Testimony of Melissa Hackett
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LD 1001, An Act to Prohibit Medical Providers and Certain Others from Reporting Prescribed Medication-assisted Treatment of Parents to Child Protective Services
March 27, 2025

Senator Ingwersen, Representative Meyer, and members of the Health and Human Servinces Committee. My name is Melissa Hackett. I am the coordinator for the Maine Child Welfare Action Network. I offer testimony today neither for nor against this bill, to offer thoughts as the committee considers this, and other related policy proposals this session.

As I testified on LD 156 recently, my hope is that this legislation is an opportunity to create better clarity and consistency of practice in notifications of substance-exposed infants to the child protection agency. This process and questions around effectiveness have been raised in other discussions related to child safety. Anecdotally, I have heard from those in the field that there are inconsistencies in practice, as well as challenges with hospitals and uniform capacity to test for substances and make notifications to the Department.

Beyond that, I would encourage the committee to consider how and to what extent any revision of this statute moves our state toward trauma-informed, family-centered best practice in maternal and newborn care in the particular experience of substance exposure.

It is important that policy delineates that a notification of a substance-exposed infant is not the same as a report of suspected child abuse and neglect (though the experience may not feel distinguishable from the patient's perspective). This should be maintained through any statutory changes and emphasized in any subsequent rulemaking and guidance.

Consideration should also be given to key partners to include in any working group to develop rules and guidance, such as providers at birthing hospitals, parents with lived experience (Maine MOM), parent legal representatives, addiction medical specialists, providers of pregnant people (OB-GYNs and primary care) and infants (pediatricians), and integrated clinicians (provider embedded social workers).

In rulemaking and guidance, consideration should be given to what determines "affected," and what substances should be included, prioritized, or alternatively handled. This is particularly important as it relates to prescriptions like methadone and buprenorphine - FDA-approved and commonly prescribed in the treatment of opioid use disorder (OUD). With this in mind, we should consider what it means for healthcare providers to be required to make notification of new mothers who are actively participating in evidence-based,

physician-recommended treatment to the same agency that investigates allegations of abuse and neglect.[1]

The generational and ongoing impact of the opioid crisis continues to impact child safety and fuels the separation of children from their families. Our child protection agency is also stretched thin, often called to respond to circumstances that do not rise to the level of child abuse or neglect, much less an imminent risk of serious harm. This leaves less capacity for the agency to intervene with families where children are truly unsafe. We must be laser-focused on deploying child protection with precision, so it can be most effective at its core task – keeping children safe. Given that, we should consider what the right-sized role of the child protection agency is in instances of substance-exposed infants.

Recognizing there are federal laws guiding states on the notification of substance-exposed infants, to the fullest extent possible, our efforts in Maine should reflect the understanding that Substance Use Disorder is a chronic and treatable health condition, and acknowledge that the stigma associated with substance use and fear of child protection often prevents mothers from seeking treatment during pregnancy. Our efforts in Maine should also reflect a recognition and value that people can and do change, and past behaviors do not dictate current or future behaviors. In short, our policies and practices should consider that even if a parent has a history of substance misuse and child protective involvement, with treatment and recovery, that same parent can safely raise a future child, and should be given the chance to do so.

We appreciate the consideration of this important issue, and hope there is intention in gathering input from a variety of perspectives in the development of statutory language and subsequent rulemaking and guidance. In closing, I hope that the Legislature will support a response to substance-exposed infants with a family-centered, trauma-informed public health and health care approach that supports and promotes parent-child bonding and connection to supports and services that meet the needs of impacted mothers and their babies. That is how we will ensure the health, safety, and well-being of these families.

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[1] https://www.cnn.com/2024/04/11/health/substance-use-pregnancy-policy-change/index.html

ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Children, Youth and Families	
	1. Log No: ACYF-CB-PI-17-02	**2. Issuance Date:** January 17, 2017
	3. Originating Office: Children's Bureau	
	4. Key Words: Child Abuse Prevention and Treatment Act (CAPTA);	

PROGRAM INSTRUCTION

TO: The State Office, Agency or Organization Designated by the Governor to Apply for a Child Abuse and Neglect State Grant

SUBJECT: Guidance on amendments made to the Child Abuse Prevention and Treatment Act (CAPTA) by Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016

LEGAL AND RELATED: Title I of CAPTA; Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016 (CARA).

PURPOSE: To provide guidance to states on implementing provisions in CAPTA, as amended by CARA, relating to infants affected by substance abuse.

BACKGROUND: Since 2003, CAPTA has included a state plan requirement that the Governor of each state provide an assurance that the state has policies and procedures to address the needs of substance-exposed infants, including requirements to make appropriate referrals to child protective services (CPS) and other appropriate services, and a requirement to develop a plan of safe care for the affected infants. As originally incorporated in sections 106(b)(2)(B)(ii) and (iii) of CAPTA[1], the provisions required states to have 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." In 2010, the provision was amended by Congress to also include infants affected by Fetal Alcohol Spectrum Disorder.

Most recently, on July 22, 2016, the President signed into law CARA which, among other provisions, amended sections 106(b)(2)(B)(ii) and (iii) of CAPTA to remove the term "illegal" as applied to substance abuse affecting infants and to specifically require that plans of safe care address the needs of

[1] As originally incorporated into the statute in 2003, these provisions appeared in sections 106(b)(2)(A)(ii) and (iii).

both infants and their families or caretakers. CARA also added requirements relating to data collection and monitoring.

The text of sections 106(b)(2)(B)(ii) and (iii) of CAPTA, as amended by CARA, appears below.
* Deleted text is shown in ~~strike-out~~
Added text is shown in **bold.

> The state must "submit an assurance in the form of a certification by the Governor of the State that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes.....
>
> (ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by *~~illegal~~ substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to –
> (I) establish a definition under Federal law of what constitutes child abuse or neglect; or
> (II) require prosecution for any illegal action;
>
> (iii)the development of a plan of safe care for the infant born and identified as being affected by *~~illegal~~ substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder **to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –
> **(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and**
> **(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.**

CARA also amended the annual data report requirements in section 106(d) of CAPTA. States will now need to report, to the maximum extent practicable:

- the number of infants identified under subsection 106(b)(2)(B)(ii);
- the number of such infants for whom a plan of safe care was developed; and
- the number of such infants for whom a referral was made for appropriate services, including services for the affected family or caregiver.

The Children's Bureau (CB) intends to collect this information through the National Child Abuse and Neglect Data System (NCANDS) beginning with the submission of fiscal year (FY) 2018 data. Information on reporting these data to NCANDS will be provided separately. As states consider any changes that may need to be made to their child welfare information systems to comply with updated data reporting requirements, they should be aware that system enhancements associated with NCANDS reporting may be eligible for Federal Financial Participation under the title IV-E foster care

program. To qualify for reimbursement, agencies must address these changes in their appropriate Advance Planning Document.

More information on the changes made to CAPTA by CARA, as well as information on best practices, can be found in Information Memorandum ACYF-CB-IM-16-05, issued August 26, 2016.

INSTRUCTION:

The changes to CAPTA made by CARA were effective upon enactment (July 22, 2016). Consistent with sections 106(b)(1)(C) and 108(e) of CAPTA, states will be required to submit an updated Governor's assurance (see Attachment A) and information on the actions the state has taken to comply with the CARA amendments as part of the Annual CAPTA Report submitted in conjunction with the FY 2018 Annual Progress and Services Report (APSR) (due June 30, 2017).

Because the changes made by CARA are already in effect, we expect states to be actively working to ensure they comply with these requirements prior to the FY 2018 APSR submission. We note that states provided updated information on the implementation of the CAPTA provisions relating to substance-exposed newborns as part of the Annual CAPTA Report submitted with the FY 2017 APSR. We encourage states to work with their CB regional offices to review that submission and determine the actions the state may need to take and the technical assistance the state may need to fully implement the changes.

To assist states in reviewing and adjusting their policies, as necessary, to comply with the provisions as amended, CB is taking this opportunity to reiterate and provide references to relevant guidance previously issued through the CB Child Welfare Policy Manual (CWPM) and provide information clarifying the scope of these changes.

What population of infants and families is covered by the CAPTA assurance in section 106(b)(2)(ii)?

CAPTA now requires states to have "policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder...." 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. 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.

We encourage states to consult with the State Substance Abuse Treatment Authority, pediatricians and other health care professionals as they review their state policies and update definitions, consistent with the amendments to CAPTA.

Must states have a law, policy and/or procedure requiring Health Care Providers to refer substance-exposed infants to child protective services (CPS)?

Yes. Consistent with the definitions adopted by the state, the state must have statewide laws, policies and/or procedures requiring health care providers involved in the delivery or care of infants born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder to notify CPS of the occurrence of such conditions of infants.

Does a notification to or referral of a case to CPS involving a substance-exposed newborn constitute a report of abuse or neglect?

Not necessarily. The CAPTA provision as originally enacted and amended requires the referral of certain substance-exposed infants to CPS and makes clear that the requirement to refer infants affected by substance abuse does not establish a federal definition of child abuse and neglect. Rather, the focus of the provision is on identifying infants at risk due to prenatal substance exposure and on developing a plan to keep the infant safe and address the needs of the child and caretakers. (See CWPM, Section 2.1F, Questions 1 and 2.) Further, the development of a plan of safe care is required whether or not the circumstances constitute child maltreatment under state law.

What is a plan of safe care?

While CAPTA does not specifically define a "plan of safe care," CARA amended the CAPTA state plan requirement at 106(b)(2)(B)(iii)(1) 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. We want to highlight that this change means that a plan of safe care must now address not only the immediate safety needs of the affected infant, but also the health and substance use disorder treatment needs of the affected family or caregiver. Consistent with good casework practice, the plan should be developed with input from the parents or other caregivers, as well as any collaborating professional partners and agencies involved in caring for the infant and family.

Who is responsible for developing and monitoring plans of safe care?

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 to the requirements for developing plans of safe care, CARA also added a CAPTA state plan requirement for state monitoring of plans of safe care to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver (section 106(b)(2)(B)(iii)(2) of CAPTA). State monitoring may be carried out by the state child welfare agency or by another state-level entity. (See CWPM Question 2.1F.1, Question 1.)

As discussed in ACYF-CB-IM-16-05, development of a multi-agency collaborative to jointly assess, treat and monitor the progress of substance-exposed infants and their families is a best practice we encourage states to consider in implementing these new CAPTA provisions.

How will CB monitor states' compliance with these provisions?

Section 114 of CAPTA, as amended by CARA, requires the Secretary of Health and Human Services to monitor states to ensure compliance with the requirements in section 106(b) and specifically the policies and procedures of sections 106(b)(2)(B)(ii) - (iii). Consistent with this provision, CB will require states to provide an update on the steps the state has taken to implement provisions in 106(b)(2)(B)(ii) - (iii), as amended, as part of their annual CAPTA report submitted with the FY 2018 APSR due June 30, 2017. CB will also require states to submit the Governor's Assurance (Attachment A) at that time. States unable to provide the required assurance and document compliance by June 30, 2017 will be required to develop a Program Improvement Plan to address needed actions to come into full compliance. Additional information on submission requirements will be provided in the annual APSR Program Instruction to be issued in the spring of 2017.

CONCLUSION:

We encourage states to work with CB regional offices now to ensure that the state is meeting these new CAPTA requirements and to discuss any technical assistance needs. We also strongly encourage states to take a multi-disciplinary approach to implementation of these CAPTA requirements by including not only the state child welfare agency, but also partner agencies and professionals, such as the State Substance Abuse Treatment Authority, hospitals, health care professionals, home visiting programs, and Public Health or Maternal and Child Health Programs in the assessment and strengthening of state policies and procedures, as necessary.

INQUIRIES TO: Children's Bureau Regional Program Managers

/s/

Rafael López, Commissioner
Administration on Children, Youth and Families

Attachments:

A – Updated CAPTA Governor's Assurance
B – CB Regional Office Program Managers