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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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

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<td>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:</td>
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<td>1. Illegal substance abuse by the child’s mother.</td>
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<td>2. Withdrawal symptoms resulting from prenatal drug exposure.</td>
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<td>3. A Fetal Alcohol Spectrum Disorder.</td>
<td>i.  under the care of a prescribing medical professional; and</td>
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<td>ii. in compliance with the directions for the administration of a prescription drug as directed by the prescribing medical professional.</td>
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<td>3. A Fetal Alcohol Spectrum Disorder.</td>
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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.

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

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|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.

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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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.