CHILD WELFARE OVERSIGHT AND ADVISORY COMMITTEE

Minutes

November 19, 2018

Call to Order and Roll Call

The Child Welfare Oversight and Advisory Committee meeting was held on Monday, November 19, 2018, at 11:00 a.m., in Room 129 of the Capitol Annex. Senator Julie Raque Adams, Co-Chair, called the meeting to order at 11:11 a.m., and the secretary called the roll.

Present were:

Members: Senator Julie Raque Adams, Co-Chair; Denise Harper Angel, and Whitney Westerfield; Representatives Angie Hatton, Joni L. Jenkins, and Suzanne Miles.

Guests: Alexa Craig, MD, Pediatric and Young Adult Neurology, Maine Medical Partners; Margaret Wile, Health Policy Specialist, National Conference of State Legislatures; Meghan McCann, Human Services Senior Policy Specialist, National State Conference of State Legislatures; Paul Robinson, MBA, President and CEO, Home of the Innocents; Randall Wallbaum, Kentucky Youth Advocates; Marian Hayden, Cull & Hayden.

LRC Staff: Ben Payne and Gina Rigsby.

Minutes

A motion to approve the October 15, 2018 minutes was made by Senator Westerfield, seconded by Senator Harper Angel, and approved by voice vote.

Neonatal Abstinence Syndrome: A National and State Perspective

Alexa Craig, MD, Pediatric and Young Adult Neurology, Maine Medical Partners, stated that an article published in *The New England Journal of Medicine* reported that the incidence of the neonatal abstinence syndrome (NAS), a drug-withdrawal syndrome that most commonly occurs after in utero exposure to opioids, is known to have increased during the past decade. However, recent trends in the incidence of the syndrome and changes is demographic characteristics and hospital treatment of these infants have not been well characterized. Another article in the *Journal of the American Medical Association* (JAMA) stated that gaps still exist, including a lack of clarity and consistency in how the syndrome is defined, measured, and managed. In addition, much of the research has focused on the infant in isolation from the mother, and many hospitals lack protocols to guide treatment. A March of Dimes article stated that in addition to opioids, using

antidepressants (prescription drugs used to treat depression) and benzodiazepines (sleeping pills) can lead to NAS in a baby.

The gastrointestinal system and the brain are predominately affected because neither is being stimulated any longer by an opioid transmitted through the placenta to the baby. Metabolic, vasomotor, and respiratory manifestations include fever, frequent yawning, sneezing, sweating, nasal stuffiness, shallow respiratory rate, mottling, and tachypnea. Gastrointestinal manifestations include projectile vomiting, regurgitation, loose or watery stools, weight loss, poor feeding, and excessive sucking. Central nervous system manifestations include tremors, high pitched crying, sleep disturbances, increased muscle tone, excoriation, myoclonic jerks, irritability, and sometimes seizures. NAS babies are admitted to the neonatal intensive care unit (NICU) requiring a prolonged hospitalization.

The *JAMA Pediatrics* data from 2004 to 2013, report the rate of NAS (NICU) admissions went from 7 cases per 1,000 to 27 cases per 1,000 admissions and the median length of stay increased from 13 to 19 days. There is a disproportionate effect of the opioid epidemic in rural areas.

In response to a question by Senator Raque Adams, Dr. Craig stated that it takes approximately one year to get a paper accepted and published in a medical journal after the article is written, so the information presented to the committee is the latest information available.

According to the JAMA, the cost to treat a NAS baby ranged from $39,400 in 2000 compared to $53,400 in 2009. The cost of all other births in 2000 was $6,600 and $9,500 in 2009.

Mothers who used Medication Assisted Therapy (MAT) want information about NAS but are not getting it from the obstetrician and addiction medicine provider. A survey showed that 55 percent of obstetricians/gynecologists and 57 percent of addiction medicine providers said it was their responsibility to educate patients about NAS. It does not take much for a person with a substance abuse disorder to feel guilty about a medical problem and believe he or she is being judged. NICU nurses are used to dealing with critically ill babies who need intensive medical therapy, not social situations where there is an intensive need for support.

An eat, sleep, console assessment is tailored to a baby to see if the baby can eat an ounce per feeding or breastfeed well, can the infant sleep for an hour without waking itself up, and can the baby be consoled within 10 minutes. If any answer is no, nonpharmacological care that include skin-to-skin contact with parents, decreased stimulation, swaddling when not being held, use of pacifiers, and breastfeeding for mothers who are not HIV or Hepatitis C positive. Maine’s paradigm shift is from morphine being used to treat the baby to the parent consoling the child.

In response to questions by Senator Westerfield, Dr. Craig stated that a 2018 study shows there are no readmissions to emergency rooms or other hospitals. The data did not look at whether law enforcement is involved once a child goes home. Maine's hospital has not seen an increase in shaken babies or babies who have been caused physical harm by being sent home to an environment that is potentially unstable.

The Maine Medical Center completed a qualitative study of mother infant bonding in the hospital. The goals of the study were to identify barriers to bonding between mothers and their babies with NAS, and identify familial, community, and inpatient resources in place to support mothers and their babies with NAS. The main characteristics the mothers had were anxiety, bipolar disorders, depression, chronic headaches, Hepatitis C, HPV and/or STD, and PTSD/trauma. Substances used during pregnancy included cocaine, heroin, marijuana, and tobacco. Healthcare was initially just for the baby, now it has expanded to the mother/infant dyad, and should be expanded further to the baby/mother/father triad. A lot of women do not go into treatment programs because of the fear that child protective services will take their child. Mothers face barriers that include experiencing guilt, feeling judged, NAS scoring tools, and symptoms of NAS. Supports include reassurance from providers, male co-parents, and peers who have been through the experience to coach them, consistent education about NAS, and the care received in the hospital. Keeping mother and child together helps the mom not to relapse as often.

In response to questions by Senator Raque Adams, Dr. Craig stated that problems with NAS babies are not noticed until a child starts preschool or kindergarten. Senator Raque Adams stated that legislation was enacted during the 2018 Regular Session to require that mothers and their babies are tested for Hepatitis C. Dr. Craig stated that mothers do not need extra pressure and guilt put on them just because their child is born with NAS. Providers need to look at the situation as a medical problem and partner with mothers instead of making the mothers feel guilty.

In response to questions by Representative Miles, Dr. Craig stated that in Maine, if a mother decides to breastfeed her child, she is encouraged not to continue to smoke marijuana. There is no study available that shows all the benefits of breastfeeding outweighs the bad side of marijuana exposure to the child. There is a Northeastern Neonatal Abstinence Syndrome database that contains over 2,400 mother/infant dyads that lists every drug taken by a mom while she is pregnant.

Margaret Wile, Health Policy Specialist, National Conference of State Legislatures (NCSL), stated that NCSL is a bipartisan membership organization that helps states with research, education, and technical assistance. Its mission is to improve the quality and effectiveness of state legislatures, promote policy innovation and communication among state legislatures, and ensure states have a strong, cohesive voice in the federal system. NCSL does not take a stance on state policy.

The Center for Disease Control and Prevention (CDC) found the incidence of NAS went from 1.5 cases per 1,000 births in 1999 to 6 cases per 1,000 births in 2013. In Kentucky during the time period, it went from .4 cases per 1,000 births to 15 cases per 1,000 births. West Virginia has the highest incidence at 35 cases per 1,000 births. According to a new study, an estimated 21,732 babies were born with NAS in the United States in 2012, a five-fold increase since 2000. Every 25 minutes, a baby is born suffering from opioid withdrawal. Approximately 86 percent of births to women who have a substance use disorder are unintended. California, Michigan, and Tennessee have sponsored legislation relating to NAS.

In response to a question by Senator Raque Adams, Ms. Wile stated that she would provide information on whether Tennessee requires local health departments to share information on NAS and access to contraceptives to women of childbearing age.

Prevention and intervention trends show an increased access to health care during pregnancy or postpartum, increased access to family planning service, increased access to MAT for expecting mothers, and increased efforts by Women Infants and Children (WIC) and executive branch agencies. Mississippi was the first state to be approved by the Centers for Medicare and Medicaid Services (CMS) to expand family planning services. Kentucky has created or funded drug treatment programs specifically targeted to pregnant women, provide pregnant women with priority access to state-funded drug treatment programs, and prohibit publicly funded drug treatment programs from discriminating against pregnant women. Legislation has been introduced in Louisiana, New York, Missouri, and Ohio relating to treatment for mothers with or at risk of developing a substance use disorder (SUD) or newborns with NAS. A maternal and child health database showing all bills enacted relating to NAS and substance use disorder database will be available in January 2019.

Meghan McCann, Human Services Senior Policy Specialist, NCSL, stated that in 2016, there were approximately 437,000 children in foster care in the United States, the highest caseload since 2008. In the same year, more than 270,000 children entered care, the highest number since pre-2008. The number of children under the age of 1 entering foster care is increasing, and is now the highest percentage, by age group, of children entering foster care. In 2015, for the first time, the Adoption and Foster Care Analysis and Reporting System (AFCARS) provided specific data showing removals due to parent drug abuse. The top five reasons to remove a child from the home is neglect, drug abuse by parent, caretaker inability to cope, alcohol abuse by parent, or a parent’s death.

The Child Abuse Prevention and Treatment Act (CAPTA) requires states to have policies and procedures for hospitals to notify child protection services (CPS) of all children born who are affected by illegal substance use or withdrawal symptoms resulting from prenatal drug exposure or indications of fetal alcohol syndrome disorder (FASD) and

requires CPS agencies to develop a plan of safe care for every infant referred to its agency and address the health and substance use disorder treatment needs of the infant.

The CAPTA was amended by the Comprehensive Addiction and Recovery Act (CARA) of 2016. CARA removed the word illegal so CAPTA applies to all substance abuse, requires the plan of safe care to also address the treatment needs of affect family or caregivers, requires states to report in the National Chide Abuse and Neglect Data System (NCANDS), requires states to develop a monitoring system to determine whether and how the local entities are providing referrals to and delivery of appropriate services for the infant and affected family or caregiver, and requires all children who are younger than three years old, who are substantiated victims of child maltreatment, to be referred to early intervention agencies that provide developmental disability services.

The 2018 federal Opioid Package set aside $60 million in the CAPTA to support states in coordinating and implementing plans of safe care. Starting in 2018, states are eligible for federal matching funds when an at-risk child is placed in family-focused treatment or foster care. In 2020, states are eligible for funding to provide evidence-based substance abuse prevention and treatment services to families with children at risk of entering foster care that includes $20 million in awards to states to develop, enhance, or evaluate family-focused treatment programs.

Twenty-four states and the District of Columbia include prenatal substance exposure in the definition of child abuse and/or neglect. Thirty-one states and the District of Columbia have specific procedures for reporting prenatal substance exposure. Connecticut, Delaware, Maryland, New Hampshire, North Dakota, Oklahoma, Pennsylvania, and Virginia have statutes to define, coordinate, fund, or implement plans of safe care. Several states, including Kentucky, have implemented various procedures within agencies to address plans of safe care. Kentucky is one of the sites that the National Center on Substance Abuse and Child Welfare (NCSACW) provides In-Depth Technical Assistance. NCSACW works with selected sites to develop a scope of work for the in-depth technical assistance that includes working with the substance abuse, child welfare and court systems, as well as local tribes, to increase their collaboration and strategic plans for working together. NCSACW will study the progress and barriers learned in each site with the aim of broadly disseminating the lessons learned so as to further the collaborative efforts and linkages among alcohol and other drug services, child welfare, family courts and tribes.

Nineteen states and the District of Columbia include long-term alcohol or drug-induced incapacity of the parent as a ground for determining unfitness for purposes of termination of parental rights. Kentucky, Missouri, and Texas include prenatal substance exposure or neonatal abstinence syndrome in its grounds for termination of parental rights.

Innovative Solutions to Achieve Positive Outcomes

Paul Robinson, MBA, President and CEO, Home of the Innocents, stated that works the Home of the Innocents with the Department for Community Based Services (DCBS) in a collaborative problem-solving approach with synergistic communication. Synergistic communication allows both parties to be open to new possibilities and novel ideas that can lead to new insights and growth. The principles to the approach (1) focused on a fundamental shift, beyond short-term programmatic work, to longer term influences over policy, regulation, and systems-level change; (2) aligned the practices and perspectives of communities, health systems, and child welfare systems under a shared vision by drawing upon the strengths of each partner; and (3) used data from clinical, medical, and child welfare sources as a tool to identify key needs, measure meaningful change, and facilitate transparency to generate a new service for Kentucky's children. Systems changes include organization shifts and scaling that sustains practice and policy, implementation of supportive regulatory, legislative, and public policies, and sustained adequate funding.

Home of the Innocents operates the Children's Assessment and Transitional Service Center. The center's vision is to provide child centric, medically necessary and integrated services to children in out of home care. The goal of the program is to provide mental and medical health interventions and intensive assessments to help prepare children to transition to the appropriate placement in the least restrictive setting. Outcomes of the center include the reduction in number of placements, prompt and proficient placement, following placement best practices, limiting further trauma, and increased efficacy of caregiver training for the special needs children and youth being placed in care.

The Home of the Innocents recommends that the Cabinet for Health and Family Services establish a Child Welfare Partner Committee (CWPC) to focus on a full range of child welfare contracted services in developing knowledge about improving outcomes for children and families in the child welfare system. A CWPC has the ability to unite individuals from public and private agencies to create better outcomes for Kentucky's children and families.

Adjournment

There being no further business, the meeting was adjourned at 12:50 p.m.