PERSPECTIVES

Improving the Child Welfare System to Respond to the Needs of Substance-Exposed Infants

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Every day in the United States, 130 people die of an opioid overdose,[1] and nearly 90 infants are admitted to hospitals with opioid withdrawal, also known as neonatal abstinence syndrome (NAS).[2] The health care system has been largely unprepared for the magnitude of this crisis. As the numbers of opioid-exposed infants grew, pediatricians focused primarily on improving clinical care. The breadth of the crisis requires alignments of the public health system, hospitals, and our nation's child welfare system. Recent improvements in the child welfare system through federal legislative action have enabled the system to be more responsive to the unique needs of families affected by the opioid crisis; however, more progress and funding are needed.

The US child welfare system evolved over the last 200 years, beginning with reliance on small nonprofit organizations in the 19th and early-20th centuries. The publication of Kempe et al.'s "The Battered-Child Syndrome" in the 1960s[3] and the passage of the Child Abuse Prevention and Treatment Act of 1974 (CAPTA)[4] coincided with the emergence of a more organized system of care, one designed primarily to protect children from neglect and physical and sexual abuse. It was not set up to be responsive to the complex needs of families affected by substance use disorder.[5]

The already overburdened child welfare system is facing new demands made on it by the opioid crisis.[6–8] Our analysis of data from the nation's foster care system reveals that from 2011 to 2017, the number of infants entering that system each year grew by nearly 10 000. By 2017, >50 000, or 1.3% of US infants, were in the foster care system. National data suggest that at least one-half of US foster care placements of infants are associated with parental substance use (Fig 1), and this is an underestimate due to underreported substance use in most states. Furthermore, just as the opioid crisis affects some states more than others, foster care placement per 1000 live births also varies substantially. For example, West Virginia, the state with the highest rate of opioid overdose death[9] and NAS,[10] also has the highest rate of foster care placements at 41 per 1000 births compared with neighboring Virginia's rate of 5 per 1000 births (Fig 2).

RECENT CHANGES TO THE CHILD WELFARE SYSTEM

The link between the opioid crisis and new demands on child welfare has recently turned the attention of policy makers and the press to challenges facing the child welfare system. In 2015, *Reuters* published a series of reports

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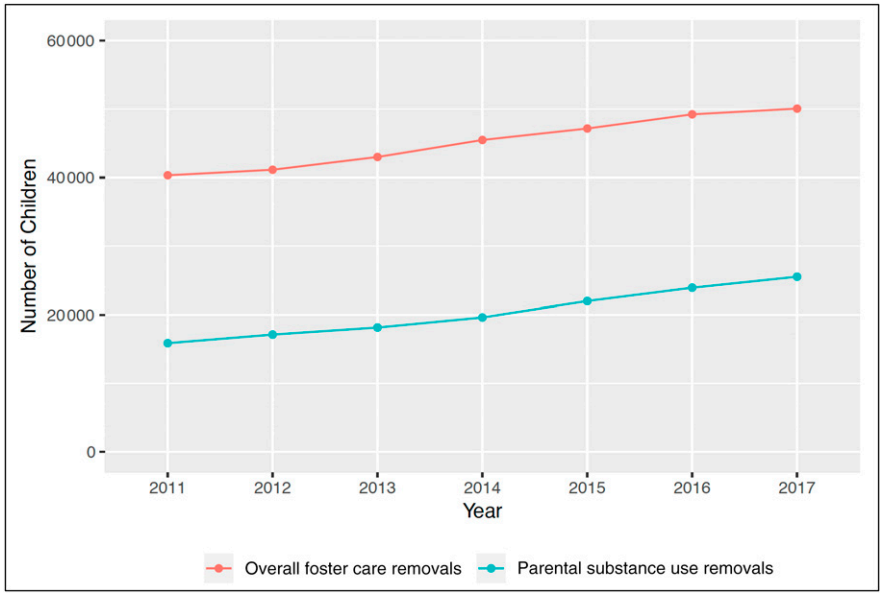

FIGURE 1 Number of US infants <1 year of age in the US foster system. Data are from authors' analysis of the Adoption and Foster Care Analysis and Reporting System.

about 110 infants with NAS who died preventable deaths after hospital discharge.[11] Congressional hearings followed and contributed to the passage of the Comprehensive Addiction and Recovery Act in 2016, which included amendments to CAPTA that changed the requirements for "plans of safe care" to be inclusive of the needs of the family or caregiver in instances when an infant experiences withdrawal symptoms or fetal alcohol spectrum disorder or is identified as affected by substance use.[12] The goal was to engage child health and welfare professionals in collaborating to ensure the safety of vulnerable infants on discharge from the hospital and to meet the treatment needs of their parents.

Unfortunately, the initial legislation appropriated no additional funding or clear guidance to states. Unsurprisingly, federal audits of plans of safe care found states were understaffed and confused about the requirement.[13] Recently, the US Congress provided an additional $60 million over 2 years to states' CAPTA block grants with a priority to fulfill plans of safe care requirements.[14] Congress also passed the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, which again amended CAPTA, providing clearer guidance and authorizing a new state grant program for states to implement plans of safe care. Yet, it remains unclear how Congress will fund that separate provision and how states will implement the new requirements. There also remains a lack of clarity among many clinicians as to what a plan of safe care should look like, who is responsible for its implementation, and what constitutes a "notification to child protective service," as CAPTA requires, versus which families need to be reported to child welfare systems as a potential case of child abuse or neglect.[15–17]

In February 2018, the Family First Prevention Services Act (FFPSA) was signed into law, which broadly allows states to use federal child welfare funds for prevention, specifically noting that funds can be used for mental illness and substance use disorder prevention and treatment. As of October 2018, the foster care maintenance funds, which formerly would have gone to place a child in foster care while a parent goes to residential treatment, can now be paid directly to keep the child with the parent in family residential treatment.[18] Taken together, the recent changes stemming from the Comprehensive Addiction and Recovery Act, the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, and the FFPSA represent a new commitment for the child welfare system to focus on families affected by substance use and mental health disorders.

THE FUTURE OF CHILD WELFARE

Ideally, our nation's child welfare system would evolve to recognize the unique needs of substance-exposed infants and the challenges faced by their parents in safely caring for them. Keeping substance-exposed infants safe is paramount, but we must also acknowledge that removing a child from his or her parents is traumatic and, when possible, should be prevented. The challenges faced by infants of mothers with substance use disorders differ from those suffering physical and sexual abuse, and our system needs to recognize those differences in responding to their needs. Although the opioid crisis exposed these issues, they will persist unless we harness recent federal and state momentum to make lasting change.

Many states are currently working to implement changes to plans of safe care and the FFPSA, often in the context of child welfare systems challenged by insufficient funding and high staff turnover. Although these changes to the child welfare system are important, early reports suggest that some states may be struggling to enact them.[19] Some states may have interpreted new requirements for hospitals to notify child protective services when an infant is identified as being synonymous with a child abuse report.[20] This may include reporting mothers solely on the basis of receiving opioid-agonist therapy for the treatment of opioid use disorder, which is potentially problematic because restricting access to children solely because of use of opioid-agonist therapies is a violation of the Americans with Disabilities Act of 1990.[21,22] It is worth asking, especially with limited child welfare resources, if this broader definition may cause more harm than good because these families are already engaged in the services they would be recommended to receive. As mandated reporters, it is notable that obstetricians and pediatricians could

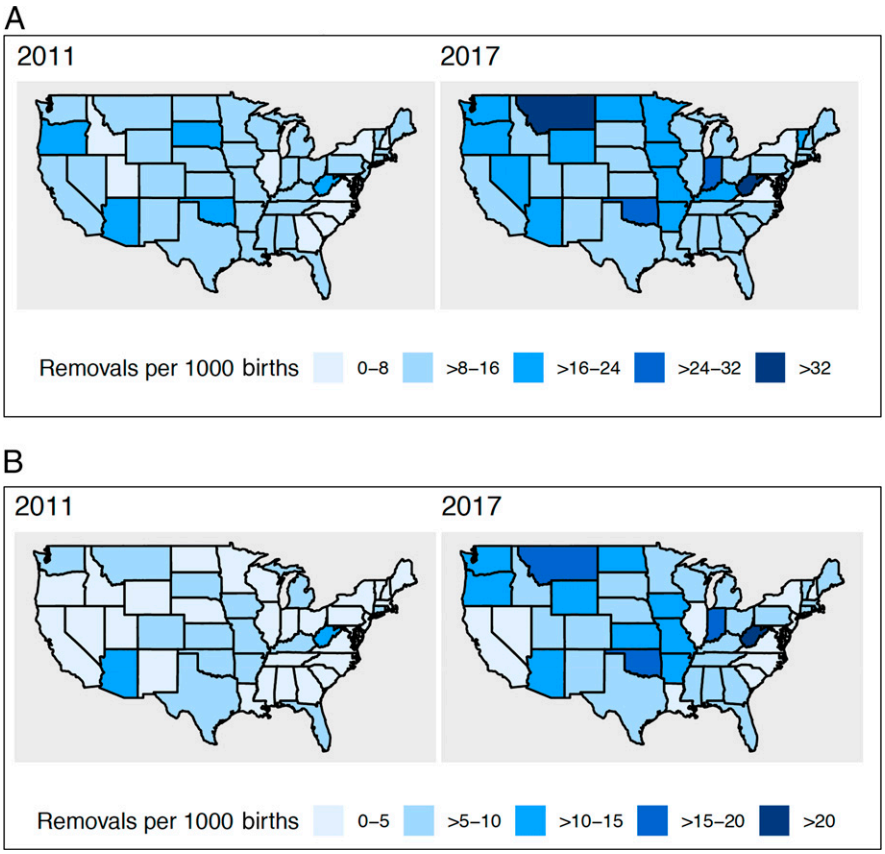

FIGURE 2 A, Rate of infants <1 year of age in foster care per 1000 live births. Data are from authors' analysis of the Adoption and Foster Care Analysis and Reporting System and Centers for Disease Control and Prevention Natality data (https://wonder.cdc.gov/natality-current.html). B, Rate of infants <1 year of age in foster care associated with parental substance use per 1000 live births. Parental substance use may be unreported in some states.

report concerns at any time and that an automatic report for substance use in the context of treatment may not be in the best interest of the family. Rather, a partnership is needed between the health care providers and the child welfare agency to identify when there are legitimate concerns for child and family safety and to differentiate when plans of safe care are being developed by treatment agencies and health providers and the family is engaged in services.

The needed transformation of the system may be challenging in the era of tight domestic budgets. Although funding for the child welfare system increased from $8.98 billion in 2014 to $10.86 billion in 2018, the president's 2019 budget proposed a 12.2% cut.[23] To realize the gains envisioned by recent legislation, the administration and Congress should prioritize additional funding and guidance to modernize our child welfare system to meet the unique needs of families affected by substance misuse.

THE ROLE OF THE PEDIATRICIAN

Recognizing that these problems occur at the intersection of the health care and welfare systems, solutions will require a cross-sectoral approach, with pediatricians playing a critical role in realizing the needed improvements to the system. Pediatricians should be informed about how their state interprets CAPTA and how that affects their local practice. In addition, pediatricians should consider a more active role in shaping how state and local policies are implemented, especially during this time of rapid change to the system. Although partnership with local and state child welfare systems may seem daunting, pediatricians are uniquely positioned to play a critical role in informing policies that protect infants and empower their families.

CONCLUSIONS

The rising opioid crisis exposed problematic gaps in our nation's child welfare system. Recently, however, there has been substantial change to federal and state policies relating to the child protection system. Because these systems rapidly evolve, pediatricians should consider what role they may play in informing positive change in their communities.

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REFERENCES

1. Centers for Disease Control and Prevention. Provisional drug overdose death counts. 2018. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. Accessed October 5, 2018
2. Winkelman TNA, Villapiano N, Kozhimannil KB, Davis MM, Patrick SW. Incidence and costs of neonatal abstinence syndrome among infants with Medicaid: 2004-2014. *Pediatrics*. 2018;141(4):e20173520
3. Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver HK. The Battered-Child Syndrome. *JAMA*. 1962; 181:17–24
4. Child Abuse Prevention and Treatment Act of 1974, Pub L No. 93–247, 88 Stat 4
5. Meyers J. A short history of child protection in America. *Fam Law Q*. 2008; 42(3):449–463
6. Quast T, Storch EA, Yampolskaya S. Opioid prescription rates and child removals: evidence from Florida. *Health Aff (Millwood)*. 2018;37(1):134–139
7. França UL, Mustafa S, McManus ML. The growing burden of neonatal opiate exposure on children and family services in Massachusetts. *Child Maltreat*. 2016;21(1):80–84

8. Ghertner R, Baldwin M, Crouse G, Radel L, Waters A. *The Relationship between Substance Use Indicators and Child Welfare Caseloads*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services; 2018
9. Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999-2016. *NCHS Data Brief*. 2017; (294):1–8
10. 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(31):799–802
11. Wilson D, Shiffman J. Helpless and hooked. *Reuters*. December 7, 2015. Available at: https://www.reuters.com/investigates/special-report/baby-opioids/. Accessed April 15, 2019
12. Comprehensive Addiction and Recovery Act of 2016, Pub L No. 114–198, 130 Stat 695
13. Substance-Affected Infants. *Additional Guidance Would Help States Better Implement Protections for Children*. Washington, DC: Government Accountability Office; 2018
14. Consolidated Appropriations Act of 2018, Pub L No. 115–141
15. SUPPORT for Patients and Communities Act 2018, Pub L No. 115–271
16. National Center on Substance Abuse and Child Welfare. Infants with prenatal substance exposure. Available at: https://ncsacw.samhsa.gov/resources/substance-exposed-infants.aspx. Accessed April 16, 2019
17. Patrick SW. Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions. 2018. Available at: https://www.help.senate.gov/imo/media/doc/Patrick.pdf. Accessed April 16, 2019
18. Family First Prevention Services Act 2018, Pub L No. 115–123
19. Quinn M. Fostering change. Governing. March 2019. Available at: https://archives.erepublic.com/GOV/GOV_Mag_Mar2019.pdf. Accessed April 15, 2019
20. Lloyd MH, Luczak S, Lew S. Planning for safe care or widening the net?: a review and analysis of 51 states' CAPTA policies addressing substance-exposed infants. *Child Youth Serv Rev*. 2019;2019(99):343–354
21. US Department of Health and Human Services, Office for Civil Rights. Drug addiction and federal disability rights laws. 2019. Available at: https://www.hhs.gov/sites/default/files/drug-addiction-aand-federal-disability-rights-laws-fact-sheet.pdf. Accessed April 16, 2019
22. Kim JH. Medication assisted treatment and the ADA. 2017. Available at: https://lac.org/wp-content/uploads/2018/02/DOJ-SDNY-ltr-to-OCA-10.3.17.pdf. Accessed April 16, 2019
23. First Focus. *Children's Budget 2018*. Washington, DC: First Focus; 2018

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