugs.

The Commonwealth's recently unveiled Opioid Dashboard includes the number of infants born onto Medicaid in 2016 and diagnosed with Neonatal Abstinence Syndrome (NAS).

This Opioid Dashboard reveals that 2,250 infants were eligible for Medicaid and diagnosed with NAS in 2016.[15]



While not included on the Dashboard, C4CJ has previously obtained data from PA DHS for any Medicaid eligible child (born in a hospital setting) who had an NAS diagnosis on any claim during the first 364 days of life.

Another data source worth exploring is what hospitals supply to the Pennsylvania Department of Health (PA DOH) related to the number of Live Births Exposed to Illegal Drugs Before Birth.

This hospital-provided data provides another reminder of the scope of the challenge before Pennsylvania and also confirms that not every infant born in Pennsylvania having been prenatally exposed to drugs is subsequently referred to a county children and youth agency (*Tables 5 and 6*).[16]

Of course, the variation in data also invites an important discussion about to what degree the infants, who are not referred to a child welfare agency, are

[9] http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/
[10] http://www.cebc4cw.org/program/nurse-family-partnership/
[11] http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-infants-toddlers-and-preschoolers/detailed
[12] http://www.cebc4cw.org/program/parents-as-teachers/
[13] http://www.cebc4cw.org/program/safecare/
[14] http://www.cebc4cw.org/program/triple-p-level-3-discussion-group/
[15] https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/
[16] http://www.statistics.health.pa.gov/HealthStatistics/HealthFacilities/HospitalReports/Pages/HospitalReports.aspx#.VtHFecAo454

now or should be (in the future) provided access to an interdisciplinary plan of safe care.

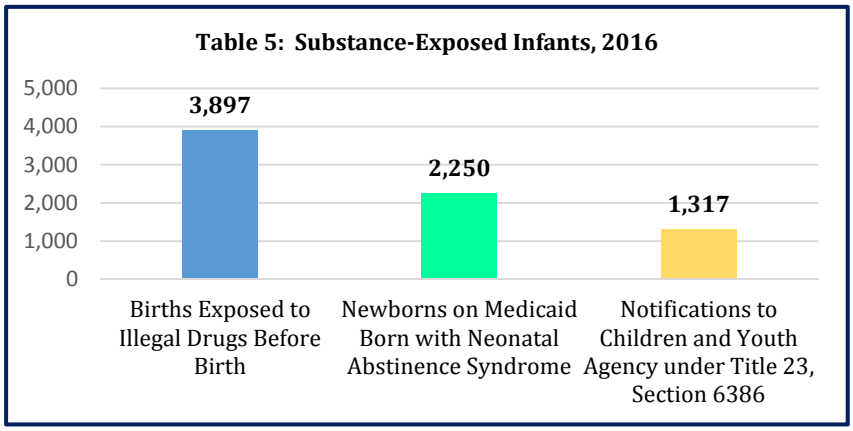


Table 6: Pennsylvania data resources related to substance-exposed infants in 2016

County	Region	County Type	Live Births Exposed to Illegal Drugs Before Birth[17]	Newborns on Medicaid Born with Neonatal Abstinence Syndrome[18]	Notifications to Children and Youth Agency under Title 23, Section 6386
Statewide			**3,897**	**2,250**	**1,317**
Adams	Central	Rural-Mix	12	19	13
Allegheny	Western	Urban	523	254	168
Armstrong	Western	Rural-Mix	8	31	18
Beaver	Western	Urban-Mix	48	33	15
Bedford	Central	Rural-Mix	8	16	13
Berks	Southeast	Urban-Mix	56	37	14
Blair	Central	Urban-Mix	33	32	17
Bradford	Northeast	Rural	0	---	0
Bucks	Southeast	Urban	83	92	72
Butler	Western	Rural-Mix	5	26	22
Cambria	Central	Rural-Mix	130	65	27
Cameron	Western	Rural	--	---	<11
Carbon	Northeast	Rural-Mix	--	11	<11
Centre	Central	Urban-Mix	6	---	<11
Chester	Southeast	Urban	52	35	30
Clarion	Western	Rural	0	---	<11
Clearfield	Western	Rural	48	22	12
Clinton	Central	Rural	0	---	<11
Columbia	Central	Urban-Mix	13	---	<11
Crawford	Western	Rural	---	18	19
Cumberland	Central	Urban-Mix	61	31	<11
Dauphin	Central	Urban	162	30	39

[17] Data published by the Pennsylvania Department of Health from the annual Hospital surveys. This data is for calendar year 2016. Retrieved on April 19, 2018 at http://www.statistics.health.pa.gov/HealthStatistics/HealthFacilities/HospitalReports/Pages/HospitalReports.aspx#.Wtk170nD8VQ.

[18] Pennsylvania Opioid Dashboard retrieved on April 19, 2018 at https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/

County	Region	County Type	Live Births Exposed to Illegal Drugs Before Birth[17]	Newborns on Medicaid Born with Neonatal Abstinence Syndrome[18]	Notifications to Children and Youth Agency under Title 23, Section 6386
Delaware	Southeast	Urban	254	113	92
Elk	Western	Rural	34	18	<11
Erie	Western	Urban-Mix	106	46	37
Fayette	Western	Rural-Mix	97	108	34
Forest	Western	Rural	---	---	---
Franklin	Central	Rural-Mix	221	38	<11
Fulton	Central	Rural	---	---	<11
Greene	Western	Rural	---	33	25
Huntingdon	Central	Rural	12	---	0
Indiana	Western	Rural	15	20	<11
Jefferson	Western	Rural	5	---	<11
Juniata	Central	Rural	---	---	<11
Lackawanna	Northeast	Urban	104	86	<11
Lancaster	Central	Urban	98	59	14
Lawrence	Western	Rural-Mix	0	30	14
Lebanon	Central	Urban-Mix	0	20	<11
Lehigh	Northeast	Urban	102	28	30
Luzerne	Northeast	Urban	150	64	<11
Lycoming	Central	Rural-Mix	13	17	<11
McKean	Western	Rural	---	---	<11
Mercer	Western	Rural-Mix	150	45	27
Mifflin	Central	Rural	25	---	<11
Monroe	Northeast	Rural-Mix	43	26	15
Montgomery	Southeast	Urban	283	81	48
Montour	Central	Rural-Mix	33	---	0
Northampton	Northeast	Urban	21	33	22
Northumberland	Central	Rural-Mix	---	11	<11
Perry	Central	Rural-Mix	---	---	<11
Philadelphia	Southeast	Urban	413	346	191
Pike	Northeast	Rural	---	---	<11
Potter	Western	Rural	14	---	<11
Schuylkill	Northeast	Rural-Mix	70	15	<11
Snyder	Central	Rural	---	---	<11
Somerset	Central	Rural-Mix	25	18	<11
Sullivan	Northeast	Rural	---	---	0
Susquehanna	Northeast	Rural-Mix	---	---	<11
Tioga	Northeast	Rural	4	---	<11
Union	Central	Rural	2	---	<11
Venango	Western	Rural	47	19	18
Warren	Western	Rural	7	---	<11
Washington	Western	Urban-Mix	74	49	34
Wayne	Northeast	Rural-Mix	14	---	<11
Westmoreland	Western	Urban-Mix	89	100	54
Wyoming	Northeast	Rural-Mix	---	---	<11
York	Central	Urban-Mix	124	75	23

Wolf Administration and the Pennsylvania Senate expeditiously seek to amend the Child Protective Services Law related to infants affected by prenatal drug exposure

Pennsylvania has multiple motivations to act, with urgency, to alter the Child Protective Services Law (CPSL) specific to the Commonwealth's approach to infants affected by prenatal drug exposure.

First, Congress has been frustrated by the fact that states have regularly received a share of (very modest) federal child abuse-related funding even when states have been out-of-compliance with federal law related to health care providers notifying child welfare agencies that an infant has been born affected by prenatal drug exposure. Without this notification process happening, the second element of federal law requiring that such infants be provided with an interdisciplinary plan of safe care rarely materializes.

Second, the Supreme Court of Pennsylvania has agreed to consider arguments about whether a woman using drugs (illegally) during pregnancy constitutes child abuse. A Clinton County mother, supported by the Women's Law Project, filed a Petition for Allowance of Appeal from the final Order of the Superior Court of Pennsylvania.[19] In that decision the Superior Court said that drug use during pregnancy may constitute child abuse and remanded the specific case back to the trial court. In the meantime, the Pennsylvania Supreme Court granted the Petition and is expecting that the parties will file briefs by May 3rd.

Congress' increased oversight of how states respond to infants affected by prenatal drug exposure and the case before the Supreme Court of Pennsylvania influenced the action taken by the Pennsylvania Senate Aging and Youth Committee on Tuesday.

In an off-the-floor action, the Pennsylvania Senate Aging and Youth Committee approved an amendment (#A06910) to House Bill 1232.[20]

House bill 1232 was introduced, last April, by Representative Tom Murt (R-Montgomery) to amend the CPSL in order to require that public and private schools display a poster about how to report suspected child abuse as well as provide information about the Pennsylvania Department of Human Services' website "that provides information and resources related to child protection."[21]

Murt's legislation, which was amended to also require that hospitals display such a poster, was approved unanimously in the Pennsylvania House of Representatives last July.[22] Since that time it has awaited action in the PA Senate Aging and Youth Committee.

Tuesday the Committed acted approving an amendment that both addresses the underlying concept in Murt's original bill and tackles a number of other child protection related issues.

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[19] http://www.womenslawproject.org/wp-content/uploads/2018/02/LB-petition-for-allowance-of-appeal.pdf

[20] http://www.legis.state.pa.us/CFDOCS/Legis/HA/Public/HaCheck.cfm?txtType=PDF&sYear=2017&sInd=0&body=H&type=B&bn=1232&pn=2194&aYear=2017&an=06910

[21] http://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2017&sInd=0&body=H&type=B&bn=1232

[22] http://www.legis.state.pa.us/CFDOCS/Legis/RC/Public/rc_view_byBill.cfm?sess_yr=2017&sess_ind=0&rc_body=H&bill_body=H&bill_type=B&bill_nbr=1232&bhDate=07/08/2017

The Committee's amendment alters the content of the required poster to contain the Statewide toll-free telephone number for reporting "suspected child abuse or neglect and any Statewide toll-free telephone number relating to school safety." This poster which should be displayed in a "high traffic area" would be required of public and private schools as well as hospitals.

Also tackled in the amended Murt bill is an effort to reverse course on the General Assembly's 2015 decision to change the CPSL removing a requirement that health care providers notify a child welfare agency when certain infants were born withdrawing from drugs.[23]

Act 15 of 2015, which was legislation unrelated to substance-exposed infants, effectively put Pennsylvania out-of-compliance with the federal Child Abuse Prevention and Treatment Act (CAPTA) risking a portion (of very modest) federal child abuse-related funding.

Since 2003, Congress has linked a state's eligibility for a share of CAPTA state grant funding to a state establishing, by statute or administrative policy, a requirement that a health care provider notify the child welfare agency when an infant is born affected by prenatal drug exposure. This notification was envisioned, within CAPTA, as the catalyst to the development and monitoring of a plan of safe care for the infant upon discharge from the birthing center or hospital.

This 2003 federal law underscored that the report to the child welfare agency was not to be interpreted as Congress establishing a federal definition of child abuse or neglect. Congress also stipulated that this CAPTA provision was not to be seen as providing cause or leverage to prosecute the mother "for any illegal action."

In 2010, Congress again amended CAPTA so that states would amend their statute or policy to further require health care providers notify child welfare agencies when an infant is born affected by a Fetal Alcohol Spectrum Disorders (FASD).

Current Pennsylvania statute (Title 23, Section 6386), influenced by the federal Child Abuse Prevention and Treatment Act (CAPTA), requires that health care providers "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.
(3) A Fetal Alcohol Spectrum Disorder.

Pennsylvania's current CPSL Section 6386 differs from federal law in two ways.

First, CAPTA (since July 2016) removed the word illegal before substance abuse.

Second, CAPTA requires notification to child welfare and the development of a plan of safe care for an infant affected by withdrawal symptoms. Federal law does not include a caveat or carve out waiving the

[23] Act 15 of 2015 retrieved at http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2015&sessInd=0&smthLwInd=0&act=15.

notification requirement or development of a plan of safe care if the infant's withdrawal is, as a result of exposure to a drug(s) the mother took, as prescribed.

Unlike federal law, Pennsylvania statute (since July 2015) does waive the mandatory notification requirement and development of a plan of safe care when an infant is born affected by withdrawal symptoms related to a drug(s) the infant's mother consumed, during pregnancy, while "under the care of a prescribing medical professional" and "in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional."[24]

This 2015 CPSL amendment placed in statute policy guidance issued by PA DHS in 2008. This 2008 bulletin identified situations where the health care provider was not under any legal obligation to notify the child welfare agency.[25] At that time, PA DHS stipulated there was no duty to notify the child welfare agency when "infants are born affected by abuse of legally prescribed medications, including but not limited to Vicodin and Oxycontin, these situations are not considered a mandated report." The guidance also said notification to the child welfare agency is "not required" when the infant's mother "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." This 2008 bulletin underscored that referrals of infants (under Section 6385) "are to be considered general protective services reports."

The 2008 bulletin and 2015 state statutory change were part of a well-intentioned effort to avoid being punitive, which is often the case with child welfare, in approaching a pregnant or postpartum woman who gave birth to an infant affected by drugs the mother took, as prescribed, for pain or as part of her treatment for an OUD/SUD.

For those infants that are prenatally exposed to drugs and determined by a health care provider to be "affected by" that exposure requiring notice to the child welfare agency, a GPS report is filed. In turn, Section 6386 of Pennsylvania's CPSL outlines a required response of the county children and youth agency.

Current - Title 23, Section 6386	**PROPOSED - Title 23, Section 6386** *(Based on amendment to House Bill 1232 adopted by the Pennsylvania Senate Aging and Youth Committee on April 24, 2018)*[26]
§ 6386. Mandatory reporting of children under one year of age. (a) When report is 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:	§ 6386. Mandatory notification for children under one year of age. (a) When notification is to be made. – A health care provider shall immediately give notice or cause notice to be given to the department 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:

[24] Title 23, § 6386. Mandatory reporting of children under one year of age.

[25] Implementation of New Reporting Requirements As Required by Act 146 of 2006 and Act 179 of 2006, Bulletin number 3490-08-04 issued October 2008 (effective date of May 2007).

[26] http://www.legis.state.pa.us/cfdocs/legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2017&sessInd=0&billBody=H&billTyp=B&billNbr=1232&pn=3432

Current - Title 23, Section 6386	PROPOSED - Title 23, Section 6386 *(Based on amendment to House Bill 1232 adopted by the Pennsylvania Senate Aging and Youth Committee on April 24, 2018)*[26]
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: i. under the care of a prescribing medical professional; and ii. 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. (b) Safety or risk assessment. – 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. (c) County agency duties. – Upon receipt of a report under this section, the county agency for the county where the child resides 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) Physically see the child within 48 hours of receipt of the report. (3) Contact the parents of the child within 24 hours of receipt of the report. (4) Provide or arrange reasonable services to ensure the child is provided with proper parental care, control and supervision.	1) Substance use or withdrawal symptoms resulting from prenatal drug exposure; or 2) a Fetal Alcohol Spectrum Disorder. (b.1) Plan of safe care. – the department, in collaboration with the Department of Health and the Department of Drug and Alcohol Programs, shall develop written protocols for implementation of a plan of safe care that include: (1) Ensuring the safety and well-being of the child following release from the care of health care providers. (2) Addressing the health and substance use disorder treatment needs of: (i) the child; (ii) the child's mother, father and any caregivers; and (iii) other children in the home. (3) Identifying the lead entity responsible for development of a plan of safe care for the child. (4) Requiring the lead entity to convene a multidisciplinary team which may include a representative from the following agencies: (i) public health; (ii) maternal and child health; (iii) home visitation programs; (iv) substance use disorder prevention and treatment providers; (v) mental health providers; (vi) public and private children and youth agencies; (vii) early intervention and developmental services; (viii) courts; (ix) local education agencies; (x) managed care organizations and private insurers; (xi) hospitals and medical providers. (5) Collecting data to meet Federal and State reporting requirements. (d) Notification not deemed child abuse. – Notification to the department of infants born affected by or exhibiting withdrawal from substance use or Fetal Alcohol Spectrum Disorder shall not be deemed child abuse.

Tuesday's amendment of House Bill 1232 would set forth a much different approach:

- Reframing Section 6386 from one of "mandatory reporting" to "mandatory notification";
- Requiring that the health care provider "shall immediately" act but the giving of "notice or cause notice to be given" is filed with the Pennsylvania Department of Human Services instead of a local children and youth agency;
- More closely aligns with federal law in terms of the infants that trigger notice from the health care provider to child welfare (so in PA that would be those infants "born an identified as affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder");
- Removes the statutory requirement that a county children and youth agency undertake a safety or risk assessment as well as respond to the infant and family in a specific timeframe;
- Requires that PA DHS along with the Departments of Health and Drug and Alcohol Programs "shall develop written protocols for implementation of a plan of safe care" and what should be included in such plans. These protocols will be essential to sorting through how communities triage and provide services to infants and their families, including in determining the role (limited or extensive) of the child welfare agency.

Legislation advancing to retain child welfare records for extended period of time

Tuesday when the Pennsylvania Senate Aging and Youth Committee amended Representative Tom Murt's legislation (House Bill 1232) the Committee opted to incorporate legislation sponsored by Senators John Sabatina (D-Philadelphia) and Randy Vulakovich (R-Allegheny).

The senators have joined together to revise expunction requirements for general protective service (GPS) reports.[27]

Senate Bill 938 was introduced earlier this year to amend Title 23 § 6337 (Disposition and expunction of unfounded reports and general protective services reports) to require that PA DHS:

(i) Retain for 10 years (versus the current 5 years) general protective service (GPS) reports that are "determined to be valid, but are not accepted for services." PA DHS would have to expunge the information from the statewide database within 120 days "after the 10-year period from when the report was received" or after the child who was the subject of the report reaches the age of 23.

(ii) Extend to 10 years (versus the existing 5 years) the retention period for GPS reports that are assessed by the county agency and "accepted for services." PA DHS would have to expunge these reports from the statewide database within 120 days after 10 years have elapsed from the date the case was closed or after the child who was the subject of the report reaches the age of 23.

[27] http://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2017&sind=0&body=S&type=B&bn=938

The legislation also proposes to give Pennsylvania's 67 county child welfare agencies discretion to "maintain information regarding protective services reports that have been expunged in the statewide database for access by the county agency to assist in future risk and safety assessments and research."

The CPSL defines "protective services" as: "Those services and activities provided by the department and each county agency for children who are abused or are alleged to be in need of protection under this chapter."

Below is a chart of the specific expunction provisions currently in place within PA's CPSL.

Type of report/referral	Current Retention Period	Current Expunction Requirement
Founded or indicated report – victim data	Until the child victim reaches the age of 23	The expunction "shall be mandated and guaranteed by the department."
Founded or indicated report – perpetrator data	Retained indefinitely "only if the individual's Social Security number or date of birth is known to the department."	Section 6338.1 does require an expunction process for certain youthful perpetrators of indicated reports of child abuse. If a youth was placed in the database as a named perpetrator of an indicated report before the perpetrator reached their 18th birthday and outside certain specific exceptions, this youthful perpetrator is to have their named expunged from the database. Expunction is to happen then the youthful perpetrator reaches the age of 21 or "when five years have elapsed" since they were placed in the database. Specific requirements, including certain perpetrators who are not eligible for expunction is outlined in Section 6338.1(a) through (c).
Child Abuse Report – unfounded after investigation	1 year from date of report	As soon as possible, but no later than 120 days after the expiration of the 1 year retention period.
Child Abuse Report – no determination made by the county agency within 60 days of initial report	1 year from date of report	No later than 120 days following the expiration of the 1 year retention period. Note that the statewide database can retain information if the department is notified that "court action or an arrest has been initiated," which would then delay expunction pending these legal proceedings.
Child Abuse Report – unfounded and family accepted for services	1 year from the date the family's case was closed by the agency	Report expunged as soon as possible but no later than 120 days after the 1 year retention period.

Type of report/referral	Current Retention Period	Current Expunction Requirement
General Protective Services (GPS) – valid report + child/family not accepted for services	5 years from the date of the report	As soon as possible, as but no later than 120 days after the five-year retention period has expired.
General Protective Services (GPS) – valid report + child/family accepted for services	5 years from the date the GPS case is closed.	As soon as possible, as but no later than 120 days after five-years have elapsed since the case was closed.
General Protective Services (GPS)– invalid reports	1 year from date of GPS report	As soon as possible but no later than 120 days after the expiration of the 1 year retention period.

Allegheny County's predictive analytics initiative touted by U.S. Senator (from Indiana)

One amendment that didn't get traction as the U.S. Senate Health, Education, Labor and Pensions (HELP Committee considered the comprehensive Opioid Crisis Response Act was prepared by United States Senator Todd Young (R-IN).

The Indiana Republican turned attention to how one "tragedy" of the opioid crisis is "the number of child welfare cases" and how agencies are just "flooded with cases."

The senator cited an increase (of 47 percent) of victims of child abuse and neglect in his home state (when compared to 2011). He underscored that 34 children died from child abuse and that, as a father of four, he wants to turn attention to what can be done "to prevent our children from dying."

He told his Senate colleagues that one "promising idea" is the "use of existing administrative data to help our child welfare in targeting much needed services to those children most at risk."

Young cited that some state and local governments "have just begun to test predictive analytics as a tool in helping to identify the children most at risk for maltreatment" specifically citing the work in Allegheny County, Pennsylvania.

The senator noted that Allegheny County had "developed an algorithm in an open and transparent way to help child protective agencies to make better initial screening and service decisions for children who have been named in reports of alleged abuse or neglect."

He termed the results, thus far, as "promising" and among the inspirations to his amendment that "would build off of this work." He hoped to create a "pilot program to vigorously test if predictive analytics has the potential to accurately predict which children are most at risk of further abuse or neglect, which also effectively targeting services to the highest risk families."

The amendment (as drafted) would have amended the Child Abuse Prevention and Treatment Act (CAPTA) related to the awarding of funding for "time-limited, demonstration projects" related to risk and safety assessments. It would have created grants for "predictive analytics pilot program."

Up to 5 eligible entities would have been tasked with developing "predictive analytics programs that provide for the development of research-based strategies for risk and safety assessments related to child abuse and neglect, for the purpose of helping children and families who come to the attention of the child welfare system.'

Senator Young had been in discussions with Democrats to try and advance a bipartisan (and well supported) amendment, but he noted that he was "regretfully" unable to secure agreement given some expressed concerns about whether the effort appropriately "ensured civil and privacy rights were protected."

He signaled that he isn't giving up.

"It is clear our children deserve better and they deserve fresh approaches. We should be testing different approaches to try and protect our children. I look forward to continuing our bipartisan work and working with child welfare and civil rights communities on a path forward."