



Report to the Ranking Member,  
Subcommittee on Children and  
Families, Committee on Health,  
Education, Labor, and Pensions,  
U.S. Senate

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January 2018

# SUBSTANCE- AFFECTED INFANTS

Additional Guidance  
Would Help States  
Better Implement  
Protections for  
Children

# GAO Highlights

Highlights of [GAO-18-196](#), a report to the Ranking Member, Subcommittee on Children and Families, Committee on Health, Education, Labor, and Pensions, U.S. Senate

## Why GAO Did This Study

Under CAPTA, states perform a range of prevention activities, including addressing the needs of infants born with prenatal drug exposure. The number of children under the age of 1 entering foster care increased by about 15 percent from fiscal years 2012 through 2015. Child welfare professionals attribute the increase to the opioid epidemic. GAO was asked to examine the steps states are taking to implement CAPTA requirements on substance-affected infants and related amendments enacted in 2016.

This report examines (1) the extent to which states have adopted policies and procedures to notify CPS of substance-affected infants; (2) state efforts to develop plans of safe care, and associated challenges; and (3) steps HHS has taken to help states implement the provisions.

To obtain this information, GAO surveyed state CPS directors in all 50 states and the District of Columbia and reached a 100 percent response rate. GAO also visited 3 states (Kentucky, Massachusetts, and Pennsylvania); reviewed relevant documents such as federal laws and regulations, and HHS guidance; and interviewed HHS officials. GAO did not assess states' compliance with CAPTA requirements.

## What GAO Recommends

GAO recommends that HHS provide additional guidance and technical assistance to states to address known challenges and enhance their understanding of requirements. HHS did not concur with the recommendation. As discussed in the report, GAO continues to believe that added guidance would benefit states.

View [GAO-18-196](#). For more information, contact Kathryn Larin at (202) 512-7215 or [larink@gao.gov](mailto:larink@gao.gov)

January 2018

## SUBSTANCE-AFFECTED INFANTS

### Additional Guidance Would Help States Better Implement Protections for Children

## What GAO Found

All states reported adopting, to varying degrees, policies and procedures regarding health care providers notifying child protective services (CPS) about infants affected by opioids or other substances. Under the Child Abuse Prevention and Treatment Act (CAPTA), as amended, governors are required to provide assurances that the states have laws or programs that include policies and procedures to address the needs of infants affected by prenatal substance use. This is to include health care providers notifying CPS of substance-affected infants. In response to GAO's survey, 42 states reported having policies and procedures that *require* health care providers to notify CPS about substance-affected infants and 8 states reported having policies that *encourage* notification. The remaining 1 state has a policy requiring health care providers to assess the needs of mothers and infants and if they conclude that infants are at risk for abuse or neglect, CPS is notified.

In response to GAO's survey, 49 states reported that their CPS agency has policies to develop a plan of safe care; 2 reported not having such a requirement. Under CAPTA, states are required to develop a plan of safe care for substance-affected infants. Although not defined in law, a plan of safe care generally entails an assessment of the family's situation and a plan for connecting families to appropriate services to stabilize the family and ensure the child's safety and well-being. States reported that plans typically address the infant's safety needs, immediate medical needs, and the caregiver's substance use treatment needs. However, officials in the 3 states GAO visited noted challenges, including uncertainty about what to include in plans and the level of intervention needed for infants at low risk of abuse or neglect.

The Department of Health and Human Services (HHS) has provided technical assistance and guidance to states to implement these CAPTA requirements. Most states reported in GAO's survey that additional guidance and assistance would be very or extremely helpful for addressing their challenges. Nevertheless, HHS officials told GAO that the agency does not anticipate issuing additional written guidance, but that states can access technical assistance through their regional offices and the National Center on Substance Abuse and Child Welfare—a resource center funded by HHS. However, of the 37 states that reported on the helpfulness of the assistance they have received, 19 said it was only moderately helpful to not helpful. States offered suggestions for improving the assistance, such as developing substance abuse training materials for staff and holding video conferences with other states to share information. In October 2017, HHS officials explained that some states have submitted plans that include details on how they are addressing the CAPTA requirements. HHS officials reported that some of the plans submitted to date indicated that states are not meeting the requirements and those states have been asked to develop program improvement plans. Without more specific guidance and assistance to enhance states' understanding of CAPTA requirements and better address known challenges such as the ones described in this report, states may miss an opportunity to provide more effective protections and services for the children and families most in need.

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## Abbreviations

ACF	Administration for Children and Families
CAPTA	Child Abuse Prevention and Treatment Act
CARA	Comprehensive Addiction and Recovery Act of 2016
CPS	child protective services
HHS	Department of Health and Human Services
MAT	medication-assisted treatment
NAS	neonatal abstinence syndrome
NCSACW	National Center on Substance Abuse and Child Welfare
SAMHSA	Substance Abuse and Mental Health Services Administration
START	Sobriety Treatment and Recovery Team

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January 19, 2018

The Honorable Robert P. Casey, Jr.  
Ranking Member  
Subcommittee on Children and Families  
Committee on Health, Education, Labor, and Pensions  
United States Senate

Dear Mr. Casey:

States reported that parental drug abuse was a factor associated with the removal of 32 percent of the children entering foster care in fiscal year 2015. In addition, the number of children under the age of 1 entering foster care increased by about 15 percent (from 41,235 to 47,219) from fiscal year 2012 through fiscal year 2015—an increase that many researchers and child welfare professionals attribute to the opioid epidemic.<sup>1</sup> Infants born to women who misuse drugs or alcohol during their pregnancy are particularly vulnerable. Many infants are born affected by substance exposure and experience withdrawal symptoms, referred to as substance-affected infants. A subset of these infants who were exposed to opioids in utero may be diagnosed with neonatal abstinence syndrome (NAS), a condition characterized by a range of symptoms, including excessive crying, irritability, and difficulties with breathing and feeding.<sup>2</sup> The health, well-being, and safety of these infants may be jeopardized if they are sent home with parents with substance use disorders who do not have a system of support and are not in treatment or recovery.<sup>3</sup>

The Child Abuse Prevention and Treatment Act (CAPTA) is one of the key pieces of federal legislation that guides child protection and includes

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<sup>1</sup>U.S. Department of Health and Human Services, Administration for Children and Families, Adoption and Foster Care Analysis and Reporting System (AFCARS), fiscal year 2012 through fiscal year 2015.

<sup>2</sup>GAO, *Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome*, [GAO-18-32](#) (Washington, D.C.: October 4, 2017).

<sup>3</sup>National survey data suggest that new mothers have a high prevalence of alcohol and illicit drug use. Depression correlates with substance use, and new mothers with postpartum depression may be at high risk for substance use. Shawna L. Carroll Chapman and Li-Tzy Wu, "Postpartum Substance Use and Depressive Symptoms: A Review," *Women & Health*, vol. 53, no. 5 (2013).

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provisions related to substance-affected infants. Under CAPTA, state governors are required to provide an assurance to the Secretary of the Department of Health and Human Services (HHS) that their states have in effect and are enforcing a law or statewide program that requires (1) health care providers to notify child protective services (CPS)<sup>4</sup> of all infants affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, and (2) a plan of safe care be developed for all such infants, including the affected caregiver.<sup>5</sup>

You asked us to examine how states are implementing these CAPTA requirements. In this review, we examine (1) the extent to which states have adopted policies and procedures to notify CPS of substance-affected infants, and to guide how CPS officials respond once they receive a notification; (2) the extent to which states have adopted policies and procedures to develop plans of safe care for substance-affected infants, and any challenges associated with implementing such policies and procedures; and (3) steps HHS has taken to assist and monitor states' efforts in implementing CAPTA provisions related to substance-affected infants.

To address these questions, we collected and analyzed information using several methods. To obtain information on all three research questions, we designed and administered a web-based survey of states directed toward CPS directors in all 50 states and the District of Columbia.<sup>6</sup> The survey was conducted between March and May 2017, with 100 percent of states responding to the survey. The survey included open-ended and closed-ended questions about state laws, policies, and procedures regarding substance-affected infants; specific requirements or processes relating to infants affected by opioids; plans for ensuring the safety and well-being of substance-affected infants; data collection efforts;

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<sup>4</sup>In most jurisdictions, CPS is the agency mandated by law to conduct an initial assessment or investigation of reports of child abuse and neglect. It also offers services to families and children where maltreatment has occurred or is likely to occur.

<sup>5</sup>42 U.S.C. § 5106a(b)(2)(B)(ii),(iii).

<sup>6</sup>For the purpose of this report, we will collectively refer to the 50 states and the District of Columbia as "states."

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challenges to implementing CAPTA requirements; and assistance and guidance provided by HHS.<sup>7</sup>

To minimize nonsampling errors, we pretested the questionnaire with four states via telephone. We chose the pretest sites to include states with moderate to high rates of drug mortalities,<sup>8</sup> moderate to high NAS rates,<sup>9</sup> variation in state CPS administrative frameworks (two state-administered, one county-administered, and one hybrid partially administered by the state and partially administered by counties), and geographic variation (states from the mid-Atlantic, north, south, and west). In the pretests and expert reviews, we were generally interested in the clarity of the questions and the flow and layout of the survey. For example, we wanted to ensure that terms used in the survey were clear and known to the respondents, categories provided in closed-ended questions were complete and exclusive, and the ordering of survey sections and the questions within each section were appropriate. The web instrument was revised based on the pretests and expert reviews. We reviewed state officials' responses and conducted follow-up, as necessary, to determine that their responses were complete, reasonable, and sufficiently reliable for the purposes of this report. Specifically, we followed up with nine states via email and, in August 2017, conducted a semi-structured phone interview with one state.

To obtain more in-depth information on all three research questions about state laws, policies or procedures, as well as challenges to implementing the CAPTA provisions, we conducted site visits to three states (Kentucky, Massachusetts, and Pennsylvania). These states were selected based on their high rates of drug mortalities in 2014<sup>10</sup> and NAS in 2012,<sup>11</sup> the most recent and comprehensive publicly available data at the time of our analysis; recommendations from subject matter experts; and for variation

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<sup>7</sup>GAO did not assess states' compliance with CAPTA requirements; rather, this report conveys information which was reported to us by states about policies and procedures they have regarding substance-affected infants.

<sup>8</sup>L.M. Rossen, B. Bastian, M. Warner, D. Khan, and Y. Chong, *Drug poisoning mortality: United States, 1999–2014* (National Center for Health Statistics, 2016).

<sup>9</sup>Jean Y. Ko et al., *Incidence of Neonatal Abstinence Syndrome – 28 states, 1999–2013*, CDC MMWR, vol. 65 (2016).

<sup>10</sup>L.M. Rossen, B. Bastian, M. Warner, D. Khan, and Y. Chong, *Drug poisoning mortality: United States, 1999–2014*.

<sup>11</sup>Jean Y. Ko et al., *Incidence of Neonatal Abstinence Syndrome – 28 states, 1999–2013*.

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in state CPS administrative frameworks (two state-administered or one county-administered). We also visited two localities in each state, selected based on their high rates of drug mortalities and counties with a high incidence of neonatal abstinence syndrome (NAS) or infants born drug exposed. During the site visits we interviewed state CPS directors, alcohol and drug abuse directors, and maternal and child health directors; local CPS staff; and hospital staff, including hospital social workers. The information gathered from interviews with officials from selected states and localities is not generalizable to all states and localities and is meant to provide illustrative examples.

To learn about the steps HHS has taken to assist and monitor states' efforts in implementing CAPTA provisions related to substance-affected infants, we reviewed relevant documents, federal laws and regulations, guidance, and other information. In addition, we interviewed officials from the Department of Health and Human Services' (HHS) Administration for Children and Families (ACF) and the Substance Abuse and Mental Health Services Administration (SAMHSA) about oversight, technical assistance, and guidance regarding CAPTA provisions related to substance-affected infants. We also interviewed officials from the National Center on Substance Abuse and Child Welfare—the technical assistance provider under contract with HHS.

We conducted this performance audit from June 2016 to November 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

### Child Abuse Prevention and Treatment Act

CAPTA, originally enacted in 1974, provides formula grants<sup>12</sup> to states to improve child protective service systems.<sup>13</sup> ACF administers the CAPTA

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<sup>12</sup>Formula grant programs are noncompetitive awards based on a predetermined formula.

<sup>13</sup>Pub. L. No. 93-247, 88 Stat. 4 (1974) (codified as amended at 42 U.S.C. §§ 5101-5119c). For purposes of this report, we use "CAPTA" to refer to this statute as amended.



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state grant program and provides guidance and oversight to states. In fiscal year 2017, Congress provided about \$25 million for the program.

As part of the CAPTA state grant program, states are required to submit to the Secretary of HHS plans outlining how they intend to use CAPTA funds to improve their child protective service systems, among other things. State plans remain in effect for the duration of states' participation in the grant program; if modifications are needed, these must be submitted. In addition to state plans, states are required to submit to HHS an annual data report providing information on agency decisions made in response to referrals of child abuse and neglect, as well as preventive services provided to families, among other things.

CAPTA requires state governors to provide a series of assurances in their state plans. Since 2003, governors have had to provide an assurance that states have in effect and are enforcing a state law or program that includes policies and procedures to address the needs of infants affected by prenatal substance abuse or displaying withdrawal symptoms at birth. Under states' policies and procedures, health care providers are required to notify CPS of such infants.<sup>14</sup> Governors must also assure that a plan of safe care is developed for these infants. Although CAPTA does not define "plans of safe care," for the purposes of this report we define them as plans to ensure the safety and well-being of infants who are born substance-affected.<sup>15</sup>

The Comprehensive Addiction and Recovery Act of 2016 (CARA) amended certain provisions of CAPTA that relate to substance-affected infants (see table 1).<sup>16</sup>

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<sup>14</sup>Most infants with NAS in the United States are treated in a hospital setting, often in the neonatal intensive care unit. [GAO-18-32](#).

<sup>15</sup>CAPTA, as amended by CARA, does state that plans of safe care must address the health and substance use disorder needs of the infants and the affected caregiver.

<sup>16</sup>Pub. L. No. 114-198, 130 Stat. 695.

**Table 1: Child Abuse Prevention and Treatment Act (CAPTA) Provisions Pertaining to Substance-Affected Infants Before and After 2016 Amendments**

Topics	CAPTA prior to Comprehensive Addiction and Recovery Act of 2016 (CARA) amendments	CAPTA after CARA amendments
Notification	States were required to have in their state plans an assurance that the state has in effect and is enforcing a state law or program that includes policies and procedures relating to “infants born and identified as being affected by illegal [emphasis added] substance abuse or withdrawal symptoms resulting from prenatal drug exposure” and for health care providers involved in the delivery and care of substance-affected infants to notify the child protective services system of the occurrence of such condition in such infants.	Changed the term “illegal substance abuse” to “substance abuse.” <sup>a</sup>
Plans of Safe Care	As part of their state law or program, states were required to develop plans of safe care for infants born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.	Required that plans of safe care address the health and substance use disorder needs of infants affected by substance abuse and their families or caregivers.
State Monitoring	Not addressed	Required states to monitor plans of safe care to determine whether and how local entities are making referrals and delivering appropriate services to the infant and affected family or caregiver.
HHS Guidance / Technical Assistance	Not addressed	Required the Secretary of Health and Human Services (the Secretary) to maintain and disseminate information about best practices related to plans of safe care for infants born and identified as being affected by substance abuse or withdrawal symptoms or a Fetal Alcohol Spectrum Disorder.
State Reporting	States were required to annually provide, to the maximum extent practicable, a data report to the Secretary that includes specified information made in response to referrals of child abuse and neglect, as well as preventive services provided to families, among other things.	<p>Added a requirement that states report the following information:</p> <ul style="list-style-type: none"> <li>The number of infants identified as substance-affected</li> <li>The number of such infants for whom a plan of safe care was developed</li> <li>The number of such infants for whom a referral was made for appropriate services, including services for the affected family or caregiver.<sup>b</sup></li> </ul>
HHS Monitoring	Not addressed	Required the Secretary of Health and Human Services to monitor state policies and procedures on addressing the needs of substance-affected infants, including the provision of plans of safe care.

Source: GAO review of CAPTA, as amended by CARA. | GAO-18-196

<sup>a</sup>According to HHS guidance, states’ policies and procedures should address the needs of infants born affected by both illegal and legal substance abuse.

<sup>b</sup>HHS intends to collect this data through the National Child Abuse and Neglect Data System.

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In addition to provisions related to substance-affected infants, CAPTA also requires governors to provide an assurance to the Secretary of HHS that they have provisions or procedures for certain individuals to report known and suspected instances of child abuse and neglect, which are generally referred to as mandated reporter laws.<sup>17</sup> All states have statutes identifying persons who are required to report suspected child maltreatment to an appropriate agency, such as child protective services, a law enforcement agency, or a state's toll-free child abuse reporting hotline, according to a 2016 HHS report.<sup>18</sup> Mandatory reporters often include social workers; teachers, principals, and other school personnel; physicians, nurses, and other health care workers; and counselors, therapists, and other mental health professionals. The circumstances under which a mandatory reporter must make a report vary from state to state, according to HHS. Typically, a report must be made when the reporter, in his or her official capacity, suspects or has reason to believe that a child has been abused or neglected. State laws require mandatory reporters to report the facts and circumstances that led them to suspect that a child has been abused or neglected; they do not have the burden of providing proof that abuse or neglect has occurred.<sup>19</sup>

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## CPS Notification and Screening Process

CPS, a division within state and local social services, is generally the agency that conducts an initial assessment or investigation of reports of child abuse and neglect. It also offers services to families and children where maltreatment has occurred or is likely to occur. Typically, when CPS agencies receive a notification about suspected child abuse, including a substance-affected infant, social workers review the referral to determine if it should be accepted for investigation.<sup>20</sup> During an

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<sup>17</sup>42 U.S.C. § 5106a(b)(2)(B)(i).

<sup>18</sup>Child Welfare Information Gateway, *Mandatory reporters of child abuse and neglect* (Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau, 2016).

<sup>19</sup>Child Welfare Information Gateway, *Mandatory reporters of child abuse and neglect*.

<sup>20</sup>For example, according to Kentucky's *Reporting Child Abuse and Neglect Handbook*, a notification may be refused if a specific act of abuse, neglect or dependency is not alleged, such as a generalized concern for the welfare of the child that does not state specific allegations reflecting child abuse or neglect. Examples are a child who is improperly dressed, but the clothing deficiency does not result in harm to the child; a child who is provided nutritious food irregularly or insufficiently, but the health of the child is not impaired; or hygiene, that although not optimal, does not adversely affect the well-being of the child.

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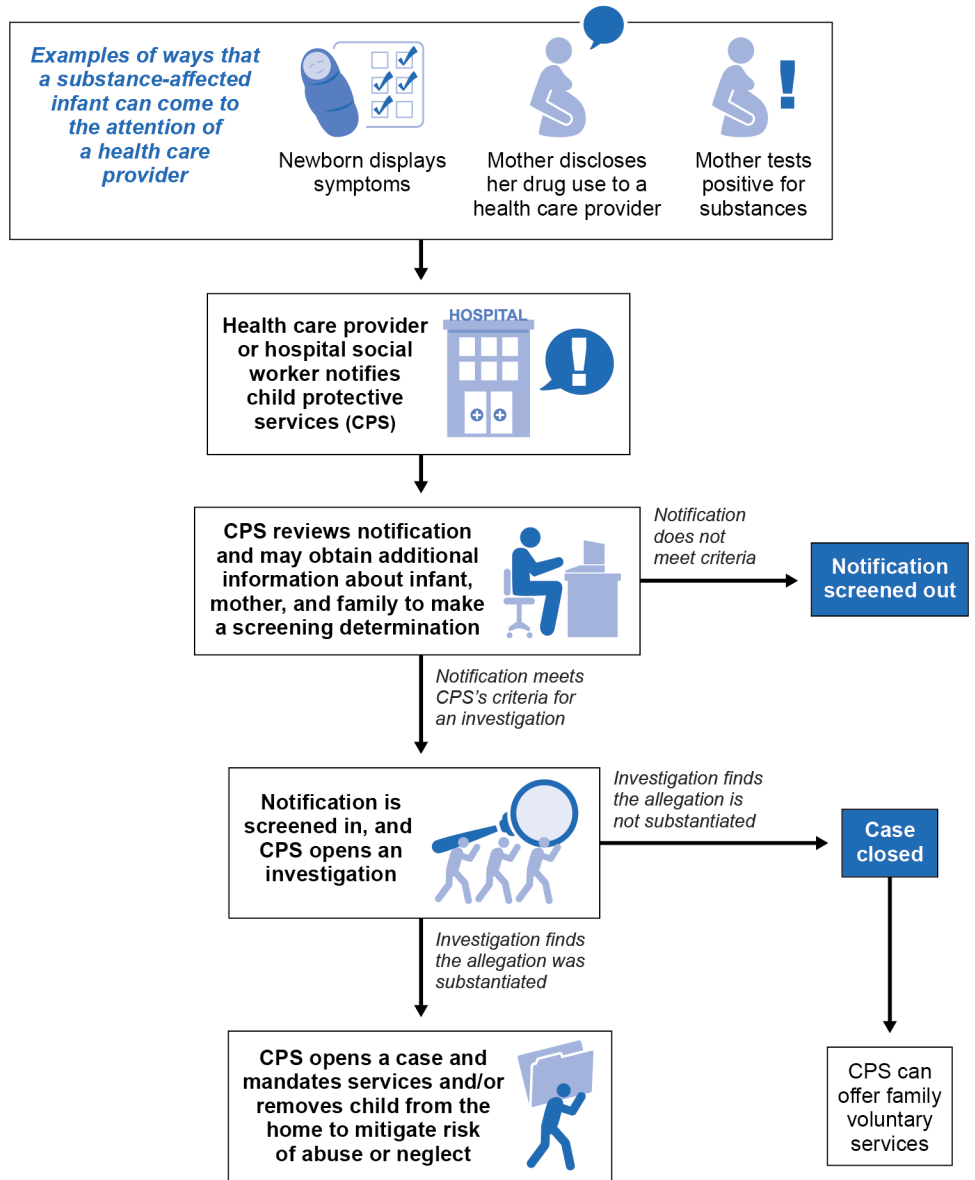
investigation, social workers determine, among other things, the nature, extent, and cause of abuse or neglect, and identify the person responsible for the maltreatment. An investigation may include the following: a visit to the hospital and/or infant's home; observation of the infant; risk and safety assessments; evaluation of the home environment; background checks, including criminal record checks of adults that reside with the family; as well as mental health evaluations.

If social workers determine that there is enough evidence to suggest that an infant is at risk for harm or neglect, or that abuse or neglect occurred, the case is substantiated. Once a case is substantiated, CPS develops a case plan with the family outlining objectives and tasks for the family. Among other things, CPS may refer the family to services in the community, such as early intervention services, parenting classes, and substance abuse treatment. Generally, CPS attempts to strengthen the family and alleviate the problems which led to maltreatment. If the case is not substantiated, but there is genuine concern about the child's situation and the family may benefit from services in the community, the case may be closed and/or the family may be referred for voluntary services (see figure 1).<sup>21</sup>

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<sup>21</sup>There are also instances in which the agency may screen in or accept a report, but not investigate it or make a determination that it is substantiated or not, and still offer services. In these instances, CPS may decide to use a differential response. Differential response is a CPS practice that generally involves two "tracks" or paths of response to reports of child abuse and neglect: traditional investigation for higher-risk cases and assessments or alternative responses for low- to moderate-risk cases.

**Figure 1: Typical Child Protective Services Notification and Investigation Process**



Source: GAO analysis of Child Welfare Information Gateway literature and interviews with officials in selected states. | GAO-18-196

Note: This figure is for illustrative purposes only as there may be variation among state procedures. GAO did not evaluate individual state laws or procedures in preparing this figure.

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## Neonatal Abstinence Syndrome and Prenatal Drug Use

Prenatal maternal opioid use has increased considerably in recent years. This increase has contributed to a significant rise in the rate of NAS. According to a recent study, the rate of NAS has increased from 1.2 per 1,000 hospital births in 2000 to 5.8 per 1,000 hospital births in 2012, reaching a total of 21,732 infants diagnosed with NAS.<sup>22</sup>

NAS occurs with considerable variability. According to a recent HHS report, various studies indicate that anywhere from 55 to 94 percent of infants exposed to opioids in-utero exhibit some degree of symptoms.<sup>23</sup> Typically, infants with NAS develop symptoms within 72 hours of birth, but may develop symptoms within the first 2 weeks of life, including after hospital discharge. For the purpose of this report, infants exposed to opioids ingested by mothers in utero are considered substance-exposed, and those born negatively affected by exposure or experiencing withdrawal symptoms are considered substance-affected. According to experts, NAS is considered an expected and treatable result of women's prenatal opioid use.

Opioid exposure during pregnancy may occur for the following reasons:

- Women receiving pain medication with a prescription under the care of a physician. Medications can include fentanyl and oxycodone.
- Women under the care of a physician and undergoing treatment for an opioid use disorder with medications, such as methadone or buprenorphine. This type of treatment is generally referred to as medication-assisted treatment (MAT).
- Women misusing opioid pain medications with or without a prescription (such as using without a prescription, using a different dosage than prescribed, or continuing to use a drug when no longer needed for pain).
- Women using or abusing illicit opioid, such as heroin.

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<sup>22</sup>[GAO-18-32](#).

<sup>23</sup>See Substance Abuse and Mental Health Services Administration (SAMHSA), *Protecting Our Infants Act: Report to Congress* (May 2017).

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## Most States Reported Having Policies About Notification and Investigation of Substance-Affected Infants

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### State Policies Generally Require or Encourage Health Care Providers to Notify Child Protective Services of Substance-Affected Infants

In response to our survey, 42 states reported that state policies and procedures require health care providers to notify CPS about substance-affected infants.<sup>24</sup> Some states reported that they explicitly require health care providers to notify CPS of substance-affected infants. For example, Wisconsin reported that under its state law if tests indicate that infants have controlled substances or controlled substance analogs in their bodily fluids, the health care provider shall report the occurrence of that condition to CPS.<sup>25,26</sup> Others reported that the requirement is met by their states' mandated reporter law—whereby people in certain positions, including health care providers, are required to notify CPS about substance-affected infants, similar to the manner in which other mandatory reporters, like school teachers, day care personnel, and social workers are required to report other instances of child abuse and neglect. For example, Kentucky statute requires that “any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately” make a report to the police or CPS. The statutory definition for an abused or neglected child in Kentucky includes situations where a child’s health or welfare is harmed or threatened with harm because of parental incapacity due to alcohol and other drug abuse.

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<sup>24</sup>GAO did not assess states' compliance with CAPTA requirements. In response to survey questions about policies and procedures they have regarding substance-affected infants, states sometimes responded with information on state laws. GAO did not verify the accuracy of specific statutory references in states' responses nor did we conduct an exhaustive examination of state laws in general.

<sup>25</sup>Controlled substances are generally regulated by the government based on their medical use, potential for abuse, and safety or dependence liability.

<sup>26</sup>Under Wisconsin law, a controlled substance analog is a substance which has a substantially similar chemical structure to that of a controlled substance.

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Of the 42 states that require health care providers to notify CPS of substance-affected infants, 21 reported that notification is required for infants affected by both illegal and legal use of opioids. For example, in Massachusetts health care providers are required to notify CPS orally and, in writing within 48 hours, about substance-affected infants physically dependent on drugs, even if the drugs were legally obtained and the mother is under the care of a prescribing medical professional. Sixteen of the 42 states reported that health care providers are required to notify CPS of infants affected only by the illegal use of opioids, and five of the 42 states reported that they did not know if health care providers were required to notify CPS of infants affected by the illegal and legal use of opioids.

The other eight states reported that although they did not have policies and procedures that require health care providers to notify CPS about substance-affected infants, they have laws or policies that *encourage* notification. Specifically, in written responses to our survey:

- Two states reported that under their state mandated reporter laws health care providers are encouraged, but not required, to notify CPS about substance-affected infants.
- Four states reported that they are working to amend their states' policies and procedures to require that health care providers refer substance-affected infants to CPS.
- Another state reported that it encourages the notification from health care providers, but has not sought legislation to require health care providers to report substance-affected infants to CPS because of concerns that any laws that criminalize prenatal substance use would further deter substance-using pregnant women from seeking prenatal care. The state's law requires all hospital personnel who suspect abuse and neglect or observe conditions that are likely to result in abuse or neglect to notify CPS.
- One state reported that all persons, including health care providers, are required to report child abuse and neglect, but reporting depends on whether a hospital's policy indicates substance abuse is child abuse or neglect. Further, the state CPS director reported collaboration with the health care community on reporting substance exposed infants to its child abuse hotline.

Although one state reported in our survey that it does not require or encourage health care providers to notify CPS about substance-affected infants, in an interview, state officials explained that its policy requires that



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health care providers notify CPS if, through an assessment, they conclude that infants are at risk for abuse and neglect. Under the state's law, health care providers in each county are required to assess the needs of mothers and substance-affected infants using a protocol established by county health departments, CPS agencies, and hospitals. State officials told us that under the state's law, the birth of a substance-affected infant is not in and of itself a sufficient basis for reporting child abuse or neglect.

In addition to having policies and procedures regarding the reporting of substance-affected infants, in written responses to our survey some states reported providing training and guidance to support the efforts of health care providers to notify CPS about these infants. Three states reported that they offer mandatory reporter training to inform health care providers that they are obligated to notify CPS about substance-affected infants.<sup>27</sup> Another state reported that its Department of Human Services developed a guide for mandated reporters that discusses what needs to be reported and where to make reports. Also, one state reported that it sent a formal letter to its state hospital association about how to report substance-affected infants to CPS. This state also sent a memo to its CPS county directors instructing them to contact their local health care providers on the importance of reporting substance-affected infants to CPS and the process for doing so. In addition, during our Massachusetts site visit, officials shared with us a memo that was sent to mandated reporters, community partners, and other stakeholders that offered guidance on when to file a report about substance-exposed infants. Further, local CPS staff at one Massachusetts field office told us that upon request they provide mandated reporter training to health care providers.<sup>28</sup>

Despite these policies, procedures, and guidance, in written responses to our survey, a few states reported concerns about requiring health care providers to notify CPS about substance-affected infants and the definition of substance-affected. All of the hospitals that we visited have

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<sup>27</sup>These states reported this information in response to an open-ended survey question.

<sup>28</sup>A state audit of a Massachusetts medical center found that 1 out of 456 substance-exposed infants born at the center, during the audit period, was not reported to CPS and an additional 79 were not sent within the required 48-hour timeframe. Commonwealth of Massachusetts Office of the State Auditor, *Review of Mandated Reports of Children Born with a Physical Dependence on an Addictive Drug at the UMass Memorial Medical Center, Inc.* (June 29, 2017).

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policies consistent with their state's law that require that health care providers, primarily hospital social workers, to notify CPS about substance-affected infants. However, one state reported that some medical personnel have been reluctant to report some infants that are positive for illegal and legal substances due to fears of mothers being arrested. Another state reported that stakeholders are concerned that having to notify CPS about substance-affected infants will have a chilling effect on the willingness of pregnant women who use substances to be honest with providers and seek the help and support they need and deserve. According to one state, there is often an inherent resistance to contacting CPS in these cases as health care providers tend to view child welfare involvement as punitive rather than a potential resource for the family.<sup>29</sup>

In addition, three states reported in written responses to our survey challenges understanding how to define terms, such as substance-affected, under CAPTA. For example, the Pennsylvania CPS director expressed concerns during our site visit, suggesting that CAPTA raises many unanswered questions, such as (1) if "affected by substances" means at-risk of being or physically affected by substances, (2) what policies relating to substance-affected infants should look like and include, and (3) whether "affected by substances" should include women who are under the care of health care or treatment providers and taking their medications as prescribed. A Kentucky public health official told us that a drug test, or whether the infant is affected by legal or illegal substances, should not be the sole factor in determining CPS' involvement with a family. Rather, a holistic view of the family, whether the substance prohibits the mother's ability to care for her child, and any risk factors present that places the infant at risk should also be considered. According to officials, an infant that is exposed to substances, but has not been affected by the substance, can still be at risk for child abuse and neglect.

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<sup>29</sup>As we previously reported, the stigma faced by pregnant women with opioid use disorders is a challenge in addressing NAS. Among other things, stigma may cause the women to fear punitive effects, such as losing custody of their children or losing their jobs. [GAO-18-32](#).

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## States Reported Having Policies That Guide Decisions About Investigating Substance-Affected Infants and Their Families

In response to our survey, 46 states reported that they have policies and procedures for deciding which notifications about substance-affected infants are accepted for investigation. Seventeen of those states reported that all notifications of substance-affected infants are accepted for investigation, regardless of the circumstances. The remaining 29 states reported that they apply specific criteria to determine if children who present as substance-affected are accepted for investigation by CPS.

- Several states reported in written responses to our survey that they base their criteria for accepting notifications on the infant's safety. For these states, drug exposure does not by itself indicate that an infant's safety is at risk. For example, one state explained that in determining a child's safety risk, staff evaluate a number of factors including the history of the family; the family's presentation at the birthing hospital (appearance of chaotic behavior, suspected intoxication of adults, lack of appropriate concern or bonding with the infant); the presentation of the infant's physical condition; the results of any testing of parent or child (blood, urine, etc.); discrepancies identified in the parent's representation of their substance use or substance use treatment; and any other concerns noted by the reporting source.
- Other states reported that their criteria for accepting notifications for investigation are based on the degree or type of drug exposure in question. For example, one state reported that its policy directs CPS agencies to accept notifications for investigation when a parent has used illegal substances or non-medical use of prescribed medication during the last trimester of pregnancy. Another state reported that it will accept notifications for investigation if the infant is born with a positive toxicology or is experiencing drug withdrawal, or if the mother tests positive for substances.
- A few states reported using both risk to the safety of infants as well as degree or type of drug as their criteria for accepting notifications. For example, one state reported that it considers factors, such as the type of drug, the parent's ability to care for the child, addiction history, and the parent's readiness and preparation to care for the infant.

In follow-up correspondences with states that reported that they do not have policies and procedures to decide whether to accept for

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investigation notices about substance-affected infants, one state reported that decisions are made on a case-by-case basis.<sup>30</sup>

A few states reported that after receiving notifications about substance-affected infants, CPS agencies may decide to opt out of investigating some families, referred to as “screening out” families. For example, in Massachusetts, CPS can “screen out” referrals of mothers if the only substance affecting the infants was used by the mothers as prescribed by their physician. In these instances, when CPS in Massachusetts is notified by the hospital about an infant, the screener gathers information from the caller and consults with a supervisor to determine whether the referral should be accepted for investigation or screened out. If the mother is on methadone, for example, but is involved with services and is in a treatment plan, CPS verifies with medical or other qualified providers that the mother used the drug as part of substance abuse or medical treatment as authorized. Additionally, CPS confirms that there are no other concerns of child abuse and/or neglect. If CPS officials in Massachusetts are unable to collect all the information that they need to screen out families, for example when a mother does not sign a release allowing CPS officials to speak with her health care providers, notifications about substance-affected infants are accepted for investigation.

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<sup>30</sup>Four states did not respond to our follow-up correspondences.

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## Most States Reported Having Requirements to Develop Plans of Safe Care, but Officials We Interviewed Reported Challenges Meeting the Needs of All Families

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### States Reported That CPS Agencies Develop Plans to Primarily Address Infants' Immediate Safety and Medical Needs and Caregivers' Substance Use

In response to our survey, 49 states reported that their CPS agency has policies to develop a plan to ensure the safety and well-being of substance-affected infants who meet the state's criteria for investigation. Two states reported that CPS staff are not required to develop such a plan, even if a notification is accepted for an investigation or an assessment. For purposes of this report, we are defining a plan of safe care as a plan to ensure the safety and well-being of the infant.<sup>31</sup> States' approaches to identifying children and families who will receive a plan of safe care generally fall into two categories:

- 38 states reported that CPS is required to develop a plan of safe care for all notifications of substance-affected infants that are accepted for investigation, including those that are not substantiated.<sup>32</sup>
- 11 states reported that CPS staff are required to develop a plan of safe care only in those instances where an investigation substantiates the notification or uncovers an unmet need or present or emerging danger. For example, local Pennsylvania CPS officials told us that they only develop plans when there is a safety threat or other concern about the infant.

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<sup>31</sup>GAO did not assess states' compliance with CAPTA requirements, including the requirement for states to provide a plan of safe care for substance-affected infants and their caregivers.

<sup>32</sup>Under guidance provided by HHS, an investigation is not substantiated when there is not sufficient evidence under state law or policy to conclude that the child has been abused or neglected, or is at risk of being abused or neglected.

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Most states reported that after a notification of a substance-affected infant is accepted for investigation, CPS always conducts a needs assessment for the infant and caregivers.<sup>33</sup> For example, one local CPS office that we visited told us that social workers assess risk to and safety of infants, their function (development, age appropriate behavior, etc.), and environment. In addition, workers assess the caregiver's ability to parent and employment status, as well as housing. The assessments conducted as part of the investigation inform the development of plans of safe care, as well as decisions about the removal of infants from the home.

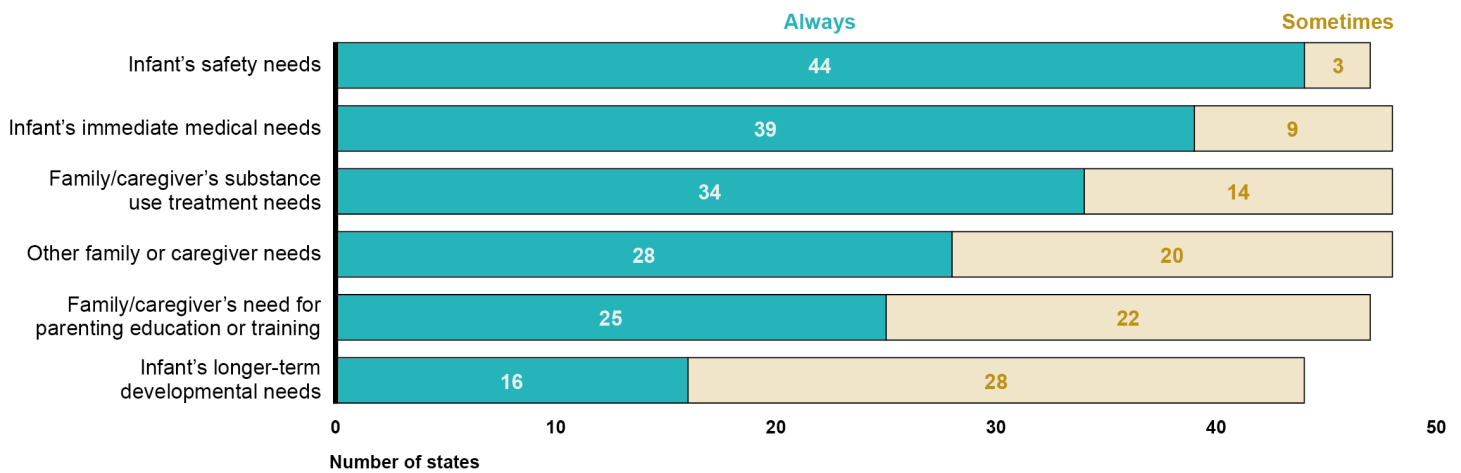
Among the 49 states that reported that plans of safe care are developed for all or some substance-affected infants, 47 reported that these plans either always or sometimes address infants' safety needs.<sup>34</sup> Plans also address other needs, such as infants' immediate medical and longer-term developmental needs, as well as caregiver's substance use treatment needs. See figure 2 for the number of states whose plans of safe care address various issues facing the infant and parent.

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<sup>33</sup>Thirty-eight of the 49 states that responded to this question reported that CPS always conducts a needs assessment for the infant. Forty of the 50 states that responded to a separate question reported that CPS always conducts a needs assessment for the caregiver.

<sup>34</sup>Two states did not provide a response regarding whether their plans of safe care address infants' safety needs.

**Figure 2: Number of States That Reported Their Plans of Safe Care Address Infants and Caregivers Needs**



Source: GAO analysis of state survey directed toward child protective services (CPS) directors. | GAO-18-196

Notes: GAO did not assess states' compliance with CAPTA requirements, including the requirement for states to provide a plan of safe care for substance-affected infants and their caregivers. The number of states that provided a response regarding the various issues their plans address varied. Total may not add up to 49. This figure does not include the number of states that reported that their plans of safe care do not address the various issues, as well as the number of states that reported that they do not know whether their plans address the various issues.

In written responses to our survey and during our site visits, officials reported that plans of safe care and referrals for services included in the plans are individualized based on the infant and family's needs. For example, Massachusetts state CPS officials told us that plans of safe care are developed for each family based on the information that staff collect from the safety, risk, and family assessments, as well as information collected from individuals who may have knowledge that would inform the family assessments, such as medical and treatment providers, and family members. Kentucky state CPS officials told us that the local organizations and service providers that they collaborate with to develop the plan of safe care also vary based on the family's needs. For example, Kentucky will only collaborate with substance use treatment providers to develop the plan of safe care when families have substance use disorders.

Similarly, during our site visits, officials from two states told us that the decision to place an infant in foster care is based on the individualized needs of the infant and caregiver. For example, Massachusetts state officials told us that their decision to remove a baby from the home depends on a myriad of factors and is determined on a case-by-case basis. Officials explained that if a mother is discharged from the hospital

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and begins using drugs again and does not have adequate supports in place to care for her baby, CPS may decide to place the infant in foster care. However, if a mother has existing support systems in place to mitigate safety risks, CPS may decide to keep the baby in the home.

In our survey, all 51 states reported that their agencies either always or sometimes refer parents or caregivers to substance use treatment programs, and most states reported that they always or sometimes refer parents or caregivers to parenting classes or programs (49), and other supportive services (49).<sup>35</sup> CPS officials in each of the three states that we visited told us that their plans of safe care include referrals to address not only the immediate needs of the infants, but also the needs of the parent or caregiver. For example, officials from a local Kentucky CPS agency told us that staff refer mothers of substance-exposed infants to a program called Sobriety Treatment and Recovery Team (START). START is comprised of a social worker and a peer support mentor who has at least 3 years of sobriety, previous involvement with CPS, and was successfully able to regain or keep custody of her own children. According to officials, the START program has been able to provide participants with quick access to substance use disorder treatment.

Officials from a Massachusetts local CPS agency told us that one of the services that they provide to parents of substance-affected infants is a parent aide who can help monitor how the parent is caring for the infant, such as administering the infant's medications appropriately and ensuring the parent is not abusing the infant's drugs. In addition, a parent aide can provide emotional support and help parents adjust after the infant is discharged from the hospital. Kentucky officials noted the effect that a healthy caregiver has on the outcome of the infant and emphasized that a baby cannot be healthy if the mother is not. Kentucky CPS officials said that they have found that the earlier caregivers enter treatment, the better the outcomes are for mothers and babies. According to Kentucky officials, parents who participate in the START program are less likely to have their child placed in foster care.

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<sup>35</sup>One state did not provide a response regarding whether they refer the family/caregiver to parenting classes or programs.



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## CPS Officials Reported Challenges Involving Caseloads, Developing Plans, and Confidentiality Restrictions

Officials from the states that we visited told us that developing and monitoring plans of safe care under CAPTA's new requirements for infants affected by their mother's legal use of prescribed medications, as well as plans for these infants' caregivers, present challenges. Specifically, officials reported concerns about increased caseloads, particularly if they are required to provide plans and services for infants at low risk of abuse or neglect, the content of plans, and confidentiality restrictions.

### Increased Caseloads

Thirty-one of 50 states reported on our survey that staffing or resource limitations was very or extremely challenging, and CPS officials across the 3 states we visited said that the opioid epidemic has directly contributed to increased caseloads.<sup>36</sup> According to a local Kentucky CPS office, the number of babies that met criteria for being accepted for investigation has increased about 55 percent from 2011 to 2016, while the number of staff has remained the same.<sup>37</sup> Similarly, hospitals reported being impacted by this challenge. For example, staff at four hospitals we visited told us that they have delayed discharging infants from the hospital because CPS social workers did not identify caregivers to whom infants may be released or make plans for infants in a timely manner. In addition, staff from three hospitals told us that some CPS workers are difficult to contact and not especially responsive to their questions. One hospital social worker told us that she is concerned that the changes to CAPTA that require notifying CPS of all substance-affected newborns will inundate the agencies with cases.

Officials from two of the three states we visited anticipated that providing services to infants affected by the legal use of prescribed medications, but not likely to be at risk for child abuse and neglect, will result in an increase in the number of families referred to CPS. This, in turn, will require a plan of safe care and further strain limited resources. Twenty-five states reported in our survey that the plan they develop for substance-affected infants is the same as for other children in CPS care, suggesting that states devote the same level of resources to these infants as other cases.

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<sup>36</sup>One state did not provide a response to this question.

<sup>37</sup>Kentucky reported on our survey that notifications of substance-affected infants are only accepted for an investigation if they meet certain criteria.

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The states we visited interpret CAPTA to require that plans of safe care be developed for all substance-affected infants who are referred to CPS, including those who may not meet usual criteria to be accepted for an investigation. Some state officials we interviewed questioned whether the new CAPTA requirements would allow for the best use of limited resources. For example, one senior state CPS official questioned whether it would be a good use of resources to develop plans of safe care for mothers in substance use disorder treatment or mothers using opioid medications due to chronic pain. A local CPS official we interviewed stated that drug exposure, in and of itself, is not necessarily a safety risk, and CPS should not intervene with families who are not at risk for child abuse or neglect. Instead, hospitals or treatment providers should intervene and refer families who do not meet criteria for CPS involvement, but could benefit from additional supports, to voluntary services. Kentucky public health officials told us that the period after a woman gives birth is a critical time for families as mothers may be stressed, sleep-deprived, exhausted, and may have other children in the home. This period may be especially challenging for mothers with substance use disorders, if adequate supports are not in place. According to officials women are typically covered for substance use treatment during pregnancy; however, this coverage ends roughly 60 days after the baby is born.

In written responses to our survey, some states reported that they would rely on other agencies to develop plans of safe care. Similarly, in order to manage limited CPS resources, officials from two of the three states that we visited said they are considering having hospitals or other agencies assume responsibility for developing plans of safe care when there is no evidence of abuse or neglect and there appears to be minimal risk to the safety and well-being of the infant. Kentucky officials told us that they envision that CPS will be responsible for developing a plan of safe care for notifications that are accepted for investigation, while hospitals, or another agency, will be responsible for developing plans of safe care for referrals that are screened out by CPS. According to CPS state officials, the plan of safe care for the infant and the family can be part of the discharge plan prior to the family leaving the hospital. However, officials reported that obtaining cooperation from other agencies may be difficult. Some state officials reported being concerned that other agencies may not feel obligated to develop these plans, in part, because CAPTA provides funding to child welfare, and other agencies may therefore believe that child welfare should be responsible for developing the plan of safe care.

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## Determining What to Include in the Plan of Safe Care

CPS officials we interviewed in two of our site visit states, as well as one state we followed up with, told us that they were unsure of whether their current plans will meet new CAPTA requirements because CAPTA does not define a plan of safe care. For example, Massachusetts officials said that their plans include everything that a family might need to ensure the safety of the child, including resources to ensure stabilization and reunification of a family, but they are not sure whether the plans meet new CAPTA requirements, in part because they are not familiar with the term “plan of safe care.” An official in another state was also unsure about whether his state’s “safety plans” would meet CAPTA requirements. According to the official, safety plans may include a treatment plan for mothers, and referral services, such as early intervention for the child. In practice, plans of safe care generally address gaps that place an infant at risk for harm or neglect. However, state officials we interviewed reported being unsure about what a plan of safe care should look like for families where these gaps do not exist. Also, in a written response to our survey, one state expressed uncertainty about CPS’ role if required to work with infants who do not typically receive CPS services. For example, a Pennsylvania official said that it is unclear what types of interventions child welfare should conduct with families of infants exposed to legal substances, such as medications prescribed by doctors, when the caregivers are taking their medications correctly.

Similarly, officials also questioned whether a plan would be necessary, and what the plan would entail, for caregivers who are already addressing their substance use disorder and taking steps to ensure their infant’s safety. Officials from a local Kentucky CPS office described a case in which a mother was participating in medication-assisted treatment, had attended counseling three times per week throughout her pregnancy, and was continuing treatment in the postpartum period. Through CPS’ investigation, the agency found that the case was not substantiated, in part, because there were no additional services that CPS could connect her with that she was not already receiving.

## Confidentiality Restrictions

Officials across the three states we visited also said that state and federal drug and alcohol confidentiality restrictions may challenge their ability to monitor plans of safe care. To monitor plans of safe care, CPS staff may need access to confidential information in order to know how caregivers are progressing in treatment, particularly now that these plans must address the substance use disorder needs of the caregiver. However, federal law restricts the disclosure and use of alcohol and drug patient

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records maintained in connection with the performance of any federal-assisted alcohol and drug abuse program.<sup>38</sup> Generally, confidential information may be disclosed in accordance with the prior written consent of the patient.<sup>39</sup> State and local CPS staff we interviewed said that strict confidentiality requirements make it challenging for drug and alcohol treatment providers to share information about mothers and infants. A CPS state director from Pennsylvania said that treatment providers are often reluctant to provide CPS case workers with information or updates on a mother's treatment, which prevents child welfare workers from fully understanding how mothers are progressing with their treatment and the extent to which those in treatment are adhering to prescribed directions as outlined by treatment providers.

In addition, one official from a state we visited said state statutes regarding sharing of drug and alcohol treatment information may be more restrictive than the federal statute. Some states have developed ways to obtain confidential information about mothers in substance use disorder treatment. For example, officials from one local CPS office told us that in instances when they have to develop a long-term plan of safe care for families, they have mothers sign a release of information form in order to obtain updates about her treatment adherence from the medication-assisted treatment provider. Similarly, a local Massachusetts CPS office told us that typically staff obtain releases from mothers so that they can verify whether mothers are actively participating in their treatment and that there are no records of relapse.

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<sup>38</sup>42 U.S.C. § 290dd-2(a). Under HHS regulations implementing this provision, restrictions on disclosure do not apply to the reporting under state law of incidents of suspected child abuse and neglect, among other things. 42 C.F.R. § 2.12(c)(6).

<sup>39</sup>42 U.S.C. § 290dd-2(b)(1).

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## Although HHS Has Provided Technical Assistance and Guidance to Assist States' Efforts to Implement CAPTA, States Want More Help

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### HHS Provided Technical Assistance Through a Resource Center and ACF Issued Formal Guidance and Began Its Oversight Efforts

In HHS' role to assist states in the delivery of child welfare services, two agencies—ACF and the Substance Abuse and Mental Health Services Administration (SAMHSA)—provided technical assistance to states through the National Center on Substance Abuse and Child Welfare (NCSACW). In addition, in ACF's role to administer and monitor states' implementation of CAPTA, the agency has provided some guidance to states on the provisions pertaining to substance-affected infants and has begun its monitoring responsibilities.

### Technical Assistance

ACF and SAMHSA, which leads public health efforts to reduce the impact of substance abuse and mental illness, established the NCSACW in 2002.<sup>40</sup> The NCSACW provides technical assistance to states, and has issued publications and hosted forums to help states develop policies and procedures around issues affecting substance-affected infants. The technical assistance has focused on a broad range of issues, including collaboration among service providers, and plans of safe care. With respect to collaboration, NCSACW has issued several studies that identify opportunities for strengthening interagency efforts to prevent, intervene, identify, and treat prenatal substance exposure. The NCSACW collaboration guides encourage states to involve CPS agencies with medical providers in an interagency collaborative setting, thereby facilitating the process for CPS agencies to be notified of substance-affected infants. Regarding plans of safe care, NCSACW has provided technical assistance and best practices to states around development of

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<sup>40</sup>HHS contracts with a vendor for the administration of the NCSACW. In a recent re-bid of the contract, Children and Family Futures was the recipient selected to continue the administration of the NCSACW.

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these plans. For example, in one state it has facilitated discussion groups to help the state develop a model plan.

From calendar year 2011 to 2016, NCSACW processed approximately 600 requests from state CPS agencies for short-term technical assistance related to improving care for substance-affected infants and their families. This short-term technical assistance included activities such as responding to telephone inquiries, mailing information, identifying needed resources, and making referrals. The NCSACW has also provided in-depth assistance to 16 states to strengthen collaboration and linkages across child welfare, addiction treatment, medical communities, early care and education systems, and family courts to improve outcomes for substance-affected infants and their families. Through this in-depth assistance, NCSACW identified areas for improvement in states, including a lack of clarity regarding compliance with CAPTA requirements (such as identification, notification, and developing plans of safe care) and the need for state models to comply with CAPTA requirements to develop plans of safe care. In one state, the project overview report indicated that a next step for the in-depth technical assistance is to continue development of the plan of safe care model and ensure practices and protocols are in place across systems to meet CAPTA requirements. The report indicated that this will include ongoing work with hospitals to ensure consistent identification of infants with prenatal exposure and notifications to CPS.

Although 18 states reported in our survey that technical assistance from the NCSACW was very or extremely helpful, 11 reported that it was moderately helpful, 7 reported that it was slightly helpful, and 1 reported that it was not at all helpful. Eleven states reported that they were not familiar with this assistance.

## Guidance

Since July 2016, when the most recent amendments to CAPTA were enacted, ACF has issued one information memorandum and two program instructions to states about provisions relating to substance-affected infants. According to an ACF official, information memoranda share information with states, while program instructions provide interpretations of the law and inform states of actions they must take. ACF issued an August 2016 information memorandum informing states of the 2016 amendments to CAPTA. The August 2016 information memorandum also provided states with best practices, drawing on an NCSACW guide on collaboration for developing multi-systemic approaches to assist child welfare, medical, substance use disorder treatment, and other systems to support families affected by opioid use disorders.

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In January 2017, ACF issued a program instruction which provided guidance to states on implementing the 2016 amendments to CAPTA made by CARA and informed states of the flexibilities that they have under the law. Particularly, the guidance noted that:

- “CAPTA does not define ‘substance abuse’ or ‘withdrawal symptoms resulting from prenatal drug exposure.’ We recognize that by deleting the term ‘illegal’ as applied to substance abuse affecting infants, the amendment potentially expands the population of infants and families subject to the provision [that states have policies and procedures in place to address their needs]. States have flexibility to define the phrase, ‘infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure,’ so long as the state’s policies and procedures address the needs of infants born affected by both legal (e.g., prescribed drugs) and illegal substance abuse.”
- “While CAPTA does not specifically define a ‘plan of safe care,’ CARA amended the CAPTA state plan requirement . . . to require that a plan of safe care address the health and substance use disorder treatment needs of the infant and affected family or caregiver.”
- “CAPTA does not specify which agency or entity must develop the plan of safe care; therefore the state may determine which agency will develop the plans. We understand that in most instances the state already has identified the responsible agency in its procedures. When the state reviews and modifies its policies and procedures to incorporate the new safe care plan requirements in CARA, the state may wish to revisit its procedures regarding which agency develops the plan of safe care, including any role for agencies collaborating with CPS in caring for the infant and family.”

In addition, in April 2017, ACF issued a program instruction on reporting requirements, including changes in those requirements brought about by the 2016 amendments to CAPTA.

## Monitoring

ACF conducted limited monitoring of states prior to the amendments passed in 2016. According to ACF officials, if presented with evidence of potential deficiencies, the agency would attempt to learn more about the state’s activities. In one instance, ACF reviewed South Carolina’s policies and found them to not be in compliance with the notification and safe care plan requirements of CAPTA. It directed the state to develop a program improvement plan to bring it into full compliance, which South Carolina submitted in April 2016. In a recent progress report (February–April

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2017), South Carolina reported that it was focused on updating statutes, developing policies and procedures, training child protective service workers, and building relations with health care providers.

In response to the 2016 amendments to CAPTA that added the requirement for HHS to monitor state policies and procedures to address the needs of substance-affected infants, ACF officials told us that staff in regional offices will review states' annual reports, submitted in June 2017. In its program instruction describing the reporting requirements, ACF asked each state to submit a new Governor's Assurance, as well as a narrative explaining what they have done in response to the amendments. Specifically, ACF asked states to provide information on any changes that were made in state laws, policies, or procedures related to identifying and referring infants affected by substance abuse to CPS as a result of prenatal drug exposure. It also requested updates on states' policies and procedures regarding the development of plans of safe care; a description of how states have developed systems to monitor plans of safe care; and a description of any outreach or coordination efforts the states have taken to implement the amendments, among other things. According to ACF officials, as of October 1, 2017, some states have provided information and a Governor's Assurance demonstrating compliance with the amended provisions and some states have been placed on Program Improvement Plans, but the agency does not yet have information on the status of all states. An ACF official explained that, in their annual reports, some states either acknowledged that they are trying to get legislation enacted to bring them into compliance with the law and it has failed, or that they are not in compliance, for example, because they were limiting their policies to those infants affected only by illegal substances.

In addition, in May 2017, ACF issued a technical bulletin informing states of the new data collection requirements that resulted from the 2016 amendments to CAPTA. ACF stated that it intends to collect data required by the amendments to CAPTA through the National Child Abuse and Neglect Data System, beginning with states' submission of fiscal year 2018 data. This system is maintained by ACF and contains data from states about children who have been abused or neglected. ACF issued a Federal Register notice about the proposed data elements and requested comments on the accuracy and quality of the proposed data collection,



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among other things;<sup>41</sup> the comment period closed in July 2017. In the Federal Register notice, ACF notes that the 2016 amendments to CAPTA require it to collect information from state CPS agencies on the number of notifications from health care providers that are accepted for investigation or screened out. Further, of those infants screened in, ACF is required to collect data on the number of safe care plans developed for substance-affected infants as well as the number of infants for whom a referral was made for appropriate services, including services for the affected family or caregiver. In the Federal Register notice, ACF proposed to collect this information using a combination of existing and new data from states.

Thirty-two states reported in our survey that they already collect data on the incidence of substance-affected and/or substance-exposed infants; 15 of those 32 states also collect data on the incidence of NAS. Further, 18 states reported that they collect data on the number of notifications health care providers make to CPS. Of those states, 8 reported that they collect specific data on notifications related to infants diagnosed with NAS.

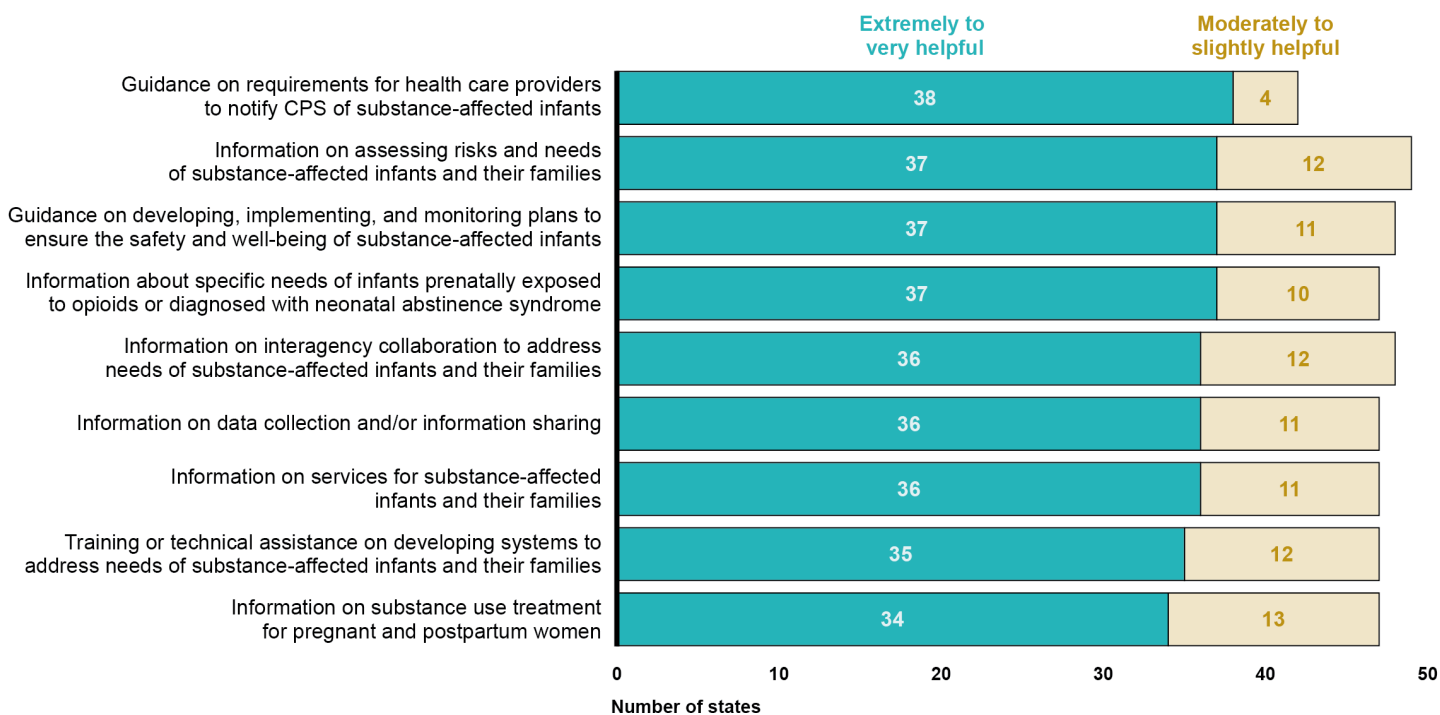
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<sup>41</sup>Proposed Information Collection Activity; Comment Request, 82 Fed. Reg. 22,143 (May 12, 2017).

## States Reported the Need for Additional Guidance and Assistance from HHS to Address Implementation Challenges

Most states reported in our survey that additional guidance and assistance would be extremely or very helpful (see figure 3). For example, 38 states reported that additional guidance on requirements for health care providers to notify CPS of substance-affected infants would be extremely or very helpful. Similarly, 37 states reported that additional guidance on developing, implementing, and monitoring plans to ensure the safety and well-being of substance-affected infants would be extremely or very helpful.

**Figure 3: Number of States That Reported a Need for Additional Guidance and Assistance from HHS in Addressing the Needs of Substance-Affected Infants and Their Families**



Source: GAO analysis of state survey directed toward child protective services (CPS) directors. | GAO-18-196

Note: This figure does not include the number of states that reported that additional guidance and assistance would not be helpful or they did not know if the type of guidance or assistance would be helpful.

In written responses to our survey, states suggested ideas for additional guidance, training, and technical assistance to help them address the needs of substance-affected infants. States' suggestions ranged from assisting in the development of substance abuse training curriculum for staff to video conferences with other states to share information about

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implementing CAPTA. A few states suggested that the guidance ACF has provided to date is not clear and reported grappling with the meaning of terms such as “affected” and “legal vs. illegal” substances, and two states requested “concrete guidance” and “specificity.” A few other states suggested that it would be helpful to obtain additional information about meeting the requirements of plans of safe care within the constraints of state and federal confidentiality laws, technical assistance on what plans of safe care look like, and a format for a plan of safe care.

ACF officials told us that states have flexibility with implementing the law and the agency does not anticipate issuing additional written guidance on the amendments to CAPTA made by CARA. ACF officials explained, in October 2017, that they were finalizing their review of the plans that states were required to submit. These plans are expected to include details on how the states are addressing the CAPTA requirements. While ACF could not provide the number, officials reported that some of the state plans submitted to date did not meet the requirements and those states have been asked to develop program improvement plans. They expect states to work with the ACF regional offices, which will provide or facilitate technical assistance to states on their implementation of the provisions, as needed. In addition to the review of state plans, ACF officials explained that regional officials may learn about states’ needs for technical assistance through meetings or informational exchanges.

Finally, the NCSACW is expected to review and prepare a summary of CAPTA state plans, current state statutes and policies and procedures relating to amended CAPTA requirements. In addition, according to ACF, NCSACW will continue to offer technical assistance on the development and implementation of plans of safe care to states. Technical assistance may include responding to requests for information, disseminating written materials and resources, and conducting webinars/conference calls. Further, ACF reported that some states will receive more in-depth technical assistance, albeit in some instances on a time-limited basis. Undertaking these actions can enhance states’ understanding of CAPTA requirements and better address known challenges such as the ones described in this report. However, more specific guidance from HHS on the issues which states have expressed confusion can assist them in better understanding CAPTA requirements and providing more effective protections and services for the children and families most in need.

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## Conclusions

The opioid epidemic has generated a significant increase in the number of substance-affected infants born and diagnosed with NAS. These vulnerable infants may be at risk for child abuse and neglect if adequate supports and services are not available to ensure their safety. CAPTA requires states to have policies and procedures to address the needs of these infants and their families, including mothers with a substance use disorder. However, states have experienced challenges implementing new CAPTA requirements. Many states reported in our survey that they are not completely adhering to the law. This is reflected in ACF's review of state plans, some of which are resulting in program improvement plans. States cite challenges that stem, in part, from ACF's lack of specificity in providing guidance on implementing CAPTA requirements. Specifically, states report that ACF has not provided clear guidance about which substance-affected infants health care providers are required to notify CPS about, as well what a plan of safe care is and for whom it should be developed. Given the challenges that states reported facing in implementing the provisions, a majority reported wanting more help from ACF, such as trainings and teleconferences with other states, to help overcome their challenges. Additional guidance and assistance from HHS would help states better understand what they need to do to develop policies and procedures that meet the needs of children and families affected by substance use.

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## Recommendation for Executive Action

The Secretary of HHS should direct ACF to provide additional guidance and technical assistance to states to address known challenges and enhance their understanding of CAPTA requirements, including the requirements for health care providers to notify CPS of substance-affected infants and the development of a plan of safe care for these infants.

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## Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. HHS's comments are reproduced in appendix I. HHS also provided technical comments, which we incorporated into our report where appropriate.

HHS did not concur with our recommendation. HHS stated that:

- in January 2017, ACF clarified in guidance several of the issues raised in the report, including the population of infants and families covered by the provision and the state flexibility inherent in

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determining which infants are “affected by” substance abuse, and the terminology used in the federal law of what a “plan of safe care” is;

- ACF believes it is necessary to allow states the flexibility to meet the requirements in the context of their state CPS program;
- several of the challenges that the GAO notes are not specific to CAPTA compliance with the safe care plan and notification requirements; and
- it does see the value in continuing to provide technical assistance to states to address known challenges and to enhance their understanding of CAPTA requirements.

With respect to HHS’ January 2017 guidance, state officials reported in our survey and during site visits that they found some terms unclear and were uncertain about what is required of them. In written responses to our survey, states reported challenges understanding how to define substance-affected under CAPTA. In addition, as we note in our report, the guidance about plans of safe care described the following: “While CAPTA does not specifically define a ‘plan of safe care,’ CARA amended the CAPTA state plan requirement . . . to require that a plan of safe care address the health and substance use disorder treatment needs of the infant and affected family or caregiver.” States reported in our survey and in follow-up discussions that this lack of specificity remained an ongoing challenge for them. For example, as we discuss in our report, one state that we followed up with in August 2017 was still unsure about whether its safety plans would meet CAPTA requirements for plans of safe care. In addition, as of October 2017, HHS confirmed that some state plans did not meet CAPTA requirements and that the states were asked to develop program improvement plans. Accordingly, a key ongoing challenge was not addressed by the January guidance.

Regarding allowing states flexibility to meet CAPTA requirements, we acknowledge in our report that HHS said that states have flexibility. However, in our survey and site visits, states indicated that they would find it helpful for HHS to provide them with greater specificity around terms, including the degree of flexibility they are allowed. States added that this would include parameters within which they can develop policies and procedures that meet CAPTA requirements. We continue to believe that additional guidance addressing these concerns would benefit states and could be provided without imposing additional mandates.

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Concerning HHS' third point that some of the issues raised in the report are not specific to CAPTA, the states we visited interpret CAPTA to require that plans of safe care be developed for all substance-affected infants who are referred to CPS. During our discussions with states and in responses to our survey, state officials did not delineate which federal requirement impacted their approach to serving children and families. As stated in our conclusion, vulnerable infants may be at risk for child abuse and neglect if adequate supports and services are not available to ensure their safety.

Lastly, HHS indicated that it will continue to provide technical assistance to states and fund demonstration sites to establish or enhance collaboration across community agencies and courts. Although continuing to provide technical assistance to states should be beneficial, our findings demonstrate that additional guidance is also needed. For example, 38 states reported that additional guidance on requirements for health care providers to notify CPS of substance-affected infants would be extremely or very helpful. Similarly, 37 states reported that additional guidance on developing, implementing, and monitoring plans to ensure the safety and well-being of substance-affected infants would be extremely or very helpful.

Overall, given the results of our review, we continue to believe our recommendation is warranted. Effective implementation of our recommendation should help states better implement protections for children.

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As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees and the Secretary of Health and Human Services. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

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If you or your staff have any questions about this report, please contact me at (202) 512-7215 or [larink@gao.gov](mailto:larink@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Sincerely yours,

A handwritten signature in black ink that reads "Kathryn Larin". The signature is written in a cursive, flowing style.

Kathryn Larin, Director  
Education, Workforce, and Income Security Issues

# Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

DEC 19 2017

Kathryn A. Larin  
Director, Education, Workforce, and Income Security  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. Larin:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Substance-affected Infants: Additional Guidance Would Help States Better Implement Protections for Children*" (GAO-18-196).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Barbara Pisaro Clark".

Barbara Pisaro Clark  
Acting Assistant Secretary for Legislation

Attachment



**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED-SUBSTANCE-AFFECTED INFANTS: ADDITIONAL GUIDANCE WOULD HELP STATES BETTER IMPLEMENT PROTECTIONS FOR CHILDREN (GAO-18-196)**

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this final report.

**GAO Recommendation**

The Secretary of HHS should direct the Administration for Children and Families (ACF) to provide additional guidance and technical assistance to states to address known challenges and enhance their understanding of the Child Abuse Prevention and Treatment Act (CAPTA) requirements, including the requirements for health care providers to notify Child Protective Services (CPS) of substance-affected infants and the development of plans of safe care for these infants.

**HHS Response**

HHS does not concur with GAO's recommendation.

It has been HHS's ongoing strategy and planned approach to assist states in addressing known challenges and enhancing their understanding of CAPTA requirements, including how states are to address substance-affected infants.

In January 2017, ACF clarified in guidance (see [ACYF-CB 17-02](#)) several of the issues raised in the report including the population of infants and families covered by the provision and explained the state flexibility inherent in determining which infants are "affected by" substance abuse, and the terminology used in the Federal law of what a "plan of safe care" is. Thus, several of the identified "known" challenges have already been addressed through official guidance. Since the conclusion of the GAO survey of states in May 2017, ACF has provided technical assistance and/or guidance to address any remaining concerns and will continue to do so. For example, one ACF regional office recently confirmed that a state may develop a plan of safe care, prior to the child being born, as long as the plan meets all of the requirements in section 106(b)(2)(B)(iii) of CAPTA.

The report states, "ACF officials told us that states have flexibility with implementing the law and the agency does not anticipate issuing additional written guidance on the amendments to CAPTA made by CARA" (p. 29). Rather than issuing federal mandates on safe care plans, including who should do them, or how to determine if an infant is "affected by" a substance, ACF believes it is necessary to allow states the flexibility to meet the requirements in the context of their state CPS program. Issuing federal mandates would be overly prescriptive and not in line with the parameters of the CAPTA Basic State Grant (BSG) program. However, it is important to note that as ACF clarified in the October 24 Exit Conference, while ACF does not anticipate issuing additional written formal policy guidance (such as a program instruction or Child Welfare Policy Manual Questions and Answers), ACF will continue to work directly with states to answer any questions about compliance with the CARA provisions and to provide assistance in implementing these changes.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED-SUBSTANCE-AFFECTED INFANTS: ADDITIONAL GUIDANCE WOULD HELP STATES BETTER IMPLEMENT PROTECTIONS FOR CHILDREN (GAO-18-196)**

Lastly, several of the challenges that the GAO notes are not specific to CAPTA compliance with the safe care plan and notification requirements, but are state specific or practice challenges outside the rubric of CAPTA compliance. For example, states noted uncertainty about the level of intervention for infants at low risk of abuse and neglect, which would be guided by an individual state worker within the structure of their CPS program. Another state queried (p 21-22) what to do when all the services the family needed were already in place, which again is a case level determination and not something on which the federal government would issue guidance. These types of issues are not within the purview of ACF guidance on CAPTA compliance.

HHS does see the value in continuing to provide technical assistance to states to address known challenges and to enhance their understanding of CAPTA requirements. Below is additional information about the CARA-related technical assistance the National Center on Substance Abuse and Child Welfare (NCSACW) is now able to offer in their new contract, awarded in September 2017. Additionally, the National Quality Improvement Center for Collaborative Community Court Teams is a new discretionary grant opportunity funded to address substance exposed infants.

- **Substance-Exposed Infants In-Depth Technical Assistance (SEI IDTA):** In September 2014, the NCSACW began their SEI IDTA initiative. For 18 months, six States: Connecticut, Kentucky, Minnesota (with a focus on tribal communities), New Jersey, Virginia, and West Virginia were selected to participate. Connecticut, Kentucky, Minnesota, New Jersey, and Virginia received additional IDTA to continue their work. Currently, New York, Delaware and Minnesota are receiving SEI IDTA under the current contract. The NCSACW will continue their work with states to help them respond to growing concerns about opioid use during pregnancy, the increasing number of infants with prenatal exposure, particularly those with Neonatal Abstinence Syndrome, and the lack of coordinated and ongoing services needed to support infants, families, and caregivers during the critical postpartum and infancy period. The NCSACW will provide IDTA focused on SEI in their new contract. The initiative is focused on strengthening collaboration and linkages among child welfare, mental health and substance use treatment, public health and medical communities, home visiting and early intervention systems, and other key stakeholders to improve outcomes for infants with prenatal exposure, their mothers and families.
- **Technical Assistance Support to assist in the implementation of CARA:** The NCSACW continues to provide technical assistance on an on-going basis to child welfare, dependency court and substance abuse treatment professionals to improve the safety, permanency, well-being and recovery outcomes for children, parents and families, including programmatic technical assistance related to implementation of Plans of Safe Care. CARA-related technical assistance will be tailored to specific state needs, as well as address the needs of all states when appropriate. Technical assistance may include: responding to requests for information; disseminating written materials and resources,

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED-SUBSTANCE-AFFECTED INFANTS: ADDITIONAL GUIDANCE WOULD HELP STATES BETTER IMPLEMENT PROTECTIONS FOR CHILDREN (GAO-18-196)**

and conducting webinars/conference calls. The second task of CARA technical assistance, to further assist in the successful implementation of CARA is similar to other IDTA provided by the NCSACW, but on a time-limited basis.

- **National Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT):** In addition to the NCSACW, the Children's Bureau funded the QIC-CCCT to support demonstration sites that establish or enhance collaborative community court teams to design, implement, and test approaches to address the rise of substance use disorder nationally and the increase in the number of infants and young children entering foster care and caregivers. In an effort to support data-driven, multi-system collaborative team approaches across the country, the QIC-CCCT will support demonstration sites to improve or develop their capacities to collaboratively serve families; design, implement and test approaches to support the needs of substance exposed infants, including addressing the provisions of CARA; and generate knowledge for the field. Demonstration sites will include intensive collaboration among the child welfare agency, Court Improvement Program, local courts, legal community, substance use treatment providers, preventative service providers, mental health providers, medical providers, and other key stakeholders.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

Kathryn A. Larin, (202) 512-7215 or [larink@gao.gov](mailto:larink@gao.gov).

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## Staff Acknowledgments

In addition to the contact above, Sara Schibanoff Kelly (Assistant Director), Ramona L. Burton (Analyst-in-Charge), Kay E. Brown, Hannah Dodd, Ada Nwadugbo, and Srinidhi Vijaykumar made key contributions to this report. Also contributing to this report were Sandra L. Baxter, James Bennett, Gina Hoover, Jessica Orr, Rhiannon Patterson, Jean McSween, and James Rebbe.

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