Public Hearing on Opioid Epidemic Impact on Infants and Children

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pennsylvania
DEPARTMENT OF HUMAN SERVICES

Good morning, Chairwoman Watson, Chairman Conklin, committee members and staff. I am Cathy Utz and I serve as the Deputy Secretary for the Office of Children, Youth and Families (OCYF) in the Department of Human Services (DHS). On behalf of Secretary Ted Dallas, I would like to thank you for the opportunity to testify today regarding the impact parental substance use has on children and families served by the child welfare system.

Historically, families served through child welfare agencies, both nationally and in Pennsylvania, have underlying substance use disorder (SUD) as one of the reasons for involvement. Recently, this trend continues to grow at an alarming rate.

Based on data from the period 2002 to 2007, the National Survey on Drug Use and Health (NSDUH) reported that 8.3 million children under 18 years of age lived with at least one substance-dependent or substance-abusing parent, now known as SUD.

Children who live with a parent or caregiver with a SUD are at increased risk for maltreatment and entering the child welfare system. A 2014 report issued by the Child Welfare Information Gateway indicates:

- The National Survey of Child and Adolescent Well-Being (NSCAW) estimates that 61 percent of infants and 41 percent of older children in out-of-home care are from families with active alcohol or drug abuse (Wulczyn, Ernst, & Fisher, 2011).
- NSCAW further found that the need for substance abuse services among in-home caregivers receiving child welfare services was substantially higher than that of adults nationwide (29 percent as compared with 20 percent, respectively, for parents ages 18 to 25, and 29 percent versus 7 percent for parents over age 26) (Wilson, Dolan, Smith, Casanueva, & Ringeisen, 2012).

- For almost 31 percent of all children placed in foster care in the United States in 2012, parental alcohol or drug use was the documented reason for removal and in several States that percentage surpassed 60 percent (National Data Archive on Child Abuse and Neglect, 2012).

According to the United States Department of Health and Human Services (HHS), maltreated children of substance abusing parents are more likely to have poorer physical, intellectual, social and emotional outcomes, and are at greater risk of developing a SUD. In addition, abused or neglected children from substance abusing families are more likely to be placed in foster care, and are more likely to remain there longer than maltreated children from non-substance abusing families (HHS, 1999).

Pennsylvania data and information suggests similar trends. Parental substance use, particularly drug use, is identified as the number one reason children enter out-of- home care in our commonwealth. As of March 31, 2016, placement data provided by county children and youth agencies, approximately 16,000 children were in out-of-home care. Of those children, nearly 55 percent were removed from their homes as a result of parental substance use. At this point, our data does not distinguish the specific drug used by the parent, but we intend to capture this data in the future on a statewide level. Counties often capture this data locally and use it to guide local planning and service delivery. Neglect is the second leading reason children enter out-of-home care, which is noted as a reason for removal for 25 percent of children. Often, the two go hand-in-hand.

Further analysis of data specific to children entering out-of-home care as a result of parental drug use suggests that 32 percent of those children had no other removal reason noted, meaning the

children were removed solely because of parental drug use. Twenty-four percent of children entered out-of-home care as a result of parental drug use and neglect, and 14 percent entered as a result of inadequate housing as the co-occurring reason for removal. As you can see, there can be more than one reason selected as a reason for removal from their home.

Children who are removed from their homes as a result of parental substance use tend to be younger than the overall population of children entering care. Fifty-nine percent of children entering out-of-home care as a result of parental drug use were under the age of 10 compared to 52 percent of the total population of children entering care. Forty-one percent were under the age of six, while 15 percent were under the age of two. The greatest variance is seen between the ages of two and five, where 26 percent of children enter as a result of parental drug use compared to 22 percent of all children entering care.

When looking at the length of time children remain in out-of-home care, there is little difference between the overall foster care population and children entering as a result of parental substance use. Children removed from their homes as a result of parental drug use are more likely to be placed in a family-like setting, including a pre-adoptive or foster family home. The data provided by the county children and youth agencies suggests that 82 percent of children removed from their homes as a result of parental drug abuse are in family-like settings, and of those children placed into a family-like setting, 47 percent are placed in relative foster homes. Seventy-seven percent of the overall foster care population is placed in a family-like setting, with 42 percent of those in a family-like setting residing in the home of a relative. When placement is warranted, county children and youth staff work tirelessly to locate family members who are able and willing to provide care to the child.

Additionally, data suggests that children entering out-of-home care as a result of parental substance use are more likely to have stability in their placement setting. Of the children removed for parental drug use, 45 percent remained in the same home throughout their time in placement compared to 41 percent for the overall population. Placement stability is essential to successful outcomes for children. Maintaining positive family connections is essential to ensuring the overall well-being needs of children. Ensuring that children have stability in their educational setting is critical for their academic success.

When looking at outcomes from the foster care system, 58 percent of all children in care return home compared to 55 percent who were removed for parental substance use. Children removed due to parental substance use are adopted at a slightly higher rate than their peers, 17 percent and 16 percent respectively.

Unfortunately, child fatalities and near fatalities have been caused by the use of substances. These devastating cases are closely reviewed to understand how they could have been prevented, and what systems, services, communities, and families can do to protect children impacted by addiction. Additionally, a team was convened approximately one year ago to analyze the data collected for all fatalities and near fatalities where abuse was suspected.

The Statewide Child Fatality and Near Fatality Trend Analysis Team is working to expand and enhance our current data collection and analysis efforts, and to use the findings and recommendations to inform policy changes at both the state and county levels, while also promoting and supporting the implementation of effective prevention efforts in Pennsylvania. The mission of the team is to collaborate with multidisciplinary partners for the analysis of trends related to child abuse fatalities and near fatalities in Pennsylvania, and to implement

research-informed recommendations. The team's membership consists of multidisciplinary members who are broadly representative of the commonwealth and have expertise in child abuse prevention and treatment. This membership mirrors the disciplines represented on the county child fatality and near fatality review teams required by Act 33 of 2008.

The Statewide Child Fatality and Near Fatality Trend Analysis Team studies multiple subsets of cases to better understand factors contributing to child fatalities and near fatalities and why they occurred. One of those subsets is incidents that occurred because of, or were impacted by, substance use. In 2015, substance use directly related to seven substantiated cases of child fatality.

County children and youth agencies have served children and families impacted by SUD for decades, but now more than ever there is a need for a coordinated approach to service delivery. County children and youth agency staff cannot serve this population alone. Instead, cross-system case specific teams are critical to child and family success. Similarly, DHS continues to work with stakeholders at a systemic level to identify service needs and gaps to better aid in this fight.

A coordinated approach is needed particular to ensuring the safety and appropriate services to infants born with and identified as being affected by illegal substance use or withdrawal symptoms resulting from prenatal drug exposure, or fetal alcohol spectrum disorder, and their families. DHS will work with stakeholders in and outside state government to develop a comprehensive plan to ensure plans of safe care are developed for identified infants, and the needs of the infants and caregivers are addressed. Following this work, policy guidance will be issued to all affected entities to ensure effective partnership and collaboration.

We know that the opioid epidemic does not discriminate and affects Pennsylvanians from all walks of life. Rather than just treating addiction, we recognize that treating the entire person through a team-based approach is critical in this fight. Our goal is to integrate behavioral health and primary care and, when appropriate, evidence-based medication assisted treatment (MAT). By doing so, treatment will address not only an individual's SUD, but also the underlying physical and behavioral health issues that are the root of addiction. The work will begin through implementation of Centers for Excellence (COEs) that will serve as the central, efficient hub around which treatment revolves. These centers will have navigators to assist people with opioid-related substance use disorders through the medical system, and ensure they receive behavioral and physical health care, as well as any evidence-based MAT as needed.

In closing, on behalf of DHS, I would like to thank you for your dedication to the children and families of Pennsylvania and for allowing us this opportunity to share our thoughts today.

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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.

FAQs: Reporting and Responding to the Substance-Exposed Infant

What is CAPTA?

CAPTA is the acronym for the federal Child Abuse Prevention and Treatment Act (CAPTA). This federal law was first enacted in 1974 and has been authorized by Congress numerous times. CAPTA was last reauthorized in 2010.[1] CAPTA authorizes funding to states to improve their child protection services and systems.

States must be in compliance with CAPTA to receive a state formula grant, which is less than $900,000 for Pennsylvania. Compliance with CAPTA qualifies a state for federal Children's Justice Act (CJA) funding. Pennsylvania receives approximately $580,000 in CJA funding. CAPTA and CJA funding have been used in Pennsylvania to support children's advocacy centers and to train mandatory reporters of suspected child abuse and neglect.

In 2003, Congress reauthorized CAPTA through the Keeping Children and Families Safe Act of 2003 (PL No: 108-36).[2] This 2003 law included language championed by retired Pennsylvania Congressman James Greenwood "to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure." Congress expected the response to these infants, in the states, to be two-fold:

1. A report is made by a health care provider to the child protection agency; and
2. A plan of safe care for the infant was to be developed.

The 2003 law, however, underscored that the report to the child protection agency should not be interpreted to be the classic child abuse or neglect report. Also, the CAPTA provision was not to be seen as cause to prosecute the mother "for any illegal action."

The provisions of CAPTA related to substance-exposed infants was amended in 2010 to include Fetal Alcohol Spectrum Disorder (FASD).

Congress is expected to take up a full CAPTA reauthorization next year. In the meantime, Congress did amend CAPTA, again related to substance-exposed infants, as part of the enacted Comprehensive Addiction and Recovery Act (CARA).[3]

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[1] P.L. 111-320 retrieved at https://www.gpo.gov/fdsys/pkg/PLAW-111publ320/html/PLAW-111publ320.htm
[2] Public Law No: 108-36 retrieved at https://www.gpo.gov/fdsys/pkg/PLAW-108publ36/content-detail.html
[3] Public Law No: 114-198 retrieved at https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf

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

CAPTA and Pennsylvania's Child Protective Services Law (CPSL) impact the specific requirements.

PA's CPSL requires that certain substance-exposed infants (up to age one) be referred, by health care providers, to a county children and youth agency when the health care provider has been involved in the delivery or care of the infant.

In July 2015, the Pennsylvania General Assembly amended the CPSL placing into statute 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 House Bill 1276 (Act 15 of 2015), waived the reporting provision in certain circumstances and, as a consequence, also then impacted whether a plan of safe care was developed for the infant.

This 2015 amendment carried forward the intent from the 2007 Bulletin that 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."

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

Before July 2015	After July 2015
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. 3. A Fetal Alcohol Spectrum Disorder.	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:** 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.

The 2015 change occurred 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.[4]

Brayden died after 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 just a few short weeks 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

[4] 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.

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.

The victim child's mother was herself active with the children and youth agency in 2009 and 2010, in part, related to her "drug use and defiant behavior."

The Carbon County fatality review report put forth by the children and youth agency notes that the infant was "born full term" and remained in the hospital "for approximately four weeks following birth due to being on methadone." The mother was visited by her probation officer once the infant was released to the parents' care, but the officer "did not actually see the child or space where the child was kept."

The county fatality review team 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 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 continues, "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 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 fatality report[5] 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 existing bulletin (now state statute) relieving 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 born in similar circumstances could still be implemented.

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

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 some 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.

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 even as the law is clear that health care providers are to notify the child welfare agency about the infant.

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.[6]

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." [7]

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

[7] 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

The ambiguity in this response demonstrates a challenge, but also an opportunity since it appears there is important 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."

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

No, federal law has consistently required reporting by health care providers to the child protection agency under one of three circumstances when the infants is "affected by":

1. illegal substance abuse; **or**
2. withdrawal symptoms resulting from prenatal drug exposure, **or**
3. a Fetal Alcohol Spectrum Disorder (FASD)

Still states often interpreted the "illegal" in #1 as affecting #2 specific to the baby born physically dependent on a drug. This led many states, including Pennsylvania, to enact a state law removing the reporting requirement for certain infants and to also then forgo the development of a plan of safe care.

Congress acted this summer with the hope of providing greater clarity in federal law.

This summer President Obama signed the Comprehensive Addiction and Recovery Act (S.524). CARA included legislative language advanced by United States Senator Bob Casey and PA Congressman Lou Barletta.

CARA amended CAPTA (see below with the text in brackets and highlighted being deleted and text that is capitalized becoming new language inside of CAPTA):

(ii) 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—

(I) establish a definition under Federal law of what constitutes child abuse or neglect; or

(II) 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 TO ENSURE THE SAFETY AND WELL-BEING OF SUCH INFANT FOLLOWING RELEASE FROM THE CARE OF HEALTH CARE PROVIDERS, INCLUDING THROUGH

(I) ADDRESSING THE HEALTH AND SUBSTANCE USE DISORDER TREATMENT NEEDS OF THE INFANT AND AFFECTED FAMILY OR CAREGIVER; AND

(II) THE DEVELOPMENT AND IMPLEMENTATION BY THE STATE OF MONITORING SYSTEMS REGARDING THE IMPLEMENTATION OF SUCH PLANS TO DETERMINE WHETHER AND IN WHAT MANNER LOCAL ENTITIES ARE PROVIDING, IN ACCORDANCE WITH STATE REQUIREMENTS, REFERRALS TO AND DELIVERY OF APPROPRIATE SERVICES FOR THE INFANT AND AFFECTED FAMILY OR CAREGIVER.

Also, S. 524 directs the Department of Health and Human Services (HHS) to set forth some "best practices" related to Plans of Safe Care and to expand the data collected and reported to HHS to include:

1. The number of infants identified "as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder;"
2. The number of infants "for whom a plan of safe care was developed;" and
3. The number of infants "for whom a referral was made for appropriate services, including services for the affected family or caregiver."

Before and after this latest CAPTA revision, states faced a challenge in understanding and defining the scope of infants that health care providers should report to child protection and which infants, irrespective of the report to child protection, should receive a plan of safe care.

Complicating the next steps is the absence of any clear definition of what is meant by and included in a plan of safe care let alone what entity initiates and monitors it.

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Pennsylvania's "Drug Epidemic" and the Impact on Children

Introduction

In December 2015, Reuters partnered with NBC News to release a year-long investigative report – Helpless and Hooked: the most vulnerable victims of America's opioid epidemic.[1]

Six-week-old Brayden Cummings died in Carbon County, Pennsylvania and was featured in the Reuters' investigation. His mother, who was just 20 years old and well known to many publicly-funded systems (e.g., child welfare, courts, probation, health care, drug treatment), was sentenced to incarceration for causing the 2014 sleep-related death of her only child.

Outside of the Reuters investigation, the toll the drug crisis has and is inflicting on infants and children living in Pennsylvania has been largely unmeasured and off-the-radar of policymakers and the public.

In addition to child deaths, many young Pennsylvania children are growing up in homes where a parent is striving to battle and recover from the chronic, often relapsing, health condition of addiction. Sometimes these parents are successful, but too often the battle is complicated by inadequate access to clinically appropriate treatment and related essential supports (e.g., housing, evidence-based home visiting, recovery services). And then there is the constant tension about how best to balance ensuring the safety and well-being of the child with the rights of parents.

This backgrounder attempts to provide some insight into the effect on children in Pennsylvania:

- Infants exposed prenatally to drugs and those infants then diagnosed with Neonatal Abstinence Syndrome (NAS);
- Young children, who may or may not have been exposed to drugs prenatally, removed from home and placed in foster care; and
- Child fatalities and near-fatalities where parental substance use was apparently a factor in the lethal or near-lethal event.

Substance-exposed infants: An infant can be exposed prenatally to illegal substances (e.g., heroin) and legal substances that are prescribed and taken as directed (e.g., prescribed pain medicine), including substances that are part of medication-assisted treatment for the pregnant woman with a substance use disorder (e.g., Methadone and Buprenorphine). Infants are also exposed to other legal substances like alcohol or tobacco products that can impact health and development.

[1] http://www.reuters.com/investigates/special-report/baby-opioids/

NAS Signs and Symptoms

- Body shakes (tremors), seizures (convulsions), overactive reflexes (twitching) and tight muscle tone
- Fussiness, excessive crying or having a high-pitched cry
- Poor feeding, poor sucking or slow weight gain
- Breathing really fast
- Fever, sweating or blotchy skin
- Trouble sleeping and lots of yawning
- Diarrhea or throwing up
- Stuffy nose or sneezing

http://www.marchofdimes.org/complications/neo

Neonatal Abstinence Syndrome (NAS) "is a postnatal drug withdrawal syndrome that occurs primarily among opioid-exposed infants shortly after birth."[2] Opioid receptors are largely situated within the central nervous system (CNS) as well as the gastrointestinal tract and "the predominant signs and symptoms of pure opioid withdrawal reflect CNS irritability, autonomic over reactivity, and gastrointestinal tract dysfunction."[3]

According to Stanford Children's Health the type and severity of symptoms an infant experiences varies "depending on the type of substance used, the last time it was used, and whether the baby is full-term or premature. Symptoms of withdrawal may begin as early as 24 to 48 hours after birth, or as late as five to 10 days."[4] Among the "most common symptoms" of NAS: "tremors (trembling), irritability (excessive crying), sleep problems, high-pitched crying, tight muscle tone, hyperactive reflexes, seizures, yawning, stuffy nose, and sneezing, poor feeding and suck, vomiting, diarrhea, dehydration, sweating, and fever or unstable temperature."[5]

The August 12, 2016 edition of the Morbidity and Mortality Weekly Report (MMWR) published by the Centers for Disease Control and Prevention (CDC) included an article (*Incidence of Neonatal Abstinence Syndrome – 28 States, 1999 -2013*) revealing that "among 28 states with publicly available data....the overall NAS incidence increased 300%, from 1.5 per 1,000 hospital births in 1999, to 6.0 per 1,000 hospital births in 2013."[6] The article also noted limited research "on long-term developmental outcomes related to opioid exposure during pregnancy and NAS."[7]

Assessing the number of infants exposed to opioids, including those legally prescribed as part of medication-assisted treatment, and diagnosed with NAS in Pennsylvania is difficult to ascertain.

↑82%
2010 = 1,080
2014 = 1,970
Babies born onto Medicaid in PA diagnosed with NAS

As a result of a Right to Know (RTK) request filed in September 2015, C4CJ learned that more than 7,500 infants were born onto Medicaid and diagnosed with NAS in Pennsylvania between 2010 and 2014 (*Table 1*).[8] Babies diagnosed with NAS were born in every county in Pennsylvania (*Table 2*).

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[2] 1.Hudak ML, Tan RC; Committee on Drugs; Committee on Fetus and Newborn; American Academy of Pediatrics. Neonatal drug withdrawal. Pediatrics 2012;129:e540–60. Retrieved at http://pediatrics.aappublications.org/content/129/2/e540

[3] Ibid.

[4] http://www.stanfordchildrens.org/en/topic/default?id=neonatal-abstinence-syndrome-90-P02387

[5] Ibid.

[6] Ko JY, Patrick SW, Tong VT, Patel R, Lind JN, Barfield WD. Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. MMWR Morb Mortal Wkly Rep 2016;65:799–802. DOI: http://dx.doi.org/10.15585/mmwr.mm6531a2.

[7] Ibid.

[8] This document identifies the number of infants born onto Medicaid that were diagnosed with Neonatal Abstinence Syndrome (NAS) in Pennsylvania between calendar years 2010 and 2014. The data was obtained through a Right to Know (RTK) request filed with the Pennsylvania Department of Human Services (DHS) on September 3, 2015. After an initial denial of the RTK request, PA DHS supplied the data on January 15, 2016. PA DHS supplied the data about the number of

In 2014, NAS diagnosed infants represented approximately 3 percent (n=1,970) of the babies born onto Medicaid (n=64,001) in Pennsylvania and the average length of stay (ALOS) in an inpatient setting immediately following the infant's birth was 15.53 days. Sixty one infants born onto Medicaid and diagnosed with NAS, between 2010 and 2014, died before celebrating their 1st birthday.

Table 1. Infants born onto Medicaid in PA , diagnosed with NAS
2010 - 2014

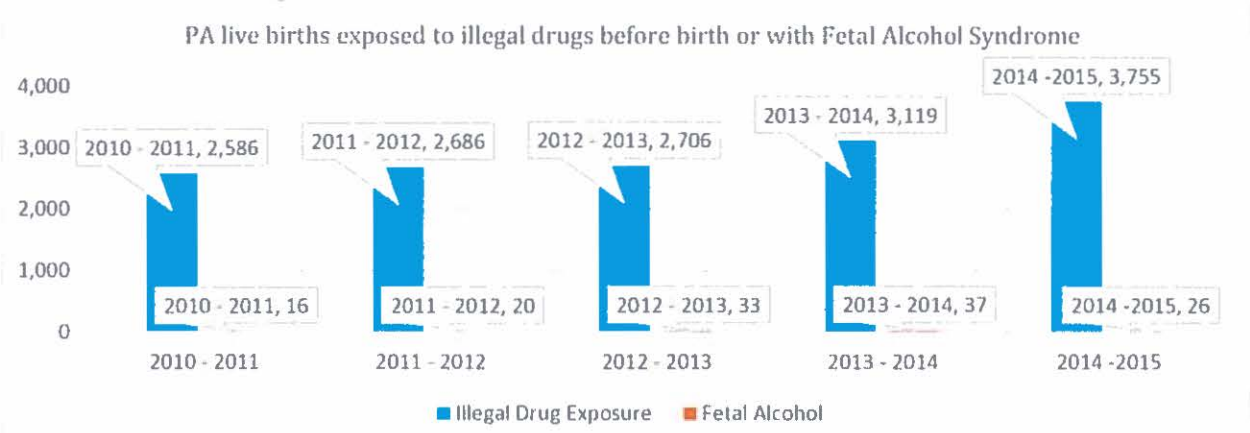
infants born onto Medicaid and having the diagnosis code of 779.5 (Neonatal withdrawal symptoms from maternal use of drugs of addiction).

Table 2: Babies diagnosed with NAS by Pennsylvania county (2010-2014)

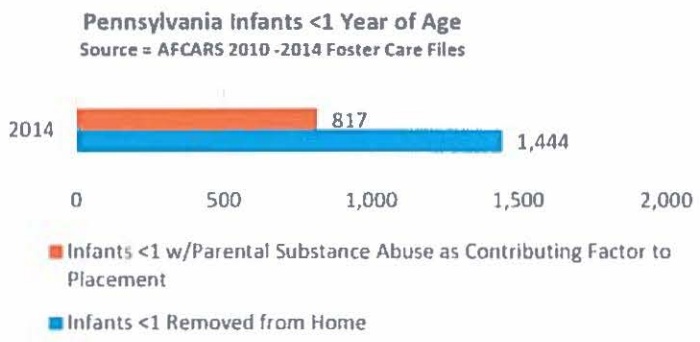
County	2010	2011	2012	2013	2014	Total
Adams	6	5	10	12	11	44
Allegheny	179	192	195	196	222	984
Armstrong	8	14	21	23	19	85
Beaver	17	23	21	34	39	134
Bedford	0	4	5	4	6	19
Berks	25	36	24	47	39	171
Blair	33	32	40	52	42	199
Bradford	0	1	4	3	4	12
Bucks	46	61	67	64	71	309
Butler	23	37	23	37	36	156
Cambria	37	37	45	46	41	206
Carbon	5	5	4	3	9	26
Centre	3	5	3	4	12	27
Chester	31	20	18	26	22	117
Clarion	8	2	6	10	8	34
Clearfield	21	26	32	41	28	148
Columbia	0	1	7	5	5	18
Crawford	4	7	8	24	14	57
Cumberland	7	6	12	9	23	57
Dauphin	11	14	23	18	27	93
Delaware	57	67	68	75	108	375
Elk	6	8	13	11	19	57
Erie	22	29	37	32	43	163
Fayette	31	44	56	66	89	286
Franklin	9	15	15	17	20	76
Fulton	0	0	1	3	1	5
Greene	6	10	11	22	23	72
Huntingdon	1	3	4	7	5	20
Indiana	5	4	16	9	10	44
Jefferson	4	4	3	15	8	34
Juniata	1	0	2	0	0	3
Lackawanna	14	15	16	18	39	102
Lancaster	27	39	41	41	58	206
Lawrence	23	47	44	39	38	191
Lebanon	2	8	9	15	13	47
Lehigh	5	5	10	9	24	53
Luzerne	39	31	39	51	41	201
Lycoming	7	4	3	14	9	37
McKean	7	9	8	7	13	44
Mercer	7	28	19	26	34	114
Monroe	7	7	16	17	19	66
Montgomery	32	31	41	66	75	245
Montour	0	0	1	1	1	3
Northampton	8	7	6	15	16	52
Northumberland	2	3	3	6	7	21
Perry	1	1	10	11	5	28
Philadelphia	160	156	227	223	256	1,022
Pike	2	2	2	4	7	17
Schuylkill	5	5	9	11	13	43
Snyder	0	0	0	3	1	4
Somerset	8	8	13	11	21	61
Susquehanna	1	3	3	1	8	16
Tioga	0	2	3	0	2	7
Union	0	0	0	0	2	2
Venango	13	15	17	24	34	103
Warren	0	2	2	5	8	17
Washington	20	30	41	35	51	177
Wayne	5	6	0	5	9	25
Westmoreland	49	62	71	69	84	335
York	21	32	32	44	57	186
TOTAL	**1,080**	**1,283**	**1,502**	**1,702**	**1,970**	**7,537**

Separate from the Medicaid specific NAS data, hospitals submit data to the PA Department of Health (DOH) through the Annual Hospital Questionnaire. Infant/Neonatal Services and Utilization data specific to the number of Live Births Exposed to Illegal Drugs Before Birth and the number of Live Births with Fetal Alcohol Syndrome is captured in the chart below. [9]

Not readily understood is the interplay between this data and the earlier cited NAS data or the degree to which these births trigger a referral from a health care provider to the child welfare agency in order to develop a Plan of Safe Care, as required by the federal Child Abuse Prevention and Treatment Act (CAPTA). The data for 2014-2015 indicates that Erie County recorded the highest number of live births where the infant was exposed to illegal drugs before birth with 393 births. Erie was followed by Philadelphia (388), Allegheny (385), Montgomery (267), Dauphin (254), Delaware (193), Franklin (175), Luzerne (138), Cambria (125), and York (122).



Children birth to 3 placed in foster care related to parental substance abuse: Many Pennsylvania infants become involved with the formal child welfare system and many are placed in foster care. Child welfare involvement and foster care placement can be precipitated by parental substance use that has led to harm or puts the infant at imminent risk of harm. There is no specific reliable measure of how many infants have been removed from home and placed in foster care due to parental substance use let alone how many of such placements then are directly related to opioid abuse. Still, the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) data does provide some insight.

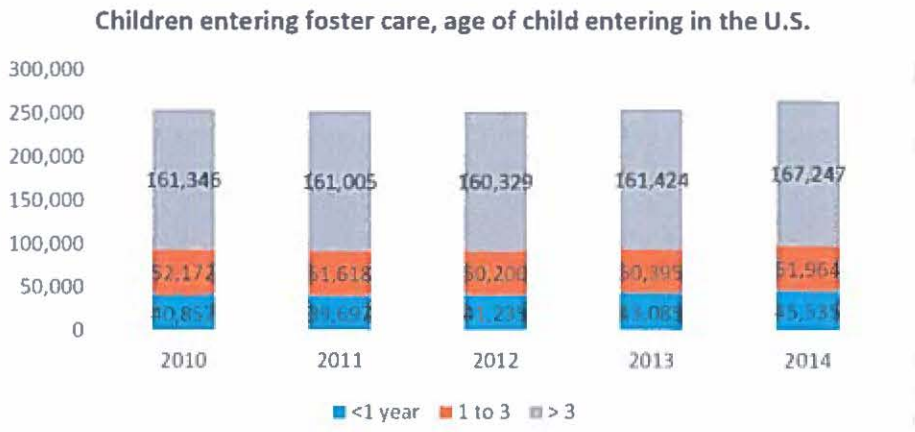


In 2014, more than 1,400 infants in Pennsylvania were removed from home and 817 (more than 56 percent of those removed) had parental substance abuse as a contributing factor to placement.

Review of the 2014 AFCARS data for all 50 states proves eye-opening. In 2014, the number of children in foster care across America increased by 3.5 percent. 264,746 children entered foster care, including

[9]http://www.statistics.health.pa.gov/HealthStatistics/HealthFacilities/HospitalReports/Pages/HospitalReports.aspx#.VtHFecAo454

45,535 infants. More than a third of the children entering foster care in the United States were three years of age or younger. Again, it proves difficult to reliably state how many of these children are entering care because of parental substance abuse. It also, however, is important to recognize that given the significant body of research about the importance of brain development and early childhood, these numbers merit an intentional response whatever the catalyst for young children entering foster care.



Children who have died or nearly-died: A diagnosis of NAS, in and of itself, is rarely fatal and yet some infants diagnosed with NAS and other substance-exposed infants have died in Pennsylvania in that critical first year of life linked, in part, to existing medical conditions but also as a consequence of the child and family's life circumstances. Examples include:

- A 2-month-old died in Beaver County in March 2015. According to the PA DHS, the child died "as a result of serious physical neglect" after the victim child, the mother and the child's sibling "were all sleeping in the mother's bed."[10] Initially all tests were "inconclusive" and the child's death "appeared to be accidental." A later toxicology report issued in July 2015, "indicated the child died from Methadone poisoning, and the child's death was ruled a homicide."[11]
- A 1-month-old died in Carbon County in October 2014 due to hazardous sleep conditions while in the same bed with his mother.[12] The baby and mother were both prescribed Methadone, but on the night of his death his mother used other non-prescribed drugs as well.
- A 3-month-old died in Fayette County in March 2014. PA DHS' summary notes that the "mother had fresh track marks and has a long history of heroin addiction." Also that the mother had been prescribed Subutex and the infant "tested positive for this at birth."
- A 7-week-old infant died in Lackawanna County in January 2015. According to PA DHS, the baby was born "drug addicted."[13]

Additional insight is found within a report released from the PA State Coroners Association. In it the state's coroners reveal that in 2014 "at least 2,489 individuals" died from "drug related deaths."[14] The report further notes, "The age of the deceased ranges from 4 months to 85 years of age."

Pennsylvania's Annual Child Abuse Report published by the PA Department of Human Services' (DHS) also proves revealing. This report and information from the media provide some added, but still limited, lens into the degree to which children are dying or nearly-dying linked to drug ingestions and/or child abuse where there is a history of parental substance use.

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[10] http://www.dhs.pa.gov/cs/groups/webcontent/documents/report/c_219870.pdf
[11] Ibid.
[12] http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_211247.pdf
[13] 2015 1st Quarter Fatalities/Near Fatalities published by the Pennsylvania Department of Human Services, page 2. Retrieved at http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_211247.pdf.
[14] http://www.pacoroners.org/Uploads/Pennsylvania_State_Coroners_Association_Drug_Report_2014.pdf

Examples in recent years include:

- **Armstrong:** Media reports revealed that an 11-year-old boy died in December 2015. The "results of an autopsy and toxicology test showed he had overdosed on methadone, a powerful prescription painkiller." The boy's mother, who was prescribed the methadone, has been criminally charged.[15]
- **Bucks:** A 2-year-old boy died in October 2014. An autopsy was conducted the following day, where 1200 mg of Oxycodone was found in the boy's system. According to the forensic pathologist, the child died from three times the amount of Oxycodone it would take to kill an average adult.[16]
- **Crawford:** It was 2012 when a 3-year-old died "as a result of ingesting his father's medication." At the hospital, "blood testing was conducted and it was determined that the child had ingested methadone." Initially the father said he had been prescribed the methadone for at-home use, but "later admitted to illegally obtaining the methadone from a friend."
- **Delaware:** An 11-month-old infant died "due to an acute heroin overdose." The family was known to the children and youth agency after the deceased child was born and the mother "tested positive for opiates."
- **Erie:** A 10-month-old infant nearly died in 2012. According to PA DHS, "the father admitted that he overdosed on methadone a few weeks prior and some pills fell on the floor but were cleaned up." On the day of the near-fatality, the child, who was experiencing "impaired breathing," was flown to a hospital where her toxicology screen was "positive for methadone."
- **Lancaster:** According to media reports in January 2015, a 4-year-old child "fell unconscious after ingesting a drug that is commonly used to treat heroin addiction." The media report continues, "Medics administered Narcan to the girl multiple times before she regained consciousness."[17]
- **Luzerne:** A 6-year-old PA nearly-died "after accidentally drinking her mother's methadone." On the night of the incident the child drank the liquid methadone when she thought it was a soda. The parents upon realizing she had drank the methadone researched how to treat her on the Internet. "Based on the parent's statement it was indicated that the child may have ingested up to 50 milligrams of methadone." The child was taken to the hospital approximately 4 hours after the parents realized she ingested the methadone. "At the time of the incident there were four children in the household, including an 8 month old infant, as well as a 4 year old, 6 year old and 17 year old."
- **Montgomery:** According to a media report, the 2-year-old child's "death was ruled an accidental combined drug intoxication by a Montgomery County forensic pathologist on July 31, 2015. A toxicology report later identified the presence of both Klonopin — a Schedule IV narcotic — and Subutex — a drug used to treat addiction — in Trinity's system."[18]
- **Philadelphia:** A 1-year-old child died in Philadelphia in 2015.[19] The child was found in her crib by her mother. The child was "not breathing" and transported to the hospital. "At the hospital it was found that the child tested positive for methadone. The mother said she did not know how the child had ingested methadone. The mother was receiving prescribed methadone treatments at a local clinic. According to the mother, she kept the medication in a locked box out of the way of the children."

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[15] http://triblive.com/news/adminpage/9998362-74/methadone-armstrong-police

[16] http://levittownnow.com/2014/11/18/man-charged-in-toddler-sons-drug-overdose/

[17] http://lancasteronline.com/news/local/police-medics-use-narcan-to-revive-girl-who-ingested-methadone/article_c4aa7b5a-e223-11e5-a363-b3ad71a50c6b.html

[18] http://www.timesherald.com/general-news/20160120/lower-providence-woman-charged-in-death-of-2-year-old-daughter?source=most_viewed

[19] The PA DHS summary includes this child as a 1-year-old child, but an Act 33 Report that appears to be for the same child lists her as a 3-year-old child.

- **Philadelphia:** Twin infants nearly-died taken to the hospital after it was difficult to awake the infants. At the hospital, "both girls tested positive for Tetra Hydro Cannabinol and Opioids." There was no explanation as to how the girls may have ingested the drugs.
- **Washington:** A 7-month-old infant nearly-died later the caregiver of the child "admitted to using heroin the day he was caring for the child." The caregiver told authorities that "he dropped the child on his head." The child was determined to have "a bilateral subdural hematoma with a non-displaced left parietal bone fracture, bilateral retinal hemorrhages and facial bruising." The family "was not known to the agency prior to this report" but the PA DHS summary also notes that the mother "has a history of illegal drug usage" and the mother is now "receiving parenting instruction and drug and alcohol services."

Recommendations from fatality/near-fatality teams have included:

- As children ingesting medication has been a common theme for near fatality and fatality, there should be statewide public service announcements that discuss child safety regarding medication storage.[20]
- Agency staff will be instructed to request toxicology screens for children who are unconscious and unresponsive, a toxicology screen should be done.[21]
- Improve the communication between BCCYSSA and the drug and alcohol providers in the area and improvement of services by drug/alcohol providers by prioritizing services to mothers of babies/young children.[22]
- The agency has recently had a few cases involving "accidental" ingestion of medication by young children. The Team discussed providing agency staff with education on the appropriate storage of medication so that staff can then review with and educate caregivers.[23]
- A recommendation from MDT that a more efficient collaboration between Delaware County Children & Youth Services and the Office of Behavioral Health is pursued to assist with identifying licensed treatment professionals.[24]
- Determine whether Methadone clinics have a protocol in place for allowing patients with small children to have "take homes" of their methadone and whether they receive education on the dangers of ingestion of the medicine by small children.[25]
- The Department recommends continuous Drug and Alcohol education with particular emphasis on the effect substance abuse can have on young children, including accidental and intentional ingestion by children.[26]

[20] http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_211654.pdf
[21] http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_019116.pdf
[22] Ibid.
[23] http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_019115.pdf
[24] http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_112064.pdf
[25] http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_124450.pdf
[26] http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_035328.pdf