**2017 SENATE HUMAN SERVICES**

**SB 2251**

# 2017 SENATE STANDING COMMITTEE MINUTES

**Human Services Committee**
Red River Room, State Capitol

SB 2251
1/25/2017
Job Number 27375

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Johnson

**Explanation or reason for introduction of bill/resolution:**

A bill relating to substance exposed newborns.

**Minutes:** Attachments 1-3

**Chair J. Lee:** Opened the hearing on SB 2251.

**Senator Poolman, District 7:** (0:55-5:15) **See Attachment #1** for testimony in favor of and to introduced the bill.

Chairman J. Lee: I am noticing on the back page of your testimony that it does indicate what their recommendations are and we will pay attention to those. Maybe we can move those on incrementally as time goes by.

Senator Poolman: I do not want you to give you the impression that no one is doing anything about the other recommendations. Certainly, Pam is doing great work trying to get the word out to both mothers and family members about the dangers of substance exposure.

Neutral testimony
**Marlys Baker, Child Protection Services Administrator, Department of Human Services:** (6:45-12:00) **See Attachment #2** for testimony in a neutral capacity on the bill.

**Chair J. Lee:** We are adding the option of the alternative response assessment?

**Marlys Baker:** That is correct.

**Chair J. Lee:** It seems like a good conclusion from that task force.

**(12:50) Chair J. Lee: See Attachment #3** for Rhonda Allery's testimony in support of the bill that was summarized.

**(13:30) Senator Anderson:** Perhaps we could hear from the department about how the current response system works, and how you would anticipate the child protective services workers to act differently once the bill is passed.

**Marlys Baker:** Currently, when a report of suspected child abuse or neglect is received, that comes within the parameters of the definition of abuse or neglect, it's assigned to a social

worker for assessment, and the assessment to determine whether there are services required for a child that is abused or neglected. The difference between the traditional response and an alternative response is that the report would still be received, assigned to a worker, but that worker , instead of assessing for facts to support whether abuse or neglect occurred would be doing an assessment of the needs of family; there would not be a decision whether the child was abused or neglected but there would be a plan of safe care for the infant and service referrals made on behalf of the child and their family to meet their needs. Whether that be evaluation and treatment, or housing, or public assistance of some kind, or infant development of some kind etc. The assistance would range according to the needs of the family.

**Senator Anderson:** In the current assessment, if the eligibility worker makes determination that the child was exposed, and it was a result of abuse, then that would be referred to the law enforcement or the court or how would that work under the current system?

**Marlys Baker:** At conclusion of the current assessment, a decision is made of whether the child has been abused or neglected under the definitions, and under the current statute we are required to provide services for the abused or neglected child and others under the same care. If the decision is that no services are required, often times no service are provided to that family.

**Senator Anderson:** if the mother refuses services, currently or under new law, what is the result and what approach does your eligibility worker take then?

**Marlys Baker:** If a parent refuses services after a decision has been made that a child is abused or neglected then the county office would consult with their State's Attorney regarding the ability to file a petition for deprivation. Then either a request from a juvenile court ordered services or for removal of the child. Under this proposal, the language in the bill indicates that if a parent refuses the alternative response assessment, then the county will conduct a traditional assessment as we do now and would follow much the same procedure.

**Senator Piepkorn:** How do these cases come to your attention?

**Marlys Baker:** Our reports come to county social service offices from the community. There are several people who are mandated under the law because of the work that they do with children, that they must report any reasonable suspicion that a child has been abused or neglected. But, any person can make a report.

**Senator Piepkorn:** And then you investigate it?

**Marlys Baker:** We first analyze the report to whether it actually contains suspicion of abuse or neglect under the definition of abused or neglected child. If there is that possibility, then there an assessment into that report.

**Senator Heckaman:** How is this changed when you get a report directly from the hospital? Does that still have to go back to social services and take that same investigative route? Does it expedite anything?

**Marlys Baker:** Basically, we follow the same process with all reports.

**Senator Heckaman:** How does this process work across tribal lines?

**Marlys Baker:** Each of the Tribes maintains their own child welfare system and they don't intersect often with our system except in making the determination about whether the child of concern is a tribal child.

**Senator Anderson:** lets follow up on that. Let's say a Tribal member has a child in a facility that is not on the reservation, then what happens when your people go to the hospital and check on that child. What happens with your communications back and forth with wherever they are residing?

**Marlys Baker:** We view the jurisdiction for the state to be where the child is physically located. If the child is physically located off the reservation, we respond to that report and then upon determining that the child is a tribal member, the Indian Child Welfare Act applies and the Tribe is notified and we work with the Tribe on how they'd like to proceed.

**Chair J. Lee:** No further testimony was present. **Closed the public hearing on SB 2251.**

**Senator Anderson: Moved a Do Pass.**

**V-Chair Larsen: Seconded.**

**Senator Anderson:** This biennium I've been especially impressed by the work that we have done with our interim committee's and this happened to be one of the studies that we did. Some good work came out of them. Certainly when I look at this I don't see a down side to this alternative response mechanism and if it gives us an opportunity to address concerns with mother and the child in a way that elicits their cooperation, I think we ought to try it. It is a step in the right direction.

**A Roll Call Vote Was Taken:** 7 yeas, 0 nays, 0 absent. (Senator Kreun's vote was recorded later in the recording at 33:05, as he was out of the room initially.)

**Motion carried.**

**Senator Heckaman will carry the bill.**

**Committee Discussion:** The committee discussed how a newborn baby or pregnant mother is determined to possibly have a drug dependency. Marlys Baker explained the process to the committee. The testing basically determined most often by the physician. The committee was concerned if it was a growing problem and it was stated that more of it was being seen. Chair J. Lee gave an observation on adoption and the committee commented on that. Senator Anderson commented that it is a benefit to the baby if we can get the mother to come forward with the substances they may have taken. The goal is healthy babies.

**(31:30) Chair J. Lee:** Reviews the bill to Senator Kreun to receive his recorded vote.

**(33:05) Senator Kreun:** Recorded his yes vote.

# 2017 SENATE STANDING COMMITTEE MINUTES

**Human Services Committee**
Red River Room, State Capitol

SB 2251
1/25/2017
Job Number 27376

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Maree Gluss

**Explanation or reason for introduction of bill/resolution:**

A bill relating to substance exposed newborns.

**Minutes:** 0 Attachments

**Amy Burke**: Clinical pregnancy checkups will test for drugs as well as medical condition. A positive test will require a follow up test, other medications can give a false positive. Once the baby is born, if there is suspicion that the mom abused substances while pregnant, they collect the baby's urine, for tests. Non-invasive.
**V-Chair Larsen:** So it's a prenatal urine test?
**Ms. Burke:** Yes, but not everyone is tested, only if they admit to drug history, or have previous substance exposed child. Then they are put on a regimen to help them stay clean.
**V-Chair Larsen:** The test isn't part of a batch of tests, it is specific.
**Ms. Burke:** Each test is specific to a drug. You have to choose which drug to test for.
**V-Chair Larsen:** would you know the cost for each test?
**Ms. Burke:** I don't know the exact cost, it is fairly expensive if there's not a documented reason for doing the test, the hospital will eat that cost.
**Senator Clemens:** Do you have any knowledge substance exposed newborns. What re some of the disabilities that show up as a result of this?
**Ms. Burke** It varies based on the drugs used, how much, how often. With Fetal Alcohol sometimes nothing may show up until school, you see behavioral problems and learning deficits. Methamphetamines it's a lot of attention deficit, or the ability process consequences. I read an article on neural muscle issues, weak muscles and late motor development, that also happens with tobacco. Impulse control is an issue with recurrent exposure.
**Senator Clemens:** If we could find a way to stop the substance abuse during the pregnancy, pay huge benefits for children as they grow into elementary school
**Ms. Burke:** As of 2 years ago, at that point there was one treatment facility allowed women to take their children in with them. I we had more places like that, where they could be safe would be a step in the right direction. In Teen Challenge, you can be pregnant, but you have to find somewhere for your child. It is key, some places have tried to incarcerate during pregnancy wo they wouldn't use, but that doesn't fix the problem or treat the addiction.
**V-Chair Larsen:** Have you done any research on the male part of the key, what that does with abnormalities with the children being born.

**Ms. Burke:** I haven't, I know there can be birth defects, it can change the constitution of the semen, but as far as mental deficit, I haven't heard anything about that.
**Chair J. Lee:** It's such a terrible waste, preventable and incurable.
**Chair J. Lee:** Closed the hearing.

Date: 1/25 2017

Roll Call Vote #: 1

**2017 SENATE STANDING COMMITTEE**
**ROLL CALL VOTES**
**BILL/RESOLUTION NO.** 2251

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen Anderson Seconded By Sen Larsen

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Senator Judy Lee (Chairman) | X | | Senator Joan Heckaman | X | |
| Senator Oley Larsen (Vice-Chair) | X | | Senator Merrill Piepkorn | X | |
| Senator Howard C. Anderson, Jr. | X | | | | |
| Senator David A. Clemens | X | | | | |
| Senator Curt Kreun | X | | | | |

Total (Yes) 7 No 0

Absent 0

Floor Assignment Sen Heckaman

If the vote is on an amendment, briefly indicate intent:

## REPORT OF STANDING COMMITTEE

**SB 2251: Human Services Committee (Sen. J. Lee, Chairman)** recommends **DO PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2251 was placed on the Eleventh order on the calendar.

**2017 HOUSE HUMAN SERVICES**

**SB 2251**

# 2017 HOUSE STANDING COMMITTEE MINUTES

**Human Services Committee**
Fort Union Room, State Capitol

SB 2251
3/14/2017
29162

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kepple

**Explanation or reason for introduction of bill/resolution:**

Relating to substance exposed newborns; to amend and reenact ND Century Code relating to substance exposed newborns.

**Minutes:** 1, 2

Chairman Weisz: Opened the hearing on SB 2251
Is there testimony in support of SB 2251?

Senator Nicole Poolman
(Attachment 1)
4:00
Chairman Weisz: Are there any questions from the committee?

Vice Chairman Rohr: What kind of discussion did you have on this bill in the senate? Were there any amendments or anything?

N. Poolman: Very positive. There were no amendments. They just feel this is one way for us to take a small bite out of the problem.

Chairman Weisz: Further questions?
Is there further testimony in support of SB 2251?

Marlys Baker, Child Protection Services Administrator
(Attachment 2)

Chairman Weisz: Are there any questions from the committee?

Chairman Weisz: Is there further testimony in support of SB 2251?

Chairman Weisz: Is there any opposition to SB 2251?

Hearing closed on SB 2251

# 2017 HOUSE STANDING COMMITTEE MINUTES

**Human Services Committee**
Fort Union Room, State Capitol

SB 2251
3/14/2017
29191

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kopple

**Explanation or reason for introduction of bill/resolution:**

Relating to substance exposed newborns.

**Minutes:**

Chairman Weisz: Called the committee to order.
Opened the discussion on SB 2251.
Remember this bill is on alternative assessments.
In a way it is similar to the syringe exchange.

Representative P. Anderson: I move a do pass on SB 2251.

Representative Schneider: Second

Representative Skroch: This means that social services will do an alternative assessment, why?

Chairman Weisz: It is help to get the services to the newborn without taking the child away. They have to comply with the plan that is set up for them to follow. If they don't do that for some reason, then they can go back and do a regular assessment. The point is not to pull the child out of the home, it is to give the child a safe environment. I guess I don't really see a down side to it. It is an alternative to a regular assessment.

Chairman Weisz: is there further discussion? Seeing none, the clerk will call the roll for a do pass on SB 2251.

Roll call vote taken Yes 12 No 0 Absent 2
Motion carried.

Chairman Weisz: Do I have a volunteer to carry this one?
Representative P. Anderson, thank you.

Adjourned.

Date: 3-14-17
Roll Call Vote #: 1

**2017 HOUSE STANDING COMMITTEE**
**ROLL CALL VOTES**
**BILL/RESOLUTION NO.** S.B 2251

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☑ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. P. Anderson Seconded By Rep. Schneider

| Representatives | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Chairman Weisz | ✓ | | Rep. P. Anderson | ✓ | |
| Vice Chairman Rohr | ab. | | Rep. Schneider | ✓ | |
| Rep. B. Anderson | ✓ | | | | |
| Rep. D. Anderson | ✓ | | | | |
| Rep. Damschen | ✓ | | | | |
| Rep. Devlin | ✓ | | | | |
| Rep. Kiefert | ✓ | | | | |
| Rep. McWilliams | ✓ | | | | |
| Rep. Porter | ab. | | | | |
| Rep. Seibel | ✓ | | | | |
| Rep. Skroch | ✓ | | | | |
| Rep. Westlind | ✓ | | | | |
| | | | | | |
| | | | | | |

Total (Yes) 12 No 0

Absent 2

Floor Assignment Rep. P. Anderson

If the vote is on an amendment, briefly indicate intent:

## REPORT OF STANDING COMMITTEE

**SB 2251: Human Services Committee (Rep. Weisz, Chairman)** recommends **DO PASS** (12 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). SB 2251 was placed on the Fourteenth order on the calendar.

**2017 TESTIMONY**

**SB 2251**

SB 2251
Attach #1
1/25

SB 2251

Testimony for Senate Human Services - Nicole Poolman

Madam Chair and members of the committee, my name is Nicole Poolman, state senator from District 7 representing Bismarck and Lincoln.

Last session, this committee - and ultimately the legislature - approved a Task Force on Substance Exposed Newborns, so I want to begin by thanking you for that. The task force brought together legislators, doctors, social workers, state's attorneys, law enforcement, DHS staff members, and representatives from the Native American community to assess what is currently happening when babies are born substance-exposed, and offer some solutions going forward. I have included the report in my testimony, and as you read it, you will notice we made many recommendations.

With an understanding of our fiscal situation, the bill before you focuses on one of those recommendations. SB 2251 creates an opportunity for DHS to respond to reports of substance exposed newborns without worrying about the need to "prove" child abuse. Over and over in our discussions with pediatricians and neonatologists, they mentioned that the government response to their reporting call was inconsistent. Social workers and states attorneys asked about the inconsistencies mentioned the difficulty in obtaining evidence and getting a judge to accept that evidence. And of course, the fact that the abuse takes place before the child is born complicates the issue even more. SB 2251 gets services to the family without charging the mother with child abuse. It attempts to take away the inconsistency so doctors know their phone call will produce results.

This bill allows us to simply provide the services mother and child need without worrying about all of the issues that have served as barriers. If a doctor calls to report substance exposure, DHS will be able to come in and develop a safe care plan for mom, baby, and any other children in the household. These plans may include treatment for mom, early intervention services for baby, and ensuring a safe environment exists for other children in the home.

The task force recommended many changes, but this, in my opinion, is the most effective way to make a difference today while continuing to work on this issue in future sessions. Most importantly, this bill sends the message to addicted mothers that we are here to help you, not to punish you.

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**The North Dakota Task Force on Substance Exposed Newborns recommends the following:**

- Addiction and drug abuse during pregnancy should be treated as a health issue rather than criminalized.

- Due to current data gaps, the North Dakota State Epidemiological Outcomes Workgroup (SEOW) should determine the best means and methods for developing short- and long-term data on the incidence and cost of NAS. The North Dakota Department of Health should work with SEOW to explore mechanisms for recording data on the numbers of newborns born exposed to substances, the substances they are exposed to and the number diagnosed with NAS.

- The state should develop education materials and an awareness campaign to educate women of childbearing age, as well as their significant others and families, about the dangers of substance abuse during pregnancy.

- The state should work to ensure health care providers are informed of - and encouraged to refer patients to - addiction treatment resources as necessary. One way to do so is to ensure a list of those resources is made available to health care providers. Another is to bring medical and behavioral health providers together to share information and strategies for coordinating treatment of patients.

- Medical providers of services to pregnant women should be trained about their testing, referring, follow-up and reporting responsibilities.

- Medical providers should develop consistent protocols for universal screening and testing of pregnant women and newborns.

- Medical offices that provide care to pregnant women should develop protocols to identify patients who might be substance abusers and schedule appointments for them early in their pregnancies so they can receive information on the dangers of substance abuse as soon as possible.

- Medical professionals should follow the current laws for testing, referring, follow-up and reporting pregnant women who are abusing alcohol or using controlled substances and for reporting substance exposed newborns.

- State agencies should work with medical professionals to develop standards of care for treating pregnant women who are addicted to various substances and to educate medical providers about these standards of care.

- Hospitals and social service agencies should partner in the development of plans of safe care for each newborn born with prenatal exposure to substances, prior to discharge from the hospital following the birth. The plans should include educational materials on NAS for parents and caregivers.



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- County social workers need training so they can better inform foster parents about care for substance exposed newborns. Social workers also need appropriate education materials and training presentations on NAS that they can offer to foster parents.

- Juvenile Court personnel need education regarding the effects of prenatal exposure to alcohol and controlled substances, the risks to newborns suffering from NAS and the risks associated with returning a substance exposed newborn to a home with a mother who is using substances without appropriate court-ordered safety and intervention services.

- Law enforcement officers need education regarding the reporting of substance abusing pregnant women to county social services.

- State's attorneys and behavioral health professionals should evaluate the pros and cons of having an affirmative defense of periodic drug testing and consent to home visits in cases where criminal child abuse and neglect stems from a parent or caregiver's substance abuse.

- Funding for home visit programs like North Dakota Maternal, Infant and Early Childhood Home Visiting should be expanded and available to more families.

- Residential pediatric care centers that provide wrap-around services for children with NAS and their families should be established and maintained.

- Information on the possible long-term effects of NAS should be available to educators, health care providers, social workers and foster parents so they can identify children who may have been affected by exposure to substances in utero and who need additional educational and medical care during childhood as a result.

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# North Dakota Task Force on Substance Exposed Newborns (2015-2016)

## Report to Legislative Management

**FINAL REPORT**
**June 17, 2016**



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## I. Introduction

Senate Bill 2367 in the sixty-fourth Legislative Assembly created a task force on substance exposed newborns "for the purpose of researching the impact of substance abuse and neonatal withdrawal syndrome, evaluating effective strategies for treatment and prevention and providing policy recommendations." The task force was directed to provide a report on its findings and recommendations to legislative management before July 1, 2016. The members of the task force hereby submit this report in fulfillment of their obligation under the senate bill.

The task force on substance exposed newborns was comprised of representatives of state agencies, the legislature, medical providers, nonprofit entities focused on children's health and wellbeing, Indian tribes, law enforcement, and the foster care community.[1] The membership represented diverse viewpoints and experiences. This diversity was essential to developing a fuller understanding of the myriad of issues involved with substance exposed newborns. The task force noted, however, that one key group of specialists was not represented. Due to the importance of prevention and early intervention, the task force believed it would have benefitted from having a member who is an obstetrician. Nonetheless, the task force brought together many stakeholders to address this important issue.

Senate Bill 2367 required the task force to meet quarterly for one year, beginning in the fall of 2015. It also set forth four goals for the task force to address during that one-year period. They were:

1. Collect and organize data concerning the nature and extent of neonatal withdrawal syndrome from substance abuse in this state;
2. Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal [from] substance abuse;
3. Identify available federal, state and local programs that provide services to mothers who abuse drugs or alcohol and to newborns who have neonatal withdrawal syndrome and evaluate those programs and services to determine if gaps in programs or ineffective policies exist; and
4. Evaluate methods to increase public awareness of the dangers associated with substance abuse, particularly to women, expectant mothers and newborns.

The task force has gathered data and information on these four issues and discussed them at length during its meetings. The task force recognizes the budget limitations state government faces and developed its recommendations based on best practices with the budget reality in mind.

[1] S.B. 2367 dictated how the members of the task force were selected and is attached as Exhibit A. A full list of the members is attached to this report as Exhibit B.

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## II. Data concerning the nature, extent and cost of neonatal withdrawal syndrome in North Dakota

Neonatal withdrawal syndrome (also known as neonatal abstinence syndrome or NAS) is the severe group of symptoms experienced by newborns whose mothers used alcohol or other addictive drugs during pregnancy. When a pregnant mother uses these substances, the substances pass through the placenta to the baby, and the baby becomes addicted to them. When the baby is born, the supply of the alcohol or drugs ends, and the baby suffers withdrawal. The acute symptoms of NAS in a newborn baby include: excessive or high-pitched crying, vomiting, diarrhea, feeding difficulty, low birth weight, fevers, seizures, respiratory distress, sensitivity to light and noise, irritability, sleep difficulty, sweating, tremors and more. The chronic symptoms may include lifelong physical and developmental impairments requiring specialized services from health care providers, social services and educators. The exact symptoms a child experiences depend on multiple factors, including the drug at issue, its dose and frequency, the child's and mother's metabolic and excretory rates and the timing of the last intrauterine exposure to the drug.

The task force identified a lack of data regarding the incidence of NAS in North Dakota. Although several states have examined this issue, it remains difficult to quantify and qualify. Many children who were exposed to alcohol or drugs in utero are simply not identified prenatally or at birth.[2] This stems, in part, from the fact that hospitals generally do not screen all newborns for NAS. Different hospitals in the state have different policies on when and how to screen for NAS. Additionally, medical records and insurance records may not specify that a child has NAS, so reviews of these records are an unreliable method for determining the incidence of NAS. For example, medical records may identify only certain symptoms of the syndrome rather than the syndrome itself.[3] Further complicating the collection of data is the fact that the signs and symptoms of NAS may not manifest until after discharge from the hospital. Some symptoms of NAS resulting from opioids may be delayed until five or more days after birth, for example.[4] For these and other reasons, the incidence data presented in this report is, at best, an estimate that almost certainly errs on the side of underreporting.

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[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Substance-Exposed Infants: State Reponses to the Program, p. 18 (2009).

[3] Hospitals and insurers use codes from the International Statistical Classification of Diseases and Related Health Problems (ICD) to identify patients' diagnoses. The ICD is on its 10th revision, and the codes are now known as ICD-10 codes. The ICD-10 code for "neonatal withdrawal symptoms from maternal use of drugs of addiction" is P96.1. Providers may use a myriad of other codes for a newborn with NAS, however. For example, the records for a child with NAS may include Code P22.8 "other respiratory distress of newborn," Code P92.9 "feeding problem of newborn (unspecified)," or any of the several codes for low birth weight or other symptoms of NAS.

[4] Committee on Drugs and Committee on the Fetus and Newborn, *Neonatal Drug Withdrawal*, Pediatrics (Feb. 2012) http://pediatrics.aappublications.org/content/129/2/e540#T2.



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### *A. National Data on Incidence and Cost of NAS:*

According to the National Institutes of Health (NIH), 21,732 babies were born with neonatal abstinence syndrome (NAS) in the United States in 2012.[5] Not only is this a large number in itself, especially considering it most likely underreports the issue, it also represents a 500 percent increase since 2000.[6] NIH found that babies with NAS are more likely to have respiratory problems and low birth weights, contributing to an average neonatal hospital stay of 16.9 days for them.[7] As a comparison, babies without NAS have an average neonatal stay of only 2.1 days.[8] Similarly, other researchers found the number of neonatal intensive care unit stays due to NAS increased 700 percent between 2004 and 2013 and the average length of those stays increased from 13 days to 19 days during that time period.[9] Researchers and public health agencies agree the incidence of NAS is growing significantly.

Many researchers and commenters have attributed the increase in NAS, at least in part, to the rapid growth in the national opioid abuse epidemic.[10] The epidemic includes abuse of both prescribed and illegal opioids such as heroin. Opioids are not the only drugs that cause NAS, however. Cocaine, barbituates, alcohol and methamphetamines are some of the many other contributors to NAS.

According to the NIH, the lengthy neonatal hospital stays for babies with NAS in 2012 alone cost approximately $1.5 billion, with more than 80 percent of those costs (more than $1.2 billion) borne by Medicaid, which is funded jointly by federal and state governments.[11] Similarly, the National Association of State and Territorial Health Officials estimates that Medicaid covers 78 percent of babies born with NAS.[12] Beyond the neonatal period, Medicaid incurs extra health care costs for each baby born with NAS throughout his or her childhood. Tennessee's Medicaid program, for example, estimates it expends $40,000 just for the first year of life, on average, for each baby born with NAS.[13] This is nine times as much as the

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[5] National Institutes of Health, National Institute on Drug Abuse, *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome*, www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome (Feb. 23, 2016). See also USA Today, *Born into Suffering: More Babies Arrive Dependent on Drugs* (July 8, 2015) (citing an article in the *Journal of Perinatology* by Vanderbilt University researchers).

[6] Id.

[7] Id.

[8] Id.

[9] 18.Anand KJ, Campbell-Yeo M. Consequences of prenatal opioid use for newborns. Acta Paediatr. 2015 Nov. 104 (11):1066-9.

[10] National Association of State and Territorial Health Officials, *Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care*, p. 3 (2014).

[11] National Institutes of Health, National Institute on Drug Abuse, Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome, www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome (Feb. 23, 2016). Also, Testimony of Stephen W. Patrick, MD, MPH, MS, before the United State House of representatives Committee on Energy and Commerce Subcommittee on Health, Hearing on H.R. 1462 (June 25, 2015).

[12] National Association of State and Territorial Health Officials, Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, p. 5 (2014).

[13] National Association of State and Territorial Health Officials, Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, p. 6 (2014).

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state's Medicaid program expends on a child without NAS during its first year of life.[14] This tremendous impact on state Medicaid budgets is one of the reasons NAS is such an urgent issue for states.

In addition to the extremely high costs of caring for a child with NAS during his or her infancy, states incur additional costs related to the child's additional needs for social services, educational interventions and health care. These needs generally stem from the child's in utero exposure to drugs and depend on many factors. Longitudinal studies have shown children exposed to drugs in utero can have lasting physical, neurodevelopmental, speech and behavioral problems including irritability, aggression, depression and others. Medicaid programs, state health and social services agencies and school systems often provide the bulk of services to address these problems.

[14] Id.



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### *B. North Dakota Data on Incidence and Cost of NAS:*

Despite the difficulty of obtaining data on the incidence of substance exposed newborns, the task force was able to find the following state-specific information for North Dakota.

The North Dakota Department of Human Services provided the following data from state Medicaid claims. Approximately 120 babies born in fiscal year 2013 were diagnosed with NAS. The average cost to North Dakota Medicaid for the first year of life for a baby born with NAS is approximately $19,300, compared to $8,200 for a baby born without NAS. Using the difference of the average costs, children diagnosed with NAS incurred medical expenses estimated to cost North Dakota Medicaid at least $1,332,000 in fiscal year 2013. Considering the impacts of underdiagnosing, increasing opioid addiction rates and increasing hospital costs, that figure has likely risen significantly since 2013.

Almost 6 percent of women who are admitted to treatment programs for substance abuse in North Dakota are pregnant.[15]

One insurer in North Dakota reviewed their claims data to help determine the incidence of NAS in North Dakota. They identified ten babies diagnosed with NAS during their neonatal period in 2014 and 2015.[16] Those babies' neonatal hospital charges amounted to more than $1,055,000. Since most babies with NAS are not diagnosed with the syndrome, these data most likely underreport the incidence and cost of NAS to insurers in our state.

At the December 17, 2015, Tribal and State Relations Committee meeting, tribal representatives noted the Three Affiliated Tribes, Spirit Lake Tribe and Turtle Mountain Tribe reported approximately 183 babies were born with NAS last year.

The North Dakota Department of Human Services found at least 67 pregnant substance abusers sought treatment at Human Service Centers in state fiscal year 2014. Pregnant women are prioritized by the centers, and all 67 women were offered services within 48 hours of contacting the centers.

Dr. Larry Burd, a longtime researcher of Fetal Alcohol Syndrome Disorder (FASD) at the University of North Dakota School of Medicine and Health Sciences, has found that approximately 80 children born in this state each year have FASD. He estimates that, "on the day before the child with FASD is born, North Dakota needs to deposit over $540,000 in the bank to cover the lifetime cost of care [for that one child]."

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[15] National Center on Substance Abuse and Child Welfare: Substance Exposed Infants, Presentation at 2011 National Conference.

[16] Specifically, the insurer identified ten babies whose initial newborn inpatient claims included the ICD-9 diagnosis codes 779 and 779.5.

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While these data provide some insight into the incidence and cost of NAS, they are incomplete. To truly understand the incidence and cost of NAS in North Dakota, the state needs short- and long-term trend (year-over-year) data. Such data would also provide important information on whether any implemented interventions are effective. The first step to developing trend data is to establish a baseline. The task force recommends that individuals trained in statistical analysis and public health determine how best to establish the baseline and develop the trend data.

One group with the skills to help fill NAS data gaps is the North Dakota State Epidemiological Outcomes Workgroup (SEOW). That workgroup was initiated in 2006 by the Division of Mental Health and Substance Abuse Services in the North Dakota Department of Human Services to use relevant data to guide substance abuse prevention programming in North Dakota. It is funded with federal funds. The SEOW members also have expertise on using health care data to guide policy and program decisions relating to substance abuse. Such expertise is needed to fully quantify the incidence of neonatal withdrawal syndrome and effectively engage state residents in efforts to prevent it.



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## III. Discussion of Available Services and Programs and Task Force Recommendations

A major theme of the task force's discussions was that substance exposure in utero creates chronic problems for children rather than acute problems that are present only during the neonatal period. As a result, addressing the problem of substance exposed newborns really requires focus on multiple life stages of the mother and child. This report therefore includes analyses and recommendations for the following life stages: (1) pre-pregnancy, (2) prenatal period, (3) birth and neonatal period, and (4) childhood. This framework is used by other states and policymakers as well.[17]

In addition to the life stages, one overarching recommendation is to utilize the North Dakota Indian Affairs Commission office through established government to government committees such as: Tribal-State Court Affairs Committee, The Tribal-State Relations Committee, and the Tribal State Health and Human Services Committee. Currently, these committees all serve on-going Tribal, State, County, and Federal working relations in regards to Memorandums of Agreements/Understanding, Jurisdiction, and Sovereignty in working together towards common goals.

### *A. Pre-pregnancy*

The task force members believe the best way to address newborn withdrawal syndrome is to prevent it. In order to prevent it, it is important to provide targeted education and outreach to women of childbearing age before they become pregnant. Moreover, there should be education efforts aimed at the general population so significant others, family members and friends can help reinforce them. The federal government and several other states have implemented public awareness campaigns on the dangers of substance use - usually alcohol use - during pregnancy, but data on their effectiveness are difficult to find.[18] There are several confounding variables that make it difficult to isolate the impact that these campaigns have. Nonetheless, at least in Minnesota, this type of campaign appears to have at least raised awareness of the harms of substance use during pregnancy.[19] The Department of Human Services' Behavioral Health Division is uniquely positioned in North Dakota to develop and implement an effective educational campaign along these lines, and the task force recommends that it do so.

In addition to education efforts, there also need to be adequate treatment options for women with addictions. The North Dakota Department of Human Services (DHS) licenses more than 50 private addiction treatment programs in the state.[20] These treatment programs provide multiple levels of residential and outpatient treatment. DHS also operates the state

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[17] National Association of State and Territorial Health Officials, Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, p. 3 (2014).

[18] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Substance-Exposed Infants: State Reponses to the Program, pp. 22-25, 60 (2009).

[19] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Substance-Exposed Infants: State Reponses to the Program, p. 60 (2009).

[20] North Dakota Department of Human Services, *Licensed Addiction Treatment Programs in North Dakota* http://www.nd.gov/dhs/info/pubs/docs/mhsa/nd-licensed-addiction-treatment-programs.pdf

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hospital in Jamestown, which provides inpatient addiction treatment and eight Regional Human Services Centers that provide outpatient addiction treatment. The Regional Human Services Centers are located in Williston (Region 1), Minot (Region 2), Devils Lake (Region 3), Grand Forks (Region 4), Fargo (Region 5), Jamestown (Region 6), Bismarck (Region 7) and Dickinson (Region 8). Additionally, Regions 2, 3, 4, 5, 6, and 8 have outreach offices in smaller communities within their geographic areas.

Some patients face financial barriers to treatment, although there are many options available to make treatment more affordable. Medicaid generally covers addiction treatment, so Medicaid patients can obtain treatment if they find a provider who accepts Medicaid payment.[21] For non-Medicaid patients, the Regional Human Services Centers use a sliding scale based on a patient's income to determine charges for addiction treatment. Under the federal Mental Health Parity and Addiction Equity Act, private insurers must provide coverage for mental health care, including addiction treatment, to the same extent they cover physical health care. The specific requirements of the law are very detailed, however, and patients and providers in North Dakota have reported difficulty in obtaining insurance coverage for some types of addiction treatment services. With the passage of Senate Bill 2048 during the 64th Legislative Session, $375,000 will be available to fund a voucher system to pay for substance use disorder treatment services in North Dakota.

While some rural patients may lack access to local addiction treatment and some non-Medicaid patients may lack insurance coverage (e.g., because they opt out of employer plans and the Affordable Care Act health insurance exchange), funding for addiction treatment in North Dakota is generally good. However, the services provided are not necessarily best practice or effective. For example, medication assisted treatment options are limited and only available in limited areas of the state. In addition, funding for and access to recovery support services is limited. Individuals who access acute treatment services are often without adequate aftercare services or supports. In addition, whether patients know where to find treatment is another question. The task force heard lots of anecdotal evidence that patients and providers often lack knowledge about available treatment resources. The task force recommends that health care providers be informed of - and encouraged to refer to - the department's list of addiction treatment resources so they can refer patients as necessary. Additionally, to the extent there is funding available, the task force recommends that the Department of Human Services look for opportunities to bring health care providers and addiction treatment providers together to share information and strategies for integrating and coordinating treatment of patients.

[21] Medicaid coverage includes addiction treatment services; however, Medicaid cannot cover services for individuals age 21-64 in an Institution for Mental Disease, in residential settings except in limited circumstances under Medicaid expansion), and services for individuals who are incarcerated.

### *B. Pregnancy*

During pregnancy, women in North Dakota have largely the same access to education and treatment options as they did before pregnancy. The department's Regional Human Services Centers prioritize pregnant women with a substance use disorder, so they can receive treatment quickly. As noted above, the Department of Human Services reports that pregnant substance abusers receive care within 48 hours of first contact with the service centers. The task force discussed the difficulty in identifying pregnant substance abusers and getting them to seek help, however.

To help identify pregnant substance abusers, the American Congress of Obstetricians and Gynecologists (ACOG) recommends universal substance use screening in early pregnancy.[22] The Association of State and Territorial Health Officials (ASTHO) suggests states can encourage this universal screening by ensuring Medicaid reimburses providers for early pregnancy visits that include screening and by helping establish screening during early pregnancy as the expected standard of care for pregnant women.[23] North Dakota's Medicaid program allows payment for substance abuse screening in conjunction with a diagnosis of pregnancy. Also, the task force recommends that universal substance use screening in early pregnancy be established as the standard of care in our state. Establishing a standard of care will require cooperation among state agencies and medical providers.

Substance abuse screening cannot occur in early pregnancy if the patient does not see an obstetrician until the end of her first trimester (as is typical), however. The task force believes medical office receptionists can play a critical role in identifying which newly-pregnant patients may be using drugs and scheduling early appointments for them. The task force recommends obstetrician offices train receptionists to ask questions designed to solicit information to identify possible substance abusers for this purpose.

If a pregnant women screens positive for substance use, her health care provider will need to know what services are available. Timely referrals to treatment services are critical to prevent and minimize the severity of NAS. Moreover, health care providers may need to provide care coordination to pregnant substance abusers (i.e. reminders and phone calls to ensure they attend medical and addiction treatment appointments). This is yet another reason why cooperation between obstetricians and addiction treatment providers is necessary. The task force recommends providers are educated on the standard of care, including medications or methadone where medically warranted, for pregnant women addicted to drugs or alcohol so appropriate interventions can be taken to minimize the incidence and severity of NAS.

Compelling addiction treatment is very difficult. In order to require a pregnant woman to obtain addiction treatment against her will, she would have to be involuntarily committed to a behavioral health services provider such as the State Hospital in Jamestown. The task force does not believe this approach would be productive as a general rule. Rather, it would likely lead to mistrust of health care providers and avoidance of prenatal care, both of which would have negative impacts on babies.

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[22] Association of State and Territorial Health Officials, *Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care*, p. 2 (2014).
[23] Id.

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A small handful of states have attempted to criminalize substance abuse during pregnancy. Based on data and experience, the task force strongly recommends against this approach. Early identification and intervention are critical elements in the prevention of NAS, and criminalization of drug abuse during pregnancy strongly discourages pregnant women from seeking addiction treatment and prenatal care. Without any prenatal care, a pregnant mother with an addiction is unlikely to abstain from drugs during pregnancy. As a result, criminalization appears to adversely affect babies born to addicted mothers without reducing the incidence of NAS.



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### C. *Birth and Neonatal Period*

The task force recognizes that, as a state, we need to fill data gaps and identify newborns with NAS in a timely manner to ensure they receive the help they need. As a result, the task force recommends that obstetricians, neonatal specialists, pediatricians and family care practitioners implement universal screening of newborns and children for NAS. There are multiple validated screening tools already available. One of the most commonly used is the Finnegan Neonatal Abstinence Scoring System. The task force recommends that the Department of Health work with providers to establish universal screening of neonates using a validated screening tool as a standard of care in North Dakota. Additionally, the task force recommends that payers cover the cost of administering the screening tool to newborns.

Under state law, if a physician believes, based on a medical assessment of a mother of newborn, that the mother used controlled substances for a nonmedical purpose during pregnancy, the physician must perform a toxicology test on the newborn.[24] If the test comes back positive or if other medical evidence of prenatal exposure to a controlled substance exists, the physician must report the results to the Department of Human Services (via the county social service office) as neglect. [25] Similarly, physicians, nurses, dentists, optometrists, dental hygienists, medical examiners, coroners, any other medical and mental health professionals, religious practitioners of healing arts, teachers, administrators, school counselors, addiction counselors, social workers, child care workers, foster parents, law enforcement officers, juvenile court personnel, probation officers, division of juvenile services employees, and members of the clergy who have knowledge of or reasonable cause to suspect child abuse or neglect must report that information to DHS if they obtained that information in their official capacities.[26] Moreover, any person may report child abuse or neglect if he or she has reasonable cause to suspect it exists.

After receiving the report, the social service office will assess the situation and make a decision about which services are necessary for the protection and treatment of the child. If the social service office finds that services are required for a newborn who has been reported as neglected, the office must also refer the child for an Early Intervention Services (EIS) evaluation. EIS are multi-disciplinary services intended to help at-risk children from birth to age five meet development milestones. They are authorized under the federal Individuals with Disabilities Education Act and are free to recipients. They are also voluntary. The state cannot require a parent to utilize EIS currently.

If child abuse[27] or neglect[28] occurs, as defined in state law, criminal charges may be brought against the perpetrator.[29] [30] The task force members discussed - but did not reach consensus on - creating an affirmative defense in law to charges of child abuse or neglect

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[24] N.D.C.C. 50-25.1-17(2). Toxicology testing – Requirements.
[25] N.D.C.C. 50-25.1-17(2). Toxicology testing – Requirements.
[26] N.D.C.C. 50-25.1-03. Persons required and permitted to report – To whom reported. Note that clergy members do not have to report if they obtain the information in their capacity as spiritual advisors.
[27] N.D.C.C. 14-09-22 Abuse of child - Penalty
[28] N.D.C.C. 14-09-22.1 Neglect of child - Penalty
[29] N.D.C.C. 19-03.1-22.2 Endangerment of child or vulnerable adult.
[30] N.D.C.C. 19-03.1-22.3 Ingesting a controlled substance – Venue for violation – Penalty.

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stemming from drug use by a parent. The affirmative defense would be available if the parent agreed to periodic drug testing and home visits. Pros and cons of this approach were addressed, and no data on the advisability and effectiveness of this approach were identified by the task force.

Newborns with NAS often have symptoms, such as feeding difficulty, agitation or fussiness, after they are discharged from the hospital. Parents, foster parents and other caregivers often have little information about NAS or what to expect with these newborns. One member of the task force - a longtime foster parent who has cared for newborns with NAS - reported that he did not receive any information or instructions from social services or hospital personnel about the special needs of the NAS newborns. He also reported that three other foster families who cared for newborns with NAS also received no information on NAS or how to respond to abnormal behaviors. The task force recommends that DHS work with county social services, physicians, addiction professionals, nurses, parent education programs and others to develop informational resources for foster families that open their homes to infants with NAS. The resources should provide education on NAS, its symptoms, how to manage the symptoms, when to seek help and whom to contact for help. Ideally, a state or county agency could offer a voluntary training presentation on NAS for foster parents who would like additional information on the condition.[27]

While foster parents may have the patience and ability to get assistance from social services or health care providers when caring for a newborn with NAS, many addicted mothers may not. One such mother in North Dakota came forward in the media last year to share her experience of accidentally smothering her baby. Caring for a fussy, poorly feeding, sick baby stresses the already-stretched coping mechanisms of addicted mothers. The task force recommends that these mothers receive the same educational resources and voluntary training provided to foster parents before being discharged from the hospital after delivery.

Additionally, the task force recommends that the state provide funding for programs to help ensure the safety of NAS infants after they return home. Prevent Child Abuse North Dakota (PCAND) operates a program called North Dakota Maternal, Infant and Early Childhood Home Visiting (ND MIECHV), funded through a federal grant, which provides parent support and education during home visits. Home visitors spend time with parents, children and family members so they can provide information about child development, help families get connected with medical providers and other services, help reduce stressors for families and generally provide support so children and parents stay safe and healthy. Resources for the program are currently limited, but the program has been effective. One key to its success is the fact that the home visitors have spent significant time in their target communities so they have built trusting relationships and earned reputations for being helpful among families that need their help. This foundation has been critical for ensuring parents and family members engage with the home visitors and accept their advice. In addition to the ND MIECHV program, North Dakota also has additional programs offering some level of

[27] The Tennessee Department of Children's Services created this type of training presentation, *Challenges of Foster Parents who Care for Infants with Neonatal Abstinence Syndrome*, available here: http://www.nationalperinatal.org/Resources/conference%20handouts/FriPlen%20Helton,%20Heather%20-%20Challenges%20of%20Foster%20Parents.pdf.



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home visitation services. Home visiting programs offer a variety of family-focused services to pregnant mothers and families with infants and young children to help build strong children and families. The degree of services varies by agency, including eligibility criteria. A listing of available providers, public and private, can be found here: http://www.ndkids.org/home-visiting-directory.html

The task force recommends North Dakota expand on this type of program to ensure trained workers are able to prevent abuse and neglect of children born to addicted mothers.

Other nonprofits have developed different programs designed to meet the same goals as ND MIECHV. In West Virginia, for example, a nonprofit called Lily's Place offers wrap-around care and support to babies with NAS and their families. When a mother struggling with addiction or having difficulty caring for a baby with NAS feels stressed, she can bring the baby to Lily's Place, where the baby will receive care and the mom can receive counseling and information on childcare. This spring, a bipartisan bill called the Cradle Act inspired by Lily's Place and similar services was introduced in both the House of Representatives and the Senate and was supported by the American Congress of Obstetricians and Gynecologists and the March of Dimes. The Cradle Act would direct the Centers for Medicare and Medicaid Services to establish guidelines for these "residential pediatric care centers" and ensure they are eligible for Medicaid payments. The bill is currently pending in committees. Regardless of whether it is enacted at the federal level, North Dakota can pass legislation at the state level to provide funding for places like Lily's Place.

### *D. Childhood*

The long-term effects of drug exposure in utero vary significantly but may include learning and behavior problems. It is important for health care providers, social workers and educators to be aware of the chronic symptoms of in utero exposure to drugs and be able to identify children who may be exhibiting them. Additionally, they will need to know what resources are available to assist children with those symptoms. The task force recommends that educational materials be developed for this purpose. Additionally, social workers should be able to provide resources and information on these issues to foster parents who care for children who are suffering from the long-term effects of in utero drug exposure, and the task force recommends that education information be developed for and provided to foster parents as well.

## IV. Conclusion

The task force has fulfilled its requirements under Senate Bill 2367. After much research and discussion, the task force identified a considerable lack of data on the incidence of NAS and the effectiveness of measures to prevent and address it. The task force believes it is critical to establish baseline incidence data and to develop trend data to determine whether and to what extent the incidence is increasing or decreasing over time. Moreover, the task force's recommendations include several methods for identifying substance abusers at risk of becoming pregnant, pregnant substance abusers, babies with NAS and children suffering long-term effects of in utero exposure to substances. The recommendations also include several methods for ensuring appropriate services are available and provided to women, babies and children identified as needing them. This will require ongoing

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educational campaigns directed to health care providers, women and the general public, as well as requiring the provision of multiple services for mothers who abuse substances and babies suffering from NAS.



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SB 2251
Attach #2
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**Testimony**
**Senate Bill Number 2251 - Department of Human Services**
**Senate Human Services Committee**
**Senator Judy Lee, Chairman**
**January 25, 2017**

Chairman Lee, and members of the Senate Human Services Committee, I am Marlys Baker, Child Protection Services Administrator with the Department of Human Services (Department). I appear before you to provide information related to Senate Bill 2251.

Section 1 of the Bill adds a definition of Alternative Response Assessment specific to substance exposed newborns in order to allow Child Protection Services workers in the counties to respond to reports of suspected child abuse and neglect involving substance exposed newborns in a manner that does not require a fact finding process (defined as assessment). The added definition requires child protection services workers to provide referrals for support services for the child, the child's caregivers and specifically to develop a Plan of Safe Care for the newborn. Section 1 also includes a definition of Substance Exposed Newborn which correlates with a medical definition of "neonate", translated as a "newborn" in common language.

The proposed changes in Section 2 provide permissive language to allow for an "Alternative Response Assessment" in addition to the current, more "traditional" Child Protection Services assessment and allows the Department to develop guidelines to determine which reports of suspected child abuse or neglect might be most appropriate for an "Alternative Response Assessment".

Section 3 allows for addition of the Alternative Response Assessment to the caseload of the county social services offices as the authorized agent of the

state and allows payment to the counties for these assessments as is provided for the currently paid assessments.

Section 4 provides for the same immunity protections for those assisting in an Alternative Response Assessment as are currently provided for persons assisting in the "traditional" assessment.

Section 5 precludes the Department from making a services required determination for individuals who comply with the Alternative Response Assessment, service referrals, and Plan of Safe Care for the infant. Section 5 also allows the Department to conduct a "traditional" assessment in cases of non-compliance, assuring that the Department will conduct an appropriate assessment of reports of substance exposed newborns.

Subsection 1 of Section 6 (lines 15 through 20) provides that appropriate referrals services are made as a part of the Alternative Response Assessment for the substance exposed newborn, the persons responsible for the welfare of the newborn, and other children under the same care and requires that a Plan of Safe Care be developed on behalf of the newborn. This section also retains the ability of the Department to take action under Chapter 25-03.1 Commitment Procedures. Section 6, Subsection 2 (lines 21 and 22) allows the Department to discharge these duties along with other duties in this chapter through county social service agencies as an authorized agent.

Background

On July 22, 2016, the United States Congress passed Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016 (CARA), which amended the Child Abuse Prevention and Treatment Act of 2010 (CAPTA).

CAPTA previously required the development of a Plan of Safe Care for an infant exposed to illegal substance abuse. CARA removed the reference to "Illegal" substances and provides that states must ensure the well-being of all infants born with and affected by substance abuse or withdrawal symptoms or a Fetal Alcohol Spectrum Disorder following their release from health care providers through addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver. CARA also requires development of a monitoring system for referrals to and delivery of services to the infant and caregivers.

During the interim, The Attorney General's Office convened a Substance Exposed Newborn Task Force, created during the preceding Legislative Session. Through information and discussion in this Task Force, it was recognized through research in other states that criminalization and removing the infant from the home were not successful strategies in resolving the problem and, in fact, often served to deter women from seeking treatment and pre-natal care, putting infants at even higher risk. Given the federal requirement to provide services to all substance exposed infants and their caregivers and the need for treatment and supportive services, the practice of conducting a "traditional" Child Protection Services assessment and then providing services regardless of the outcome of the assessment would not seem to be a good use of child protection resources and may serve as a detriment to substance exposed infants and their caregivers.

I am available to answer your questions. Thank you.

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Attach #3
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**Testimony**
**Senate Human Services Committee**
**Senator Judy Lee, Chairperson**
**Senate Bill 2251-Substance Exposed Newborns**
**January 25, 2017**

Chairperson Lee, members of the Senate Human Services Committee, I am Rhonda Allery, Director of Lakes Social Service District. (Ramsey and Towner Counties), a member of the North Dakota Task Force on Substance Exposed Newborns, and a member of the North Dakota County Social Service Director's Association. Please consider my written testimony in support of Senate Bill 2251.

In 2015, the North Dakota Legislature created The North Dakota Task Force on Substance Exposed Newborns in order to research "the impact of substance abuse and neonatal withdrawal syndrome (NAS), evaluating effective strategies for treatment and prevention, and providing policy recommendations." The committee developed goals. Goal number three includes: 1) Identification of available federal, state, and local programs that provide services to mothers who use/abuse drugs or alcohol and to newborns who have NAS, and 2) Evaluation of programs and services to determine if gaps in programs or ineffective policies exist.

The task force determined that current polices fail to meet the needs of neonatal exposed newborns and their families. Senate Bill 2251 aims to address this

policy gap and better meet the diverse needs of neonatal exposed newborns and their families.

Section 6 of Senate Bill 2251 provides opportunity for innovative and family-friendly approach to providing case management services to exposed newborns and their families. This approach is treatment-focused with court-invention if needed to protect the safety and wellbeing of the infant exposed to drugs and alcohol. The bill also provides opportunity and authority for child welfare workers to provide services to the person responsible for the care of the newborn child and respond quickly if efforts were needed to protect a child.

I respectfully ask you to support Senate Bill 2251 allowing further services and innovation in protecting at-risk infants and their families.

Rhonda Allery, Director of Lakes Social Services

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SB 2251

Testimony for House Human Services - Nicole Poolman

Chairman Weisz and members of the committee, my name is Nicole Poolman, state senator from District 7 representing Bismarck and Lincoln.

Last session, this committee - and ultimately the legislature - approved a Task Force on Substance Exposed Newborns, so I want to begin by thanking you for that. The task force brought together legislators, doctors, social workers, state's attorneys, law enforcement, DHS staff members, and representatives from the Native American community to assess what is currently happening when babies are born substance-exposed, and offer some solutions going forward. I have included the report in my testimony, and as you read it, you will notice we made many recommendations.

With an understanding of our fiscal situation, the bill before you focuses on one of those recommendations. SB 2251 creates an opportunity for DHS to respond to reports of substance exposed newborns without worrying about the need to "prove" child abuse. Over and over in our discussions with pediatricians and neonatologists, they mentioned that the government response to their reporting call was inconsistent. Social workers and states attorneys asked about the inconsistencies mentioned the difficulty in obtaining evidence and getting a judge to accept that evidence. And of course, the fact that the abuse takes place before the child is born complicates the issue even more. SB 2251 gets services to the family without charging the mother with child abuse. It attempts to take away the inconsistency so doctors know their phone call will produce results.

This bill allows us to simply provide the services mother and child need without worrying about all of the issues that have served as barriers. If a doctor calls to report substance exposure, DHS will be able to come in and develop a safe care plan for mom, baby, and any other children in the household. These plans may include treatment for mom, early intervention services for baby, and ensuring a safe environment exists for other children in the home.

The task force recommended many changes, but this, in my opinion, is the most effective way to make a difference today while continuing to work on this issue in future sessions. Most importantly, this bill sends the message to addicted mothers that we are here to help you, not to punish you.

**The North Dakota Task Force on Substance Exposed Newborns recommends the following:**

- Addiction and drug abuse during pregnancy should be treated as a health issue rather than criminalized.

- Due to current data gaps, the North Dakota State Epidemiological Outcomes Workgroup (SEOW) should determine the best means and methods for developing short- and long-term data on the incidence and cost of NAS. The North Dakota Department of Health should work with SEOW to explore mechanisms for recording data on the numbers of newborns born exposed to substances, the substances they are exposed to and the number diagnosed with NAS.

- The state should develop education materials and an awareness campaign to educate women of childbearing age, as well as their significant others and families, about the dangers of substance abuse during pregnancy.

- The state should work to ensure health care providers are informed of - and encouraged to refer patients to - addiction treatment resources as necessary. One way to do so is to ensure a list of those resources is made available to health care providers. Another is to bring medical and behavioral health providers together to share information and strategies for coordinating treatment of patients.

- Medical providers of services to pregnant women should be trained about their testing, referring, follow-up and reporting responsibilities.

- Medical providers should develop consistent protocols for universal screening and testing of pregnant women and newborns.

- Medical offices that provide care to pregnant women should develop protocols to identify patients who might be substance abusers and schedule appointments for them early in their pregnancies so they can receive information on the dangers of substance abuse as soon as possible.

- Medical professionals should follow the current laws for testing, referring, follow-up and reporting pregnant women who are abusing alcohol or using controlled substances and for reporting substance exposed newborns.

- State agencies should work with medical professionals to develop standards of care for treating pregnant women who are addicted to various substances and to educate medical providers about these standards of care.

- Hospitals and social service agencies should partner in the development of plans of safe care for each newborn born with prenatal exposure to substances, prior to discharge from the hospital following the birth. The plans should include educational materials on NAS for parents and caregivers.

- County social workers need training so they can better inform foster parents about care for substance exposed newborns. Social workers also need appropriate education materials and training presentations on NAS that they can offer to foster parents.

- Juvenile Court personnel need education regarding the effects of prenatal exposure to alcohol and controlled substances, the risks to newborns suffering from NAS and the risks associated with returning a substance exposed newborn to a home with a mother who is using substances without appropriate court-ordered safety and intervention services.

- Law enforcement officers need education regarding the reporting of substance abusing pregnant women to county social services.

- State's attorneys and behavioral health professionals should evaluate the pros and cons of having an affirmative defense of periodic drug testing and consent to home visits in cases where criminal child abuse and neglect stems from a parent or caregiver's substance abuse.

- Funding for home visit programs like North Dakota Maternal, Infant and Early Childhood Home Visiting should be expanded and available to more families.

- Residential pediatric care centers that provide wrap-around services for children with NAS and their families should be established and maintained.

- Information on the possible long-term effects of NAS should be available to educators, health care providers, social workers and foster parents so they can identify children who may have been affected by exposure to substances in utero and who need additional educational and medical care during childhood as a result.

# North Dakota Task Force on Substance Exposed Newborns (2015-2016)

## Report to Legislative Management

**FINAL REPORT**
**June 17, 2016**

## I. Introduction

Senate Bill 2367 in the sixty-fourth Legislative Assembly created a task force on substance exposed newborns "for the purpose of researching the impact of substance abuse and neonatal withdrawal syndrome, evaluating effective strategies for treatment and prevention and providing policy recommendations." The task force was directed to provide a report on its findings and recommendations to legislative management before July 1, 2016. The members of the task force hereby submit this report in fulfillment of their obligation under the senate bill.

The task force on substance exposed newborns was comprised of representatives of state agencies, the legislature, medical providers, nonprofit entities focused on children's health and wellbeing, Indian tribes, law enforcement, and the foster care community.[1] The membership represented diverse viewpoints and experiences. This diversity was essential to developing a fuller understanding of the myriad of issues involved with substance exposed newborns. The task force noted, however, that one key group of specialists was not represented. Due to the importance of prevention and early intervention, the task force believed it would have benefitted from having a member who is an obstetrician. Nonetheless, the task force brought together many stakeholders to address this important issue.

Senate Bill 2367 required the task force to meet quarterly for one year, beginning in the fall of 2015. It also set forth four goals for the task force to address during that one-year period. They were:

1. Collect and organize data concerning the nature and extent of neonatal withdrawal syndrome from substance abuse in this state;
2. Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal [from] substance abuse;
3. Identify available federal, state and local programs that provide services to mothers who abuse drugs or alcohol and to newborns who have neonatal withdrawal syndrome and evaluate those programs and services to determine if gaps in programs or ineffective policies exist; and
4. Evaluate methods to increase public awareness of the dangers associated with substance abuse, particularly to women, expectant mothers and newborns.

The task force has gathered data and information on these four issues and discussed them at length during its meetings. The task force recognizes the budget limitations state government faces and developed its recommendations based on best practices with the budget reality in mind.

[1] S.B. 2367 dictated how the members of the task force were selected and is attached as Exhibit A. A full list of the members is attached to this report as Exhibit B.

## II. Data concerning the nature, extent and cost of neonatal withdrawal syndrome in North Dakota

Neonatal withdrawal syndrome (also known as neonatal abstinence syndrome or NAS) is the severe group of symptoms experienced by newborns whose mothers used alcohol or other addictive drugs during pregnancy. When a pregnant mother uses these substances, the substances pass through the placenta to the baby, and the baby becomes addicted to them. When the baby is born, the supply of the alcohol or drugs ends, and the baby suffers withdrawal. The acute symptoms of NAS in a newborn baby include: excessive or high-pitched crying, vomiting, diarrhea, feeding difficulty, low birth weight, fevers, seizures, respiratory distress, sensitivity to light and noise, irritability, sleep difficulty, sweating, tremors and more. The chronic symptoms may include lifelong physical and developmental impairments requiring specialized services from health care providers, social services and educators. The exact symptoms a child experiences depend on multiple factors, including the drug at issue, its dose and frequency, the child's and mother's metabolic and excretory rates and the timing of the last intrauterine exposure to the drug.

The task force identified a lack of data regarding the incidence of NAS in North Dakota. Although several states have examined this issue, it remains difficult to quantify and qualify. Many children who were exposed to alcohol or drugs in utero are simply not identified prenatally or at birth.[2] This stems, in part, from the fact that hospitals generally do not screen all newborns for NAS. Different hospitals in the state have different policies on when and how to screen for NAS. Additionally, medical records and insurance records may not specify that a child has NAS, so reviews of these records are an unreliable method for determining the incidence of NAS. For example, medical records may identify only certain symptoms of the syndrome rather than the syndrome itself.[3] Further complicating the collection of data is the fact that the signs and symptoms of NAS may not manifest until after discharge from the hospital. Some symptoms of NAS resulting from opioids may be delayed until five or more days after birth, for example.[4] For these and other reasons, the incidence data presented in this report is, at best, an estimate that almost certainly errs on the side of underreporting.

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[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Substance-Exposed Infants: State Reponses to the Program, p. 18 (2009).

[3] Hospitals and insurers use codes from the International Statistical Classification of Diseases and Related Health Problems (ICD) to identify patients' diagnoses. The ICD is on its 10th revision, and the codes are now known as ICD-10 codes. The ICD-10 code for "neonatal withdrawal symptoms from maternal use of drugs of addiction" is P96.1. Providers may use a myriad of other codes for a newborn with NAS, however. For example, the records for a child with NAS may include Code P22.8 "other respiratory distress of newborn," Code P92.9 "feeding problem of newborn (unspecified)," or any of the several codes for low birth weight or other symptoms of NAS.

[4] Committee on Drugs and Committee on the Fetus and Newborn, *Neonatal Drug Withdrawal*, Pediatrics (Feb. 2012) http://pediatrics.aappublications.org/content/129/2/e540#T2.

### *A. National Data on Incidence and Cost of NAS:*

According to the National Institutes of Health (NIH), 21,732 babies were born with neonatal abstinence syndrome (NAS) in the United States in 2012.[5] Not only is this a large number in itself, especially considering it most likely underreports the issue, it also represents a 500 percent increase since 2000.[6] NIH found that babies with NAS are more likely to have respiratory problems and low birth weights, contributing to an average neonatal hospital stay of 16.9 days for them.[7] As a comparison, babies without NAS have an average neonatal stay of only 2.1 days.[8] Similarly, other researchers found the number of neonatal intensive care unit stays due to NAS increased 700 percent between 2004 and 2013 and the average length of those stays increased from 13 days to 19 days during that time period.[9] Researchers and public health agencies agree the incidence of NAS is growing significantly.

Many researchers and commenters have attributed the increase in NAS, at least in part, to the rapid growth in the national opioid abuse epidemic.[10] The epidemic includes abuse of both prescribed and illegal opioids such as heroin. Opioids are not the only drugs that cause NAS, however. Cocaine, barbituates, alcohol and methamphetamines are some of the many other contributors to NAS.

According to the NIH, the lengthy neonatal hospital stays for babies with NAS in 2012 alone cost approximately $1.5 billion, with more than 80 percent of those costs (more than $1.2 billion) borne by Medicaid, which is funded jointly by federal and state governments.[11] Similarly, the National Association of State and Territorial Health Officials estimates that Medicaid covers 78 percent of babies born with NAS.[12] Beyond the neonatal period, Medicaid incurs extra health care costs for each baby born with NAS throughout his or her childhood. Tennessee's Medicaid program, for example, estimates it expends $40,000 just for the first year of life, on average, for each baby born with NAS.[13] This is nine times as much as the

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[5] National Institutes of Health, National Institute on Drug Abuse, *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome*, www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome (Feb. 23, 2016). See also USA Today, *Born into Suffering: More Babies Arrive Dependent on Drugs* (July 8, 2015) (citing an article in the *Journal of Perinatology* by Vanderbilt University researchers).

[6] Id.

[7] Id.

[8] Id.

[9] 18.Anand KJ, Campbell-Yeo M. Consequences of prenatal opioid use for newborns. Acta Paediatr. 2015 Nov. 104 (11):1066-9.

[10] National Association of State and Territorial Health Officials, *Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care*, p. 3 (2014).

[11] National Institutes of Health, National Institute on Drug Abuse, Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome, www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome (Feb. 23, 2016). Also, Testimony of Stephen W. Patrick, MD, MPH, MS, before the United State House of representatives Committee on Energy and Commerce Subcommittee on Health, Hearing on H.R. 1462 (June 25, 2015).

[12] National Association of State and Territorial Health Officials, Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, p. 5 (2014).

[13] National Association of State and Territorial Health Officials, Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, p. 6 (2014).

state's Medicaid program expends on a child without NAS during its first year of life.[14] This tremendous impact on state Medicaid budgets is one of the reasons NAS is such an urgent issue for states.

In addition to the extremely high costs of caring for a child with NAS during his or her infancy, states incur additional costs related to the child's additional needs for social services, educational interventions and health care. These needs generally stem from the child's in utero exposure to drugs and depend on many factors. Longitudinal studies have shown children exposed to drugs in utero can have lasting physical, neurodevelopmental, speech and behavioral problems including irritability, aggression, depression and others. Medicaid programs, state health and social services agencies and school systems often provide the bulk of services to address these problems.

[14] Id.

### *B. North Dakota Data on Incidence and Cost of NAS:*

Despite the difficulty of obtaining data on the incidence of substance exposed newborns, the task force was able to find the following state-specific information for North Dakota.

The North Dakota Department of Human Services provided the following data from state Medicaid claims. Approximately 120 babies born in fiscal year 2013 were diagnosed with NAS. The average cost to North Dakota Medicaid for the first year of life for a baby born with NAS is approximately $19,300, compared to $8,200 for a baby born without NAS. Using the difference of the average costs, children diagnosed with NAS incurred medical expenses estimated to cost North Dakota Medicaid at least $1,332,000 in fiscal year 2013. Considering the impacts of underdiagnosing, increasing opioid addiction rates and increasing hospital costs, that figure has likely risen significantly since 2013.

Almost 6 percent of women who are admitted to treatment programs for substance abuse in North Dakota are pregnant.[15]

One insurer in North Dakota reviewed their claims data to help determine the incidence of NAS in North Dakota. They identified ten babies diagnosed with NAS during their neonatal period in 2014 and 2015.[16] Those babies' neonatal hospital charges amounted to more than $1,055,000. Since most babies with NAS are not diagnosed with the syndrome, these data most likely underreport the incidence and cost of NAS to insurers in our state.

At the December 17, 2015, Tribal and State Relations Committee meeting, tribal representatives noted the Three Affiliated Tribes, Spirit Lake Tribe and Turtle Mountain Tribe reported approximately 183 babies were born with NAS last year.

The North Dakota Department of Human Services found at least 67 pregnant substance abusers sought treatment at Human Service Centers in state fiscal year 2014. Pregnant women are prioritized by the centers, and all 67 women were offered services within 48 hours of contacting the centers.

Dr. Larry Burd, a longtime researcher of Fetal Alcohol Syndrome Disorder (FASD) at the University of North Dakota School of Medicine and Health Sciences, has found that approximately 80 children born in this state each year have FASD. He estimates that, "on the day before the child with FASD is born, North Dakota needs to deposit over $540,000 in the bank to cover the lifetime cost of care [for that one child]."

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[15] National Center on Substance Abuse and Child Welfare: Substance Exposed Infants, Presentation at 2011 National Conference.

[16] Specifically, the insurer identified ten babies whose initial newborn inpatient claims included the ICD-9 diagnosis codes 779 and 779.5.

While these data provide some insight into the incidence and cost of NAS, they are incomplete. To truly understand the incidence and cost of NAS in North Dakota, the state needs short- and long-term trend (year-over-year) data. Such data would also provide important information on whether any implemented interventions are effective. The first step to developing trend data is to establish a baseline. The task force recommends that individuals trained in statistical analysis and public health determine how best to establish the baseline and develop the trend data.

One group with the skills to help fill NAS data gaps is the North Dakota State Epidemiological Outcomes Workgroup (SEOW). That workgroup was initiated in 2006 by the Division of Mental Health and Substance Abuse Services in the North Dakota Department of Human Services to use relevant data to guide substance abuse prevention programming in North Dakota. It is funded with federal funds. The SEOW members also have expertise on using health care data to guide policy and program decisions relating to substance abuse. Such expertise is needed to fully quantify the incidence of neonatal withdrawal syndrome and effectively engage state residents in efforts to prevent it.

## III. Discussion of Available Services and Programs and Task Force Recommendations

A major theme of the task force's discussions was that substance exposure in utero creates chronic problems for children rather than acute problems that are present only during the neonatal period. As a result, addressing the problem of substance exposed newborns really requires focus on multiple life stages of the mother and child. This report therefore includes analyses and recommendations for the following life stages: (1) pre-pregnancy, (2) prenatal period, (3) birth and neonatal period, and (4) childhood. This framework is used by other states and policymakers as well.[17]

In addition to the life stages, one overarching recommendation is to utilize the North Dakota Indian Affairs Commission office through established government to government committees such as: Tribal-State Court Affairs Committee, The Tribal-State Relations Committee, and the Tribal State Health and Human Services Committee. Currently, these committees all serve on-going Tribal, State, County, and Federal working relations in regards to Memorandums of Agreements/Understanding, Jurisdiction, and Sovereignty in working together towards common goals.

### *A. Pre-pregnancy*

The task force members believe the best way to address newborn withdrawal syndrome is to prevent it. In order to prevent it, it is important to provide targeted education and outreach to women of childbearing age before they become pregnant. Moreover, there should be education efforts aimed at the general population so significant others, family members and friends can help reinforce them. The federal government and several other states have implemented public awareness campaigns on the dangers of substance use - usually alcohol use - during pregnancy, but data on their effectiveness are difficult to find.[18] There are several confounding variables that make it difficult to isolate the impact that these campaigns have. Nonetheless, at least in Minnesota, this type of campaign appears to have at least raised awareness of the harms of substance use during pregnancy.[19] The Department of Human Services' Behavioral Health Division is uniquely positioned in North Dakota to develop and implement an effective educational campaign along these lines, and the task force recommends that it do so.

In addition to education efforts, there also need to be adequate treatment options for women with addictions. The North Dakota Department of Human Services (DHS) licenses more than 50 private addiction treatment programs in the state.[20] These treatment programs provide multiple levels of residential and outpatient treatment. DHS also operates the state

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[17] National Association of State and Territorial Health Officials, Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, p. 3 (2014).

[18] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Substance-Exposed Infants: State Reponses to the Program, pp. 22-25, 60 (2009).

[19] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Substance-Exposed Infants: State Reponses to the Program, p. 60 (2009).

[20] North Dakota Department of Human Services, *Licensed Addiction Treatment Programs in North Dakota* http://www.nd.gov/dhs/info/pubs/docs/mhsa/nd-licensed-addiction-treatment-programs.pdf

hospital in Jamestown, which provides inpatient addiction treatment and eight Regional Human Services Centers that provide outpatient addiction treatment. The Regional Human Services Centers are located in Williston (Region 1), Minot (Region 2), Devils Lake (Region 3), Grand Forks (Region 4), Fargo (Region 5), Jamestown (Region 6), Bismarck (Region 7) and Dickinson (Region 8). Additionally, Regions 2, 3, 4, 5, 6, and 8 have outreach offices in smaller communities within their geographic areas.

Some patients face financial barriers to treatment, although there are many options available to make treatment more affordable. Medicaid generally covers addiction treatment, so Medicaid patients can obtain treatment if they find a provider who accepts Medicaid payment.[21] For non-Medicaid patients, the Regional Human Services Centers use a sliding scale based on a patient's income to determine charges for addiction treatment. Under the federal Mental Health Parity and Addiction Equity Act, private insurers must provide coverage for mental health care, including addiction treatment, to the same extent they cover physical health care. The specific requirements of the law are very detailed, however, and patients and providers in North Dakota have reported difficulty in obtaining insurance coverage for some types of addiction treatment services. With the passage of Senate Bill 2048 during the 64th Legislative Session, $375,000 will be available to fund a voucher system to pay for substance use disorder treatment services in North Dakota.

While some rural patients may lack access to local addiction treatment and some non-Medicaid patients may lack insurance coverage (e.g., because they opt out of employer plans and the Affordable Care Act health insurance exchange), funding for addiction treatment in North Dakota is generally good. However, the services provided are not necessarily best practice or effective. For example, medication assisted treatment options are limited and only available in limited areas of the state. In addition, funding for and access to recovery support services is limited. Individuals who access acute treatment services are often without adequate aftercare services or supports. In addition, whether patients know where to find treatment is another question. The task force heard lots of anecdotal evidence that patients and providers often lack knowledge about available treatment resources. The task force recommends that health care providers be informed of - and encouraged to refer to - the department's list of addiction treatment resources so they can refer patients as necessary. Additionally, to the extent there is funding available, the task force recommends that the Department of Human Services look for opportunities to bring health care providers and addiction treatment providers together to share information and strategies for integrating and coordinating treatment of patients.

[21] Medicaid coverage includes addiction treatment services; however, Medicaid cannot cover services for individuals age 21-64 in an Institution for Mental Disease, in residential settings except in limited circumstances under Medicaid expansion), and services for individuals who are incarcerated.

### *B. Pregnancy*

During pregnancy, women in North Dakota have largely the same access to education and treatment options as they did before pregnancy. The department's Regional Human Services Centers prioritize pregnant women with a substance use disorder, so they can receive treatment quickly. As noted above, the Department of Human Services reports that pregnant substance abusers receive care within 48 hours of first contact with the service centers. The task force discussed the difficulty in identifying pregnant substance abusers and getting them to seek help, however.

To help identify pregnant substance abusers, the American Congress of Obstetricians and Gynecologists (ACOG) recommends universal substance use screening in early pregnancy.[22] The Association of State and Territorial Health Officials (ASTHO) suggests states can encourage this universal screening by ensuring Medicaid reimburses providers for early pregnancy visits that include screening and by helping establish screening during early pregnancy as the expected standard of care for pregnant women.[23] North Dakota's Medicaid program allows payment for substance abuse screening in conjunction with a diagnosis of pregnancy. Also, the task force recommends that universal substance use screening in early pregnancy be established as the standard of care in our state. Establishing a standard of care will require cooperation among state agencies and medical providers.

Substance abuse screening cannot occur in early pregnancy if the patient does not see an obstetrician until the end of her first trimester (as is typical), however. The task force believes medical office receptionists can play a critical role in identifying which newly-pregnant patients may be using drugs and scheduling early appointments for them. The task force recommends obstetrician offices train receptionists to ask questions designed to solicit information to identify possible substance abusers for this purpose.

If a pregnant women screens positive for substance use, her health care provider will need to know what services are available. Timely referrals to treatment services are critical to prevent and minimize the severity of NAS. Moreover, health care providers may need to provide care coordination to pregnant substance abusers (i.e. reminders and phone calls to ensure they attend medical and addiction treatment appointments). This is yet another reason why cooperation between obstetricians and addiction treatment providers is necessary. The task force recommends providers are educated on the standard of care, including medications or methadone where medically warranted, for pregnant women addicted to drugs or alcohol so appropriate interventions can be taken to minimize the incidence and severity of NAS.

Compelling addiction treatment is very difficult. In order to require a pregnant woman to obtain addiction treatment against her will, she would have to be involuntarily committed to a behavioral health services provider such as the State Hospital in Jamestown. The task force does not believe this approach would be productive as a general rule. Rather, it would likely lead to mistrust of health care providers and avoidance of prenatal care, both of which would have negative impacts on babies.

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[22] Association of State and Territorial Health Officials, *Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care*, p. 2 (2014).
[23] Id.

A small handful of states have attempted to criminalize substance abuse during pregnancy. Based on data and experience, the task force strongly recommends against this approach. Early identification and intervention are critical elements in the prevention of NAS, and criminalization of drug abuse during pregnancy strongly discourages pregnant women from seeking addiction treatment and prenatal care. Without any prenatal care, a pregnant mother with an addiction is unlikely to abstain from drugs during pregnancy. As a result, criminalization appears to adversely affect babies born to addicted mothers without reducing the incidence of NAS.

### *C. Birth and Neonatal Period*

The task force recognizes that, as a state, we need to fill data gaps and identify newborns with NAS in a timely manner to ensure they receive the help they need. As a result, the task force recommends that obstetricians, neonatal specialists, pediatricians and family care practitioners implement universal screening of newborns and children for NAS. There are multiple validated screening tools already available. One of the most commonly used is the Finnegan Neonatal Abstinence Scoring System. The task force recommends that the Department of Health work with providers to establish universal screening of neonates using a validated screening tool as a standard of care in North Dakota. Additionally, the task force recommends that payers cover the cost of administering the screening tool to newborns.

Under state law, if a physician believes, based on a medical assessment of a mother of newborn, that the mother used controlled substances for a nonmedical purpose during pregnancy, the physician must perform a toxicology test on the newborn.[24] If the test comes back positive or if other medical evidence of prenatal exposure to a controlled substance exists, the physician must report the results to the Department of Human Services (via the county social service office) as neglect. [25] Similarly, physicians, nurses, dentists, optometrists, dental hygienists, medical examiners, coroners, any other medical and mental health professionals, religious practitioners of healing arts, teachers, administrators, school counselors, addiction counselors, social workers, child care workers, foster parents, law enforcement officers, juvenile court personnel, probation officers, division of juvenile services employees, and members of the clergy who have knowledge of or reasonable cause to suspect child abuse or neglect must report that information to DHS if they obtained that information in their official capacities.[26] Moreover, any person may report child abuse or neglect if he or she has reasonable cause to suspect it exists.

After receiving the report, the social service office will assess the situation and make a decision about which services are necessary for the protection and treatment of the child. If the social service office finds that services are required for a newborn who has been reported as neglected, the office must also refer the child for an Early Intervention Services (EIS) evaluation. EIS are multi-disciplinary services intended to help at-risk children from birth to age five meet development milestones. They are authorized under the federal Individuals with Disabilities Education Act and are free to recipients. They are also voluntary. The state cannot require a parent to utilize EIS currently.

If child abuse[27] or neglect[28] occurs, as defined in state law, criminal charges may be brought against the perpetrator.[29] [30] The task force members discussed - but did not reach consensus on - creating an affirmative defense in law to charges of child abuse or neglect

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[24] N.D.C.C. 50-25.1-17(2). Toxicology testing – Requirements.

[25] N.D.C.C. 50-25.1-17(2). Toxicology testing – Requirements.

[26] N.D.C.C. 50-25.1-03. Persons required and permitted to report – To whom reported. Note that clergy members do not have to report if they obtain the information in their capacity as spiritual advisors.

[27] N.D.C.C. 14-09-22 Abuse of child - Penalty

[28] N.D.C.C. 14-09-22.1 Neglect of child - Penalty

[29] N.D.C.C. 19-03.1-22.2 Endangerment of child or vulnerable adult.

[30] N.D.C.C. 19-03.1-22.3 Ingesting a controlled substance – Venue for violation – Penalty.

stemming from drug use by a parent. The affirmative defense would be available if the parent agreed to periodic drug testing and home visits. Pros and cons of this approach were addressed, and no data on the advisability and effectiveness of this approach were identified by the task force.

Newborns with NAS often have symptoms, such as feeding difficulty, agitation or fussiness, after they are discharged from the hospital. Parents, foster parents and other caregivers often have little information about NAS or what to expect with these newborns. One member of the task force - a longtime foster parent who has cared for newborns with NAS - reported that he did not receive any information or instructions from social services or hospital personnel about the special needs of the NAS newborns. He also reported that three other foster families who cared for newborns with NAS also received no information on NAS or how to respond to abnormal behaviors. The task force recommends that DHS work with county social services, physicians, addiction professionals, nurses, parent education programs and others to develop informational resources for foster families that open their homes to infants with NAS. The resources should provide education on NAS, its symptoms, how to manage the symptoms, when to seek help and whom to contact for help. Ideally, a state or county agency could offer a voluntary training presentation on NAS for foster parents who would like additional information on the condition.[27]

While foster parents may have the patience and ability to get assistance from social services or health care providers when caring for a newborn with NAS, many addicted mothers may not. One such mother in North Dakota came forward in the media last year to share her experience of accidentally smothering her baby. Caring for a fussy, poorly feeding, sick baby stresses the already-stretched coping mechanisms of addicted mothers. The task force recommends that these mothers receive the same educational resources and voluntary training provided to foster parents before being discharged from the hospital after delivery.

Additionally, the task force recommends that the state provide funding for programs to help ensure the safety of NAS infants after they return home. Prevent Child Abuse North Dakota (PCAND) operates a program called North Dakota Maternal, Infant and Early Childhood Home Visiting (ND MIECHV), funded through a federal grant, which provides parent support and education during home visits. Home visitors spend time with parents, children and family members so they can provide information about child development, help families get connected with medical providers and other services, help reduce stressors for families and generally provide support so children and parents stay safe and healthy. Resources for the program are currently limited, but the program has been effective. One key to its success is the fact that the home visitors have spent significant time in their target communities so they have built trusting relationships and earned reputations for being helpful among families that need their help. This foundation has been critical for ensuring parents and family members engage with the home visitors and accept their advice. In addition to the ND MIECHV program, North Dakota also has additional programs offering some level of

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[27] The Tennessee Department of Children's Services created this type of training presentation, *Challenges of Foster Parents who Care for Infants with Neonatal Abstinence Syndrome*, available here: http://www.nationalperinatal.org/Resources/conference%20handouts/FriPlen%20Helton,%20Heather%20-%20Challenges%20of%20Foster%20Parents.pdf.

home visitation services. Home visiting programs offer a variety of family-focused services to pregnant mothers and families with infants and young children to help build strong children and families. The degree of services varies by agency, including eligibility criteria. A listing of available providers, public and private, can be found here: http://www.ndkids.org/home-visiting-directory.html

The task force recommends North Dakota expand on this type of program to ensure trained workers are able to prevent abuse and neglect of children born to addicted mothers.

Other nonprofits have developed different programs designed to meet the same goals as ND MIECHV. In West Virginia, for example, a nonprofit called Lily's Place offers wrap-around care and support to babies with NAS and their families. When a mother struggling with addiction or having difficulty caring for a baby with NAS feels stressed, she can bring the baby to Lily's Place, where the baby will receive care and the mom can receive counseling and information on childcare. This spring, a bipartisan bill called the Cradle Act inspired by Lily's Place and similar services was introduced in both the House of Representatives and the Senate and was supported by the American Congress of Obstetricians and Gynecologists and the March of Dimes. The Cradle Act would direct the Centers for Medicare and Medicaid Services to establish guidelines for these "residential pediatric care centers" and ensure they are eligible for Medicaid payments. The bill is currently pending in committees. Regardless of whether it is enacted at the federal level, North Dakota can pass legislation at the state level to provide funding for places like Lily's Place.

### *D. Childhood*

The long-term effects of drug exposure in utero vary significantly but may include learning and behavior problems. It is important for health care providers, social workers and educators to be aware of the chronic symptoms of in utero exposure to drugs and be able to identify children who may be exhibiting them. Additionally, they will need to know what resources are available to assist children with those symptoms. The task force recommends that educational materials be developed for this purpose. Additionally, social workers should be able to provide resources and information on these issues to foster parents who care for children who are suffering from the long-term effects of in utero drug exposure, and the task force recommends that education information be developed for and provided to foster parents as well.

## IV. Conclusion

The task force has fulfilled its requirements under Senate Bill 2367. After much research and discussion, the task force identified a considerable lack of data on the incidence of NAS and the effectiveness of measures to prevent and address it. The task force believes it is critical to establish baseline incidence data and to develop trend data to determine whether and to what extent the incidence is increasing or decreasing over time. Moreover, the task force's recommendations include several methods for identifying substance abusers at risk of becoming pregnant, pregnant substance abusers, babies with NAS and children suffering long-term effects of in utero exposure to substances. The recommendations also include several methods for ensuring appropriate services are available and provided to women, babies and children identified as needing them. This will require ongoing

educational campaigns directed to health care providers, women and the general public, as well as requiring the provision of multiple services for mothers who abuse substances and babies suffering from NAS.

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SB 2251
3-14-17

**Testimony**
**Senate Bill Number 2251 - Department of Human Services**
**House Human Services Committee**
**Representative Robin Weisz, Chairman**
**March 14, 2017**

Chairman Weisz, and members of the House Human Services Committee, I am Marlys Baker, Child Protection Services Administrator with the Department of Human Services (Department). I appear before you to provide information related to Senate Bill 2251.

Section 1 of the Bill adds a definition of Alternative Response Assessment specific to substance exposed newborns in order to allow county child protection services workers to respond to reports of suspected child abuse and neglect involving substance exposed newborns in a manner that does not require a "traditional" child protection services assessment. The added definition requires child protection services workers to provide referrals for support services for the child, the child's caregivers and specifically to develop a Plan of Safe Care for the newborn. Section 1 also includes a definition of Substance Exposed Newborn which correlates with a medical definition of "neonate", translated as a "newborn" in common language.

The proposed changes in Section 2 provide permissive language to allow for an "Alternative Response Assessment" in addition to the current, more "traditional" Child Protection Services assessment and allows the Department to develop guidelines to determine which reports of suspected child abuse or neglect might be most appropriate for an "Alternative Response Assessment".

Section 3 allows for addition of the Alternative Response Assessment to the caseload of the county social services offices as the authorized agent of the

state and allows payment to the counties for these assessments as is provided for the currently paid assessments.

Section 4 provides for the same immunity protections for those assisting in an Alternative Response Assessment as are currently provided for persons assisting in the "traditional" assessment.

Section 5 precludes the Department from making a services required determination for individuals who comply with the Alternative Response Assessment, service referrals, and Plan of Safe Care for the infant. Section 5 also allows the Department to conduct a "traditional" assessment in cases of non-compliance, assuring that the Department will conduct an appropriate assessment of reports of substance exposed newborns.

Subsection 1 of Section 6 (lines 15 through 20) provides that appropriate referrals for services are made as a part of the Alternative Response Assessment for the substance exposed newborn, the persons responsible for the welfare of the newborn, and other children under the same care and requires that a Plan of Safe Care be developed on behalf of the newborn. This section also retains the ability of the Department to take action under Chapter 25-03.1 Commitment Procedures. Section 6, Subsection 2 (lines 21 and 22) allows the Department to discharge these duties along with other duties in this chapter through county social service agencies as an authorized agent.

<u>Background</u>

On July 22, 2016, the United States Congress passed Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016 (CARA), which amended the Child Abuse Prevention and Treatment Act of 2010 (CAPTA).

CAPTA previously required the development of a Plan of Safe Care for an infant exposed to illegal substance abuse. CARA removed the reference to "Illegal" substances and provides that states must ensure the well-being of all infants born with and affected by substance abuse or withdrawal symptoms or a Fetal Alcohol Spectrum Disorder following their release from health care providers through addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver. CARA also requires development of a monitoring system for referrals to and delivery of services to the infant and caregivers.

During the interim, The Attorney General's Office convened a Substance Exposed Newborn Task Force, created during the preceding Legislative Session. Through information and discussion in this Task Force, it was recognized through research in other states that criminalization and removing the infant from the home were not successful strategies in resolving the problem and, in fact, often served to deter women from seeking treatment and pre-natal care, putting infants at even higher risk. Given the federal requirement to provide services to all substance exposed infants and their caregivers and the need for treatment and supportive services, the practice of conducting a "traditional" Child Protection Services assessment and then providing services regardless of the outcome of the assessment would not seem to be a good use of child protection resources and may serve as a detriment to substance exposed infants and their caregivers.

I am available to answer your questions. Thank you.

# NORTH DAKOTA TASK FORCE ON SUBSTANCE EXPOSED NEWBORNS

## Summary of Recommendations: Report to Legislative Management

The North Dakota Task Force on Substance Exposed Newborns was comprised of representatives from state agencies, the legislature, medical providers, nonprofit entities focused on children's health and wellbeing, Indian tribes, law enforcement, and the foster care community.

### GOAL ONE

Collect and organize data concerning the nature and extent of Neonatal Withdrawal Syndrome/Neonatal Abstinence Syndrome (NAS) from substance use/abuse in the state.

### GOAL TWO

Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from substance use/abuse.

### GOAL THREE

Identify available federal, state and local programs that provide services to mothers who use/abuse drugs or alcohol and to newborns who have NAS* and evaluate those programs and services to determine if gaps in programs or ineffective policies exist.

### GOAL FOUR

Evaluate methods to increase public awareness of the dangers associated with substance use/abuse, particularly to women, expectant mothers and newborns.

### PRE-PREGNANCY

This timeframe offers the opportunity to promote awareness of the effects of prenatal substance use among women of child-bearing age and their family members.

### PRENATAL

This intervention point encourages health care providers to screen pregnant women for substance use as part of routine prenatal care and make referrals that facilitate access to treatment and related services for women who need those services.

### BIRTH

Interventions during this timeframe incorporate testing newborns for substance exposure at the time of delivery.

### NEONATAL

Developmental assessment and the corresponding provision of services for the newborn as well as the family at this intervention point, immediately after the birth event, are the emphasis.

### CHILDHOOD & ADOLESCENCE

This timeframe calls for ongoing provision of coordinated services for both child and family.

### GENERAL CONSIDERATIONS

Addiction and drug abuse during pregnancy should be treated as a health issue since research shows universal criminalization has been ineffective.

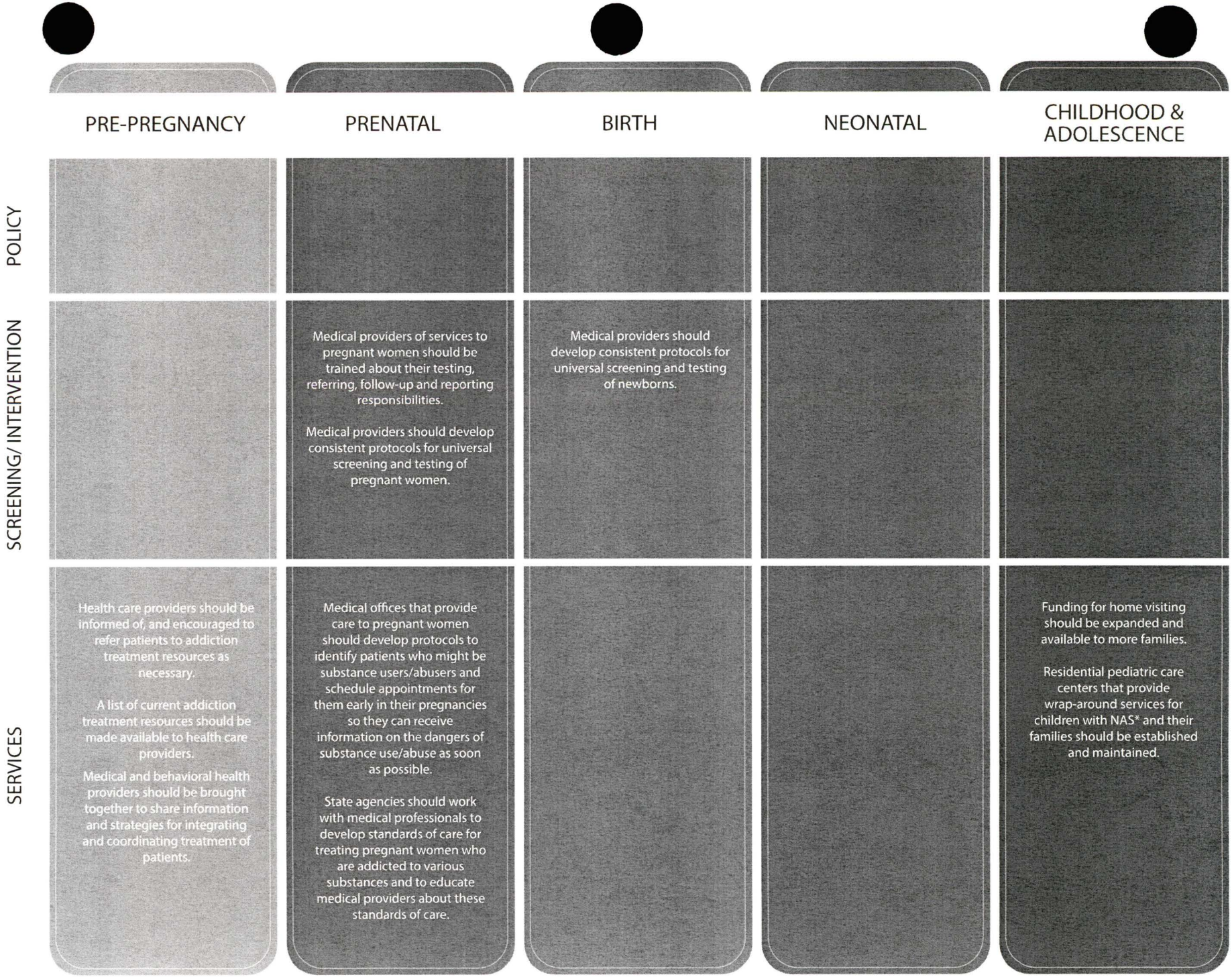
Due to current data gaps, the North Dakota State Epidemiological Outcomes Workgroup (SEOW) should determine the best means and methods for developing short- and long-term data on the incidence and cost of Neonatal Withdrawal Syndrome/Neonatal Abstinence Syndrome (NAS).

The North Dakota Department of Health should explore mechanisms for recording data on the numbers of newborns born exposed to substances, the substances they are exposed to and the number diagnosed with NAS*.

Medical professionals should follow the current laws for testing, referring, follow-up and reporting pregnant women who are abusing alcohol or using controlled substances and for reporting substance exposed newborns.

State's attorneys and behavioral health professionals should evaluate the pros and cons of having an affirmative defense of periodic drug testing and consent to home visits in cases where criminal child abuse and neglect stems from a parent or caregiver's substance abuse.

*NAS: Neonatal Abstinence Syndrome (also known as Neonatal Withdrawal Syndrome)




*NAS: Neonatal Abstinence Syndrome (also known as Neonatal Withdrawal Syndrome)

COMMUNICATION/ EDUCATION

| PRE-PREGNANCY | PRENATAL | BIRTH | NEONATAL | CHILDHOOD & ADOLESCENCE |
|---|---|---|---|---|
| Develop education materials and an awareness campaign to educate women of childbearing age, as well as their significant others and families, about the dangers of substance use/abuse during pregnancy. | Law enforcement officers need education regarding the reporting of substance using/abusing pregnant women to county social services. | | Hospitals and social service agencies should partner in the development of plans of safe care for each newborn born with prenatal exposure to substances, prior to discharge from the hospital following the birth. The plans should include educational materials on NAS* for parents and caregivers. | Information on the possible long-term effects of NAS* should be available to educators, health care providers, social workers and foster parents so they can identify children who may have been affected by exposure to substances in utero and who need additional educational and medical care during childhood as a result.<br><br>County social services and direct service providers need training so they can better inform foster parents about care for substance exposed newborns. Social workers also need appropriate education materials and training presentations on NAS* that they can offer to foster parents.<br><br>Juvenile Court personnel need education regarding the effects of prenatal exposure to alcohol and controlled substances, the risks to newborns suffering from NAS* and the risks associated with returning a substance exposed newborn to a home with a mother who is using substances without appropriate court-ordered safety and intervention services. |

*NAS: Neonatal Abstinence Syndrome (also known as Neonatal Withdrawal Syndrome)